

Aged Care Assessment Program

Minimum Data Set

Annual Report

**Victoria
2003–2004**

**Victorian ACAP Evaluation Unit
Lincoln Centre for Ageing and Community Care Research**

Aged Care Assessment Program

Minimum Data Set Annual Report Victoria 2003–2004

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Aged Care Assessment Program

Victoria

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Report structure

The ACAP Evaluation Report comprises three parts:

Executive summary

Part One: The ACAP Minimum Data Set and Program evaluation

Chapter 1: Introduction

Chapter 2: Program throughput and characteristics of the assessment process

Chapter 3: Client characteristics and access to ACAP

Chapter 4: ACAP Recommendations

Part Two: Appendices

Appendix A: Minimum Data Set Tables

Appendix B: Additional Tables

CONTENTS

List of Tables	iv
list of Figures.....	vi
Abbreviations	vii
Terms used in this report	vii
Glossary of statistical terms	viii
Executive Summary	1
Introduction	1
Program throughput and characteristics of the assessment process ..	2
Client characteristics and access to ACAP	4
Recommendations	8
Conclusion.....	11
Part One: The ACAP Minimum Data Set and Program evaluation.....	13
Introduction	13
The Aged Care Assessment Program	13
Introduction of the ACAP Minimum Data Set Version 2.0.....	14
Differences between MDS v1 and MDS v2	15
Content of this report.....	17
Caveats on reliability and completeness	17
Program throughput and characteristics of the assessment process	18
Section 1: Assessment numbers and rates	18
Section 2: Timeliness.....	22
Section 3: Location of assessment	29
Section 4: Assessor profession.....	31
Client characteristics and access to ACAP	32
Section 5: Age	32

Section 6: Usual accommodation setting	35
Section 7: Functional profile and health conditions	37
Section 8: Access for special needs groups	43
Recommendations	49
Section 9: Recommendations—general	49
Section 10: Recommendations for special needs groups	56
Conclusion.....	61
References.....	63

LIST OF TABLES

Table 1: Categories of cases in MDSV2 defined by data included in the dataset	16
Table 2: Number of records in MDS v1 and MDS v2.....	18
Table 3: Proportion of MDS v2 records at each level (%).....	18
Table 4: Reason for Ending Assessment (%).....	19
Table 5: Number of referrals, number of assessments, and assessment rates	20
Table 6: Time from Referral to First intervention by First face-to-face contact setting.....	22
Table 7: Time from Referral to First face-to-face contact by First face to-face contact setting	23
Table 8: Time from Referral to End of assessment by First face to-face contact setting.....	24
Table 9: Time from Referral to Delegation date by First face-to-face contact setting.....	25
Table 10: Time from Referral to First intervention by Priority category (Hospital settings).....	26
Table 11: Referral to First intervention by Priority category (Non-hospital settings).....	27
Table 12: Location of assessment.....	29
Table 13: Proportions of assessment include types of assessor profession	31
Table 14: Age of ACAS clients	33
Table 15: Usual accommodation setting of ACAS clients.....	36
Table 16: Diagnosed diseases/disorders – all listed (12 most common conditions)	42
Table 17: Diagnosed diseases/disorders – primary condition (12 most common conditions)	42
Table 18: Assessments clients from CALD backgrounds.....	43
Table 19: Numbers of clients from Indigenous backgrounds.....	44
Table 20: Proportion of assessments involve clients from Indigenous backgrounds.....	45
Table 21: Proportion of assessments involve clients with dementia.....	46
Table 22: Proportion of assessments involve clients with carers.....	47
Table 23: Proportion of clients “at risk” of admission to residential care given a multi-disciplinary assessment.....	48
Table 24: Recommended long-term care setting by Accommodation setting—usual (%s)	49

Table 25: Recommendations for CACPs.....	52
Table 26: Recommendations for respite care.....	54
Table 27: Recommendations for clients not “at risk”	56
Table 28: Recommendations for “younger” clients living in the community at assessment	57
Table 29: Recommendations for clients with dementia living in the community at assessment	58
Table 30: Recommendations for clients assessed in an acute hospital and living in the community at assessment	59
Table 31: Recommendations for older “at risk” clients living in the community at assessment (%s).....	60

LIST OF FIGURES

Figure 1: Flowchart of MDS v2 records	17
Figure 2: Total assessment numbers, 1994-1995 to 2003-2004.	20
Figure 3: Aggregated time for the assessment process	27
Figure 4: Proportion of assessments take place in hospital settings, 1995-1996 to 2003-2004	30
Figure 5: Client age, 1994-1995 to 2003-2004	32
Figure 6: Activity limitations of clients usually living in the community.....	37
Figure 7: Activity limitations of clients usually living in residential care.....	38
Figure 8: Formal assistance with activities (clients living in the community)	38
Figure 9: Informal assistance with activities (clients living in the community)...	39
Figure 10: Proportion of assessments from CALD background, 1994-1995 to 2003-2004	44
Figure 11: Number of Indigenous clients, 1994-1995 to 2003-2004.....	45
Figure 12: Recommendations for community-dwelling clients (%)	50
Figure 13: Recommendation for clients in low-level residential care (%)	51
Figure 14: Recommendations for CACPs for community-recommended clients (counts)	53
Figure 15: Recommendations for residential respite for community-recommended clients (counts)	54

ABBREVIATIONS

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ACAP	Aged Care Assessment Program
ACAS	Aged Care Assessment Service
ACAT	Aged Care Assessment Team
CACP	Community Aged Care Package
CALD	Culturally and Linguistically Diverse
DVA	Department of Veterans' Affairs
HACC	Home and Community Care
LGA	Local Government Area
MDS	Minimum Data Set
SLA	Statistical Local Area

TERMS USED IN THIS REPORT

The following terms are used in this report consistent with the Data Dictionary (AIHW, 2002).

At risk	Clients are defined as being “at risk” of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 or over (or Indigenous and aged 60 or over); having a severe or profound core activity restriction; having dementia; living alone; and not having a carer.
Complete assessment	In MDS v2, assessments are defined as complete if the Reason for ending assessment is coded “Assessment complete--care plan developed to the point of effective referral”. The MDS v1 equivalent is assessments with a valid recommended long-term living arrangement.
Dementia	Clients are defined as having dementia if they received Health condition codes 0500 to 0532 as one of the 10 conditions per client reportable in MDS v2. This includes Alzheimer’s disease, vascular dementia, and dementia as a symptom of other diseases.
Multidisciplinary assessment	This is defined as involving more than one of the professions listed in Assessor profession, counting all medical practitioners as one profession and all nursing professionals as one profession.
Severe core profound disability	Clients are defined as having a severe or profound core activity restriction if they require assistance or supervision with self-care, movement activities, moving around places at or away from home, or communication.
Target group	Clients are defined as belonging to the target group for the ACAP if aged 70 years or over (or Indigenous and aged 50 years or over). Young clients are defined as not belonging to the target group for the ACAP.
Younger clients	Younger clients are those not belonging to the ACAP target group, i.e., Indigenous clients aged under 50 years, and non-Indigenous clients under 70 years of age.

GLOSSARY OF STATISTICAL TERMS

Mean	Arithmetic mean or average
Trimmed mean	The mean of the remaining cases after the lowest 5% and the highest 5% have been removed. The trimmed mean is a more stable estimate than the arithmetic mean because it is less influenced by extreme values.
Median	The middle value in a set of ordered numbers. For example, the median time from referral to First Intervention is the time by which 50% of the assessments have included a first intervention. In examining waiting times, the median is a more reliable measure than the mean. The mean can be inflated by a small proportion of cases with long waiting times.
Mode	The value with the highest frequency, or the most common value.
90 th percentile	A percentile is the relative position of a score. The 90 th percentile is the value at or below which 90% of the other values fall. The 90 th percentile time from referral to First Intervention is the time by which 90% of the assessments have included a first intervention.

EXECUTIVE SUMMARY

Introduction

The Aged Care Assessment Program

This Annual Report for the Aged Care Assessment Program in Victoria reports on records with assessment end dates from 1st July 2003 and 30th June 2004. Almost all records were collected under the ACAP Minimum Data Set Version 2.0.*

The Aged Care Assessment Program (ACAP) is jointly funded by the Commonwealth, and States and Territories. The States and Territories also provide the infrastructure and the broader health system within which teams operate. At present there are 18 teams operating in Victoria.

Assessment by the Aged Care Assessment Service (ACAS) is mandatory for admission to residential care, to receive Extended Aged Care at Home or a Community Aged Care Package, or for admission to residential respite. ACAS also refer people to community services provided under the Home and Community Care Program, to the Linkages Program (which provides intensive community care packages), to rehabilitation services—both inpatient and community-based—and to general community services.

The ACAP Minimum Data Set

The core objective of the ACAP is to assess the needs of frail older people comprehensively and to facilitate access to available services appropriate to their care needs. The program also promotes the coordination of aged care and other support services to improve the appropriateness and range of services available to frail and older people.

The ACAP MDS is an important source of information fundamental to achieving these objectives. The ACAP MDS is designed to:

- Provide ACAP program managers, at both Commonwealth and state/territory levels, with access to data for policy and program development, strategic planning and performance monitoring against agreed outcomes;
- Assist ACAS to provide high quality services to their clients by facilitating improved internal management and local/regional area planning and coordinated service delivery; and
- Facilitate consistency and comparability of ACAP data with other relevant information in the health and community services field.

Introduction of the Minimum Data Set Version 2.0

In response to a request from ACAP Officials in 1999, a review of the ACAP Minimum Data Set was initiated. As a result, the ACAP MDS Version 2 (MDS v2) was developed and a Data Dictionary developed by the Australian Institute for Health and Welfare in 2002.

Differences between MDS v1 and MDS v2

The number of data items and their complexity are greater in MDS v2 than in MDS v1. Further, criteria for inclusion as a record are quite different in MDS v2 from what they were in MDS v1. In

* The majority of Victorian teams (13) began collecting MDS v2 data on 1 May 2003, 4 teams began on 1 July 2003 and 1 team on 14 August 2003.

Victoria, MDS v1 records were included if they were defined as “assessments”, that is if a face-to-face meeting with the client had taken place. Hence, the dataset included completed assessments and some incomplete records (e.g., cancellations, clients who died before a complete assessment etc).

MDS v2 includes all referrals that are accepted for a comprehensive assessment. Cases are included if there are data on 6 items: client ID number, adequate information to form a Statistical Linkage Key (name, sex, and date of birth), referral date, reason for ending the assessment, and assessment end date. Therefore, the MDS includes for the first time clients who were accepted for comprehensive assessment but did not proceed to receive any intervention.

In this report tables/figures may report on: referrals (e.g., to provide a measure of all recorded ACAS activity), referrals with face-to-face contact (for comparison with MDS v1), or complete assessments (i.e., the Reason for ending assessment was coded “Assessment complete”) for discussion on recommendations.

Program throughput and characteristics of the assessment process

Section 1: Assessment numbers and rates

Overall result:

- The total number of referrals in 2003–04 was 56,003, including 613 (1.1%) MDS v1 assessments.
- The total number of assessments with face-to-face contact was 52,704—94.1% of all assessments.
- Of the MDS v2 referrals, 94.1% had face-to-face contact, and 87.2% were completed assessments. Only 3.8% of MDS v2 records were referrals only.
- The most common reasons for incomplete assessments were unstable functional status (4.0%) and the client choosing to withdraw (3.5%).
- The overall assessment rate was 94.9 completed assessments of people in the target group per 1000 target group in the community.

Trends:

- Against a trend of year-to-year increases since 1994–95, total assessment numbers in 2003–04 were 3.9% lower than the previous year.
- This decrease can be attributed to changes in the definition of an ACAS assessment for national ACAP MDS v2 as consultation data collected in hospitals indicates similar or higher output (assessments and consultations) than in 2002–03.

Rural metropolitan and inter-team comparison:

- Approximately a third (31.9%) of all assessments were carried out by teams in rural areas.
- The total assessment rate was higher in rural than metropolitan areas.

Range:

- A number of factors, including team policy and practice, recording practice, and the availability of services such as rehabilitation, result in considerable variation across Victorian teams. For example, the proportion of assessments that were referrals only

ranged from 0% to 13.2%; and the proportion of complete/delegated assessments from 65.2% to 98.4%

Section 2: Timeliness of assessment

Overall result:

- Response times to referrals varied considerably between hospital and non-hospital settings.
- On average, Victorian ACAS responded to half of the referrals (referral to first intervention) in hospital settings within one calendar day (trimmed mean 1.5 days) and 90% of referrals within a month. In non-hospital settings the median response was 10 calendar days (trimmed mean 13.1 days) with a response to 90% of referrals within 36 days.
- From referral to the beginning of the assessment process (first face-to-face date) took, on average (trimmed mean), a further half day in hospital settings and 6 days in non-hospital settings.
- The assessment process (first face-to-face date to end of assessment date) took, on average (trimmed mean), about 3 calendar days in both hospital and non-hospital settings.
- For those assessments that went on to delegation, this took a further three days in hospital settings and two days in non-hospital settings.
- On average (trimmed mean), the time from referral to end of assessment took 5.5 calendar days in hospital settings and 21.8 calendar days in non-hospital settings.
- Overall, the great majority of referrals (89%) were seen “on time” (i.e., priority 1 within 2 calendar days, and priority 2 within 14 calendar days) in both hospital and non-hospital settings.

Rural metropolitan comparison:

- Similar average response times for rural and metro teams.
- Response times in hospitals were shorter for metro teams than rural teams.
- Similar proportion seen “on time” in rural and metro areas.

Range:

- Response times from referral to first intervention: hospital settings (trimmed mean) 0.1 to 7.3 calendar days; non-hospital settings 5.1 to 21.9 days.
- Response times from referral to first face-to-face contact: hospital settings (trimmed mean) 0.2 to 9.5 calendar days; non-hospital settings 7.8 to 32.1 days.
- Response times from referral to approval: hospital settings (trimmed mean) 1.9 to 20.9 calendar days; non-hospital settings 6.4 to 36.7 days.
- The proportion seen “on time” for Priority 1 ranged between 64.3% and 100.0%; and Priority 2 between 76.2% and 100.0%.

Section 3: Location of assessment

Overall result:

- The great majority of Victorian clients were assessed in their usual accommodation setting—53.9% were assessed in the community and 9.6% in residential care.
- About a fifth of assessments (23.2%) took place in hospital, and a further 6.8% in other inpatient settings.

Rural metropolitan comparison:

- Relatively fewer clients were assessed in hospitals in rural areas compared to metro areas.

Range:

- The proportion of assessments carried out in hospitals ranged considerably across the Victorian teams—from 5.1% to 40.4%.

Trend:

- Since 1995–96, the proportion of clients assessed in hospital in Victoria has decreased, and in 2003–04 there was a further decrease to the lowest recorded.

Section 4: Assessor profession

Overall result:

- The majority of assessments (57.1%) were multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (59.8%).

Client characteristics and access to ACAP

Section 5: Age

Overall result:

- Two-thirds of clients assessed by Victorian ACAS were aged 80 years and over.
- Assessments of non-target clients comprised a small proportion (8.6%) of all assessments.

Rural metropolitan comparison:

- Similar age distribution.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 66.8%.
- The proportion of non-target clients has decreased from 15.5% to 8.6%.

Section 6: Usual accommodation setting

Overall result:

- The great majority of Victorian clients (72.6%) lived in the community or other community setting (8.4%) at assessment.
- 11.6% lived in residential care (10.8 in low-level care; 0.8% in high-level care).

Rural metropolitan comparison:

- Relatively more clients live in the community, particularly private residences, in rural areas than metro areas.
- Similar proportions of clients in residential care.

Range:

- The proportion of clients living in the community ranged from 74.5% to 88.6%.

Section 7: Functional profile and health conditions

7.1: Activity limitations

Overall result:

- The great majority of Victorian ACAS clients living in the community were assessed as needing assistance with domestic activities, meals and transport just prior to their assessment. Assistance with self-care was also relatively common.
- Nearly two-thirds (65.0%) of clients had a severe or profound core activity restriction.

Rural metropolitan comparison:

- The level of the need for assistance was similar in rural and metropolitan areas.

Range:

- There was considerable range across the teams, for example the need for domestic assistance among clients in the community ranged from 62.7% to 92.0% of clients, meals 51.3% to 82.4%, transport 50.0% to 84.7%, and self-care 35.4% to 68.3%.
- The need for assistance among clients living in residential care ranged from 71.3% to 99.4% for self-care, from 77.2% to 98.2% for health, from 60.6% to 88.4% for transport, and from 65.1% to 93.3% for social participation.

7.2: Formal and informal assistance with activities

Overall result:

- Just prior to assessment, most clients were receiving formal assistance with domestic activities (64.2%), self-care (59.1%) or health tasks (52.7%).
- The level of informal assistance was considerably higher than formal assistance. The average for the most commonly provided activities were mobility (86.7%), communication (86.5%), transport (87.1%) and social participation (80.8%).
- There appears to be a considerable degree of complementarity between formal and informal assistance in that there was a greater level of informal assistance for those activities with a low level of formal assistance.

Rural metropolitan comparison:

- The level of formal assistance prior to assessment was slightly higher in rural than metropolitan areas.
- The level of informal assistance for most activities was lower in rural areas than metropolitan areas.

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranged between 48.9% and 74.4%, self-care between 48.7% and 74.8%) and health tasks between 39.4% and 81.0%.
- Informal assistance with mobility activities ranged from 74.6% to 96.0%, communication from 74.0% to 95.8%, transport from 78.0% to 91.1% and social participation from 71.9% to 91.1%.

7.3: Health conditions

Overall result:

- Overall, heart conditions, arthritis, dementia, and hypertension were the most common diagnoses among ACAS clients.
- The most common primary health condition was dementia (18.0%).

Rural metropolitan comparison:

- Rural and metropolitan clients has similar health condition profiles.

Other comments

- Dementia is a significant condition in precipitating an ACAS assessment—it was more than twice as frequent as the primary health condition than other diagnoses.

Section 8: Access for specific needs groups

8.1: Clients from CALD backgrounds

Overall result:

- About a fifth of all assessments in Victoria (18.4%) were of clients from culturally and linguistically different backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS was below their representation in the 70+ years population.

Rural metropolitan comparison:

- There were relatively fewer CALD clients assessed in rural areas compared to metro areas.

Trend:

- The proportion of referrals from people of CALD backgrounds was lower than the previous year and went against a trend of increasing proportions over the previous ten years.

8.2: Clients from Indigenous backgrounds

Overall result:

- In 2003–04 there were 278 referrals (0.5% of all referrals) of people from Indigenous backgrounds.

Rural metropolitan comparison:

- Indigenous referrals to metropolitan teams were more than expected from the proportion in the population, while among rural teams it was the reverse.

Range:

- The proportion of Indigenous to total referrals ranged from 0% to 2.8%.

Trend:

- The number of Indigenous clients has increased in most years since 1994–95.
- In 2003–04 there was a marked increase over previous years, probably due to improved data recording with the introduction of MDS v2 in early/mid 2003.

8.3: Clients with dementia

Overall result:

- Over a quarter (27.9%) of target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) had a diagnosis of dementia at the time of assessment.
- 15% of non-target clients had a diagnosis of dementia at the time of assessment.

Rural metropolitan comparison:

- Similar proportions of diagnosed dementia among rural and metro clients.

Range:

- The proportion of target group clients with dementia ranged from 13.4% to 37.8%.
- The proportion of non-target clients with dementia ranged from 9.2% to 26.0%.

8.4: Clients and carers

Overall result:

- The great majority of clients (81%) had carers.
- The majority of carers were co-resident.

Rural metropolitan comparison:

- The proportion of clients with carers was slightly higher in rural areas than metropolitan areas.
- Non-resident carers were relatively more common in rural than metropolitan areas.

8.5: Client's "at risk"

Overall result:

- Overall, 9.1% of clients living in the community were "at risk"* of admission to a residential care facility.
- "At risk" clients were more likely to receive a multidisciplinary assessment than all clients—61.7% of "at risk" clients received a MDS compared with 47.4% of all clients.

Rural metropolitan comparison:

- The proportions "at risk" in rural and metropolitan areas were similar.
- A MDA was more likely if the client lived in a metropolitan area.

Recommendations

Section 9: Recommendations—general

9.1: Long-term care setting by accommodation setting

Overall result:

- The majority of clients living in the community at assessment (60.8%) received a recommendation to continue living in the community.
- The great majority (80.8%) of clients living in low-level residential care at assessment were recommended to high-level care.
- The great majority (79.9%) of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care.
- However, a significant minority (14.5%) of clients living in high-level care were recommended to low-level care, and a further 4.0% received community recommendations.

Trends:

- In contrast to the trend up to 2001–02, the last few years have seen a decrease in the proportion of clients living in the community recommended to the community, and an increase in the proportion recommended to residential care.
- In 2003–04 this trend continued, the proportion recommended to residential care, particularly high-level, from the community increased again.
- Consistent with the trend in previous years, in 2003–04 there was a further increase in the proportion of clients living in low-level residential care and recommended to high-care.

Rural metropolitan comparison:

- The proportion of community to community recommendations was similar in rural and metropolitan areas.

* Clients are defined as being "at risk" of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 or over (or Indigenous and aged 60 or over); having a severe or profound core activity restriction (needs assistance with one or more the tasks of self-care, mobility or communication); having dementia; living alone; not having a carer.

- The proportion of low-level to high-level recommendations was similar in rural and metropolitan areas.

Range:

- Across the teams the proportion community to community recommendations ranged from 47.9% to 75.7%.
- Low-level to high-level recommendations ranged from 67.8% to 90.9%.

9.2: Recommendation for CACPs**Overall result:**

- CACPs are recommended in about a third of assessments of people given a community recommendation, including new recommendations for CACPs from nearly a quarter of these assessments.

Trends:

- After marked increases between 1995–96 and 2001–02, in the last three years the number of CACPs recommended has declined and new recommendations have stabilised.

Rural metropolitan comparison:

- The proportion of CACPs recommended (new and ongoing) was similar in rural and metropolitan areas, but new recommendations were more likely in rural areas.

Range:

- Across the teams the proportion of assessments with a CACPs recommendation (new and ongoing) ranged from 21.1% to 52.4%.
- The proportion of new recommendations ranged from 14.3% to 43.7%.

9.3: Recommendation for respite**Overall result:**

- Almost two-thirds of clients (65.0%) recommended to the community receive a recommendation for residential respite and over 11.3% a recommendation for non-residential respite.

Trends:

- Consistent with the trend between 1995–96 and 2001–02, recommendations for residential respite increased in 2003–04.
- After increasing between 1995–96 to 2000–01, the proportion of community assessments with a recommendation for non-residential respite have declined, and 2003–04 was consistent with this recent trend.

Rural metropolitan comparison:

- Clients in rural areas were less likely to receive a recommendation for residential respite and more likely to receive a recommendation for non-residential respite than in metropolitan areas

Range:

- Recommendations for residential respite ranged between 38.2% and 89.1% of clients recommended to the community.
- For non-residential respite the range was between 3.6% and 23.7%.

Section 10: Recommendations for special needs groups

10.1: Recommendation for clients not “at risk”

Overall result:

- “At risk” clients were almost twice as likely to receive a residential care recommendation than clients not “at risk”.
- Of those clients not “at risk” 63.3% were recommended to the community and 35.9% to residential care (20.4% to low-care and 15.4% to high-care).
- The corresponding recommendations for “at risk” clients were community 35.5%, low-level care 38.5%, and high-level care 25.0%.

Rural metropolitan comparison:

- Little difference in the recommendations for clients not “at risk”.

10.2: Recommendation for non-target clients

Overall result:

- Non-target clients were more likely to be recommended to the community and less likely to be recommended to low-level residential care than ACAS clients as a whole.
- Nearly two-thirds (65.9%) of non-target clients living in the community are recommended to remain in the community, 15.6% to low-level care and 16.4% to high-level care.
- For all clients living in the community, 60.8% were recommended to remain in the community, 22.0% to low-level care, and 16.3% to high-level residential care.

Rural metropolitan comparison:

- Non-target clients living in rural areas were more likely to receive a community or low-level care recommendation than those in metropolitan areas.

Range:

- The proportion of non-target clients recommended to remain in the community ranged from 48.4% to 81.2%.

10.3: Recommendations for clients with dementia

Overall result:

- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 50.6% of clients with dementia received a recommendation for residential care compared to 38.3% of all clients living in the community.

- Further, 25.4% clients with dementia receive a high-level care recommendation compared to 16.3% of all clients living in the community.

Rural metropolitan comparison:

- The proportion of clients recommended to residential care was similar in rural and metropolitan areas but clients in rural areas were more likely to receive a recommendation for low-level care than those in metropolitan areas.

10.4: Recommendation for clients assessed in acute hospital

Overall result:

- Clients usually living in the community and assessed in an acute hospital were more likely to receive a recommendation for residential care (particularly high-level care) than clients living in the community and assessed in another setting.
- 37.5% of community clients assessed in acute hospitals received a community recommendation for residential care, 20.7% were recommended low-level care and 37.5% high-level care.
- For clients living in the community and assessed in the community the comparable recommendations were: community 75.0%, low-level care 18.9%, and high-level care 5.4%.

Rural metropolitan comparison:

- Recommendations in rural and metropolitan areas were similar.

Range:

- The recommendation pattern was similar across all teams but there was a considerable range in the proportion recommended to the community—from 8.7% to 69.2%

10.5: Clients “at risk” recommended for a CACP

Overall result:

- “At risk” clients were more likely to receive a recommendation for a CACP than those not at risk.
- Of the “at risk” clients recommended to the community, over half (51.5%) received a recommendation for a package, compared with a third (32.2%) of all clients recommended to the community.

Rural metropolitan comparison:

- Relatively more clients assessed in metropolitan areas received a recommendation for CACPs than clients assessed in rural areas.

Range:

- The proportion of “at risk” clients living in the community who received a recommendation for a CACP ranged from 3.6% to 30.2%.

Conclusion

This is the first Annual Report to analyse MDS v2 data and it provides new information on the operation of the Victorian Aged Care Assessment Service and the people who access it. MDS v2 includes information on the assessment process and timeliness not previously

recorded, as well as providing more information on health conditions, and new information on carers, and activity limitations.

Total assessment numbers with face-to-face contact in 2003–04 (52,704) were lower than the previous year. Assessment rates have steadily decreased in Victoria since 1995–96 and the 2003–04 rate of 112 assessments per 1000 target population was consistent with this trend. Access to the ACAP by people of CALD background and Indigenous people was lower than their representation in the population indicates. This too was consistent with previous years. In comparison with other states/territories, Victoria reported above average access to the ACAP for these special groups.

Historically, the time between referral and first face-to-face contact has been increasing in all settings. In 2003–04, response times increased in community settings, decreased in residential care, and remained the same in hospital settings. Victoria's timeliness compared favourably with other states/territories.

Victorian data quality in 2003–04 was reasonably good. However, some teams reported high missing rates for some items, in particular, the carer items, Indigenous status and DVA entitlement. There were also problems with date sequencing, particularly with the Delegation date preceding the Assessment end date. Changes to the ACE software introduced in 2005 should overcome this problem.

Anecdotal evidence also suggests that a return to "core business" by teams may have contributed to reduced assessment numbers. Future reports will determine whether this is a long-term trend. In addition, further changes to aged care policy and data recording will be evaluated in terms of their impact on assessment numbers. Ongoing updates to the ACE software (used by almost all teams) will assist in improving data quality and client management.

PART ONE: THE ACAP MINIMUM DATA SET AND PROGRAM EVALUATION

INTRODUCTION

This Annual report utilises data collected by the Victorian Evaluation Unit on records with Assessment end dates between 1st July 2003 and 30th June 2004 and includes records coded using Minimum Data Set Version 1 (MDS v1) and Minimum Data Set Version 2 (MDS v2).^{*} It includes updated data sets from all four quarters of 2003-2004.

This report uses many of the Key Performance Indicators outlined in the Aged Care Assessment Program Data Dictionary Version 1 (AIHW, 2002). And, in line with other national reports previously produced by the Lincoln Centre for Ageing and Community Care Research, it also includes some trend analyses.

The remainder of the Introduction outlines the introduction of the MDS v2 and describes any local conditions that should be kept in mind in reading the report.

The Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) is jointly funded by the Commonwealth, and States and Territories. The States and Territories also provide the infrastructure and the broader health system within which teams operate. At present there are 18 teams operating in Victoria.

The Commonwealth Guidelines for the ACAP provide a national framework for the operation of assessment teams. The core objective of the ACAP is “to comprehensively assess the needs of frail older people and facilitate access to available care services appropriate to their care needs” (Department of Health and Ageing, 2002, p.17). The work of assessment services is based on the principle that wherever possible older people should be supported in their own homes and their own communities.

Assessment by an Aged Care Assessment Service (ACAS) is mandatory for admission to residential care, to receive a Community Aged Care Package or for admission to residential respite. ACAS also refer people to community services provided under the Home and Community Care Program, to the Community Options Program[†] (which provides intensive community care packages), to rehabilitation services—both inpatient and community-based—and to general community services.

ACAS are required to conduct a holistic assessment of the client’s care needs; taking into account the physical, medical, psychiatric and social needs of frail older people, including their rehabilitation potential, in order to help them choose the most appropriate services to meet their needs. While the composition of assessment teams is not prescribed in the Guidelines, they are required to either include, or have access to, a range of disciplines, skills and experience sufficient to make accurate, holistic assessments of their clients’ needs. The main professional groups represented in assessment teams are geriatricians, nurses, social workers, physiotherapists and occupational therapists.

The Guidelines stipulate some basic operational procedures that teams are expected to adopt: including the acceptance of referrals from any source, including self-referral; client, family and GP

^{*} The majority of Victorian teams (13) began collecting MDS v2 data on 1 May 2003, 4 teams began on 1 July 2003 and 1 team on 14 August 2003.

[†] Known as Linkages in Victoria

involvement in the assessment process; the initial assessment of clients in their normal place of residence whenever possible; the institution of quality assurance mechanisms; the designation of a case co-ordinator for each assessment; and follow-up of assessed clients to ensure that care plans are still relevant and satisfactory to the client. Appeal procedures are set out for clients who are not satisfied with the outcome of an assessment.

Introduction of the ACAP Minimum Data Set Version 2.0

The core objective of the ACAP is to comprehensively assess the needs of frail older people and to facilitate access to available care services appropriate to their needs. The program also promotes the coordination of aged care and other support services to improve the appropriateness and range of services available to frail and older people.

The ACAP MDS is an important source of information fundamental to achieving these objectives. The ACAP MDS is designed to:

- Provide ACAP program managers, at both Commonwealth and state/territory levels, with access to data for policy and program development, strategic planning and performance monitoring against agreed outcomes;
- Assist ACAS to provide high quality services to their clients by facilitating improved internal management and local/regional area planning and coordinated service delivery; and
- Facilitate consistency and comparability of ACAP data with other relevant information in the health and community services field.

A reliable and robust national dataset on the ACAP program is thus an essential tool for the effective delivery and future development of aged care services in Australia.

The first national ACAP MDS was agreed in principle in 1987, refined in 1991, and introduced from 1st January 1994. Prior to this there were slightly different state-based minimum data sets. The national MDS identified the minimum reporting requirements, which then formed the basis of a condition of grant between the Commonwealth and the State and Territory Governments for the ACAP. In 1987, an Evaluation Unit (EU) was established in each State and Territory to report on MDS Version 1 (MDS v1) data, and to promote national consistency in the collection and recording of data by ACAS.

Evaluation Units were established to provide monitoring and evaluation of the Program within States and Territories. They provide a central point for ACAS data collection and reporting and undertake analysis to assist in the monitoring, evaluation and planning for ACAS and aged care within the States. Prior to the introduction of the MDS v2, the Victorian EU produced six-monthly reports incorporating reporting and analysis of MDS v1 and Team Narrative Reports. The EU also provided aggregated de-identified client data to the Lincoln Gerontology Centre at La Trobe University* for compilation into the “National Evaluation Report” annually.

In August 1999, the Department requested the Australian Institute of Health and Welfare (AIHW) undertake a review of the ACAP MDS. ACAP Officials comprising Commonwealth and State and Territory government officials responsible for the Program initiated the review. The purpose of the review was to ensure the relevance and usefulness of the data collected to national planning, policy and performance monitoring process and to ACAS. As a result of the review, the ACAP MDS Version 2 (MDS v2) was developed. The Data Dictionary for the MDS v2 was published by AIHW in 2002.

* Now the Lincoln Centre for Ageing and Community Care Research.

Differences between MDS v1 and MDS v2

The number of data items and their complexity are greater in MDS v2 than in MDS v1. Further, criteria for inclusion as a record are quite different in MDS v2 compared to MDS v1.

Assessments in MDS v1

In MDS v1, records were included if they were defined as “assessments” and all records in the MDS were counted in reporting to government. In most States/Territories, a necessary condition for defining an episode as an assessment was that there had to be some intervention with the client. However, in Victoria, a face-to-face meeting with the client had to have taken place. Hence, in addition to completed assessments, the MDS included:

- a) Assessments that were cancelled after the first intervention;
- b) Assessments of clients who died before the assessment could be completed; and
- c) Other assessments that did not result in a clear-cut recommendation for long-term living arrangement (“other”, missing, or unable to determine).

Altogether, these incomplete assessments formed a minor but significant part of the MDS.

Assessments in MDS v2

MDS v2 includes all referrals that are accepted for a comprehensive assessment. Cases are included if there are data on 6 items: client ID number, adequate information to form a Statistical Linkage Key (name, sex, and date of birth), referral date, reason for ending the assessment, and assessment end date. Therefore, the MDS includes for the first time clients who were accepted for comprehensive assessment but did not proceed to receive any intervention (see Table 1 and Figure 1—following pages).

In MDS v2, “complete assessments” in MDS v2 are those for which recommendations are made regarding living arrangements. No recommendations should be made for clients whose assessments are incomplete. Clients who receive a **comprehensive** assessment but for whom recommendations for living arrangements are not made are coded as having **incomplete** assessments. Therefore, the proportion of assessments that are classified as “incomplete assessments” will be larger than was the case in MDS v1. Six categories (or levels) of records can be differentiated in MDS v2, as in Table 1 on the next page.

It was agreed at the Data Working Group in June 2004 that the number of records at all six levels would be reported, and that, for most purposes, records would be counted as assessments for the purposes of comparison with previous years if they had a First Intervention Date (or First Face-to-face Contact Date in the case of Victoria). Some analyses are required by the Data Dictionary to include only complete assessments.

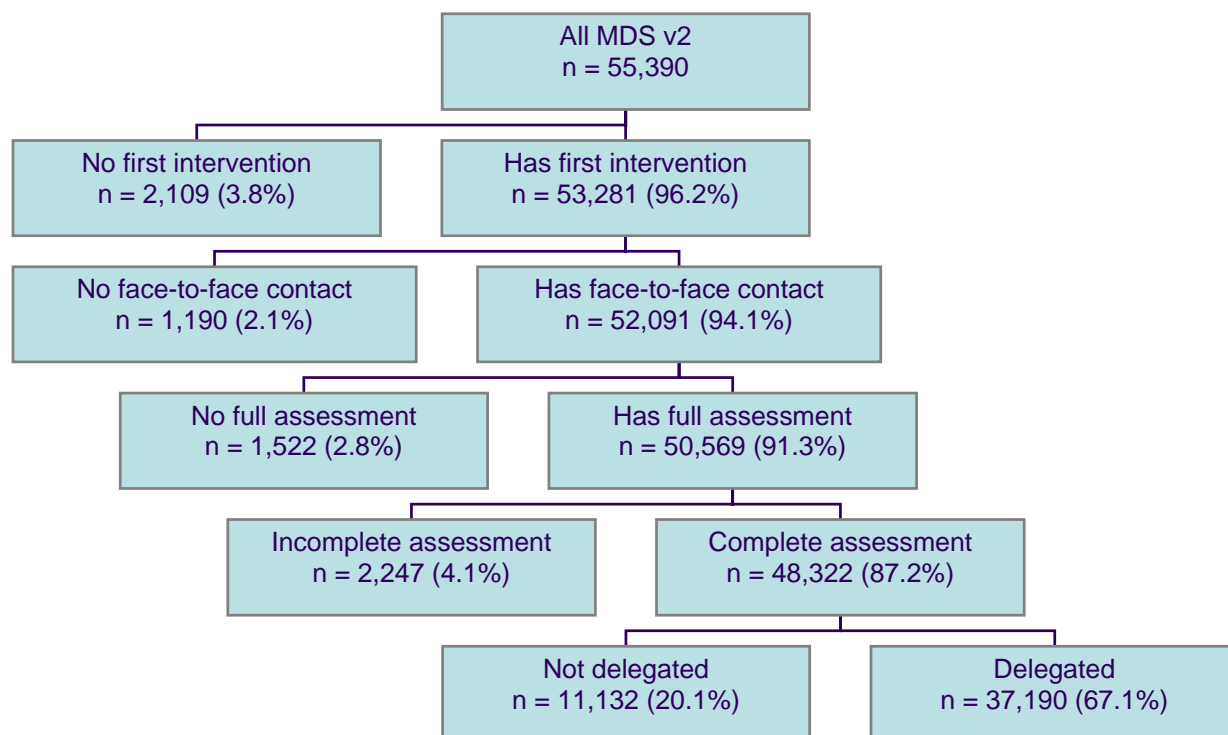
In this report most of the analysis is based on assessments which have a First Face-to-face Contact Date, that is Levels 3–6 in Table 1 above. For particular analyses, some tables present other levels of assessment, for example all referrals or complete assessments. These are noted on the appropriate table or figure and in the accompanying text.

Table 1: Categories of cases in MDSV2 defined by data included in the dataset

Level	Data included
<p>Level 1. Referral only. Denotes cases where referrals are accepted but do not result in any ACAS intervention.</p>	<ul style="list-style-type: none"> • Client ID • Record linkage key • Referral date • Reason for ending assessment • Assessment completion date
<p>Level 2. Minimalist. Denotes cases where referrals are accepted and there is some subsequent intervention (e.g., phone call to GP or carer) but no face-to-face assessment.</p>	<ul style="list-style-type: none"> • Client ID • Record linkage key • Referral date • First intervention date • Reason for ending assessment, • Assessment completion date <p>Other information is likely to be minimal</p>
<p>Level 3. Simple. Denotes records where referrals result in face-to-face assessment but the assessment process is halted at that point (e.g., it is clear on meeting the client that his/her medical condition is unstable).</p>	<ul style="list-style-type: none"> • Client ID • Referral date • Record linkage key • First intervention date • First face-to-face assessment date • Reason for ending assessment • Assessment completion date <p>Other information will be patchy, depending on how far the assessment proceeded.</p>
<p>Level 4. Comprehensive. Denotes assessments that involve substantial assessment activity but are defined in the MDS as “incomplete”.</p>	<p>Full information on the client should be included in the MDS record, including ACCR Items 23 (current need for assistance) and 28 (health condition). However, recommendations (Items 25, 29, and 30) will be coded ‘unable to determine’ and Item 31 will be blank.</p>
<p>Level 5. Complete. Denotes comprehensive assessments where recommendations are made and included in the MDS.</p>	<p>Full information on the client should be included in the MDS record.</p>
<p>Level 6. Delegated. Assessments are complete and also approvals are made.</p>	<p>Full information on the client should be included in the MDS record and Parts 5 and 6 of the ACCR completed.</p>

Figure 1 on the following page illustrates the structure of MDS v2 and provides counts and proportions of MDS v2 referrals at each Level.

Figure 1: Flowchart of MDS v2 records



Content of this report

Most of the analyses in this report pertain to MDS v2 data. However, on a number of data items the coding for MDS v1 can be mapped to MDS v2, and this enabled the records to be combined. The source of the data is noted in the various sections, and in tables and figures. Tables compare rural and metropolitan teams with the state total.

Wherever possible, analyses in this report conform to the standards set out in the Aged Care Assessment Program Data Dictionary Version 1 (AIHW, 2002). Analyses are based on accepted referrals or assessments (not individuals assessed), except for the section on CACPs recommended to clients “at risk” (see AIHW, 2002). Many analyses are restricted to complete assessments (i.e., Reason for ending assessment is coded 1 = Assessment complete). In order to make comparisons with MDS v1 data as valid as possible, in this report assessments are defined as complete in MDS v1 if records include legitimate recommendations for living arrangements (i.e., not including “client died”, “assessment cancelled”, etc.)

Caveats on reliability and completeness

The 2003-2004 financial year saw the introduction of MDS v2 and the Aged Care Client Record (ACCR) as a data collection tool. Because the data set is new, it is likely to contain coding errors, missing data, and errors of other kinds that are attributable to the fact that staff were still relatively unfamiliar with the ACCR and guidelines for completing the forms. Hence, the figures presented in this report should be treated with some caution. Footnotes throughout the report will indicate where the EU is aware that there is particular cause for concern. Some areas of concern are known because of the National Data Repository’s validation procedure and through feedback from staff in ACAS on difficulties that they have experienced. However, there may be other areas that we are not aware of.

PROGRAM THROUGHPUT AND CHARACTERISTICS OF THE ASSESSMENT PROCESS

Section 1: Assessment numbers and rates

1.1 Definition

“The ACAT assessment is a process used to develop a comprehensive understanding of the needs and capabilities of an older person (and their carer/advocate) and of their current situation. ACAT assessment processes lead to decisions and recommendations regarding immediate and long-term care needs” (Commonwealth Department of Health and Ageing, 2002, p.26). Five core activities are seen as critical to the ACAT comprehensive assessment process:

- Initial client assessment and needs identification
- Development of a care plan
- Arranging the care plan to the point of effective referral
- Ensuring care plan implementation
- Overall care plan review.

1.2 Number of records

Table 2 provides the number of records submitted to the Evaluation Unit during 2003-2004. It should be noted that MDS v1 records are not the same as MDS v2 records—see explanation in the Introduction (Chapter 1).

Table 2: Number of records in MDS v1 and MDS v2

	MDS v1 records	MDS v2 records	% records MDS v2	Total Records
Rural	7	17,883	99.9	17,890
Metropolitan	606	37,507	98.4	38,113
Total	613	55,390	98.9	56,003*

Note: MDS v1 records are assessments with face-to-face contact.
MDS v2 records are “referrals”.

There were 613 MDS v1 records and 55,390 MDS v2 records during the 2003-2004 year, giving a combined total of 56,003 records.

1.3 Types of records

MDS v2 records can be described by the 6 Levels as indicated in the Introduction. Table 3 compares teams that submitted MDS v2 records during the year on the proportion that can be attributed to each of the levels.

Table 3: Proportion of MDS v2 records at each level (%)

	Level 1: Referral only	Level 2: Minimalist	Level 3: Simple	Level 4: Compre- hensive	Level 5: Complete	Level 6: Delegated
Rural	3.9	1.6	1.7	2.3	29.7	60.8
Metropolitan	3.8	2.4	3.3	4.9	15.5	70.2
Total	3.8	2.1	2.8	4.1	20.1	67.1

* The total number of records in this report differs slightly from the 2003–04 National Report (MDS v1 614; MDS v2 55,295; total 55,909) because there was further “cleaning” of the data after this report was written.

Across Victoria the great majority (86.9%) of all referrals (MDS v1 and v2) result in a recommended long-term living arrangement (completed or delegated assessments). Table 3 (MDS v2 data) shows that a relatively small proportion of all assessments (3.8%) go no further than the referral stage, nearly 5% go beyond referral but don't involve a comprehensive assessment, and 4.0% involve a comprehensive assessment with no resultant recommendation. The great majority of this latter group are referred to rehabilitation or further treatment.

There is considerable inter-team variation within the averages presented in Table 3. The proportion of referrals that went no further ranged from 0% to 13.2%, and the proportion of minimalist/simple assessments from 0.1% to 13.7%. The proportion of incomplete assessments involving a comprehensive assessment (level 4) ranged from 0.1% to 19.3%. The proportion of completed/delegated assessments ranged from 65.2% to 98.4%. These variations are the result of a number of factors, including team policy and practice, recording practice, and the availability of services such as rehabilitation.

1.4 Reason for Ending Assessment

Table 4 provides a breakdown on reason for ending assessment. The great majority of recorded assessments were completed (including delegated), that is a care plan developed with an effective referral. Completed assessments correspond to Levels 5 and 6 in Table 3 above. Of the incomplete assessments (Levels 1 to 4 in Table 3), most were because the client's functional or medical condition required further rehabilitation or treatment, or because the client withdrew.

Table 4: Reason for Ending Assessment (%)

	Assessment complete	Client withdrew	Client died	Client transferred	Medical condition unstable	Functional status unstable	Other reason/missing	Total
Rural	90.2	4.1	1.0	0.3	1.9	1.5	0.8	100.0
Metro	85.3	3.3	1.0	1.9	1.8	5.2	1.5	100.0
Total	86.9	3.5	1.0	1.4	1.8	4.0	1.3	100.0

Note: Includes all MDS v1 and MDS v2 records. In MDS v1, the category functional status unstable includes transfers to another ACAS.

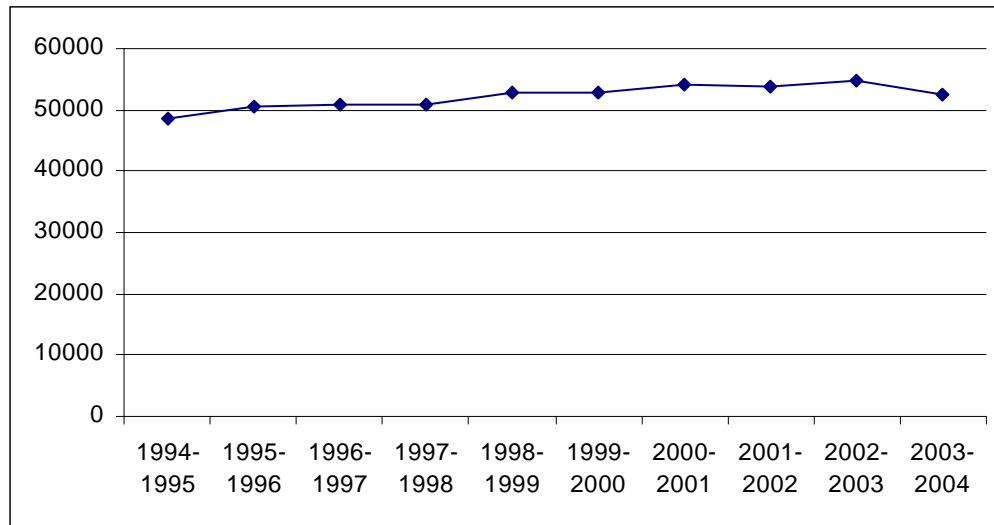
1.5 Trends in assessment numbers

Figure 2 illustrates change in total assessment numbers from 1994-1995 to 2003-2004. For comparability with previous years, MDS v2 records are included for 2003-2004 only if they include a First face-to-face contact date.

Victorian teams in 2003-04 reported 2,010 (3.9%) fewer assessments than in 2002-03. However, in almost all years, assessment numbers have increased over the previous year. The 2003-04 total of 52,704 assessments (with face-to-face contact) was 4,230 more than in 1994-95, an increase of 8.5%. The decrease in assessments in 2003-04 was consistent with other states (National Data Repository, 2005).

Due to the tightening in definitions of an ACAS assessment for national ACAP MDS v2, Victoria introduced an ACAS data collection item into the statewide hospital data collection—Victorian Admitted Episode Data (VAED). This collection allows ACAS to identify workload in the form of consultations that are no longer reported in the national ACAP MDS because they do not comply with the national ACAP definition of a comprehensive assessment. In 2003-04 it is estimated that 3,096 consultations were carried out in metropolitan hospitals. This workload, when added to the ACAP MDS assessments shows that the output of the ACAS (including assessments and consultations) was at a similar or higher level than in 2002-03.

Figure 2: Total assessment numbers, 1994-1995 to 2003-2004.



Note: 2003-04 includes all MDS v1 records, and MDS v2 records with a First face-to-face contact date.

1.6 Assessment rates

The assessment rate represents the number of assessments of clients in the target group per 1000 target group population in the catchment area. Some of these figures should be treated with some caution, for example Census counts of Indigenous people in each state (and hence the target populations) are likely to be underestimates.

In accordance with the standards set out in the Data Dictionary (AIHW, 2002), rates are estimated on complete assessments only. Table 5 shows the number of referrals and assessments (MDS v1 and MDS v2) reported for the year, and estimates of rates. The target population for the ACAP program is all people aged 70 and over, together with people from Indigenous backgrounds aged 50–69. The population figures were obtained from the Australian Bureau of Statistics

Table 5: Number of referrals, number of assessments, and assessment rates

	2003 Estimated Target Population ¹	Total Number of Accepted Referrals ²	Total Number of assess- ments with Face-to- face contact	Total Number of Completed Assess- ments ³	Total Number of Completed Target group Assess- ments ⁴	Target group as % of Total Completed Assess- ments	Rate ⁵
Rural	149,839	17,890	16,909	16,143	14,826	91.8	98.9
Metropolitan	320,792	38,113	35,795	32,510	29,830	91.8	93.0
Total	470,631	56,003	52,704	48,653	44,656	91.8	94.9

Note: ¹ Estimates provided to the Lincoln Centre for Ageing and Community Care Research and used with permission from the Australian Bureau of Statistics.

² Includes MDS v1 assessments and MDS v2 referrals.

³ Includes MDS v1 assessments with valid recommendations and MDS v2 completed assessments.

⁴ Includes MDS v1 assessments with valid recommendations and MDS v2 completed assessments for target group.

⁵ Rate = (Total completed target group assessments/target population) x 1000.

Estimated Resident Population for each SLA as at 30 June 2003. The number of people from Indigenous backgrounds aged 50–69 years is from the 2001 Census (Census counts), and is not updated annually.

The overall assessment rate (not shown in Table 5) in 2003–04 was 112.0 assessments/1000 target group (people age 70+ years and Indigenous people age 50–69 years). This was consistent with a declining trend since 1995–96. Table 5 shows that 91.8% of completed assessments were of clients from the target group, with little variation among the teams (range 89% to 94%). The assessment rate was 94.9 completed target group assessment/1000 target population with a higher rate in rural than metropolitan areas. This rate showed considerable variation among teams across the state—75 to 167.

Summary: Assessment numbers and rates

Overall result:

- The total number of records in 2003–04 was 56,003, including 613 (1.1%) MDS v1 assessments and of these 94.1% had face-to-face contact and 86.9% were completed assessments.
- Of the MDS v2 records, 3.8% were referrals only, 9.0% were other incompletes, 20.1% were completed assessments (but not delegated), and 67.1% were delegated assessments.
- Across Victoria, 91.8% of completed assessments were of people in the target population. The overall assessment rate was 94.9 completed assessments on people in the target group per 1000 target group.

Trends:

- Against a trend of year-to-year increases since 1994–95, total assessments with face-to-face contact in 2003–04 were 3.9% lower than the previous year. This decrease can be attributed to changes in the definition of an ACAS assessment for national ACAP MDS v2 as consultation data collected in hospitals indicates similar or higher output (assessments and consultations) than in 2002–03.

Rural metropolitan and inter-team comparison:

- Approximately a third (31.9%) of all assessments were carried out by teams in rural areas.
- The assessment rate was higher in rural than metropolitan areas.

Range:

- A number of factors, including team policy and practice, recording practice, and the availability of services such as rehabilitation, result in considerable variation across Victorian teams. For example, the proportion of assessments that were referrals only ranged from 0% to 13.2%; and the proportion of complete/delegated assessments from 65.2% to 98.4%.

Summary: Reason for ending assessment

Overall result:

- The great majority of recorded assessments (86.9%) were completed or delegated.

- The most common reasons for incomplete assessments were unstable functional status (4.0%) and the client choosing to withdraw (3.5%).

Section 2: Timeliness

This section reports on the ACAS response to requests for assessment. Times from Referral date to First intervention date and First face-to-face contact date provide an indication of how long ACAS take to respond to requests for service. Times from referral to Assessment End Date and Delegation date provide an indication of how long the assessment process takes. Summary statistics for times from referral to each point in the assessment process in hospital (acute hospital and other inpatient) and non-hospital (residential care and other) locations are provided. All times are calendar days.

2.1 Referral to First intervention

Table 6 presents the times between Referral and First intervention for the four face-to-face contact settings (acute hospital, other inpatient, residential care and community).

Table 6: Time from Referral to First intervention (in calendar days) by First face-to-face contact setting

	Valid n	Missing n	Trimmed Mean - days (range)	Median - days (range)	90 th %ile - days (range)
Acute hospital					
Rural	3,568	23	3.1 (1.9–7.3)	2 (1–6)	11 (5–21)
Metropolitan	9,212	213	1.0 (0.1–2.0)	0 (0–1)	4 (1–7)
Total	12,780	236	1.5	1	6
Other inpatient					
Rural	661	1	3.5 (1.7–6.0)	2 (1–5)	13 (6–18)
Metropolitan	3,132	182	1.3 (0.2–3.4)	0 (0–2)	7 (1–21)
Total	3,793	4	1.7	0	8
Residential care					
Rural	1,970	3	7.8 (5.1–13.6)	6 (4–12)	25 (15–35)
Metropolitan	3,233	182	12.3 (6.3–19.7)	10 (2–19)	32 (15–42)
Total	5,203	185	10.6	7	29
Other*					
Rural	10,565	28	10.8 (5.8–20.3)	7 (5–9)	34 (15–78)
Metropolitan	19,288	298	15.0 (6.5–21.9)	13 (1–22)	38 (17–43)
Total	29,853	326	13.5	10	37

Note: MDS v2 records only.

Missing values include those that were negative or over 364 days, cases that did not proceed to First intervention, and cases without a valid contact setting.

* Community settings, mainly the client's home.

Table 6 shows considerable differences in the response times between hospital and non-hospital settings for both rural and metropolitan teams. On average (trimmed mean), Victorian ACAS take about a day and a half to respond to a request for service in hospital settings, but nearly two weeks in non-hospital settings. Median and 90th percentile responses showed a similar pattern. Response times in rural areas were longer than metropolitan areas in hospital settings but shorter in non-hospital settings. Both rural and metropolitan teams reported a considerable range in response times in all settings, but there was less variation in acute hospital and inpatient settings than non-hospital settings—trimmed means ranged from 0.1 to 7.3 calendar days in acute settings; 0.2 to 6.0 in other inpatient settings; 5.1 to 19.7 in residential care; and 5.8 to 21.9 calendar days in community settings.

2.2 Referral to First face-to-face contact

Table 7 provides response times between Referral and First face-to-face contact by First face to-face contact setting. In general, response times from referral to beginning the assessment process were shorter in hospital and other inpatient settings than residential care or other settings. Response times in hospital settings reported by metropolitan teams were shorter than rural teams. However, response times in residential care and other settings were shorter in rural areas than metropolitan areas. The ranges in response times varied considerably among both rural and metropolitan teams in the various settings.

Table 7: Time from Referral to First face-to-face contact (in calendar days) by First face to-face contact setting

	Valid n	Missing n	Trimmed mean - days (range)	Median - days (range)	90 th %ile - days (range)
Acute hospital					
Rural	3,556	35	4.6 (2.1–9.4)	3 (1–8)	14 (5–23)
Metropolitan	9,353	72	1.2 (0.2–2.2)	0 (0–1)	5 (3–7)
Total	12,909	107	2.0	1	8
Other inpatient					
Rural	659	3	4.5 (2.1–9.5)	3 (1–8)	15 (6–25)
Metropolitan	3,127	8	1.6 (0.4–4.5)	0 (0–4)	8 (3–21)
Total	3,786	11	2.1	0	10
Residential care					
Rural	1,968	5	11.1 (6.4–15.9)	8 (6–13)	29 (19–39)
Metropolitan	3,394	21	15.3 (8.2–22.4)	13 (7–21)	35 (21–46)
Total	5,362	26	13.8	11	33
Other*					
Rural	10,560	33	16.5 (7.8–28.5)	13 (7–15)	45 (18–98)
Metropolitan	19,512	74	20.9 (11.4–28.7)	19 (9–27)	45 (26–57)
Total	30,072	107	19.3	16	45

Note: Includes MDS v1 (where actual domicile matched MDS v2 contact setting) and MDS v2 assessments. In MDS v1, all hospital-based assessments are included with acute hospital assessments.

Missing values include those with negative times or times over 364 days, incomplete cases, and cases without a valid contact setting.

* Community settings, mainly the client's home.

Since 1999–00, the time between referral and first face-to-face contact has been increasing in all settings. In 2003–04, response times in hospital settings were similar to the previous year, in residential care they were shorter and in the community they were longer than previous years.

2.3 Time from Referral to Assessment end date

Times from Referral date to Assessment end date and Delegation date provide an indication of how long the assessment process lasts. Table 8 presents total time from the date of Referral to the Assessment end date. On average (trimmed mean), the assessment process from referral to the end of assessment takes about 6 days in hospital settings, 17 days in residential care settings and 22 days in the community. The assessment process (difference in trimmed means from face-to-face contact to end of assessment) took about three days in all settings. As with the other measures of timeliness, there was considerable variation within settings among both rural and metropolitan teams.

Table 8: Time from Referral to End of assessment (in calendar days) by First face to-face contact setting

	Valid n	Missing n	Trimmed mean - days (range)	Median - days (range)	90 th %ile - days (range)
Acute hospital					
Rural	3,583	8	6.6 (3.4–16.1)	5 (3–13)	20 (8–41)
Metropolitan	9,269	156	4.7 (1.7–7.3)	2 (1–5)	18 (6–35)
Total	12,852	164	5.2	3	19
Other inpatient					
Rural	662	0	8.7 (3.8–11.2)	6 (2–13)	25 (13–32)
Metropolitan	3,133	2	6.2 (0.9–18.1)	2 (0–16)	26 (7–40)
Total	3,795	2	6.7	3	26
Residential care					
Rural	1,969	4	13.1 (7.8–19.1)	10 (6–18)	33 (22–43)
Metropolitan	3,242	173	18.7 (10.6–27.5)	16 (9–27)	41 (22–55)
Total	5,211	177	16.5	14	39
Other*					
Rural	10,581	12	18.7 (8.5–30.8)	14 (7–17)	50 (19–101)
Metropolitan	19,305	281	23.8 (16.5–32.1)	22 (16–35)	49 (32–62)
Total	29,886	293	22.0	20	49

Note: MDS v2 records only.

Missing values include those with negative times or times over 364 days, incomplete cases, and cases without a valid contact setting.

* Community settings, mainly the client's home.

2.3 Time from Referral to Delegation date

On average (trimmed mean), approval for services (end of assessment to delegation date) takes from one to three days depending on the setting. Approval following assessment in residential care and acute hospitals was quicker than in other settings (Table 9). Response times from referral to the end of the assessment process were shorter in hospital and other inpatient settings than residential care or other (community-based) settings. Response times in these settings reported by metropolitan teams were shorter than rural teams. However, response times in residential care and other settings were shorter in rural areas than metropolitan areas. The ranges in response times (calendar days) between teams in the various settings for the trimmed mean were: hospital—1.9 to 14.9; other inpatient—3.1 to 20.9; residential care—6.4 to 26.0; other—9.2 to 36.7.

Table 9: Time from Referral to Delegation date (in calendar days) by First face-to-face contact setting

	Valid n	Missing n	Trimmed mean - days (range)	Median - days (range)	90 th %ile - days (range)
Acute hospital					
Rural	2,323	1,268	8.2 (5.0–14.9)	6 (4–12)	22 (13–35)
Metropolitan	5,049	4,376	7.2 (1.9–14.6)	6 (1–10)	21 (7–38)
Total	7,372	5,644	7.5	6	22
Other inpatient					
Rural	404	258	10.0 (4.9–15.0)	7 (3–12)	29 (15–60)
Metropolitan	2,989	146	9.6 (3.1–20.9)	7 (1–20)	31 (11–43)
Total	3,393	404	9.6	7	30
Residential care					
Rural	1,367	606	15.1 (6.4–21.6)	13 (5–20)	36 (16–48)
Metropolitan	2,656	759	18.8 (9.4–26.0)	16 (7–25)	41 (21–55)
Total	4,023	1,365	17.5	15	40
Other*					
Rural	6,666	3,927	22.0 (9.2–34.2)	17 (7–21)	56 (24–103)
Metropolitan	15,409	4,177	26.5 (13.0–36.7)	24 (11–38)	54 (28–69)
Total	22,075	8,104	25.1	22	54

Note: MDS v2 records only.

Missing values include those with negative times or times over 364 days, cases that were not delegated, and cases without a valid contact setting.

* Community settings, mainly the client’s home.

2.2 Timeliness and Priority category

Tables 10 and 11 present response times in the three Priority categories for hospital (acute hospital and inpatient) and non-hospital (residential care and community) settings. The tables also present the proportion of clients who are seen “on time” in the two settings. These tables provide more

detailed information of response time within settings and Priority categories. The mean (rather than the trimmed mean) and the median are presented, and these, together with the 90th percentile, provide a detailed picture of average response times and the spread within the range. A large difference between the mean and the median indicates that there is a considerable spread of response times within the particular category.

As indicated in the tables above, response times in hospital settings were shorter than in non-hospital settings, and this was so for all Priority categories. Overall, the great majority of referrals were seen “on time” (i.e., Priority 1 within 2 calendar days, and Priority 2 within 14 calendar days), with little difference between rural and metro teams. The proportion seen “on time” was higher in hospital settings than non-hospital settings. The range among the teams in the proportion seen “on time” was between 64% and 100%, with the widest range among clients categorised as Priority 1 in both settings.

Table 10: Time from Referral to First intervention (in calendar days) by Priority category (Hospital settings)

	Valid n	Missing n	Mean - days (range)	Median - days (range)	90th %ile - days (range)	% seen “on time” * (range)
Priority = 1, < 48 hours						
Rural	619	1	1.4 (0.7–3.4)	0 (0–1)	4 (2–18)	84.8 (64.3–95.3)
Metropolitan	6,164	33	1.5 (0.7–1.8)	0 (0–0)	3 (1–3)	88.4 (79.3–97.5)
Total	6,783	34	1.5	0	3	88.0
Priority = 2, 3–14 days						
Rural	3,185	21	4.0 (2.4–9.6)	2 (1–5)	9 (4–14)	96.4 (90.5–99.0)
Metropolitan	5,248	8	2.1 (1.2–3.1)	0 (0–1)	6 (3–7)	98.1 (94.0–100.0)
Total	8,433	29	2.8	1	7	97.5
Priority = 3, more than 14 days						
Rural	401	1	13.4 (11.6–33.5)	8 (7–21)	31 (30–94)	NA
Metropolitan	748	1	5.3 (1.0–15.6)	0 (0–10)	20 (1–43)	NA
Total	1,149	2	8.1	1	26	NA

Note: MDS v2 records only.

Missing values include those that were negative or over 364 days, cases that did not proceed to First intervention, cases without a valid contact setting, and cases without a valid priority category.

* % of clients whose priority category was 48 hours and had an intervention within 48 hours;
% of clients whose priority category was 3-14 days and had an intervention within 14 days.

The data also indicates considerable variability in the coding of priority category and that coding may be influenced by the location of assessment. Overall, 15.9% of referrals were categorised as Priority 1, but in hospital settings 41.5% were categorised as Priority 1 compared to 4.2% in non-hospital settings. Metropolitan teams (50.8%) were much more likely to categorise referrals as Priority 1 in hospital settings than rural teams (14.7%). However, the range in the proportion of referrals given a Priority 1 category was almost as variable among rural teams (0.6%–66.5%) as metropolitan teams (0.7%–76.4%).

Table 11: Referral to First intervention (in calendar days) by Priority category (Non-hospital settings)

	Valid n	Missing n	Mean - days (range)	Median - days (range)	90 th %ile - days (range)	% seen “on time” * (range)
Priority = 1, < 48 hours						
Rural	594	1	2.2 (0.2–4.1)	0 (0–0)	5 (1–14)	86.2 (77.3–100.0)
Metropolitan	889	1	3.0 (1.0–5.3)	1 (0–1)	7 (3–20)	79.5 (68.7–90.8)
Total	1,483	2	2.7	0	6	82.2
Priority = 2, 3–14 days						
Rural	6,797	11	8.3 (6.3–10.5)	6 (5–7)	19 (13–27)	84.5 (76.2–92.8)
Metropolitan	6,769	9	7.7 (2.7–10.0)	6 (0–6)	17 (10–26)	86.3 (79.6–97.8)
Total	13,566	20	8.0	6	18	85.4
Priority = 3, more than 14 days						
Rural	5,085	12	21.7 (12.4–47.3)	14 (8–35)	52.4 (28–119)	NA
Metropolitan	14,819	19	20.7 (9.8–26.5)	19 (7–26)	42 (21–45)	NA
Total	19,904	31	20.9	17	43	NA

Note: MDS v2 records only.

Missing values include those that were negative or over 364 days, cases that did not proceed to First intervention, cases without a valid contact setting, and cases without a valid priority category.

* % of clients whose priority category was 48 hours had an intervention within 48 hours; % of clients whose priority category was 3-14 days had an intervention within 14 days.

2.3 Timeliness by stage

Figure 3: Aggregated time for the assessment process

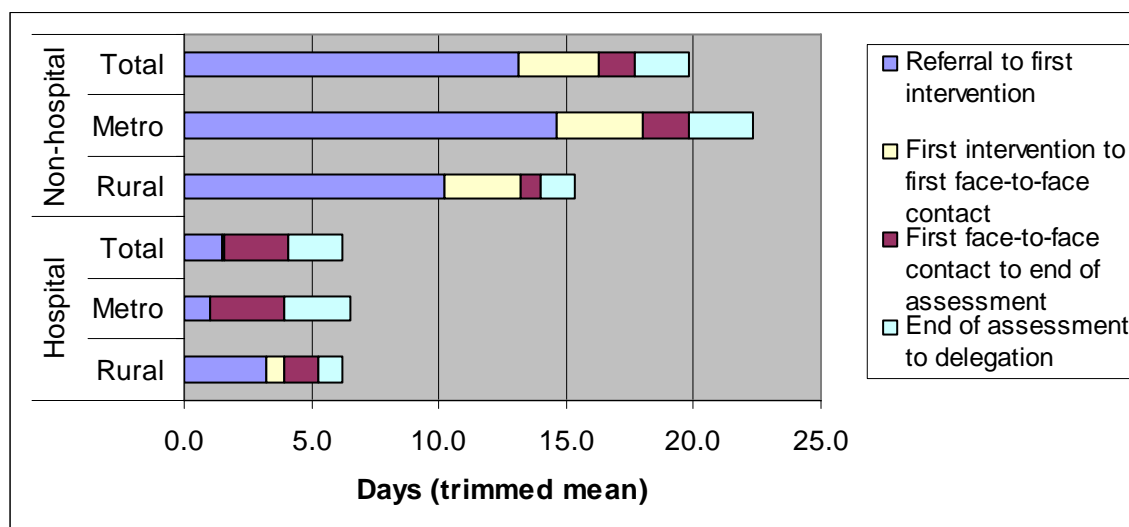


Figure 3 (previous page) provides an overall picture of the time taken for each stage of the assessment process in hospital and non-hospital settings. It highlights some of the points discussed above. The figure shows the considerable difference in total time between hospital and non-hospital settings. It also shows that most of this difference occurs in the first stage of the assessment process, the much shorter response times between referral and first intervention, and the shorter period between first intervention and face-to-face contact in hospital settings.

Summary: Timeliness of assessment

Overall result:

- Response times to referrals varied considerably between hospital and non-hospital settings.
- On average, Victorian ACAS responded to half of the referrals (referral to first intervention) in hospital settings within one calendar day (trimmed mean 1.5 days) and 90% of referrals within a month. In non-hospital settings the median response was 10 calendar days (trimmed mean 13.1 days) with 90% of referrals within 36 days.
- From referral to the beginning of the assessment process (first face-to-face date) took, on average (trimmed mean), a further half day in hospital settings and 6 days in non-hospital settings.
- The assessment process (first face-to-face date to end of assessment date) took, on average (trimmed mean), about 3 calendar days in both hospital and non-hospital settings.
- For those assessments that went on to delegation, this took a further three days in hospital settings and two days in non-hospital settings.
- On average (trimmed mean), the time from referral to end of assessment took 5.5 calendar days in hospital settings and 21.8 calendar days in non-hospital settings.
- Overall, the great majority of referrals (89%) were seen “on time” (i.e., priority 1 within 2 calendar days, and priority 2 within 14 calendar days).

Rural metropolitan comparison:

- Similar average response times for rural and metro teams.
- Response times in hospitals were shorter for metropolitan teams than rural teams.
- Similar proportion seen “on time” in rural and metropolitan areas.

Range:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.1 to 7.3 calendar days; non-hospital settings 5.1 to 21.9 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.2 to 9.5 calendar days; non-hospital settings 7.8 to 32.1 days.
- Response times from referral to approval: hospital settings, trimmed mean 1.9 to 20.9 calendar days; non-hospital settings 6.4 to 36.7 days.
- The proportion seen “on time” for Priority 1 ranged between 64.3% and 100.0%; and Priority 2 between 76.2% and 100.0%.

Section 3: Location of assessment

Whenever possible, clients should be assessed in their usual accommodation setting (Commonwealth Department of Health and Ageing, 2002, p.27). For the majority of clients this will be a community setting or a residential care facility. Because of their medical or functional status, a significant minority of clients are assessed in hospitals or other inpatient facilities. Assessments in hospital settings are often undertaken by staff with multiple roles, such as geriatricians. Assessments in “other hospital settings” are often undertaken by or in conjunction with staff who work in those settings, such as allied health professionals. Most assessments in residential care occur in response to a request to approve high-level care for clients who are currently living in low-level care.

The majority of clients were assessed in a community (“other”) setting, a fifth in acute hospitals and a further tenth in residential care facilities (Table 12). Rural teams assessed relatively more clients in community or residential care settings than metropolitan teams. Clients in metropolitan areas were more likely to be assessed in hospitals or other inpatient settings.

Table 12: Location of assessment

	Hospital (Acute) %	Other inpatient setting %	Residential care setting %	Other* %	Missing %
Rural	21.1	3.9	11.7	62.6	0.8
Metropolitan	26.2	8.8	9.5	54.4	1.2
Total	24.5	7.2	10.2	57.0	1.1

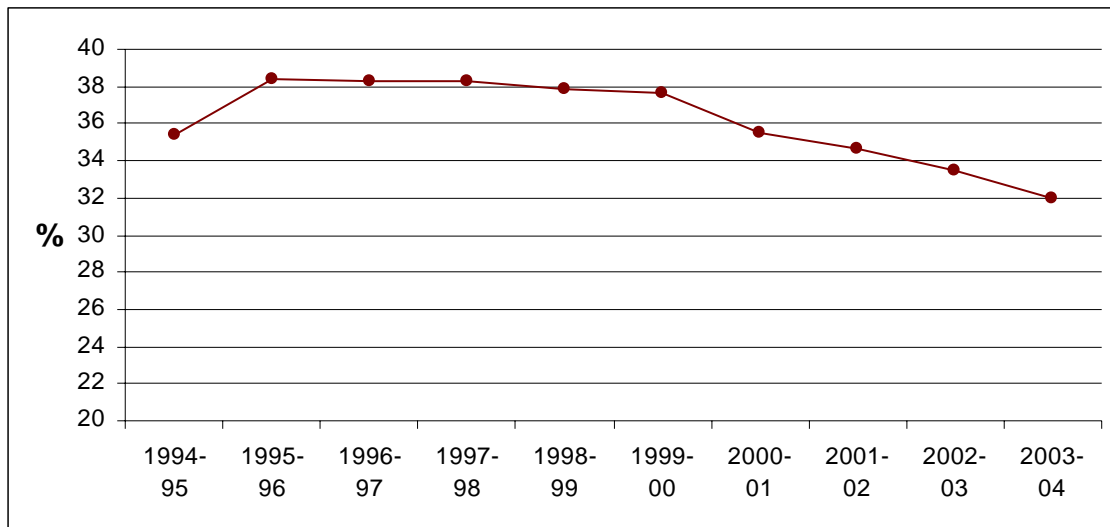
Note: Includes MDS v1 and MDS v2 records. In MDS v1, assessments in other inpatient facilities are included with acute hospital assessments.

* Community settings, mainly the client’s home.

The proportion of clients assessed in the various settings varied considerably among the 18 Victorian teams. Those assessed in hospital ranged from 5.1% to 40.4%; other inpatient from 1.0% to 17.3%; residential care from 5.8% to 13.0; and other 36.4% to 78.8%. These differences are influenced considerably by the availability of facilities (particularly other inpatient facilities) and individual team/auspice policy and practice.

Figure 4 illustrates change over time in the proportion of assessments that take place in hospital settings. Acute hospital and other inpatient settings are classified together to produce this graph. Since 1995–96, the proportion of clients assessed in hospital settings in Victoria has decreased (Figure 4), and in 2003–04 there was a further decrease to the lowest recorded.

Figure 4: Proportion of assessments take place in hospital settings, 1995-1996 to 2003-2004



Note: Assessments in hospital settings includes other inpatient.
2003-04 includes MDS v1 records, and MDS v2 records with a First face-to-face contact date.

Summary: Location at assessment

Overall result:

- The great majority of Victorian clients in their usual accommodation setting—53.9% were assessed in the community and 9.6% in residential care.
- About a fifth of assessments (23.2%) took place in acute hospitals, and a further 6.8% in other inpatient settings.

Rural metropolitan comparison:

- Relatively fewer clients were assessed in acute hospital/other inpatient settings in rural areas compared to metro areas.

Range:

- The proportion of assessments carried out in acute hospital/other inpatient settings ranged considerably across the Victorian teams—from 5.1% to 40.4%.

Trend:

- Since 1995–96, the proportion of clients assessed in acute hospital/other inpatient settings in Victoria has decreased, and in 2003–04 there was a further decrease to the lowest recorded.

Section 4: Assessor profession

Overall, one professional was involved in 42.9% of assessments, two in 18.8%, three in 9.5%, and 18.5 involved four or more assessments with assessor profession recorded. Table 13 shows that over half of all assessments involved a nurse, about 40% a medical professional, about 40% an other health professional, and nearly 40% a social professional (mainly social workers but also welfare workers, counsellors, psychologists and interpreters). Geriatricians were more likely to participate in assessments by metropolitan teams (36.2%) than rural teams (16.0%). Overall, 52.2% of assessments were multidisciplinary, that is, two or more different professions were involved. The proportion of all assessments with no profession recorded was 9.2%. Not recording assessor profession was most common among incomplete assessments, particularly those where the client withdrew or died, or needed further medical treatment.

Table 13: Proportions of assessment include types of assessor profession

	Medical Profession	Nursing Profession	Other health profession	Social profession	Other profession
Rural	30.5	61.0	24.5	21.7	1.2
Metropolitan	48.3	59.3	45.2	45.2	1.7
Total	42.6	59.8	38.6	37.7	1.5

Note: MDS v2 assessments only.

Summary: Assessor profession

Overall result:

- The majority of assessments (57.1%) were multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (59.8%).

CLIENT CHARACTERISTICS AND ACCESS TO ACAP

This section of the report describes the characteristics of clients assessed by Victorian ACAS in 2003–04 and discusses access to the ACAP by clients who may experience difficulty in doing so. The Data Dictionary (AIHW, 2002) specifies that the proportion of older ACAT clients belonging to a special needs group (such as those from culturally and linguistically diverse backgrounds, those who are Aboriginal and/or Torres Strait Islanders, and people living in rural and remote areas) should be consistent with the proportion of older people in the population belonging to these groups. Further, it specifies maintaining or increasing assessment among older population with a severe or profound core activity restriction and older clients with dementia, and decreasing assessment among younger clients with no severe or profound core activity restriction.

Section 5: Age

The age distribution for 2003–04 in Table 14 overleaf shows that two-thirds of ACAS clients were aged 80 years and over. Clients aged 60 years and under comprised 2.6% of total assessments. The age distribution in rural and metro areas was similar. The age distribution has been steadily becoming older since 1994–95. Figure 5 below presents the change in the mean client age over time by comparing compares the age distribution in 1994–95 with that in 2003–04, and shows the increase in the proportion of clients in the older age groups in that time. In the ten years since 1994–95, the proportion of clients aged 80 years and over has increased from 54.7% to 66.8%. In the same time the proportion of clients under 60 years has decreased from 5.9% to the present 2.6%.

Figure 5: Client age, 1994-1995 to 2003-2004

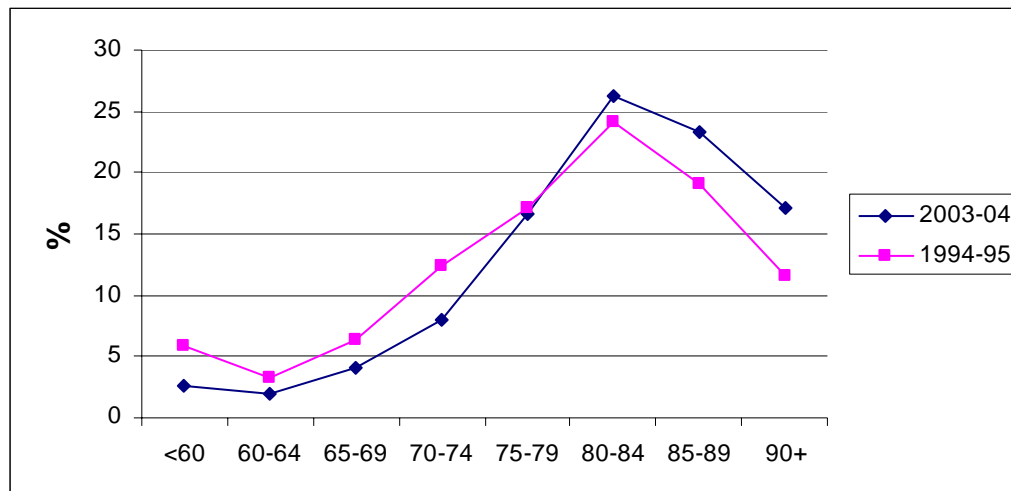


Table 14: Age of ACAS clients

	< 60 years	60-64 years	65-69 years	70-74 years	75-79 years	80-84 years	85-89 years	90-94 years	95+ years	Unknown	Total
Team	%	%	%	%	%	%	%	%	%	%	N.
Rural	2.6	2.0	4.0	7.6	16.8	26.7	23.5	13.3	3.4	0.1	17,890
Metropolitan	2.5	2.0	4.0	8.1	16.6	26.1	23.3	13.6	3.7	0.0	38,113
Total	2.6	2.0	4.0	7.9	16.6	26.3	23.3	13.5	3.6	0.0	56,003

Note: Includes MDS v1 and MDS v2 records.

Summary: Client age

Overall result:

- Two-thirds of clients assessed by Victorian ACAS were aged 80 years and over
- Non-target group clients comprised 8.6% of all assessments.

Rural metropolitan comparison:

- Similar age distribution.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 66.8%.
- The proportion of non-target group assessments has decreased from 15.5% to 8.6% of total assessments.

Section 6: Usual accommodation setting

The usual accommodation setting at assessment of the great majority of ACAS clients was a private residence (72.6%) or other community setting (8.4%). A further 11.6% lived in residential care settings. Table 15 (overleaf) compares the rural with metropolitan teams on client usual accommodation setting. The proportion of clients living in the community ranged from 74.5% to 88.6%, including the range in the proportion living in a private residence from 72.6% to 84.5%. The proportion of clients usually living in low-level residential care ranged from 5.9% to 12.8%; and those in high-level care from 0.3% to 2.0%. The overall proportion of missing data was 4.3% but ranged from 0.3% to 12.6%.

Summary: Accommodation setting

Overall result:

- The great majority of Victorian clients (72.6%) lived in the community or other community setting (8.4%) at assessment.
- 11.6% lived in residential care (10.8 in low-level care; 0.8% in high-level care).

Rural metropolitan comparison:

- Relatively more clients live in the community, particularly private residences, in rural areas than metro areas.
- Similar proportions of clients in residential care.

Range:

- The proportion of clients living in the community ranged from 74.5% to 88.6%.

Table 15: Usual accommodation setting of ACAS clients

	Private residence	Other community	Community total	Low Care	High Care	Residential Total	Other	Unknown/Missing	Total
	%	%	%	%	%	%	%	%	n
Rural	76.6	5.6	82.2	10.3	1.0	11.3	3.0	3.5	17,890
Metro	70.7	9.7	80.3	11.0	0.8	11.8	3.2	4.7	38,113
Total	72.6	8.4	80.9	10.8	0.8	11.6	3.1	4.3	56,003

Note: Includes MDS v1 and MDS v2 records.

Table 15a: Usual accommodation setting of ACAS clients—community settings

	Private residence - owned	Private residence - private rent	Private residence - public rent	Retirement village (ILU)	Boarding/rooming house	Crisis, emergency or transitional accomm.	Supported community accomm.	Total
	%	%	%	%	%	%	%	n
Rural	64.5	6.4	5.7	3.6	0.2	0.1	1.7	82.2
Metro	62.7	3.8	4.2	5.8	0.3	0.2	3.4	80.3
Total	63.2	4.6	4.7	5.1	0.3	0.1	2.8	80.9

Note: Includes MDS v1 and MDS v2 records.

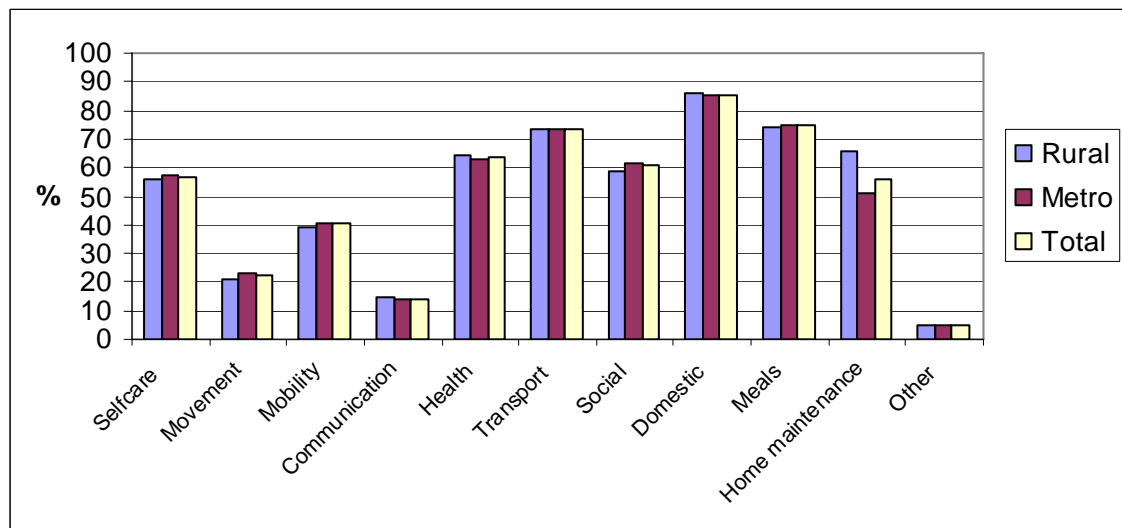
Section 7: Functional profile and health conditions

This section provides functional profiles—in terms of activity limitations—of clients usually living in the community and in residential care, and the formal and informal assistance they were receiving at assessment. Activity limitation is defined as whether the person needs the help or supervision of another individual in ten activities of daily living. This profile also identifies people with a severe or profound core activity restriction, defined as someone who sometimes, or always needs assistance with one or more of the tasks of self-care, mobility (includes movement and mobility below) or communication (AIHW, 2002).

7.1 Activity limitations

Figure 6 below shows that the great majority of Victorian ACAS clients living in the community were assessed as needing assistance with domestic activities (including washing, ironing, cleaning), meals and transport (including using public transport, getting to and from places away from home and driving) just prior to their assessment. Need for assistance with self-care was also relatively common. The level of the need for assistance was similar in rural and metropolitan areas. The range across teams for the need for domestic assistance was 62.7% to 92.0% of clients, for meals 51.3% to 82.4%, for transport 50.0% to 84.7%, and for self-care 35.4% to 68.3%. Among Victorian clients, nearly two-thirds (65.0%) had a severe or profound core activity restriction, with a similar proportion across rural (64.7%) and metropolitan teams (65.1%).

Figure 6: Activity limitations of clients usually living in the community



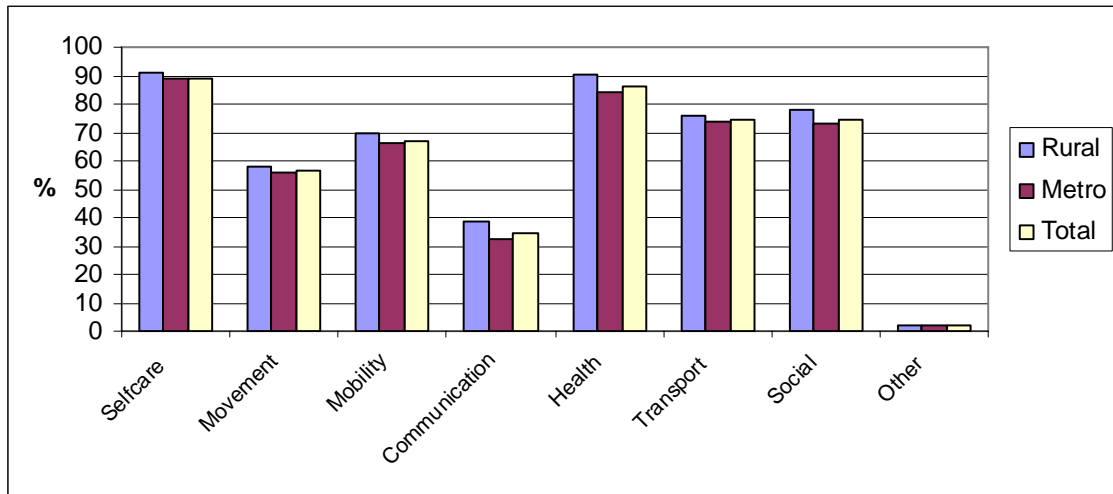
Note: Complete MDS v2 assessments only.

As expected, proportionately more clients living in residential care needed assistance than those living in the community. Almost 90% received assistance with self-care and health care tasks (including taking medication, dressing wounds), and three-quarters received assistance with social and community participation (includes shopping, managing finances, and participation in recreational, cultural or religious activities) and transport (Figure 7 next page).^{*} The level of activity limitations in residential care was consistently higher in rural than metropolitan areas.

^{*} Note that the need for assistance with domestic activities, meals and home maintenance is not recorded for people living in residential care, assistance with these activities is provided as part of the care.

The range across teams for self-care was 71.3% to 99.4% of clients, for health 77.2% to 98.2%, for transport 60.6% to 88.4%, and for social participation 65.1% to 93.3%.

Figure 7: Activity limitations of clients usually living in residential care

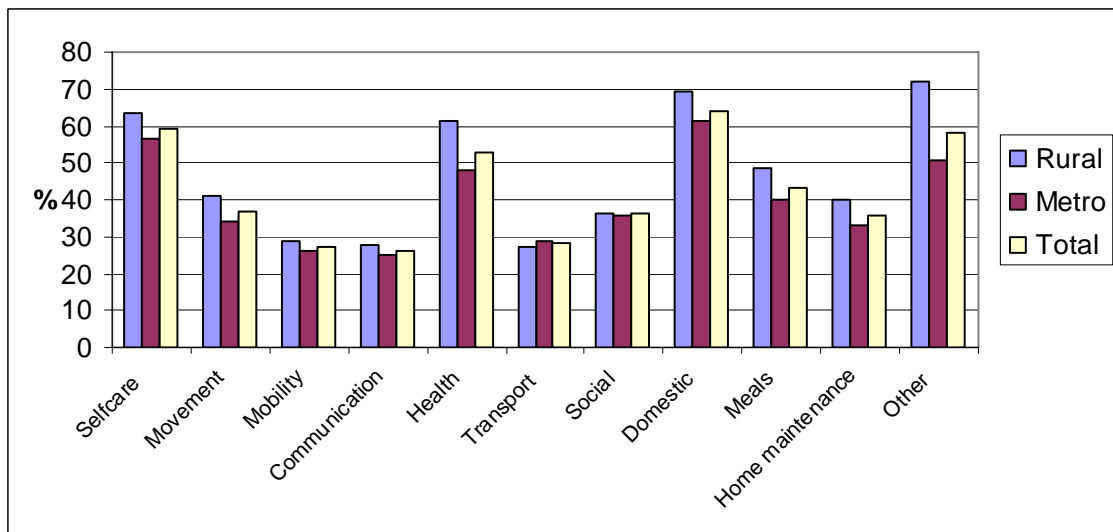


Note: Complete MDS v2 assessments only.

7.2 Assistance with activities

Figure 8 shows the proportion of clients who received formal assistance (or formal and informal assistance) with each activity. Just prior to assessment, most clients were receiving formal assistance with domestic activities (64.2%; range 48.9%–74.4%), self-care (59.1%; range 48.7%–74.8%) or health tasks (52.7%; range 39.4%–81.0%)*. The level of formal assistance prior to assessment was slightly higher in rural than metropolitan areas.

Figure 8: Formal assistance with activities (clients living in the community)

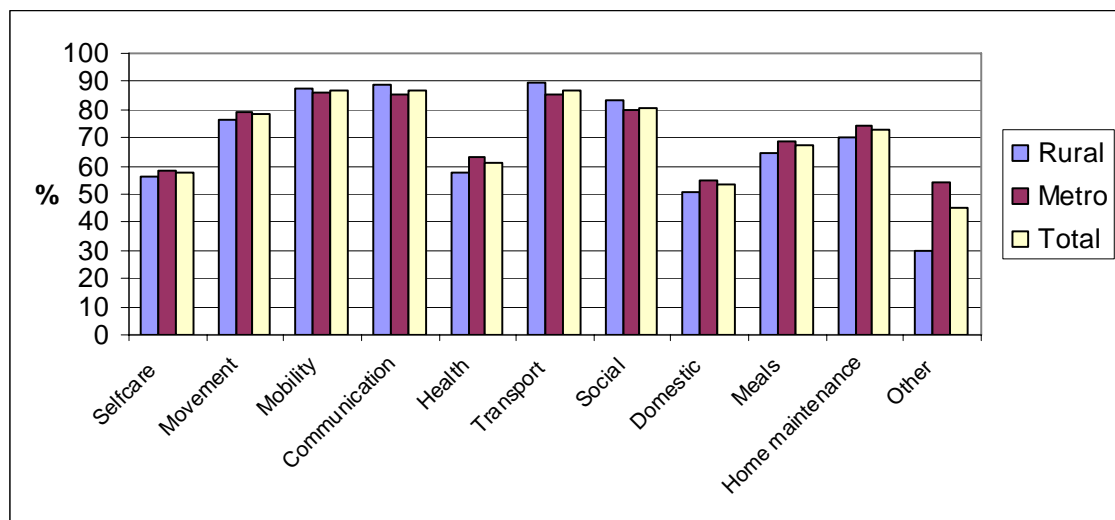


Note: Complete MDS v2 assessments only. Numbers are the proportion of people who received assistance with an activity who received formal assistance with the activity.

* The high proportion of “other” may be due in part to inappropriate coding.

Figure 9 shows the proportion of clients who received informal assistance (or formal and informal assistance) with each activity. The level of informal assistance was considerably higher than formal assistance. Just prior to assessment, the great majority clients were receiving informal assistance with mobility, communication, transport, social participation, movement activities and home maintenance, and the majority received assistance with the other activities. There appears to be a considerable degree of complementarity between formal and informal assistance in that there was a greater level of informal assistance for those activities with a low level of formal assistance. The average and range for the most commonly provided activities were mobility (86.7%; range 74.6%–96.0%), communication (86.5%; range 74.0%–95.8%), transport (87.1%; range 78.0%–91.1%) and social participation (80.8%; range 71.9%–91.1%). The level of informal assistance for most activities was lower in rural areas than metropolitan areas.

Figure 9: Informal assistance with activities (clients living in the community)



Note: Complete MDS v2 assessments only. Numbers are the proportion of people who received assistance with an activity who received informal assistance with the activity.

Summary: Activity limitations

Overall result:

- The great majority of Victorian ACAS clients living in the community were assessed as needing assistance with domestic activities, meals and transport just prior to their assessment. Assistance with self-care was also relatively common.
- Nearly two-thirds (65.0%) of clients had a severe or profound core activity restriction.
- Proportionately more clients living in residential care were assessed as needing assistance than those living in the community. Almost 90% needed assistance with self-care and health care tasks, and three-quarters needed assistance with social and community participation, and transport.
- The level of activity limitation in residential care was consistently higher in rural than metropolitan areas.

Rural metropolitan comparison:

- The level of the need for assistance was similar in rural and metropolitan areas.

Range:

- There was considerable range across the teams, for example the need for domestic assistance among clients in the community ranged from 62.7% to 92.0% of clients, meals 51.3% to 82.4%, transport 50.0% to 84.7%, and self-care 35.4% to 68.3%.
- The need for assistance among clients living in residential care ranged from 71.3% to 99.4% for self-care, from 77.2% to 98.2% for health, from 60.6% to 88.4% for transport, and from 65.1% to 93.3% for social participation.

Summary: Assistance with activities

Overall result:

- Just prior to assessment, most clients were receiving formal assistance with domestic activities (64.2%), self-care (59.1%) or health tasks (52.7%).
- The level of informal assistance was considerably higher than formal assistance. The average for the most commonly provided activities were mobility (86.7%), communication (86.5%), transport (87.1%) and social participation (80.8%).
- There appears to be a considerable degree of complementarity between formal and informal assistance in that there was a greater level of informal assistance for those activities with a low level of formal assistance.

Rural metropolitan comparison:

- The level of formal assistance prior to assessment was slightly higher in rural than metropolitan areas.
- The level of informal assistance for most activities was lower in rural areas than metropolitan areas.

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranged between 48.9% and 74.4%, self-care between 48.7% and 74.8%) and health tasks between 39.4% and 81.0%.
- Informal assistance with mobility activities ranged from 74.6% to 96.0%, communication from 74.0% to 95.8%, transport from 78.0% to 91.1% and social participation from 71.9% to 91.1%.

7.3 Health conditions

Tables 16 and 17 (overleaf) provide a profile of the Health conditions of clients who had a complete assessment. Table 16 provides the proportions of clients with the 12 most common diagnoses, and Table 17 provides the same figures for first health condition listed. The first health condition listed in MDS v2 records is the Primary Diagnosis/condition, that is, the diagnosis or condition that has the most impact on the client's need for assistance with activities of daily living and social participation.

Overall, heart conditions, arthritis, dementia, and hypertension were the most common diagnoses among ACAS clients, with similar relative frequencies in rural and metropolitan areas (Table 16). The most common primary health condition was dementia (18.0%). A comparison between Tables 16 and 17 provides an indication of the relative importance of the health conditions that lead to an assessment and the complexity of client conditions assessed by ACAS. In particular, the part played by dementia in precipitating an assessment. Dementia was

not the most common among all listed conditions but was more than twice as frequent compared to other diagnoses reported for the primary health condition.

Summary: Health conditions

Overall result:

- Overall, heart conditions, arthritis, dementia, and hypertension were the most common diagnoses among ACAS clients.
- The most common primary health condition was dementia (18.0%).

Rural metropolitan comparison:

- Rural and metropolitan clients had similar health condition profiles.

Other comments

- Dementia is a significant condition in precipitating an ACAS assessment—it was more than twice as frequent as the primary health condition than other diagnoses.

Table 16: Diagnosed diseases/disorders – all listed (12 most common conditions)

	Arthritis %	Dementia %	Hypertension %	Heart %	CVA %	Eye and vision %	Diabetes %	CLRD %	Psycho- affective %	Osteoporosis %	Fracture %	Parkinson's %
Rural	27.5	22.1	22.6	28.9	13.7	13.6	12.5	12.1	10.6	8.9	7.4	4.1
Metro	26.7	25.5	25.7	28.1	14.9	14.0	13.3	11.3	11.6	9.6	9.5	4.2
Total	26.9	24.4	24.7	28.4	14.5	13.9	13.0	11.5	11.3	9.4	8.8	4.2

Table 17: Diagnosed diseases/disorders – primary condition (12 most common conditions)

	Arthritis %	Dementia %	Hypertension %	Heart %	CVA %	Eye and vision %	Diabetes %	CLRD %	Psycho- affective %	Osteoporosis %	Fracture %	Parkinson's %
Rural	9.1	16.3	2.7	8.7	7.8	2.8	3.5	5.1	2.8	2.0	3.7	2.8
Metro	7.9	18.8	3.0	7.6	8.2	2.3	3.6	4.0	2.9	1.4	4.3	2.9
Total	8.3	18.0	2.9	8.0	8.1	2.5	3.5	4.3	2.9	1.6	4.1	2.9

Note:

Combined codes	Arthritis	Includes Rheumatoid arthritis (1301), osteoarthritis and other arthritis (1302)
	Dementia	Includes all dementias (codes 0500 to 0532)
	Heart	Includes angina (903), heart attack (904), heart disease (905), heart failure (906) and other heart diseases (907)
	CVA	Includes codes for cerebrovascular disease and stroke (codes 0910 to 0916)
	Vision	Includes all diseases of the eye and adnexa (codes 0701 to 0799)
	Diabetes	Includes Type 1 (code 0402), Type 2 (code 0403) and Unspecified (code 0404)
	CLRD	Chronic lower respiratory disease, Code 1005 (includes emphysema, COAD, asthma)
	Fracture	Includes all codes for fractures (codes 1606 to 1612)
Single codes	Hypertension = Code 0921, Osteoporosis = Code 1306, Depression = code 0552 (includes all affective disorders)	

Section 8: Access for special needs groups

8.1 Clients from Culturally and linguistically diverse backgrounds

Table 18 shows that 18.4% of all accepted referrals were people of Culturally and Linguistically Diverse (CALD) backgrounds, with a higher proportion in metropolitan than rural areas. Accepted referrals are used as the basis for forming an index for clients from CALD backgrounds because the issue is access to ACAS (rather than the assessment completion rate). Table 18 also presents an index that compares the proportion of accepted referrals that involve clients from CALD backgrounds with the proportion of CALD people in the target population. An index below 1.0 indicates that fewer people from CALD backgrounds are referred than would be expected from their proportion of the target population for ACAS. The index shows that access of people from CALD backgrounds to both rural and metropolitan ACAS was below their representation in the 70+ years population. It should also be noted that the proportion of people from CALD backgrounds probably is an underestimate because it is based on counts from the 2001 ABS Census. Across the teams the index ranged from 0.7 to 1.1.

Table 18: Assessments clients from CALD backgrounds

	CALD in population aged 70+ N (2001 Census)	Proportion of target population is CALD (%) ¹	CALD referrals N	Proportion of CALD referrals (%) ²	Index (proportion of referrals/ proportion of target population) ³
Rural	12,164	8.1	1,392	7.8	0.96
Metro	84,064	26.2	8,892	23.3	0.89
Total	96,228	20.4	10,284	18.4	0.90

Note: Includes MDS v1 and MDS v2 records with valid country of birth.

¹ (Population count CALD background aged 70+) * 100/(Total population aged 70+).

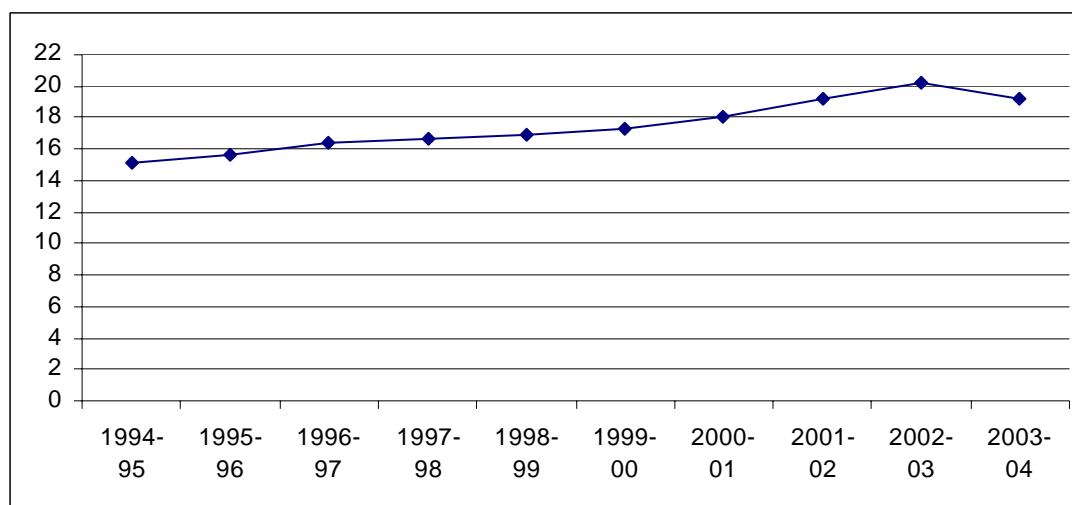
² (Referrals with CALD background) * 100/(Total referrals).

³ Column 5/column 3.

Source: 2001 ABS Census.

Figure 10 (next page) presents the proportion of total assessments of people of CALD backgrounds over the previous ten years (for comparison with previous years only assessments with face-to-face contact were included). In 2003–04 the proportion of assessments of people of CALD backgrounds was lower than the previous year and went against a trend of increasing proportions over previous years.

Figure 10: Proportion of assessments from CALD background, 1994-1995 to 2003-2004



Note: 2003–04 data includes MDS v1 referrals and MDS v2 referrals with face-to-face contact.

Summary: Clients from CALD backgrounds

Overall result:

- About a fifth of Victorian assessments (18.4%) were of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS was below their representation in the 70+ years population.

Rural metropolitan comparison:

- There were relatively fewer CALD clients assessed in rural areas compared to metro areas.

Trend:

- The proportion of referrals from people of CALD backgrounds was lower than the previous year and went against a trend of increasing proportions over the previous ten years.

8.2 Clients from Indigenous backgrounds

Table 19 presents the numbers of referrals of Indigenous clients and the number of referrals with face-to-face contact. Of all referrals of Indigenous clients, the great majority went to a complete assessment (25.2%) or delegated assessment (63.7%).

Table 19: Numbers of clients from Indigenous backgrounds

	Indigenous clients (referrals)	Total referrals	Indigenous clients with face-to-face contact	Total referrals with face-to-face contact
Rural	94	17,641	85	16,732
Metro	184	35,535	172	33,306
Total	278	53,176	257	50,038

Note: MDS v2 data only.

Table 20 presents the number (and proportion) of accepted referrals of clients from Indigenous backgrounds, and compares this with the proportion of indigenous people in the target population to produce an index. An index below 1.00 indicates that fewer people from indigenous backgrounds are referred for assessment than would be expected from their proportion of the target population for ACAP. Referrals are used as the basis for forming an index for clients from Indigenous backgrounds because the issue is access to ACAS rather than the assessment completion rate.

It is likely that the size of the Indigenous population is underestimated because the available data is from the 2001 Census counts, and there are large proportions of missing data in the Census on this item. (Also, people who did not state indigenous status are included in the target population, thus reducing the proportion of people with Indigenous status.)

Less than 1% of all referrals involve people from Indigenous backgrounds (Table 20). Table 20 also shows that overall, Indigenous referrals to metropolitan teams were more than expected from the proportion in the population, while among rural teams it was the reverse. The proportion of Indigenous to total referrals ranged from 0.2% to 2.0%.

Table 20: Proportion of assessments involve clients from Indigenous backgrounds

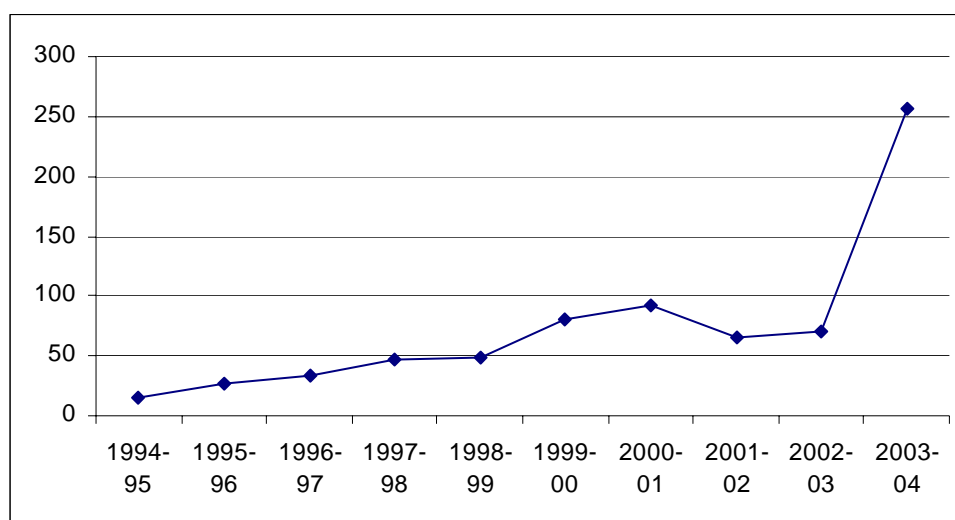
	Indigenous population aged 50+ (2001 Census)	Proportion of target population is Indigenous	Indigenous referrals	Proportion of referrals are Indigenous	Index (proportion of referrals/ proportion of target population)
	N	%	N	%	
Rural	1,427	0.95	94	0.53	0.56
Metro	1,248	0.39	184	0.48	1.23
Total	2,675	0.57	278	0.50	0.88

Note: MDS v2 data only.

Source: 2001 ABS Census.

Figure 11 charts the numbers of Indigenous clients assessed in Victoria since 1994–95. It shows a marked increase in 2003–04 over previous years. It is likely this is mainly due to improved data recording with the introduction of MDS v2 in early/mid 2003.

Figure 11: Number of Indigenous clients, 1994-1995 to 2003-2004



Note: 2003–04 data includes MDS v1 referrals and MDS v2 referrals with face-to-face contact.

Summary: Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.5% of all referrals involve people from Indigenous backgrounds while 0.57% of the target population are Indigenous.

Rural metropolitan comparison:

- Indigenous referrals to metropolitan teams were more than expected from the proportion in the population, while among rural teams it was the reverse.

Range:

- The proportion of Indigenous to total referrals ranged from 0.2% to 2.8%.

Trend:

- The number of Indigenous clients has increased in most years since 1994–95.
- In 2003–04 there was a marked increase in Indigenous assessments (with face-to-face contact) over previous years. This is probably due to improved data recording with the introduction of MDS v2 in early/mid 2003.

8.3 Clients with dementia

Table 21 shows that over a quarter of complete assessment of target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) and 15% of “non-target group” clients were diagnosed with dementia at the time of assessment.* These proportions were similar in rural and metropolitan areas. There was more variation among the teams. The proportion of non-target group clients with dementia ranged from 9.2% to 26.0%, and the proportion of target group clients ranged from 13.4% to 37.8%.

Table 21: Proportion of assessments involve clients with dementia

	“Non-target group” clients with dementia (%)	Target group clients with dementia (%)
Rural	14.5	24.5
Metropolitan	15.6	29.6
Total	15.2	27.9

Note: Includes complete MDS v2 assessments only.

While health conditions are recorded differently in MDS v2 than MDS v1, it is worth noting the previously related measures of dementia collected under MDS v1. The principal diagnosis and orientation disability were recorded in MDS v1. In 2002–03 a principal diagnosis of dementia was reported for 20.4% of clients, and 33.1% were reported to have an orientation disability (not aware of time and place).

* Includes Alzheimer’s disease (early and late onset), vascular dementia, dementia in other diseases (including Huntington’s disease, Parkinson’s disease and Pick’s disease), and other dementia (including alcoholic dementia)—health condition codes 0500 to 0532.

Summary: Clients with dementia

Overall result:

- Over a quarter (27.9%) of target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) were diagnosed with dementia at the time of assessment.
- 15% of non-target group clients were diagnosed with dementia at the time of assessment.

Rural metropolitan comparison:

- Similar proportions of diagnosed dementia among rural and metro clients.

Range:

- The proportion of target group clients with dementia ranged from 13.4% to 37.8%.
- The proportion of non-target group clients with dementia ranged from 9.2% to 26.0%.

8.4 Clients and carers

Table 22 shows that the great majority of clients (81.0%) had carers, and that the majority of carers were co-resident. The proportion of clients with carers was slightly higher, and non-resident carers were relatively more common, in rural areas than metropolitan areas.

Table 22: Proportion of assessments involve clients with carers

	Clients with no carer	Clients with co-resident carer	Clients with non-resident carer	Not known
Rural	17.2	40.5	36.9	5.4
Metropolitan	19.9	42.3	28.5	9.3
Total	19.0	41.7	31.3	8.0

Note: Includes clients living in the community and complete assessments only

Information on carers was not recorded under MDS v1 and no historical comparisons are possible.

Summary: Clients and carers

Overall result:

- The great majority of clients (81.0%) had carers.
- The majority of carers were co-resident.

Rural metropolitan comparison:

- The proportion of clients with carers was slightly higher in rural areas than metropolitan areas.
- Non-resident carers were relatively more common in rural than metropolitan areas.

8.5 Clients “at risk” of admission to residential care

Clients are defined as being “at risk” of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 or over (or Indigenous and aged 60 or over); having a severe or profound core activity restriction (needs assistance with one or more the tasks of self-

care, mobility or communication); having dementia; living alone; not having a carer. A multidisciplinary assessment is defined as involving more than one of the professions listed in ACCR item 34, counting all medical practitioners as one profession and all nursing professionals as one profession. It is acknowledged that one ACAS member may be able to incorporate more than one dimension of care need into their assessment of a client's care needs.

Table 23 shows that in 2003–04 nearly a tenth of clients living in the community were “at risk” of admission to residential care facility. The proportions “at risk” in rural and metropolitan areas were similar. Table 23 also shows that nearly half of all clients receive a multi-disciplinary assessment (MDA) but this was more likely if the client lived in a metropolitan area. Nearly two-thirds of “at risk” clients received a MDA.

Table 23: Proportion of clients “at risk” of admission to residential care given a multi-disciplinary assessment

	Community clients (n)	Clients at risk		Clients get MDA		Clients at risk get MDA	
		n	%	n	%	n	%
Rural	13,705	1,154	8.4	5,180	37.8	579	50.2
Metro	27,286	2,556	9.4	14,254	52.2	1,710	66.9
Total	40,991	3,710	9.1	19,434	47.4	2,289	61.7

Note: Clients “at risk” are defined as living in the community and being at risk of entering residential care through having at least 4 of the following 5 risk factors; aged 80+ (or Indigenous aged 60+); having a severe or profound core activity restriction; having dementia; living alone; and having no carer.

Includes only complete MDS v2 assessments with valid values for the 5 risk factors.

MDA = Multi-disciplinary assessment.

Summary: Client's “at risk”

Overall result:

- Overall, 9.1% of clients living in the community were “at risk” of admission to a residential care facility.
- “At risk” clients were more likely to receive a multidisciplinary assessment than all clients—61.7% of “at risk” clients received a MDS compared with 47.4% of all clients.

Rural metropolitan comparison:

- The proportions “at risk” in rural and metropolitan areas were similar.
- A MDA was more likely if the client lived in a metropolitan area.

RECOMMENDATIONS

This section documents assessment recommendations as an indicator of the movements of ACAS clients within the aged care system.

Section 9: Recommendations—general

In this section, overall recommendation patterns for ACAP-delegated services are examined. Recommended long-term care settings by accommodation setting are examined first. This subsection provides an analysis of the proportions of clients who are recommended to residential care from the community, and to high-level care from low-level care. In the next two subsections, recommendations for two community services that require ACAP delegation—CACPs and residential respite—are examined.

9.1 Recommended long-term care setting by Accommodation setting—usual

In Table 24, the proportions of assessments that result in recommendations for long term care settings in the community, in residential care, and ‘other’ are presented. (See Table D1 in Appendix B for raw numbers on which this table is based.)

Table 24: Recommended long-term care setting by Accommodation setting—usual (%)

	Community	Low-level care	High-level care	Other/missing	Total
Clients living in the community at assessment					
Rural	60.4	23.4	15.6	0.6	100.0
Metropolitan	60.9	21.4	16.7	1.0	100.0
Total	60.8	22.0	16.3	0.9	100.0
Clients living in low-level residential care at assessment					
Rural	1.6	16.3	81.6	0.5	100.0
Metropolitan	1.3	17.6	80.4	0.8	100.0
Total	1.4	17.2	80.8	0.7	100.0
Clients living in high-level residential care at assessment					
Rural	3.0	17.4	77.8	1.8	100.0
Metropolitan	4.7	12.5	81.2	1.6	100.0
Total	4.0	14.5	79.9	1.7	100.0
Clients living in other settings (or missing usual accommodation setting) at assessment					
Rural	36.1	32.0	26.4	5.5	100.0
Metropolitan	39.1	30.3	23.1	7.5	100.0
Total	38.2	30.8	24.1	6.9	100.0

Note: Complete assessments only. Counts are very low in some cells (see Appendix B).

Accommodation setting—usual: community includes private residence; retirement village (independent living); boarding house/rooming house/private hotel; short-term, emergency or transitional accommodation; and supported community accommodation (SRS). Other includes hospital, other institutional care, public place/temporary shelter and “other”.

Recommended long-term care: community includes private residence; retirement village (independent living); boarding house/rooming house/private hotel; and supported community accommodation. Other includes hospital; other institutional care; and “other”.

Table 24 shows that the majority of clients living in the community at assessment (60.8%) receive a recommendation to continue living in the community. Overall, this was similar in rural and metropolitan areas but there was more variation across the 18 teams—community to community recommendations ranged from 47.9% to 75.7%.

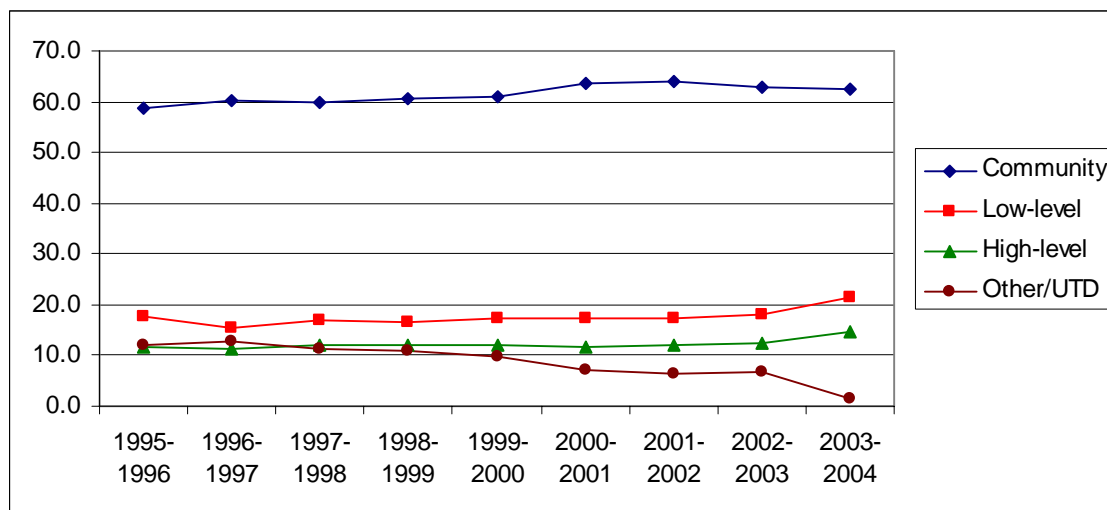
As would be expected, the great majority of clients living in low-level residential care at assessment (80.8%) were recommended to high-level care, with similar proportions in rural and metropolitan areas. Across the teams the proportion of low-level to high-level recommendations ranged from 67.8% to 90.9%.

The great majority of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care in 2003–04. However, a significant minority (14.5%) were recommended to low-level care, and a further 4.0% received community recommendations. (Ranges across the teams are not meaningful because of small cell numbers.)

Under MDS v1 coding, supported residential services were categorised as low-level residential care. In 2003–04, 2.8% of assessments were of people living in a SRS, with proportionally more in metropolitan (3.4%) than rural areas (1.7%). The recommendations resulting from these assessments were community 2.7%, supported community accommodation (SRS) 13.3%, low-level care 34.0%, and high-level care 48.9%. If clients living in supported community accommodation are coded with low-level care, the main impact on Table 24 is to increase the proportion of residential care recommendations for those clients usually living in low-level residential care by about 6%. Other outcomes were within 2% of those in Table 24. For clients living in low-level care at assessment the recommendations are as follows: community 1.4% (rural 1.6%; metropolitan 1.3%), low-level care 17.2% (rural 16.3%; metropolitan 17.6%), and high-level care 80.8% (rural 81.6%; metropolitan 80.4%).

Historical data provides a context for the current recommendations. Figure 12 presents the recommendations resulting from assessments of clients usually living in the community, while Figure 13 presents recommendations for clients in low-level residential care. For historical comparison, the analysis is based on referrals with a face-to-face contact date and clients living in supported community accommodation are considered to be living in low-level residential care.

Figure 12: Recommendations for community-dwelling clients (%)



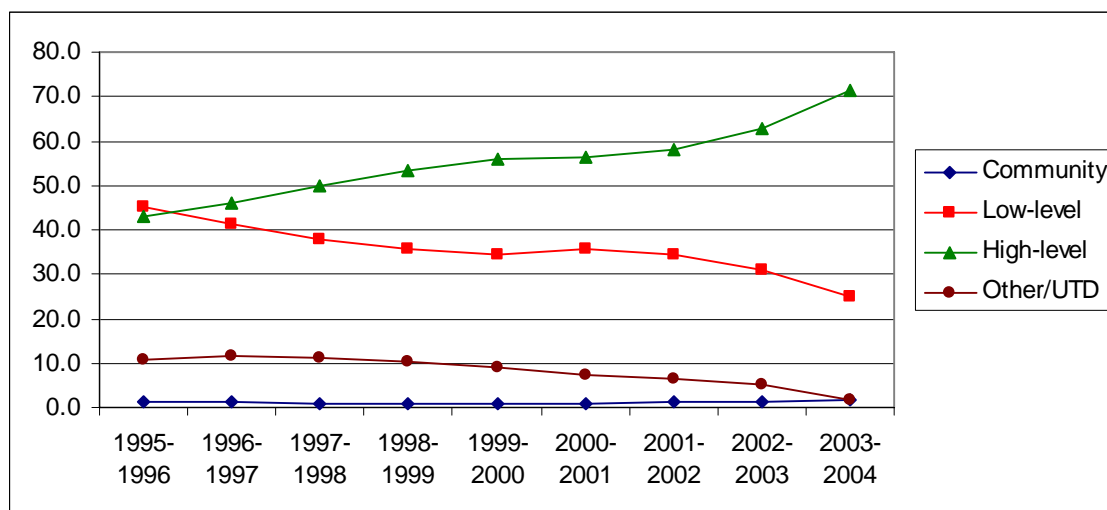
Note: Clients living in the community with a face-to-face assessment date recorded. Clients living in SRS included in low-level care.

Prior to 2001-02 there was a steady (but slow) increase in the proportion of community-dwelling clients recommended to remain in the community. The last few years have seen a reversal of that trend and a decrease in the proportion recommended to the community, with an increase in residential care recommendations. There has also been a consistent decrease in the

proportion of other/unable to determine category. Recommendations for 2003–04 continued this recent trend.

Over the previous nine years the proportion of clients living in low-level residential care and recommended to high-care has steadily increased, with a corresponding decrease in recommendations to remain in low-level care and in the proportions of other/UTD. In 2003-04 this trend continued with a further increase in high-level and a decrease in low-level recommendations (Figure 13). The proportion of other/unable to determine also continued to decline.

Figure 13: Recommendation for clients in low-level residential care (%)



Note: Clients living in low-level residential care with a face-to-face assessment date recorded.

Summary: Long-term care by accommodation setting

Overall result:

- The majority of clients living in the community at assessment (60.8%) received a recommendation to continue living in the community.
- The great majority (80.8%) of clients living in low-level residential care at assessment were recommended to high-level care.
- The great majority (79.9%) of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care.
- However, a significant minority (14.5%) of clients living in high-level care were recommended to low-level care, and a further 4.0% received community recommendations.

Trends:

- In contrast to the trend up to 2001–02, the last few years have seen a decrease in the proportion recommended to the community and an increase in the proportion recommended to residential care.
- In 2003–04 this trend continued, the proportion recommended to residential care from the community increased again.

- Consistent with the trend in previous years, in 2003–04 there was a further increase in the proportion of clients living in low-level residential care and recommended to high-care.

Rural metropolitan comparison:

- The proportion of community to community recommendations was similar in rural and metropolitan areas.
- The proportion of low-level to high-level recommendations was similar in rural and metropolitan areas.

Range:

- Across the teams the proportion of community to community recommendations ranged from 47.9% to 75.7%.
- Low-level to high-level recommendations ranged from 67.8% to 90.9%.

9.2 Recommendations for CACPs

Recommendations for community services may be new (i.e., the client was not receiving the service at assessment) or on-going (i.e., the client was already receiving the service at assessment).

Of the 25,588 complete assessments resulting in a community recommendation in 2003-2004, 8,229 assessments resulted in recommendations for CACPs: 5,995 for newly recommended CACPs, and 2,234 for on-going CACPs, that is CACPs are recommended in about a third of community assessments, including new recommendations for CACPs from nearly a quarter of assessments (Table 25). The proportion of CACPs recommended (new and ongoing) was similar in rural and metropolitan areas, with new recommendations more likely in rural areas. Across the teams the proportion of assessments with a CACPs recommendation (new and ongoing) ranged from 21.1 to 52.4. The proportion of new recommendations ranged from 14.3% of assessments to 43.7%.

Table 25: Recommendations for CACPs

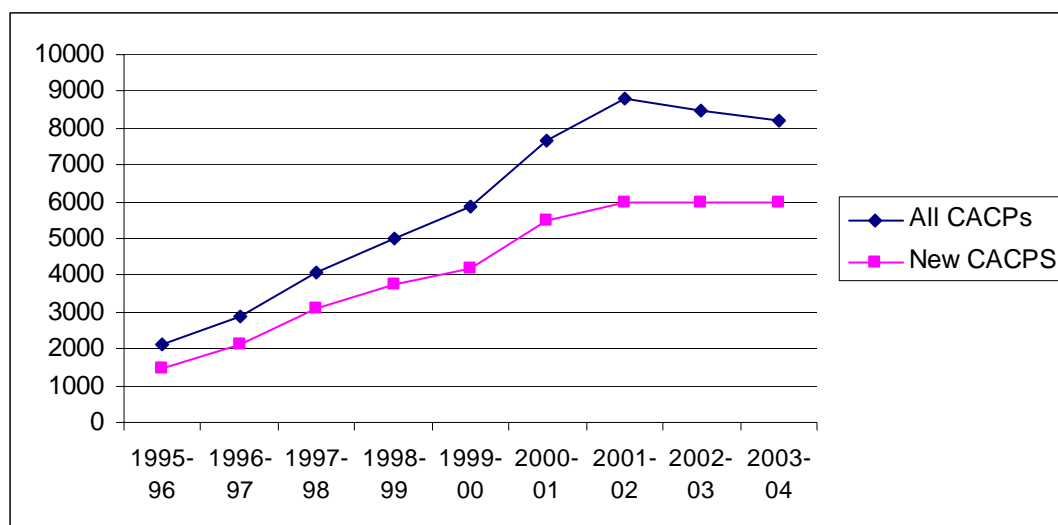
	Newly-recommended CACPs		On-going CACPs		Total recommended CACPs		Total recommended to community
	n	%	n	%	n	%	N
Rural	2,139	25.2	575	6.8	2,714	31.9	8,495
Metropolitan	3,856	22.6	1,659	9.7	5,515	32.3	16,907
Total	5,995	23.4	2,234	8.7	8,229	32.2	25,402

Note: Community-recommended clients with complete assessments only.

The percentages in this table are the proportions of community-recommended clients who are recommended CACPs.

Figure 14 shows that the number of CACPs recommended increased markedly between 1995–96 and 2001–02. In the last three years the number of CACPs recommended has declined and new recommendations have stabilised.

Figure 14: Recommendations for CACPs for community-recommended clients (counts)



Summary: Recommendation for CACPs

Overall result:

- CACPs are recommended in about a third of assessments of people usually living in the community, including new recommendations for CACPs from nearly a quarter of assessments.

Trends:

- After marked increases between 1995–96 and 2001–02, the number of CACPs recommended has declined in the last three years and new recommendations have stabilised.

Rural metropolitan comparison:

- The proportion of CACPs recommended (new and ongoing) was similar in rural and metropolitan areas, but new recommendations were more likely in rural areas.

Range:

- Across the teams the proportion of assessments with a CACPs recommendation (new and ongoing) ranged from 21.1% to 52.4%.
- The proportion of new recommendations ranged from 14.3% to 43.7%.

9.3 Recommendations for respite

Almost two-thirds of clients recommended to the community receive a recommendation for residential respite care, and over a tenth a recommendation for non-residential respite. Clients in rural areas were less likely to receive a recommendation for residential respite and more likely to receive a recommendation for non-residential respite. Recommendations for residential respite ranged between 38.2% and 89.1% of clients recommended to the community, and for non-residential respite between 3.6% and 23.7%.

Table 26: Recommendations for respite care

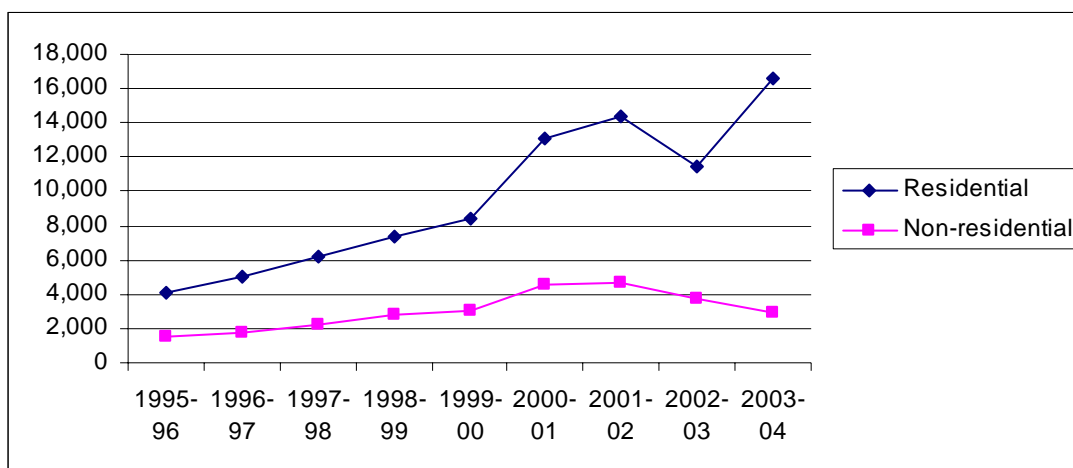
	Residential respite care		Non-residential respite care		Total recommended to community
	n	%	N	%	N
Rural	4,995	58.8	1,189	14.0	8,495
Metropolitan	11,801	69.8	1,708	10.1	16,907
Total	16,791	66.1	2,896	11.4	25,402

Note: Community-recommended clients with complete assessments only.

The percentages in this table are the proportions of community-recommended clients who are recommended respite care.

Figure 15 shows that the number of clients recommended for residential and non-residential respite increased between 1995–96 and 2001–02. In 2002–03 the number of recommendations for residential respite dropped markedly, with a smaller decline in non-residential respite recommendations. This year recommendations for residential respite increased in line with the previous trend. The drop in 2002–03 was partly because complete data was not available for the whole year and had to be estimated on a pro-rata basis, and further incomplete data from one team.

Figure 15: Recommendations for residential respite for community-recommended clients (counts)



Summary: Recommendation for respite

Overall result:

- Almost two-thirds of clients (65.0%) recommended to the community receive a recommendation for residential respite and 11.3% a recommendation for non-residential respite.

Trends:

- Consistent with the trend between 1995–96 and 2001–02, recommendations for residential respite increased in 2003–04.
- After increasing between 1995–96 to 2000–01, the proportion of community assessments with a recommendation for non-residential respite declined, and 2003–04 was consistent with this recent trend.

Rural metropolitan comparison:

- Clients in rural areas were less likely to receive a recommendation for residential respite and more likely to receive a recommendation for non-residential respite than in metropolitan areas.

Range:

- Recommendations for residential respite ranged between 38.2% to 89.1% of clients recommended to the community.
- For non-residential respite the range was between 3.6% and 23.7%.

Section 10: Recommendations for special needs groups

10.1 Recommendations for clients not “at risk”

Clients living in the community are defined as being “at risk” if they have any 4 of the following 5 characteristics: aged 80 or over (or Indigenous and aged 60 or over); having a severe or profound core activity restriction; having dementia; living alone; not having a carer. Table 27 presents recommendations for clients who are not “at risk”.

Table 27: Recommendations for clients not “at risk”

	Community		Low-level care		High-level care		Other/missing		Total	
	n	%	n	%	n	%	n	%	n	%
Rural	7,874	62.9	2,683	21.4	1,891	15.1	80	0.6	12,528	100.0
Metropolitan	15,655	63.5	4,907	19.9	3,854	15.6	248	1.0	24,664	100.0
Total	23,529	63.3	7,590	20.4	5,745	15.4	328	0.9	37,192	100.0

Note: MDS v2 only.

Almost two-thirds of clients not “at risk” were recommended to remain living in the community in 2003–04, a fifth were recommended to low-level residential care and 15% to high-level care. The recommendation pattern was similar in rural and metropolitan areas. The corresponding recommendations for “at risk” clients were community 35.5%, low-level care 38.5%, and high-level care 25.0%. That is, “at risk” clients were almost twice as likely to receive a residential care recommendation than clients not “at risk”.

Previously (under MDS v1 coding) people living in supported community accommodation (SRS) were included in low-level care but in MDS v2 are included in community clients. For the clients not “at risk” living in supported community accommodation at assessment (1,235), the recommendations were: 3.0% community; 14.4% to supported community accommodation; 36.2% to low-level care; 45.3% to high-level care; and 1.1% to other.

Summary: Recommendation for clients not “at risk”

Overall result:

- “At risk” clients were almost twice as likely to receive a residential care recommendation than clients not “at risk”.
- Of those clients not “at risk” 63.3% were recommended to the community and 35.9% to residential care (20.4% to low-care and 15.4% to high-care).
- The corresponding recommendations for “at risk” clients were community 35.5%, low-level care 38.5%, and high-level care 25.0%.

Rural metropolitan comparison:

- Little difference in the recommendations for clients not “at risk”.

10.2 Recommendations for residential care for “younger” clients

“Younger” clients are defined as those not in the target group, i.e., Indigenous clients aged 49 years or under and non-Indigenous clients aged 69 years or under at assessment. Table 28 shows that about two-thirds of “younger” clients living in the community are recommended to remain in the community, with the other third evenly split between low-level and high-level

care recommendations. “Younger” clients living in rural areas were more likely to receive a community or low-level care recommendation than those in metropolitan areas. Across the teams, the proportion of “younger” clients recommended to remain in the community ranged from 48.4% to 81.2%.

Table 28: Recommendations for “younger” clients living in the community at assessment

	Community		Low-level care		High-level care		Other / missing		Total	
	n	%	n	%	n	%	n	%	n	%
Rural	815	70.0	139	11.9	193	16.6	17	1.5	1,164	100.0
Metropolitan	1,445	63.8	397	17.5	370	16.3	54	2.4	2,266	100.0
Total	2,260	65.9	536	15.6	563	16.4	71	2.1	3,430	100.0

Note: MDS v2 only.

For the “younger” clients living in supported community accommodation at assessment (203), the recommendations were: 4.9% community; 18.7% to supported community accommodation; 39.4% to low-level care; 33.0% to high-level care; and 3.9% to other.

Summary: Recommendation for “younger” clients

Overall result:

- “Younger” (non-target) clients were more likely to be recommended to the community and less likely to low-level residential care than ACAS clients as a whole.
- Nearly two-thirds (65.9%) of “younger” clients living in the community are recommended to remain in the community, 15.6% to low-level care and 16.4% to high-level care.
- For all clients living in the community, 60.8% were recommended to remain in the community, 22.0% to low-level care, and 16.3% to high-level residential care.

Rural metropolitan comparison:

- “Younger” clients living in rural areas were more likely to receive a community or low-level care recommendation than those in metropolitan areas.

Range:

- The proportion of “younger” clients recommended to remain in the community ranged from 48.4% to 81.2%.

10.3 Recommendations for residential care for clients with dementia

Clients are defined as having dementia if they received health condition codes 0500 to 0532.* Table 29 presents recommendations for clients with dementia. Just over half of clients with dementia living in the community at assessment were recommended to move to residential care (a quarter to low-level and a quarter to high-level). The proportion of clients recommended to residential care was similar in rural and metropolitan areas but clients in rural areas were more likely to receive a recommendation for low-level care than those in metropolitan areas.

* Includes Alzheimer’s disease (early and late onset), vascular dementia, dementia in other diseases (including Huntington’s disease, Parkinson’s disease and Pick’s disease), and other dementia (including alcoholic dementia).

Table 29: Recommendations for clients with dementia living in the community at assessment

	Community		Low-level care		High-level care		Other/ missing		Total	
	n	%	n	%	n	%	n	%	n	%
Rural	1,367	47.3	855	29.6	660	22.8	7	0.2	2,889	100.0
Metropolitan	3,473	49.7	1,631	23.3	1,848	26.4	36	0.5	6,988	100.0
Total	4,840	49.0	2,486	25.2	2,508	25.4	43	0.4	9,877	100.0

Note: MDS v2 only.

A comparison between assessment outcomes for clients with dementia living in the community and all clients living in the community shows that the presence of dementia increases the likelihood of a residential care recommendation. Table 29 above shows that 50.6% of clients with dementia received a recommendation for residential care compared to 38.3% of all clients living in the community (Table 24). Further, a high-level care recommendation is more likely for clients with dementia (25.4%) than all clients living in the community (16.3%) while recommendations for the two groups for low-level care were of similar magnitude (25.2% for clients with dementia compared to 22.0% for all clients).

For the clients with dementia living in supported community accommodation at assessment (580), the recommendations were: 1.7% community; 8.4% to supported community accommodation; 24.8% to low-level care; 64.1% to high-level care; and 0.9% to other.

Summary: Recommendations for clients with dementia

Overall result:

- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 50.6% of clients with dementia received a recommendation for residential care compared to 38.3% of all clients living in the community.
- Further, 25.4% clients with dementia receive a high-level care recommendation compared to 16.3% of all clients living in the community.

Rural metropolitan comparison:

- The proportion of clients recommended to residential care was similar in rural and metropolitan areas but clients in rural areas were more likely to receive a recommendation for low-level care than those in metropolitan areas.

10.4 Recommendations for clients living in the community and assessed in hospital

Clients were defined as being in hospital if their face-to-face contact setting was acute hospital (MDS v2) or if their domicile at assessment was hospital (MDS v1). Table 30 presents recommendations for clients living in the community and assessed in an acute hospital. Clients assessed in an acute hospital were more likely to receive a recommendation for residential care (58.2%) than the community (37.5%), and were more likely to receive a recommendation for high-level care (37.5%) than low-level care (20.7%). Recommendations in rural and metropolitan areas were similar. The recommendation pattern evident in Table 30 was similar across all teams but there was a considerable range in the proportion recommended to the community—from 8.7% to 69.2%.

Table 30: Recommendations for clients assessed in an acute hospital and living in the community at assessment

	Community		Low-level care		High-level care		Other/missing		Total	
	n	%	n	%	n	%	n	%	n	%
Rural	838	29.2	682	23.8	1,236	43.1	111	3.9	2,867	100.0
Metropolitan	2,847	40.9	1,354	19.4	2,452	35.2	313	4.5	6,966	100.0
Total	3,685	37.5	2,036	20.7	3,688	37.5	424	4.3	9,833	100.0

Note: Includes MDS v1 and MDS v2 records.

The association between assessment in an acute hospital and a recommendation for residential care is evident through a comparison of the proportions in Table 30 above and the recommendations for clients living in the community and assessed in the community. Clients usually living in the community and assessed in an acute hospital were more likely to receive a recommendation for residential care—particularly high-level care—than clients living in the community and assessed in the community. For these latter clients the comparable recommendations were: community 75.0%, low-level care 18.9%, and high-level care 5.4%.

For the clients living in supported community accommodation and assessed in an acute hospital (456), the recommendations were: 2.2% community; 4.2% to supported community accommodation; 14.7% to low-level care; 77.4% to high-level care; and 1.5% to other.

Summary: Recommendations for clients assessed in an acute hospital

Overall result:

- Clients usually living in the community and assessed in an acute hospital were more likely to receive a recommendation for residential care (particularly high-level care) than clients living in the community and assessed in another setting.
- 37.5% of community clients assessed in an acute hospital received a recommendation to the community, 20.7% were recommended low-level care and 37.5% high-level care.
- For clients living in the community and assessed in the community the comparable recommendations were: community 75.0%, low-level care 18.9%, and high-level care 5.4%.

Rural metropolitan comparison:

- Recommendations in rural and metropolitan areas were similar.

Range:

- The recommendation pattern was similar across all teams but there was a considerable range in the proportion recommended to the community—from 8.7% to 69.2%.

10.5 Percentage older ACAS clients “at risk” recommended for a CACP

This section examines recommendations for older clients (people aged 70+ years or Indigenous people aged 50+ years) “at risk” (defined in previous sections). Note that the analysis is concerned with individuals rather than assessments. If clients were assessed more than once in the period the most recent assessment was used for the analysis.

Nearly a fifth (17.6%) of older, “at risk” clients living in the community received a recommendation for a CACP, with relatively more clients assessed in metropolitan areas receiving a CACPs recommendation than clients assessed in rural areas. This proportion ranged between 3.6% to 30.2%. That 17.6% of clients overall receive a CACPs recommendation means that just over half of older, “at risk” clients recommended to the community received a recommendation for a CACP. This was relatively more than the corresponding proportion (32.2%) of all clients recommended to the community who received a CACPs recommendation (Table 25).

Table 31: Recommendations for older “at risk” clients living in the community at assessment (%s)

	Community with no CACP	Community with CACP	Low-level care	High- level care	Other / missing	Total
Rural	15.4	15.4	45.1	23.4	0.6	100.0
Metropolitan	17.1	18.5	35.0	28.3	1.0	100.0
Total	16.6	17.6	38.0	26.9	0.9	100.0

Note: Complete MDS v2 assessments of clients living in the community at assessment aged 70+ years and Indigenous clients aged 50+ years.

Summary: Clients “at risk” recommended for a CACP

Overall result:

- “At risk” clients were more likely to receive a recommendation for a CACP than those not at risk.
- Of the “at risk” clients recommended to the community, over half (51.5%) received a recommendation for a package, compared with a third (32.2%) of all clients recommended to the community.

Rural metropolitan comparison:

- Relatively more clients assessed in metropolitan areas receiving a CACPs recommendation than clients assessed in rural areas.

Range:

- The proportion of “at risk” clients living in the community who received a recommendation for a CACP ranged from 3.6% to 30.2%.

CONCLUSION

This is the first Annual Report to analyse MDS v2 data (MDS v1 comprises a very small proportion of the data), and it provides new information on the operation of the Victorian Aged Care Assessment Service and the people who access it. MDS v2 provides additional information on timeliness and health conditions, and new information on carers, and activity limitations. Also, MDS v2 includes information on the assessment process that was not recorded in MDS v1. Previously rejected records (because there was no face-to-face contact with the client) are included as incomplete. Thus, there is information on accepted referrals that did not go on to the face-to-face assessment phase.

Total assessment numbers (with face-to-face contact) in 2003–04 were lower than the previous year. Lower assessment numbers were also reported in other states. They may be due the introduction of MDS v2 and/or a change in criteria for what is included in the MDS. Anecdotal evidence also suggests that a return to “core business” by teams may have contributed to reduced assessment numbers. Further data is needed to determine the longer-term trend.

Assessment rates have steadily decreased in Victoria since 1995–96 and the 2003–04 rate of 112 assessments per 1000 target population was consistent with this trend (Lincoln Centre for Ageing and Community Care Research, 2004). Access to the ACAP by people of CALD background and Indigenous people was lower than their representation in the population indicates. This too was consistent with previous years. Access of these special groups is also an issue in other states/territories. In comparison with other states/territories, Victoria reported the second highest proportion of CALD assessments and the index of CALD referrals to target population was similar to the Australian average. Indigenous access to the ACAP is better in Victoria than other states/territories. Victoria had the highest rate of Indigenous referrals and the highest index of Indigenous referrals to target population.

Since 1999–00, the time between referral and first face-to-face contact has been increasing in all settings. In 2003–04, response times increased in community settings, decreased in residential care, and remained the same in hospital settings. Nationally, Victoria’s timeliness compared favourably with other states/territories. Victoria recorded the shortest waiting times for hospital assessments (referral to completion/delegation), and was better than most states/territories in non-hospital settings. The proportion of referrals seen “on time” was also above the national average.

Victorian data quality in 2003–04 was reasonably good. The National Data Repository aims for a missing or error rate of less than 1%. For records coded assessment complete, and excluding date items, this level was achieved in Victoria for over half of the items, and the remainder had a missing rate between 5% and 6%. However, some teams reported high missing rates for some items, in particular, the carer items, Indigenous status and DVA entitlement. There were also problems with date sequencing, particularly with the Delegation date preceding the Assessment end date. Changes to the ACE software introduced in 2005 should overcome this problem. There were indications of under-recording of the incidence of continence because some staff believed that incontinence recorded under ACCR items in Part 5 of the form would be included in the MDS. There also were indications that for some teams the coding of

Priority category (particularly in hospitals) reflected the requirements of the facility rather than client need.

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