2002

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Kathy Eagar
University of Wollongong, keagar@uow.edu.au

Alan G. Owen
University of Wollongong, aowen@uow.edu.au

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Keywords
community, care, models, options, assessment, future

Disciplines
Business

Publication Details
Eagar, K. M. & Owen, A. G. (2002). The Options for Future Assessment Models in Community Care. NSW Aged and Community Services Association Community Care Conference University of Wollongong: NSW Aged and Community Services Association.

The Options for Future Assessment Models in Community Care

Kathy Eagar and Alan Owen
Centre for Health Service Development
University of Wollongong

This paper describes some of the key issues being considered in the current reform of community care assessment systems and suggests options for where we might go from here.

1. Context

Policy and implementation issues surrounding community assessment models have been receiving increasing attention for several years. The initial impetus for reform was the policy review after a decade of the HACC program – the *Home But Not Alone (House of Representatives Standing Committee on Community Affairs)* report in 1994. This was supported by the administrative reform agenda embodied in the national report on the *Efficiency and Effectiveness Review of the Home and Community Care Program* (Department of Human Services and Health, Housing and Community Services, 1995), a national report in 1995.

Also in 1995, Michael Fine and others reviewed the factors influencing the effectiveness of community care programs, with lessons from the international literature (Fine and Thomson, 1995). One important finding was the consistent reporting of the value of periodic re-assessment, both as a program planning tool, and as a clinical tool for capturing data on outcomes and for changing service and care plans as clients' needs change.

Gradually the momentum for change moved from policy to management issues, and to increased attention to management tools. This was especially the case where standard measures of client need were being explored as the building blocks for a client classification system for community care (Lewin and Eagar, 1996, Hindle, 1998)

Discussion of the structural and system design implications of these micro-level reforms increased with the release of the *National framework for comprehensive assessment of the HACC program* (Charlton et al: March 1998). In NSW, the release in that same year of *Community Care Assessment in NSW: A Framework for the Future – A Discussion Paper* (NSW Ageing and Disability Department. 1998) illustrated some commitment to taking action on the national approach.

More recently, the work undertaken by the Centre for Health Service Development (Eagar et al, 2001) to develop a national measure of functional dependency for the HACC program has again increased the likelihood of common approaches and some standardisation of tools that might lessen, rather than increase 'reform fatigue'.

At present, 3 sectors (health, HACC, veterans) are undertaking similar reforms (mostly in parallel) but with common themes around standardising approaches to assessment. Of course, creating a degree of commonality across these reforms would be ideal, so that standardisation, but not necessarily complete uniformity, would be a more common feature. Most of these common themes are driven by common goals requiring better measurement tools as a means for reform:

- Integration
- Substitution
- Efficiency
- Outcomes
- Value for money

The purpose of all current reforms, now well and truly on the agenda for 8 years, is not to introduce assessment into the community sector. Community care workers already assess clients all the time. The focus of current reform is about replacing the current model of informal (subjective) assessments with a system of formal (less subjective) assessments. In the ideal situation, common and more standardised, valid and reliable approaches to measurement might serve a number of different functions at the same time.

Table 1: Different functions for common tools.

MDS items	Client contact details	Client characteristics
Program reporting	Sharing between agencies	Measuring client outcomes
State & National monitoring	CIARR etc	Establishing the goal of care
Population group planning	Agency & area planning	Agency comparisons
		State, regional comparisons

In theory, assessment models should result in more equitable decisions, allow for more objective and transparent measurement of need and should not necessarily result in additional burdens on staff. In practice, the necessary tools are yet to be designed, tested and refined. The success of implementation will depend on replacing more cumbersome and less useful data collections with a smaller number of more useful data items. This goes somewhat against the popular tendency to continually add more on, regardless of the burden on staff and clinicians.

2. Emerging issues and trends

Assessment and system planning issues are emerging at State level that have important implications for the design and sustainability of future models. Some key issues are worth mentioning in so far as they are related to questions of the design of screening and assessment tools and their implementation in real service systems (not just in trials or demonstration projects).

2.1 Design questions

There is now broad acceptance that there are at least 2 levels of assessment:

- Screening (increasingly being referred to as Initial Needs Identification (INI) because of recent work in Victoria) and

- Assessment (various types and levels).

This view reflects an increasing recognition that not everyone needs an assessment and that it wastes resources assessing people who do not need it.

Technical work (but not enough) is still proceeding on tool development and on how screening should trigger assessments for those that do need them. This work has to combine both client and management concerns. It is not only more efficient if we don't over-assess, but it is also clinically important that those that do need assessment, get it, either as initial clients presenting to a service, or as existing clients whose needs have changed.

The response to these service design issues has been mixed. In some cases, the focus of reform efforts is on common assessment instruments, in others on common assessment processes or systems. Some Sates are attempting to do both, and some are not yet sure what it is they want to achieve.

2.2 Implementation questions

There is a general policy direction to separate assessment from service provision but many key issues remain unresolved. For example, is it screening or assessment or both that is being separated? Should we be thinking about the entry point to service systems differently to how we see ongoing provision, and how best do we link screening, assessment and re-assessment with the allocation of resources for service provision?

These are objectively complicated issues that get no less complex when we consider the implications in relation to duty of care. What are the resource implications, including staffing, when we take screening seriously? What about when a person's needs change, what should trigger a re-assessment?

The competency and **training** issues are being addressed on the run at this stage but will require a planned and hopefully national approach.

The relationship between assessment and **outcomes** measurement varies depending on the service sector we are talking about. It is clear and explicit in the national mental health plan's approach, has been built into the thinking in rehabilitation, but is rarely being considered in other sectors at this point.

Standardised processes of assessment imply the **sharing of information**. But there is little agreement on what should be shared and how it might be more uniformly collected. The sharing of information is raising a whole set of different, important but also complicated issues. Examples include consent; IT capacity; and the inevitable trade-off between privacy and confidentiality on the one hand and coordination and communication on the other.

3. *Ways of separating screening and assessment*

3.1 Start with measures of function

Our research to develop a national measure of functional dependency for the HACC program resulted in a 2 tiered system in which screening constitutes the first level and assessment the second. The first tier is a 9 item functional screen designed for all potential consumers and for use by phone or face to face with either the consumer or a proxy (referring agency, relative or carer). The aim of the screen is to differentiate between people who:

- have no problems and need no services;
- have minor problems (ie. low need), need some HACC services (eg, meals, home maintenance), but do not need a full assessment; and
- have medium to high needs and require a full assessment

The second tier consists of up to 4 functional assessments (covering self-care, domestic, cognitive and behavioural functioning), but only for those that need them (Eagar K et al 2001).

3.2 Link to a system of comprehensive assessment

The Victorian Better Access to Services (BATS) project has taken a comprehensive approach across the whole of the primary and community care sectors (DHS, 2001). After an international literature review and a national practice review (Owen 2001), a range of tools were developed and have been field-tested to cover a wider set of domains of client characteristics. The scope of the tools was limited to those services, agencies and GPs involved in Victorian Primary Care partnerships.

The field testing of the suite of tools resulted in some refinements to the original model proposed in the initial policy documents and the result is summarised in Table 2. This makes a distinction between the depth and scope of different activities, and it is the depth that defines the difference between screening and assessment.

Table 2: *A tiered screening and assessment model – the Victorian approach*

Activity	Depth	Scope	Used for referral purposes?	Current status
Initial Needs Identification:				
Consumer Information	Shallow	Narrow	Yes	Required
Summary and Referral Information	Shallow	Narrow	Yes	Required for all referrals and should be used for intake summary functions
Supplementary Profiles	Shallow	Broad	Yes, where relevant	Optional, to be used at discretion of the professional, except in the case of HACC referrals where the living arrangements and functional profiles should be used (both to make and receive a referral)
Assessment:				
Service specific	Deep	Narrow	No	Undertake as part of service provision
Specialist	Deep	Narrow	No	Undertake when required by consumer
Comprehensive	Deep	Broad	Yes, where relevant	Undertake when required by consumer
Care Plan	Deep	Narrow	No	Local agency responsibility
Service Coordination Plan	Deep	Broad	Yes, where relevant	Should be used with consumers with both multiple agency involvement and complex needs

The scope of primary care is more problematic and the question of how many issues should be canvassed at the screening stage is one that will likely attract considerable debate across sectors and jurisdictions for some time to come. An important feature of the Victorian approach is that it is not limited to HACC but also includes community health, primary medical care and community aged care. One implication of this partnership model is that the scope of screening must necessarily be wide, leaving of course, plenty of scope for disagreement.

4. Current developments

Variations on this type of approach are being increasingly considered by other jurisdictions, including NSW, and it now seems that options for the future will be essentially variations around this broad model. NSW will be conducting a series of pilot studies during 2002 but the scope is likely to be limited to HACC services.

At the national level, National HACC/ACAP Officials recently resolved that the HACC Program would:

- Develop a common glossary to be used regarding assessment in the HACC, aged care and primary care areas;
- Adopt the four functional domains developed and trialed by the CHSD;
- Adopt a tiered or graduated approach to assessment; and
- Incorporate the items into the next version of the HACC Minimum Data Set (MDS).

It was also restated that the HACC Program should continue to refine its approach towards the separation of assessment from service provision.

These decisions represent an important development and have implications well beyond HACC and ACAT services. Importantly, this was a decision to work to achieve consistency across HACC, aged care and primary care. Options for the future will essentially depend on how well this ambitious goal is achieved.

5. *Options for the future*

At this point there are a number of possibilities about how the system might evolve. Which way it develops will be largely dependent on leadership and clear thinking at both the state and national levels and how consumers and providers respond. While the number of problems and our understanding of the issues for the future will continue to evolve, the following four are key:

5.1 Defining entry point activities

Screening and assessment are seen as the first step in entering the service system. A key issue that will define the future is the scope of the service system. Comprehensive networks and primary health care, rather than specialised and acute care-driven activities are the only future direction. Why worry so much about fragmentation and inefficiency and then encourage strategies that promote those problems?

Area responsibility, not narrow program logic is important. In particular, this comes down to whether agencies and programs continue to see the purpose of assessment as being largely restricted to assessing simply for the services that they provide. Area responsibility also includes concern for, and planning for, the whole of the population.

For example, will the HACC assessment system focus solely on assessing consumers in relation to their need for HACC services or more broadly for needs that might be met by the aged care or primary care sectors or beyond? This same question applies to aged care, community health, GPs, housing services and the like. It also applies to hospitals.

The wider the service system is defined, the broader the scope of screening that is required. It is for this reason that the scope of screening will attract increasing debate.

5.2 Why separate assessment and service provision?

Separation of these functions has been on the policy agenda for some time and, in some cases, has already occurred (eg, Veterans Home Care). One option is that this style of separation is implemented system-wide. Another is that, while standardised screening and assessment tools will be used, the screening and assessment functions will be undertaken by a mix of specialist assessors and services providers, as well as entry point staff.

The residential aged care sector already has a model that represents an interesting compromise in which initial assessments for residential aged care are undertaken by an independent agency (the ACAT). However, once in the system, service providers undertake re-assessments. It is the same with GPs, where periodic assessment and ongoing service provision are expected to go hand in hand (Byles 2000).

Just who might take on the screening and assessment functions if they are separated from service provision is yet to be resolved although various models are emerging. These include the Veterans Home Care model of contracted assessment agencies and the Sydney Home Care Service model in which a HACC service provision agency has separated the assessment function internally and uses a call centre approach.

A confounding issue in the community care context is the lack of agreement on defining the breadth of the service system, which is dependent on local arrangements and agreements. If the system is defined broadly, there would be no reason why, for example, a hospital, a GP or a community health centre could not undertake a HACC assessment.

5.3   Virtual organisations – the future?

With both standard ways to collect and share information, and by using the right information technology, we will soon have the opportunity to create virtual community care organisations in which various agencies work together as a virtual system. The advantages for consumers are obvious – no longer having to tell their story numerous times, the ability to access the system at any point and the opportunity to receive care from providers who actually know what the system as a whole is doing.

However, a move towards virtual organisations would represent a massive cultural leap and would require the support of both providers and consumers. While virtual organisations are within our grasp, we have a long way to go from 'joined up worrying' to get to 'joined up working' (Warner, 2001). But the more that funding bodies move to competitive purchasing, the longer the distance will become, because the incentives to cooperate may be undermined.

5.4   Assessing for what?

There is now growing acceptance that the introduction of standard screening and assessment is important at the local level for referral purposes and for facilitating appropriate service provision. There is less recognition (as yet) that assessment data have other potentially important purposes such as for use in service planning, for measuring need independent of supply and for service monitoring.

To maximise this potential for a synergy of functions and an easing of reporting burdens, it will be necessary to turn assessment data into useful information. This will inevitably involve the development of a client classification for use across the whole sector. Creating a common language, and learning how to use the information that is generated, is one of the key challenges ahead.

It is an option we can soon realistically achieve. One question is whether we want to. The other is whether we have any real choice. In our view, we don't.

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