Integrating aged care assessment for older rural people of north-east Victoria

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Introduction

Current assessment processes for older people entering the aged care system are acknowledged as fragmented and complex in the new aged care policy reforms (1). There is need to transform and simplify the entrance into aged care to meet growing demand and ensure consistency and ready access to care for the growing ageing population (1). It is well understood that assessment is the entrance to comprehensive total care, directing treatment and intervention according to individual needs (2). However over the course of care, there is real danger of duplication of assessment process and assessment data in view of the varying levels of need and multiple assessment service involvement. The current policy imperative for assessment integration is driving new and innovative models of governance and improved assessment streams and structures, however, there is limited knowledge of the reality of delivering interagency assessments and the impact to rural areas (3). In a climate of funding rationalisation and prevailing rural health workforce decline, services must consider how to best meet rural needs (4-6). In this way, specialist assessment services are forced to balance increasing system demands and rural consumer disadvantage if they are to deliver quality of person-centred care and the necessary supports for older people to remain living at home (3, 7). To respond to these challenges, it is important to consult the key stakeholders in order to identify the opportunities for integrated assessment in rural and regional areas (8). This is of particular importance in view that there are many complexities in the assessment process of specialist teams that must be married across different communication systems and structures, as well as the diversity of assessment skills, mechanisms and tools.

In this context, this paper reports on a local collaboration brought together in one region of North-East Victoria in order to inform the future development of integrated multi-level assessment model to meet local rural needs. The project was funded by the Central Hume Primary Care Partnership, and involved three local services who undertake aged care assessment (an Aged Care Assessment Service (ACAS-regional); a local HAS (Home and Community Care Assessment Service); and Older Persons Mental Health Service (OPMHS-regional)) with a local University partner (John Richards Initiative, La Trobe University).

This project conceptualises assessment processes as the facilitation, delivery and implementation of the three stages i) intake; ii) comprehensive assessment, iii) referral. The project has identified a range of factors that impact the interagency activities over these three stages, including gaps of wider sector knowledge. As no mechanism currently exists to track the intersection of ACAS, HACC and Mental Health assessment, some of the major outputs of this project have been to identify the potential rate of multiple involvement of these services and isolate the common elements of assessment provision. Finally, and a distinction of this project is the inclusion of Mental Health assessment. The provisions of Mental Health assessment are clearly defined under the Mental Health Act (1986) and must be carefully considered across future development of collaborative processes.

Project design and methodology

The project sought to investigate and identify opportunities for assessment integration across one local region of North East Victoria. Using a mixed methods design, the project explored the strengths and challenges of the different assessment structures and systems. The three principal research questions sought to identify:

- how services can work together to achieve common ends in relations to assessment aged care
• the patterns of commonalities and differences associated with assessment processes across the agencies

• the key challenges and opportunities of current assessment processes as expressed by key stakeholders.

The project was conducted over a 12 month period and comprised three stages:

• Stage 1 Literature review

• Stage 2
  Part A - Mapping of assessment processes across the three services
  Part B - Comparative analysis of assessment tools

• Stage 3 Semi-structured interviews ‘Professional Group’ (n=25) and ‘Consumer/carer Group’ (n=16).

The project addressed four key priorities of the Primary Care Partnership: (1) to build the evidence base; (2) to strengthen partnerships, (3) progress interagency work; and (4) to provide a more coordinated service for consumers. Members from all agencies plus departmental representatives formed the project reference group.

Stage 1: A literature review was conducted to contextualise the project within the contemporary period of aged care reform.

Stage 2: The current patterns and characteristics of assessment activities of the LGA and region were extracted from existing datasets (2010-2011). (A) A Service Profile was developed to explore consumer characteristics and demand for services; (B) An Assessment Tools Analysis’ was conducted to explore commonalities and differences across aspects such as data collection mechanisms, areas of specialty, and questioning styles and approach.

Stage 3: Semi-structured interviews were conducted to provide a rich insight of the challenges and barriers to assessment. To ensure different perspectives, interviews were conducted with two primary groups, (1) consumers / carers (n=16; and (2) professionals (n=25), which included CEOs (n=2), Managers (n=6) and practitioners (n=17). Interviews were audio recorded and transcribed, and then subject to thematic analysis utilising the software program NVivo 8.,

• Professional participants were recruited from the three services to consider (i) provision of quality assessment service across the stages of assessment initiation, implementation and coordination; (ii) innovative practice required (current and proposed) to build collaborative opportunities; (iii) working relations and maintaining knowledge of the services; (iv) issues and gaps that prevent stakeholders (services and consumers) from readily accessing and engaging in services.

• Consumers/ Carer participants were recruited randomly from agency lists, and comprised either current recipients of HACC services or past ACAS and OPMHS consumers who had been discharged at least 12 months ago. These participants were asked to consider (i) the key supports to their experience of assessment ; (ii) issues that enabled or impeded their engagement in the assessment process(iii) key factors contributing to the outcome; and (iv) their perception of what is required to assist others entering the aged care system. The latter group were also asked to complete a brief service history survey.

Ethical approval was obtained from La Trobe University Faculty of Health Sciences Human Ethics committee. All participants provided informed consent, and all data were de-identified. Data collected across these three stages were considered at a workshop with the project reference group, and recommendations developed.
Results

Stage 1

The Policy context
In accordance with ABS projections (2008), it is expected that adults over 65 will represent 25% of the total Australian population by 2056 (9, 10). Currently one third of older people now reside in rural and remote areas, and this is expected to increase over coming decades (11). There are prevailing trends of rural disadvantage including poorer health of older rural people, coupled with inequity of access to service supports (12). The Aged Care Reforms Package (2012) highlights the need to build a more seamless entrance into the aged care system, and a more integrated assessment process. What is far less clear in the literature is the degree of fragmentation and duplication across specialist assessment services and the impact upon rural communities.

Stage 2

Part A. The Assessment Service profile
A profile was developed which included: consumer demographics, target and performance structures, level and rate of demand and response, variances across structures and systems of both intake and comprehensive assessments (including staffing structures), and the inherent provisions of assessment. The service profile was privileged two levels of statistical results, (1) the targeted LGA service area and (2) sub region.

Some of the major findings suggest that:

- The three services are commonly servicing the “older old”, cohort (80 +), a cohort with more complex health needs and co-morbidities.
- Of the full 11 LGAs serviced across the sub region, the LGA service area targeted by the study amounted to approximately 30% of the total combined assessments and denotes the disproportionate spread of demand across a large geographical area.
- Each team is limited to only x3 practitioners who can be assigned to the targeted LGA
- Up to third of all participants (survey sample n=16) have been seen by all three services over at least the last 12 months
- There are different eligibility criterion for each service; as well as different response structures, and priority frameworks. In relation to the latter, for example, response can vary from immediate response to 14 days.
- Each of the services collects a common set of baseline data at point of entry (intake/ triage) in conjunction with service specific data.
- Both structures and systems of assessment vary. This includes: 1) the depth and breadth of data taken at different phases of collection; 2) structure of the intake team; 3) location and mode of comprehensive assessment although most commonly conducted in the home and face-to-face; 4) preferred referral format.
- The major referral source differs between the three services. The common referrers were GPs, hospital, and sub-acute services. Referral activities between the three assessment services were negligible
• Measurable input/outputs that inform service performance differ between the services. These included: i) number of assessments per day; ii) number of hours of direct contact over the week; and iii) level of budgetary expenditure (package allocations).

Part B: The Assessment Tool Comparative Analysis
This phase investigated the 1) the commonality of data collection mechanisms and tools, 2) the commonality and differences of assessment data collected, 3) the areas (domains) of specialty and 4) the variances in questioning style and approach. All provided tools were coded into a biopsychosocial analysis framework. From this analysis all three services attend to a broad spectrum of needs, as well as discrete areas of specialty based on the focus of care. At the same time, there was also evidence of duplication. The overall findings suggest:

• There is 45% commonality across the Full Assessment Suites of the three organisations (aggregate data)

• The select Comprehensive Assessment Tool provided discrete areas of specialty.
  – 21% of the data values were specific to only ACAS
  – 25% of the data values were specific to only OPMHS
  – 9% of the data values were specific only to HAS.

• Assessment tool questioning styles differed across the three services. Some examples include narrative (conversational), Likeart scaling and Boolean

• Data collected is purposed to fulfil the service parameters of the assessment service

• There are four main elements of the assessment tool structure that assist the skilled assessor. These are the range of data, targeted domains of data, rating of data, and questioning style.

Stage 3
The stakeholder perspective of the principal challenges to assessment

The Professional Group
The data of professional group (n=25) were analysed for recurrent themes to isolate the principal challenges of assessment process and practice. These insights were distilled into four main classifications, with some of the main findings below:

Assessment performance:

• Funding Allocations to rural areas: a key challenge to the management of limited fiscal resources is the added costs of geographical distance and rural disadvantage.

• Workforce capacity – All services reported increasing rural consumer demand and complexity of needs that extend assessment activities yet within a context of limited resources, there were serious challenges to workforce sustainability.

• Targets - Practitioners are experiencing the ongoing tension to fulfil performance and/or target markers and ensure quality outcomes for consumers/carers of their allocated areas. Whilst practitioners highlighted they are currently balancing waitlists (min to nil) they are also frequently offsetting competing tasks.

• Time – building capacity: Participants noted that time constraints limited their capacity to (1) access professional development and (2) participate in interagency assessment activities, despite the fact
that most participants agreed that there is need to broaden case collaboration and contribute to wider service knowledge.

Assessment communication:

- **Assessment sites**: all three assessment teams are increasingly advocating against the conflicting agenda of referrers, the most common examples included the urgency of hospital discharge, and misinformed referral.

- **Increasing intake demand**: all three services report increasing demand for services, other key patterns include emerging trends of an ‘older old’ consumer group, who equally have minimal service involvement at entrance despite high complexity and need. A future query would be then to investigate this late entrance into aged care.

- **Assessment activities**: increasing complexity has added to the level and degree of data collection (intake and comprehensive data); and rates of data entry, write-up and post assessment follow-up and liaison.

- **Interagency Assessment Implementation**: key challenges to interagency operations include a) inoperable assessment ICT structures; b) differing mechanisms and approach to assessment facilitation (interview style, skill-sets, tools and use of tools), c) service specific assessment outcomes, and d) lack of coordinated involvement. This will be discussed in the next section

Interagency collaboration:

- **Communication and Data transference** – a lack of clear communication pathways emerged across three key areas i) the absence of common or operable interagency ICT data systems; ii) unclear agreement for cross service report provisions; and iii) lack of indicators to signal multiple service involvement.

- **Wider collaborative systems**: lack of wider service knowledge affected the timeliness of response and enactment of assessment. Participants highlighted the receipt of inappropriate or indiscriminate referrals or communications demonstrating a lack of knowledge of eligibility criterion, scope and role. A further challenge to assessment service operations is the frequent omission of GPs from feedback pathways by wider services as assessment recommendations are referenced to the GP and must be aligned to ensure continuity of care.

- **Lack of cross-service opportunities**- opportunities for interagency collaboration are currently lacking given the absence of organised, formal care forums and interagency meetings. The main challenges to participation as identified by practitioners were: time available, lack of coordination, uncertainty of confidentiality, and lack of cross-service cohesion.

Consumer/carer engagement:

- **Consumer Complexity**: the increasing occurrence of complex needs was also associated to increased rates of advocacy by the assessment practitioners. Practitioners are commonly pursuing wider service involvement/ supports given the i) absence of service involvement at first entrance; or ii) lack of recognition by the involved service/s of the complex needs or symptom identification; the iii) heightened consumer vulnerability (stress of health status); iv) challenged rights imposed by wider services (impacting the dignity of choice); and iii) poor consumer understanding and knowledge of available services. Practitioners further reported of the need to reiterate and explain the purposes of the referral given to their service, alongside explaining assessor role, future involvement and process of outcomes.
Carer Complexity: Participants highlighted the challenge associated with a high carer burden. In this regard both consumer and carer are negotiating difficulties of complex needs, with carers themselves requiring support through the practicalities of care and system demands.

The Consumer and Carer group

Findings from the consumer and carer interviews (n=16) can be summarised as follows:

Engagement:

- **Assessment exchange**: key factors associated to reluctance to seek assistance included:
  - lack of knowledge of the services and role
  - passive help seeking behaviours
  - negative beliefs of the loss of the locus of control (independence)
  - loss of role/s and identity
  - under-evaluation of the need for care (of self) and over-evaluation of the carer capacity
  - lack of involvement of General Practitioner to endorse assessment process and recommendations.

- **Perception of Care**: factors associated with the reluctance to interact in assessment processes included:
  - lack of established rapport (relationship) with practitioner/service
  - lack of knowledge of referral source and purpose
  - lack of supportive networks (informal and formal supports);

- **Relationship /Consumer capacity**: The majority of participants nominated the importance of trust in the service and/or practitioner/s. The active building of trust couched in “relationship”, was described to assist readiness to engage in assessment involvement and ensuing recommendations. Participants noted the importance of direct contact and positive interaction. Majority of participants related their assessment experience to restorative outcomes.

Collaborative assessment:

- **Assessment initiation and coordination** some participants stated the poor level of understanding of complex needs by other services was the direct cause of the delay to positive outcomes. The delay to enact referral and/or the lack of access to essential service was further described to heighten the level of stress of the consumer (and carer) and add to carer burden.

- **Absence of key player (GP)**: All participants nominated the importance of GP involvement who they perceived to actively endorse and be part to the coordination of aged care service. For the small number of participants without GP involvement, the influence of GP absence to outcomes was highlighted.

- **Shift to consumer capacity** – assessment and/or service involvement assisted the level of consumer knowledge of the aged care systems and moreover improved confidence to seek out assistance in the future.
The way forward: a series of collaborative measures

The National Aged Care Reforms policy agenda ‘Living longer, Living Better’ (2012) has proposed a seamless aged care system with the view to maximise the structures and systems surrounding assessment. Aged care assessment informs the range and degree of intervention at the gateway to care. In the light of an increasing level of demand due to the ageing population, the system pathways must be effective to signal and generate ready access to assessment services and activate efficient and comprehensive assessment outcomes. Findings from this project highlight the importance of this broad message, as the three assessment services are being challenged by a range of issues emerging from fragmented pathways across all three stages of assessment i) intake, ii) comprehensive assessment, and iii) referral. The results demonstrate that all three agencies must operate in the context of disproportionate funding of rural service provision; inoperable cross-service communication systems; the compounding issues of referral and access; limited rural workforce capacity; and rural consumer disadvantage. Whilst the analysis suggests that the rural assessment services are currently meeting targets, the shared perspective highlights the reality of growing consumer complexity and demand. The inherent strain therefore will continue upon systems and is closely related to the capacity of practitioners to ensure assessment quality and heightened output. This proposes serious concerns for future sustainability.

Specifically, evidence from this project shows data duplication (45% duplication across full assessment suites of ACAS, HACC and Mental Health) suggesting scope for enhanced linkage across common assessment data, as well as an opportunity for a planned, stepped response to address biopsychosocial needs. There is a clear need to promote and align assessment processes to enhance collaborative assessment activities and to support best practice outcomes. Moves towards process alignment must take into account differences in approach and facilitation styles alongside structural requirements. In short, the series of recommendations that emerged from this project put forward ways to build more collaborative measures. These can be summarised as 1) to develop cross-service arrangements and agreements for collaborative assessment systems; 2) improve assessment communication mechanisms and pathways; 3) reduce duplication of data and process across collection points; 4) develop the knowledge and capacity of the wider service sector to initiate appropriate referrals; and 5) to optimise engagement of the older rural consumer and carer. These five areas of the recommendations are now briefly considered.

The findings show significant gaps in shared understanding of service processes and role, and a high rate of concurrent assessment, both indicating development of clear guidelines and the formalisation of inter-service agreements to assist clarity of inter-service pathways. Second, there are evident challenges to existing information and technology pathways with a need for further steps to refine the collection and direction of assessment data, and the provision of funding and/or resources to improve existing structures and mechanisms of communication. Mental Health and HAS participants highlighted ICT systems are inoperable or cumbersome (outdated) impacting both data collection and the transference of data across service systems. The third area encompasses the principal recommendation with need to address both data and process duplication, as evidenced by challenges identified across the project. Without structured arrangements assessment services continue to invariably replicate processes that subject consumers/carers to multiple system demands. Fourthly, difficulties emerged for all three services due to problems associated with referrals leading to fragmented pathways. Practitioners reported of the mismatch of referrer purpose, referral format and poor level of referral content impacting collaborative outcomes. This together with evident gaps in wider knowledge of service role, specialty, priorities and eligibility challenged both team efficiency and service equity. Development of wider service capacity will be essential for health and community services to appropriately assist consumers into aged service at any point of entry. Finally, consumers/carers highlight the central need for supportive engagement across the assessment experience, and the importance of trusted relationships across assessment and care. This is an important consideration for all those involved in the assessment journey, including assessment practitioners, GPs and wider referrers.
Conclusion and key recommendation

This community based aged care assessment project was initiated in response to shared concerns of assessment duplication and apparent difficulties of many consumers/carers to navigate the entrance into aged care. All three organisations regarded the importance of investing in the development of integrated processes to optimise best outcomes for the consumer and carer underpinned by the paradigm of person-centred care. Achievable change considers operational procedures and cross-agency arrangements that supports targeted assessment practice. This project has produced a series of recommendations developed to consider i) local cross-agency solutions for the improvement of assessment experience, and ii) mechanisms for a wider integrated approach to build assessment efficiency and equity in an environment of increasing demand and complexity. As findings from this study show, there is an urgent need for cross-service innovations to stay ahead of the growing demand by rethinking current rural resources. The use of increased collaborative processes and assessment proficiency are a means to ease the assessment journey for older rural people.

The principal recommendation is to develop a multi-level assessment process to assist simplicity and improve access of consumers to necessary service.

References