Australian Government

Department of Health and Ageing

Aged Care Assessment Program

Minimum Data Set

Annual Report

Victoria
2009–2010

Report by the Victorian ACAP Evaluation Unit,
Lincoln Centre for Research on Ageing
on behalf of the Victorian Department of Health

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This report has been prepared as an aid for program managers in the Aged Care Assessment Program. It has been designed for use within the Australian Department of Health and Ageing and the Victorian Department of Health.
It describes the content of final datasets for the year 1 July 2009 to 30 June 2010 from Victorian ACASs. Care should be taken not to interpret the data contained in this report out of context.

For further information contact:
Lincoln Centre for Research on Ageing
La Trobe University
VICTORIA 3086
Phone: (03) 9479 3700
Fax: (03) 9479 5977
Email: acg@latrobe.edu.au
http://www.latrobe.edu.au/aipca/lincoln.htm

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Victorian Evaluation Unit

Prof Yvonne Wells	Administrative assistance:
Karen Teshuva	Mary Caruana
Judy Tang	Elizabeth Perry
Laura Varanelli	Shane O'Meara
Janette Collier	
Ary Winata	
Joanne Vanzwol	
Faye Petroulakis	
Sharon Gibson	

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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
EACH	Extended Aged Care in the Home
EACH-D	Extended Aged Care in the Home Dementia
HACC	Home and Community Care
LGA	Local Government Area
MDS	Minimum Data Set
SLA	Statistical Local Area
TCP	Transition Care Package
VAED	Victorian Admitted Episode Data

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.
90th percentile	A percentile is the relative position of a score. The 90th percentile is the value at or below which 90% of the other values fall. For example, the 90th percentile time from referral to First Intervention is the time by which 90% of the assessments have included a first intervention.

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).

EXECUTIVE SUMMARY

INTRODUCTION

This Annual Report analyses records with assessment end dates from July 1 2009 to June 30 2010.

This Executive Summary begins with a brief description of the Aged Care Assessment Program and the Minimum Data Set, then presents a summary of all sections in the body of the report, and ends with an overall concluding section.

Aged Care Assessment Program

The Aged Care Assessment Program (ACAP) is jointly funded by the Commonwealth, and States and Territories and is a crucial component of the aged care system. 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.

The following objectives are designed to achieve the core objective:

- To ensure that older persons who belong to the following groups have equitable access to ACAT services:
  - Aboriginal and Torres Strait Islander people
  - people of culturally and linguistically diverse backgrounds
  - people living in rural and remote areas
  - veterans, their spouses, widows and widowers
  - people with dementia.
- To ensure that access to ACAT services is based on need
- To prevent premature or inappropriate admission to residential aged care services
- To help frail older people remain in the community
- To facilitate access to the combination of services that best meet the needs of assessed clients
- To ensure that assessments of the care needs of frail older persons are comprehensive, incorporating the restorative, physical, medical, psychological, cultural and social dimensions of need
- To involve clients, their carers and other service providers in the assessment and care planning process
- To promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people
- To optimise assessment services provided within available resources.[*]

Assessment by an Aged Care Assessment Service (ACAS) is mandatory for admission to residential care and residential respite, to receive Australian Government funded community care (Community Aged Care Package) and flexible care (Extended Aged Care at Home, Extended Aged Care at Home–Dementia, Transition Care). ACAS also refer people to community services provided under the Home and Community Care Program, to the Linkages

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[*] Department of Health and Ageing. *Aged Care Assessment Program Operational Guidelines*. Canberra: Department of Health and Ageing, 2002, p. 5.

Program (which provides intensive community care packages), to rehabilitation services—both inpatient and community-based—and to general community services.

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.

SUMMARY OF MDS ANALYSIS

Access to the ACAP

Assessment numbers and rates

Overall result:

- The total number of records accepted by the Victorian Evaluation Unit in 2009–10 was 57,504, including 51,982 (90.4% of the total) with face-to-face contact.
- Of the total records, 6.7% are referrals only, 6.2% other incompletes, 9.8% completed assessments (but not delegated), and 77.2% delegated assessments.
- Across Victoria, 93.1% of completed assessments are of people in the target population.
- The completed assessment rate (PI 2.2) is 85.3 completed assessments per 1,000 people aged 70+ years and Indigenous people aged 50–69 years.
- The rate of assessments with face-to-face contact (i.e., comparable with previous years) is 95.1 per 1,000 target population.

Trends:

- Total referrals and completed assessments are lower (by 4.77% and 4.59% respectively) than in 2008–09.
- The number of assessments with face-to-face contact decreased by 3.83% over the previous year.
- Total assessment activity (face-to-face assessments and consultations recorded in the VAED) is 5.2% lower than in 2008–09.
- The proportion of target group assessments (93.1%) is the same as the previous year.
- The completed assessment rate (PI 2.2) decreased by 3.7 compared to the previous year (2009–10 85.3; 2008–09 89.1; 2007–08 93.9; 2006–07 90.6; 2005–06 92.2; 2004–05 89.9; 2003–04 94.9).

Rural metropolitan and inter-team comparison:

- Approximately a third (30.4%) of all referrals is to teams in rural areas.
- The assessment rate is slightly higher in metropolitan (85.4) than rural areas (84.9).

Range across teams:

- 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 are referrals only ranges from 0.3% to 20.5%; and the proportion of complete/delegated assessments from 74.5% to 97.5%.

Summary: Reason for ending assessment

Overall result:

- The great majority of recorded assessments (87.1%) are completed or delegated.
- The most common reasons for incomplete assessments are the client choosing to withdraw (4.5%) and unstable medical (3.4%) or functional status (1.4%).

Access for particular groups

Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.50% of all referrals and 0.49% of referrals that go on to face-to-face contact involve people from Indigenous backgrounds while 0.71% of the target population are Indigenous.
- Decreased access of Indigenous clients in 2009–10.

Trends:

- The number of Indigenous clients referred to ACAS decreased in 2009–10, compared to recent years.
- The index that compares the proportion of Indigenous clients with their representation in the general population (PI 1.1) remains less than 1.0 and but is higher than the previous year (2009–10 0.70; 2008–09 0.64; 2007–08 0.80; 2006–07 0.51; 2005–06 0.53; 2004–05 0.71).

Rural metropolitan comparison:

- Indigenous referrals to both rural and metropolitan teams are less than expected from the proportion in the population.
- Rural teams received relatively more Indigenous referrals than metropolitan teams and are slightly higher in the proportion relative to their target population.

Range:

- The proportion of Indigenous to total referrals ranges from 0.1% to 2.4% across Victorian teams.

Clients from culturally and linguistically diverse backgrounds

Overall result:

- Nearly a quarter of Victorian referrals (24.5%) are of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS is lower than their representation in the target population.

Trends:

- Consistent with the overall trend, the proportion of referrals from people of CALD backgrounds is higher than the previous year.
- The index (PI 1.2) that compares the proportion of CALD clients with their representation in the general population is higher than the previous year but remains less than 1.0 (2009–10 0.83; 2008–09 0.8; 2007–08 0.7; 2006–07 0.8; 2005–06 0.7; 2004–05 0.1.0; 2003–04 0.9).

Rural metropolitan comparison:

- Considerably more CALD clients are assessed by metropolitan than rural teams.

Range:

- The proportion of CALD people among accepted referrals ranges from 2.1% to 45.5%.
- The index comparing the proportion of accepted referrals involving CALD people relative to their representation in the target population ranges from 0.20 to 1.05.

Clients with severe or profound core activity limitation

Overall result:

- Over two-thirds (71.2%) of target group (older) clients living in the community have a severe or profound core activity limitation.
- Over three-quarters (76.7%) of non-target group (younger) clients living in the community have a severe or profound core activity limitation.

Trends:

- In 2009–10 there was small increase (to 71.2%) in the proportion of target group clients living in the community with a severe or profound activity limitation at assessment (PI 2.3) (in 2008-09 it was 70.3%; 2007–08 68.3%; 2006–07 70.0%; 2005–06 68.4%; 2004–05 67.5%; 2003–04 60.9%).
- There was a small increase (to 76.7%) in the proportion of non-target group clients living in the community with a severe or profound activity limitation at assessment (PI 2.4) (75.9% in 2008-09; 6.1% in 2007–08; 77.3% in 2006–07, 76.5% in 2005–06, 75.1% in 2004–05 and 65.3% in 2003–04).

Rural metropolitan comparison:

- A similar proportion of target and non-target clients with a severe or profound core activity limitation reported by rural and metropolitan teams.

Range:

- The proportion of target group clients with a severe or profound core activity limitation ranges from 53.2% to 82.4% among rural teams and 56.5% to 90.7% among metropolitan teams.
- The proportion of non-target group clients with a severe or profound core activity limitation ranges from 53.5% to 88.7% among rural teams and from 64.6% to 94.4% among metropolitan team.

Clients with dementia

Overall result:

- 23.7% of ACAS assessments involve clients with a diagnosis of dementia.
- Target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) are more likely (24.1%) to have a diagnosis of dementia than non-target group (younger) clients (18.5%).

Trends:

- For PI 2.5, the proportion of target group clients with dementia (24.1%) is lower compared to previous years (2008-09 26.6%; 2007–08 27.1%; 2006–07 28.1%; 2005–06 28.1%; 2004–05 27.7%; 2003–04 27.9%).
- The proportion of non-target group clients with dementia (18.5%) is similar to previous years (2008-09 17.9%; 2007–08 16.5%; 2006–07 18.8%; 2005–06 19.2%; 2004–05 17.6%; 2003–04 15.2%).

Rural metropolitan comparison:

- Diagnosed dementia is more common among metropolitan than rural clients.

Range:

- The proportion of target group clients with dementia ranges from 13.8% to 30.3%.
- The proportion of non-target group clients with dementia ranges from 2.8% to 27.1%.

Timeliness

Overall result:

- Assessment times vary considerably between hospital and non-hospital settings.
- The average (trimmed mean) time from referral to end of assessment is 3.4 calendar days in hospital settings and 23.0 calendar days in non-hospital settings.
- Most of the difference in assessment times between hospital and non-hospital settings is in the initial stages.

- Victorian ACAS respond (referral to first intervention) to half of the referrals in hospital settings within one calendar day (median) and 90% of referrals within 7 days. In non-hospital settings the median response is 14 calendar days, with 90% of referrals seen within 45 days. The respective trimmed means for hospital and non-hospital settings are 1.6 and 17.5 calendar days.
- From first intervention to the beginning of the assessment process (first face-to-face date) takes, on average (trimmed mean), there is a further 0.8 days in non-hospital settings. The trimmed mean is 0 days for hospital settings
- The assessment process (first face-to-face date to end of assessment date) takes a similar time in hospital settings (trimmed mean 0.9 calendar days) and non-hospital settings (trimmed mean 1.8 calendar days).
- For those assessments that went on to delegation, this takes a further 1.3 days in hospital settings and 3.0 days in non-hospital settings.
- Overall, the great majority of referrals (92.5%) receive “timely assistance” (PI 2.1), (Priority 1 within 2 calendar days, and Priority 2 within 14 calendar days).
- A higher proportion of referrals in hospital settings receive “timely assistance” (93.3% of Priority 1 and 98.5% of Priority 2 referrals), than in non-hospital settings (91.2% of Priority 1 and 83.8% of Priority 2 referrals).

Trends:

- The time from referral to end of assessment is lower in both hospital settings (3.4 days c.f. 3.9 days in 2008–09) and in non-hospital settings (23.0 days c.f. 25.6 days in 2008–09).
- The proportion of people who receive “timely assistance” is similar to the previous five years (2009–10 92.5%; 2008–09 93.0%; 2007–08 91.8%; 2006–07 92.0%; 2005–06 91.9%; 2004–05 91.0%).

Rural metropolitan comparison:

- Response times in hospitals are shorter for metropolitan teams than rural teams.
- The average proportion seen “on time” by metropolitan teams is higher than rural teams in both hospital and non-hospital settings.

Range across teams:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.4 to 7.0 calendar days; non-hospital settings 7.5 to 41.2 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.5 to 8.6 calendar days; non-hospital settings 7.7 to 50.3 days.
- Response times from referral to end of assessment date: hospital settings, trimmed mean 0.7 to 9.7 calendar days; non-hospital settings 8.2 to 52.0 days.

- The proportion seen "on time" for Priority 1 ranged between 70.0% and 100.0% in hospital settings, and between 71.4% and 100.0% in non-hospital settings; and Priority 2 between 91.9% and 99.9% in hospital settings, and between 62.3% and 95.5% in non-hospital settings.

Location at assessment

Overall result:

- Nearly two-thirds of Victorian clients (64.6%) are assessed in a private residence/other community setting, 17.9% in acute hospitals, 11.0% in other inpatient settings and 6.0% in residential care.

Trend:

- Consistent with the increasing trend over the past few years, the proportion in 2009–10 (28.9%) was slightly higher than the previous year (27.2%).

Rural metropolitan comparison:

- Relatively more clients were assessed in acute hospital setting in rural areas than metropolitan areas. However, more clients were assessed in other inpatient settings in metropolitan areas than rural areas.

Range:

- The proportion of assessments carried out in acute hospital/other inpatient settings ranged considerably across the Victorian teams—from 15.8% to 50.2%.

Assessor profession

Overall result:

- Over half of assessments (54.2%) with face-to-face contact recorded are multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (76.4%).
- Interpreters were involved in a small minority of assessments.

Client characteristics

Age

Overall result:

- The profile of Victorian ACAS clients continues to age.
- The mean age of clients in 2009–10 is 82.5 years.
- 70% of accepted referrals are of people aged 80 years and over.
- Referrals from people aged 85 years and over comprise 45.4% of the total.
- Clients aged under 70 years comprise 7.3% of all referrals.
- A small minority of clients (1.3%) are aged under 60 years.
- People from the ACAP target population comprise 92.7% of total referrals.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 70.6%; and the proportion 85 years and over has increased from 30.6% to 45.4%.
- Since 1994–95 the proportion of assessments of clients under 70 years has decreased from 15.5% to 7.3% of total referrals.

Rural metropolitan comparison:

- Similar age distribution in rural and metropolitan areas.
- Similar proportions of target group referrals accepted in rural (92.2%) and metropolitan teams (92.9%).

Usual accommodation

Overall result:

- The great majority of Victorian clients lived in the community at assessment (private residence 84.1% or other community accommodation 10.1%).
- 5.3% lived in residential care (4.8% in low-level care; 0.5% in high-level care).

Rural metropolitan comparison:

- Overall, similar proportions of clients live in the community in rural and metropolitan areas, but there are relatively more in private residences in rural (86.4%) compared with metropolitan areas (83.1%).
- Retirement village and supported community accommodation is relatively more common in metropolitan areas.
- Similar proportions of clients in residential care.

Range across teams:

- The proportion of clients living in the community ranged from 72.2% to 89.6%.

- The proportion of clients living in low-level residential care ranged from 2.9% to 9.0%, and in high-level care from 0.2% to 1.2%.

Activity limitations

Overall result:

- The great majority of Victorian ACAS clients living in the community are assessed as needing assistance with domestic activities, meals and transport just prior to their assessment. Assistance with self-care is also relatively common.
- Over two-thirds (71.6%) of clients living in the community have a severe or profound core activity restriction.
- Proportionately more clients living in residential care are assessed as needing assistance than those living in the community. Almost all (96.4%) need assistance with self-care and health care tasks, and 90% need assistance with social and community participation, and transport.

Trends:

- In 2009–10 there was small increase (to 71.6%) in the proportion of clients living in the community with a severe or profound activity limitation at assessment.

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 in the proportion needing assistance at assessment, for example the need for assistance with domestic tasks among clients in the community ranged from 89.2% to 97.2% of clients, for transport 77.4% to 93.6%, for meals 71.5% to 91.3%, and for self-care 44.9% to 89.3%.
- The need for assistance among clients living in residential care ranged from 91.6% to 99.3% of clients for self care, for health 88.2% to 100.0%, for transport 81.6% to 98.4%, and for social participation 80.5% to 99.0%.

Assistance with activities

Overall result:

- Just prior to assessment, the most common formal assistance (including clients who receive both formal and informal) is with domestic activities (57.9%), health care tasks (37.5%), meals (27.5%) and self-care (25.5%).
- The most commonly provided informal assistance (including clients who receive both formal and informal) is with transport (70.5%),

meals (58.2%), social participation (64.8%), home maintenance (53.8%), and domestic tasks (54.1%).

- A small minority of clients (3.9%) receive no assistance at assessment.

Trends:

- In general, the level of formal assistance is lower than the previous year. The level of formal assistance for eight of the ten activities decreased by between 0.1% to 1.7% and the level of informal assistance for four of the ten activities decreased by between 0.5% and 1.4%. The level of informal assistance for communication, social participation, transport, domestic assistance, meals and home maintenance increased.

Rural metropolitan comparison:

- Overall, the level of formal and informal assistance was similar in rural and metropolitan areas.

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranges from 44.0% to 68.2%; assistance with health tasks from 17.4% to 51.1%, meals from 20.8% to 45.2%, and assistance with self-care tasks from 18.2% to 41.9%.
- Informal assistance with transport ranged from 52.6% to 78.1%, social participation from 34.0% to 76.4%, meals from 40.8% to 68.5%, and assistance with domestic tasks from 27.8% to 71.2%.

Health conditions

Overall result:

- Overall, heart conditions, hypertension, arthritis and dementia are the most common diagnoses among ACAS clients.
- The most common primary health condition is dementia (18.1%).

Trends:

- A further increase in the prevalence of most of the common health diseases/disorders.

Rural metropolitan comparison:

- The prevalence of dementia is lower in rural areas.

Range:

- The range across the teams in the proportion of clients reported with diagnosed dementia is considerable and the inclusion of clients with symptoms and signs of dementia reported (i.e., can be coded by ACAS clinicians independently of a diagnosis from a medical practitioner) increases the average rate/1000 target population and decreases the range to some degree but it is still significant.

Other comments

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

Clients and carers

Overall result:

- The great majority of clients (88.1%) have carers.
- The majority of carers are co-resident.

Rural metropolitan comparison:

- Overall, the proportion of clients with carers is similar in rural and metropolitan areas.
- Co-resident carers are relatively more common in metropolitan areas.

Clients at risk of admission to residential care

Overall result:

- Overall, 8.4% of clients living in the community are "at risk" of admission to a residential care facility.
- "At risk" clients are more likely to receive a multi-disciplinary assessment than all clients—64.6% of "at risk" clients received a MDA compared with 54.1% of all clients living in the community.

Trends:

- The proportion of assessments of clients living in the community "at risk" of admission to a residential care facility in 2009–10 is slightly lower than the previous years (2008–09 9.1%; 2007–08 9.2%; 2006–07 9.9%; 2005–06 10.1%; 2004–05 9.7%; 2003–04 9.1%).
- The proportion of assessments of clients living in the community "at risk" of admission to a residential care facility who receive a MDA (PI 6.1) increased compared with previous years (2009–10 64.6%; 2008–09 63.3%; 2007–08 58.1%; 2006–07 63.8%; 2005–06 63.6%; 2004–05 63.6%; 2003–04 61.7%).

Rural metropolitan comparison:

- The proportion "at risk" is higher in metropolitan than rural areas.
- A MDA is more likely if the client is assessed by a metropolitan team.

Recommendations

Long-term care setting

Overall result:

- Over two-thirds of clients living in the community at assessment (70.3%) receive a recommendation to continue living in the community.
- The great majority (83.6%) of clients living in low-level residential care at assessment are recommended to high-level care.
- The great majority (84.3%) of clients usually living in high-level residential care at assessment are recommended to continue living in high-level care.
- A minority (8.6%) of clients living in high-level care are recommended to low-level care, and a further 7.1% received community recommendations.

Trends:

- 2009–10 is consistent with the long-term trend of an increase in the proportion of community-dwelling clients recommended to remain in the community.
- In 2009–10 the proportion of clients living in low-level residential care and recommended to high-care is slightly lower than the previous year.

Rural metropolitan comparison:

- The proportion of community to community recommendations is slightly higher in rural than metropolitan areas.
- The proportion of low-level to high-level recommendations is similar in rural and metropolitan areas.

Range:

- Across the teams the proportion of community to community recommendations range from 54.0% to 85.0%; community to low care from 5.6% to 24.8%; and community to high care from 9.4% to 24.3%.
- Low-level to high-level recommendations range from 69.3% to 90.6%.

Government-funded care programs

Overall result:

- Of the assessments with a long-term care recommendation to the community, 54.8% are recommended HACC service(s), 29.9% CACP, 16.1% the National Respite for Carers Program, and 6.7% an EACH package.
- Under a tenth (8.5%) of assessments with a long-term care recommendation to the community have no recommendation for a government program (excludes respite care).

- A tenth (10.8%) of completed assessments result in a recommendation for a Transition Care Package.

Rural metropolitan comparison:

- Average recommendations by rural and metropolitan teams are similar for most government-funded programs, but there are differences for HACC and the National Respite for Carers Program.

Range:

- There was considerable variation among the teams in recommendations for government-funded services, particularly for NRCP.
- HACC ranged between 39.6% and 73.5%; CACP between 22.2% and 41.1%; EACH package between 4.2% and 11.3%; and EACH-D between 1.1% and 5.1%, and NRCP between 4.1% and 56.8% of complete assessments for clients give a community recommendation.
- Recommendations for a TCP range between 0.1% and 26.7% of completed assessments.

CACPs

Overall result:

- CACPs are recommended for nearly a third of assessments (29.9%) of people recommended to the community on-going 7.3% and new 22.6%.

Trends:

- The total number of CACPs recommended increased compared with the previous year.

Rural metropolitan comparison:

- The proportion of newly and on-going recommended CACPs is similar among rural and metropolitan teams.

Range:

- Across the teams the proportion of assessments with an on-going CACP recommendation ranged from 3.7% to 11.8%.
- The proportion of new recommendations ranged from 14.1% to 33.0%.

Respite

Overall result:

- Nearly three-quarters of clients (74.3%) recommended to the community receive a recommendation for residential respite in 2009–10, and 14.3% a recommendation for non-residential respite.

Trends:

- 2009–10 is not consistent with the overall increasing trend. The number of recommendations for residential respite is 3.9% lower, and non-residential respite 4.5% lower in 2009–10 compared to the previous year.

Rural metropolitan comparison:

- Recommendations for respite are similar in rural and metropolitan areas.

Range:

- Recommendations for residential respite range between 53.0% and 91.0% of clients recommended to the community
- For non-residential respite the range is between 6.8% and 31.7%.

Clients not "at risk"

Overall result:

- The great majority of complete ACAS assessments are of clients (91.6%) not "at risk" of admission to residential care.
- Of those clients living in the community not "at risk", 73.5% are recommended to the community and 26.4% to residential care (11.9% to low-care and 14.5% to high-care).
- Clients not "at risk" are half as likely to receive a recommendation to residential care than "at risk" clients.

Trends:

- In line with Performance Indicator 3.1, recommendations to residential care for clients not "at risk" have remained lower compared to previous years (2009–10 26.4%; 2008–09 26.3%; 2007–08 27.4%; 2006–07 28.3%; 2005–06 30.3%; 2004–05 32.3%; 2003–04 35.9%).

Rural metropolitan comparison:

- Rural clients not "at risk" are less likely to receive a recommendation to residential care than metro clients.

Non-target (younger) clients

Overall result:

- 68.9% of non-target clients living in the community are recommended to remain in the community, 12.3% to low-level care and 18.3% to high-level care.

- Compared to all clients living in the community, non-target group clients are slightly more likely to be recommended to the high-level care and less likely to be recommended low-level care.

Trends:

- The proportion of non-target clients recommended to residential care is higher than previous years, going against the desired outcome of Performance Indicator 3.2 (2009–10 30.6%; 2008–09 26.8%; 2007–08 28.9%; 2006–07 28.3%; 2005–06 32.0%; 2004–05 32.8%; 2003–04 32.0%).

Rural metropolitan comparison:

- Non-target group clients living in rural areas are more likely to receive a community recommendation and less likely to receive a recommendation for residential care than those in metropolitan areas.

Range:

- There was a considerable range across the teams in the recommendations for non-target group clients: community ranged from 52.8% to 87.5%; low-level care from 4.2% to 21.8%; and high-level care from 7.8% to 30.6%.

Target group clients with dementia

Overall result:

- The proportion of target group clients with dementia and living in the community given a community recommendation is 59.4%.
- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 40.4% of ACAP clients with dementia receive a recommendation for residential care compared to 29.6% of all clients living in the community.
- Further, 25.6% ACAP clients with dementia receive a high-level care recommendation compared to 16.4% of all clients living in the community.

Trends:

- In line with Performance Indicator 4.1, there was a further increase in the proportion of target group clients with dementia given a community recommendation compared with previous years (2009–10 59.4%; 2008–09 57.2%; 2007–08 56.9%; 2006–07 55.3%; 2005–06 52.7%; 2004–05 51.4%; 2003–04 46.6%).

Rural metropolitan comparison:

- Compared with rural teams, clients assessed by metropolitan teams are less likely to be recommended to the community and more likely to receive a recommendation for residential care.

“At risk” target group clients

Overall result:

- Nearly a fifth of “at risk” target group individual clients receive a recommendation for a CACP.
- Of the “at risk” target group clients recommended to the community, nearly a fifth (18.8%) receive a recommendation for a CACP, compared with 29.9% of all clients recommended to the community.

Trends:

- The proportion of “at risk” target group clients given a recommendation for a CACP (PI 4.2) is higher than the previous year (2009–10 18.8; 2008–09 17.7%; 2007–08 19.5%; 2006–07 19.5%; 2005–06 17.4%; 2004–05 19.0%; 2003–04 17.5%).

Rural metropolitan comparison:

- Rural teams recommend a CACP more often than metropolitan teams.

Range:

- The proportion of “at risk” target group individuals recommended a CACP ranges between 9.0% and 39.3%, between 0.4% and 7.9% for an EACH package, and between 0.4% and 3.5% for EACH-D packages.

Clients assessed in community settings

Overall result:

- The great majority of assessments (86.4%) in community settings result in a recommendation for long-term care in the community.

Trends:

- In line with Performance Indicator 4.3, the proportion of clients assessed in a community setting and whose usual accommodation was in the community increased by 1.9% compared with 2009–10 and is higher than all previous years (2008–09 86.1%; 2007–08 84.0%; 2006–07 82.1%; 2005–06 80.7%; 2004–05 78.4%; 2003–04 74.9%).

Rural metropolitan comparison:

- Overall, rural and metropolitan teams recommended similar proportions of clients to long-term care in the community.

Range:

- There was a considerable range across the teams in the recommendations of people assessed in the community—to the community from 65.5% to 96.7%, low-level care from 1.8% to 23.7%, and high-level care from 1.3% to 10.9%.

Clients assessed in an acute hospital

Overall result:

- Clients usually living in the community and assessed in an acute hospital are more likely to receive a recommendation for residential care (particularly high-level care) than clients assessed in a community setting.
- 31.9% of community clients assessed in an acute hospital receive a recommendation to the community, 18.1% are recommended low-level care and 49.6% high-level care.
- For clients assessed in the community the comparable recommendations are: community 86.4%, low-level care 9.5%, and high-level care 3.9%.

Trends:

- The proportion of clients assessed in hospital and given a community recommendation (PI 4.4) is higher than the previous year (2009–10 31.9%; 2008–9 26.8%; 2007–08 27.2%; 2006–07 23.7%; 2005–06 25.3%; 2004–05 27.2%; 2003–04 30.2%).
- Note that year-to-year changes in PI 4.4 is confounded by team practice to wait till post-discharge to assess clients likely to return to the community (also reflected in the long-term trend of decreasing numbers of assessments in acute hospitals).
- The increase in community recommendations from hospital assessments is not consistent with the long-term trend; since 1995–96 the proportion has steadily decreased from 42.0% to the 26.8% in 2008–09.
- There was a continuation of the long-term trend for decreasing proportions, and numbers, of assessments in acute hospitals.

Rural metropolitan comparison:

- Recommendations to the community were more likely in rural than metropolitan areas, while the reverse was true for low-level and high-level care.

Range:

- There is a considerable range across the teams in the recommendations of people assessed in hospital—to the community (11.2% to 58.7%), low-level (11.4% to 30.1%) and high-level care (28.3% to 66.9%).

Care coordination

Overall result:

- In 2009–10 under a tenth of clients (8.5%) received care coordination.
- Level 1 care coordination was much more common (6.5% of complete assessments) than Level 2 (0.8%) or both (1.2%).
- The average duration for care coordination (of any level) is 11.8 calendar days, and half of all care coordination episodes are closed within a week.
- In general, the care coordination provided is similar across a number of selected variables that might influence the likelihood of care coordination (age, availability of carer, presence of dementia, profound disability and recommended long-term care setting), with the likelihood of care coordination slightly more for clients aged between 50 and 69 years than other ages, for clients with a co-resident carer, and for assessments with a recommendation to the community compared to those to residential care.
- The level of missing data for care coordination (6.7%) increased compared to the previous year and is still higher than other items.

Rural metropolitan comparison:

- Overall, the proportion of clients receiving care coordination is similar among rural and metropolitan teams.
- The average duration of care coordination provided by rural teams is shorter than metropolitan teams.

Range:

- The proportion of clients who received any care coordination ranges between 0.1% and 17.3% among rural teams, and between 0.0% and 12.1% among metropolitan teams.
- The corresponding ranges for Level 1 care coordination are 2.0% to 17.3% for rural teams and 0.4% to 12.1% for metropolitan teams; and for Level 2 care coordination 0.1% to 2.8% for rural teams and 0.0% to 2.5% for metropolitan teams.
- Across all teams, the mean duration of care coordination ranged between 3.1 and 19.9 calendar days, and the median between 0 and 22 calendar days.

CONCLUSION

This Annual Report analyses records with assessment end dates from July 1 2009 to July 30 2010, and is the sixth to comprise all MDS v2 data.

Assessment numbers

In contrast to the previous year, assessment numbers are higher in 2009–10. Total referrals are 4.7% lower and completed assessments are 4.6% lower than 2008–09. Total assessments with face-to-face contact are 3.8% lower and total assessment activity (face-to-face assessments and consultations recorded in the VAED) is 5.2% lower than the previous year.

Access to assessment

Consistent with the decrease in numbers, the completed assessment rate (Performance Indicator 2.2) of 85.3 per 1,000 target population decreased by 3.8 compared to 2008–09, and the face-to-face contact rate of 95.1 is also lower. The proportion of target group assessments has steadily increased since 1995–96, and 2009–10 (93.1%) is similar to the previous year.

A small minority (0.50%) of all referrals to the ACAS involve people from Indigenous backgrounds. Referrals of Indigenous clients increased in 2009–10 but continued to be below their representation in the target population. The index (PI 1.1) of Indigenous referrals compared to their representation in the target population (0.71) is higher than 2008–09 and still below 1.0 (an index of 1.0 indicates that referrals of Indigenous people are commensurate with their representation in the target population).

In 2009–10 just under a quarter (24.5%) of referrals were of people of culturally and linguistically diverse (CALD) backgrounds. While access to the ACAP is higher than the previous year (referrals of people from CALD background are 11.17% higher than the previous year and consistent with the longer term trend), the proportion of CALD referrals continues to be below their representation in the population. The index comparing the representation of CALD referrals to their representation in the target population (PI 1.2) is 0.83, slightly higher than 2008–09 (an index of 1.0 indicates that referrals of people from CALD background are commensurate with their representation in the target population).

Over two-thirds (71.2%) of complete assessments involve people with a severe or profound core activity limitation, a small increase compared to 2008–09. A severe or profound core activity limitation was more likely among non-target group (younger) clients (76.7%) than among target group (older) clients (71.2%). The proportion of target group clients (PI 2.3) is slightly higher and the proportion of non-target group clients (PI 2.4) with a severe or profound core activity limitation slightly higher than the previous year.

Almost a quarter (23.7%) of complete ACAS assessments involve clients with a diagnosis of dementia, with a higher prevalence among target group clients (24.1%) than non-target group clients (18.5%). The proportion of target group clients with dementia (PI 2.5) is slightly lower than the previous year.

Timeliness of assessment

There is a considerable difference in time taken to complete the assessment process in hospital and non-hospital settings. However, most of this difference occurs in the first stages of the assessment process, between referral and first face-to-face contact. On average, Victorian ACAS take 1.7 calendar days to respond to a need for a comprehensive assessment (referral to first intervention 5% trimmed mean) in acute hospital/other inpatient settings, and 17.5 days in non-hospital settings (residential care/community), with a further 0.3 days in hospital settings and 0.8 days in non-hospital settings to face-to-face contact. To complete the assessment process (face-to-face contact to end of assessment) takes on average a further 0.9 days in hospital settings and 1.8 days in non-hospital settings; and delegation 1.3 days in hospital settings (end of assessment to delegation) and 3.0 days in non-hospital settings.

Overall, the time taken to complete the assessment process decreased in 2009–10 compared to previous years. Times in hospital settings decreased (referral to end of assessment decreased by an average of 3.4 days), and the assessment time (referral to end of assessment) in other settings also decreased from an average of 25.6 days to the present 23.0 days.

The proportion of clients (92.5%) who receive “timely assistance” (PI 2.1) is similar to previous years.[*] Timely assistance was relatively more common in hospital settings (98.2%) than in non-hospital settings (84.2%). The higher proportion of timely assistance in hospital settings reflects the agreements many teams have with their auspice to respond to requests for assessment within a specified time (usually 48 hours).

Client characteristics

The complexity of clients continued to increase (albeit slightly) compared with previous years. The proportion of clients aged 80 years and over continued to increase (by 0.4% compared with 2008–09) and this is reflected in increases in the proportion of clients reported with activity limitations and health conditions. The proportion of clients with an activity limitation is slightly higher (by between 0.6% and 3.2%) this year compared to 2008–09 for nine of the ten activities, and the proportion with no activity limitation decreased by 0.1%. In addition, relatively more clients were reported with many of the common health conditions compared to 2008–09.

Support at assessment

The level of support reported for clients living in the community is lower than the previous year—reported formal support for eight of the ten activities decreased by between 0.1% to

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[*] Timely assistance is the number of clients categorised as Priority 1 who were seen within 48 hours (i.e., referral to first intervention) and the number of Priority 2 clients seen within 14 days, as a proportion of all Priority 1 and Priority 2 clients.

1.7% and the level of informal assistance for four of the ten activities decreased by between 0.5% and 1.4%.

The data also shows the importance of informal assistance in supporting people in the community. With the exception of assistance with domestic tasks, the proportion of clients receiving informal assistance is higher than those receiving formal assistance. In particular, in the areas of communication, mobility, movement, transport and social participation, almost all the assistance is from informal sources.

Recommendations

The great majority of clients (94.2%) live in a community setting at the time of assessment, and 70.3% are recommended to continue living in the community, a small increase (0.3%) on the previous year. This increase is consistent with the long-term trend of increased proportions of community to community recommendations, from 58.9% in 1995–96 to the present 70.3%. It is also consistent with Performance Indicator 4.3 (the proportion of clients assessed in the community and given a long-term recommendation for a community setting). Over the same period, community recommendations for clients assessed in acute hospitals (PI 4.4) decreased from 42.8% to the present 31.9% (an increase of 5.1% compared to 2008–09). The decrease in the proportion of clients assessed in an acute hospital and given a community recommendation is off-set to some extent by the decreasing proportions, and numbers, of clients assessed in acute hospital (e.g., 9,833 community-dwelling assessments—23.2% of records with face-to-face contact—were assessed in hospital in 2003–04, compared with 7,561 assessments in 2009–10—14.0% of records with face-to-face contact). This decrease indicates that assessments in acute hospitals are increasingly targeting people who need approval for residential care.

An important objective of the ACAP is to prevent premature or inappropriate admission to residential care, particularly groups of clients such as those not "at risk" of admission to residential care (PI 3.1), non-target group (younger) clients (PI 3.2), clients with dementia (PI 4.1), and target group (older) clients (PI 4.2).[*] In line with PI 3.1 recommendations to residential care for clients not "at risk" have decreased over the past four years from 35.9% in 2002–03 to 26.4% in 2009–10. The proportion of non-target clients recommended to residential care (30.6%) is higher than the previous year. The proportion of long-term community recommendations for target group clients with dementia living in the community at assessment (59.4%) is slightly higher than the previous year and consistent with an increasing trend (PI 4.1). The proportion of target group clients "at risk" of admission to residential care given a recommendations for a CACP (18.8%) is higher than the previous year (PI 4.2).

Range across teams

As in previous years, there is considerable inter-team variation in assessment numbers, timeliness and recommendations. For example, the proportion of referrals that do not proceed further ranged from 0.3% to 20.5 %, and the proportion of completed (but not delegated) assessments from 0.3% to 32.2% and delegated assessments ranged from 60.9% to 91.5%. Taken together, complete and delegated assessments showed less variability (range 79.5% to 99.0%). There is also considerable variation in the allocation of priority category in both hospital and non-hospital settings. Referrals in hospital settings categorised as Priority 1 range across teams from 0.3% to 18.5%; Priority 2 between 57.9% and 98.7%; and Priority 3 between 0.5% and 39.9%. The corresponding proportions in non-hospital settings are: Priority 1 0.0% and 6.3%; Priority 2 8.5% and 68.0%; and Priority 3 30.6% and 91.2%. Variability in

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[*] "At risk" clients are those with any 4 of the following 5 characteristics: aged 80 years or over, or Indigenous and aged 60 years or over; having a severe or profound core activity restriction; having dementia; living alone; not having a carer)

policy and practice (particularly intake procedures), recording practice, catchment size, and the availability of services (particularly rehabilitation), impact on the assessment profile of teams.

While there was a relatively narrow range in the proportion of completed target group assessments to all assessments (90.2% to 95.4%) across the teams, the rate of completed target group assessments per 1,000 target population varies considerably (73.1 to 152.1). If the two highest rates (a metropolitan team with a relatively small catchment based at a hospital that draws people from a much wider area, and a small rural team) are removed the rates range from 73.1 to 112.7 completed assessments/1000 target population, still a considerable range.

Both rural and metropolitan teams reported a considerable range in timeliness in all settings. Average response times (referral to face-to-face contact) ranged from 0.5 to 8.6 calendar days in hospital settings and from 7.7 to 50.3 calendar days in non-hospital settings (5% trimmed means). The assessment process (referral to end of assessment) ranged from 0.7 to 9.7 calendar days in hospital settings, and from 8.2 to 52.0 calendar days in non-hospital settings (trimmed means).

The outcomes of assessment (recommendations) also varied considerably across the teams. For example, the proportion of people living in the community and given a long-term care recommendations to the community ranged from 54.0% to 85.0%; and the proportion living in low-level care and recommended high-level care ranged from 69.3% to 90.6%.

Care coordination

Care coordination is activity that ensures that the care plan is implemented by: monitoring the implementation of the care plan and assisting clients access services (Level 1); and/or helping clients who require close monitoring or active assistance from the ACAS, such as those with complex needs, or who are in an unstable or dangerous situation (Level 2). Data on care coordination activity provided to ACAP clients was introduced to further document team activity.

In 2009–10 just under a tenth of clients (8.5%) received care coordination, and over two-thirds (76.5%) of these clients received Level 1 care coordination. The average duration for care coordination (of any level) was 11.8 calendar days, and half of all care coordination episodes were closed within a week. There is considerable variation across the teams in the proportion of clients who receive care coordination and the duration of the care coordination provided.

In general, the care coordination provided is similar across a number of selected variables that might influence the likelihood of care coordination (age, availability of carer, presence of dementia, profound disability and recommended long-term care setting). However, care coordination slightly more likelihood for clients aged between 50 and 69 years than other ages, for clients with a co-resident carer, and for assessments with a recommendation to the community compared to those to residential care.

Data quality

Victorian data quality in 2009–10 is very good and there were improvements compared with the previous year. The National Data Repository aims for a missing or error rate of less than 1%. For records with face-to-face contact, and excluding date items, this level was achieved in Victoria for almost all items. Items with an error rate of more than 1% are: country of birth, care coordination and priority category.

There continues to be a high level of missing data for care coordination (6.7% c.f. 2.7% in 2008–09). In addition to the missing data, there are a high proportion of records with the duration of zero days, that is the care coordination was provided before the care plan was finalised or on the same day. Of complete assessments with some level of care coordination recorded, nearly a third (26.3%) show a duration of zero days. As care coordination is aimed at supporting the client to implement the care plan, most care coordination should occur after the end of assessment. It should be remembered that routine referrals arising from the care plan are not care coordination, they are part of the assessment/care plan process.

The continuing and considerable, inter-team variation in assessment numbers, timeliness and recommendations is noted in a previous section. In addition to this variation there appears to be considerable variation in the coding of some items. The ACAP target population is older people and there is limited variation across the teams in the age and sex profile of clients—the largest difference in any age group across the 18 teams is 7.8% and in the proportion of women 6.1%. However, a number of items vary considerable more than this, for example, activity limitations and health conditions. Across the teams the proportion of clients reported with a severe or profound activity limitation ranges between 53.2% and 90.7%; the need for domestic assistance between 89.3% and 97.3%; transport between 77.4% and 93.7%; meals between 71.5% and 91.3%, and self-care between 44.9% and 89.3%. The proportion recorded with a heart condition or disease ranges from 39.4% to 66.4%; diabetes from 18.5% to 26.4% and cerebrovascular disease/stroke from 13.8% to 25.2%.

PART 1: THE ACAP AND PROGRAM EVALUATION

The Aged Care Assessment Program (ACAP) is jointly funded by the Commonwealth, and States and Territories and is a crucial component of the aged care system. 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.

The following objectives are designed to achieve the core objective:

- To ensure that older persons who belong to the following groups have equitable access to ACAT services:
  - Aboriginal and Torres Strait Islander people
  - people of culturally and linguistically diverse backgrounds
  - people living in rural and remote areas
  - veterans, their spouses, widows and widowers
  - people with dementia.
- To ensure that access to ACAT services is based on need
- To prevent premature or inappropriate admission to residential aged care services
- To help frail older people remain in the community
- To facilitate access to the combination of services that best meet the needs of assessed clients
- To ensure that assessments of the care needs of frail older persons are comprehensive, incorporating the restorative, physical, medical, psychological, cultural and social dimensions of need
- To involve clients, their carers and other service providers in the assessment and care planning process
- To promote the co-ordination of aged care and other support services to improve the appropriateness and range of care services available to frail older people
- To optimise assessment services provided within available resources.[*]

ACCESS TO THE ACAP

This Annual Report utilises records submitted to the Victorian Evaluation Unit with Assessment end dates between 1st July 2009 and 30th June 2010, and includes updated data from all four quarters of 2009–2010. Totals for rural and metropolitan teams, and the overall total for the state are presented in the body of the report, with individual team data in Part 2 (not publically available). With the exception of two sections, the report uses accepted referrals or assessments (not individuals assessed), and most analyses are based on complete assessments (i.e., Reason for ending assessment is coded 1 = Assessment complete). In sections that compare current records with previous Victorian reports, an MDS v2 record is considered an assessment if there is a First Face-to-face Contact Date. This report includes the Key Performance Indicators outlined in the Aged Care Assessment Program Data Dictionary.[†] And, in line with previous reports, it also includes some trend analyses. Further information on the Aged Care Assessment Program, and the Minimum Data Set Version 2 can be found in Appendix 2.

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[*] Department of Health and Ageing. *Aged Care Assessment Program Operational Guidelines*. Canberra: Department of Health and Ageing, 2002, p. 5.

[†] Australian Institute of Health and Welfare. *Aged Care Assessment Program Data Dictionary Version 1*. Catalogue no. AGE 26. Canberra: AIHW, 2002.

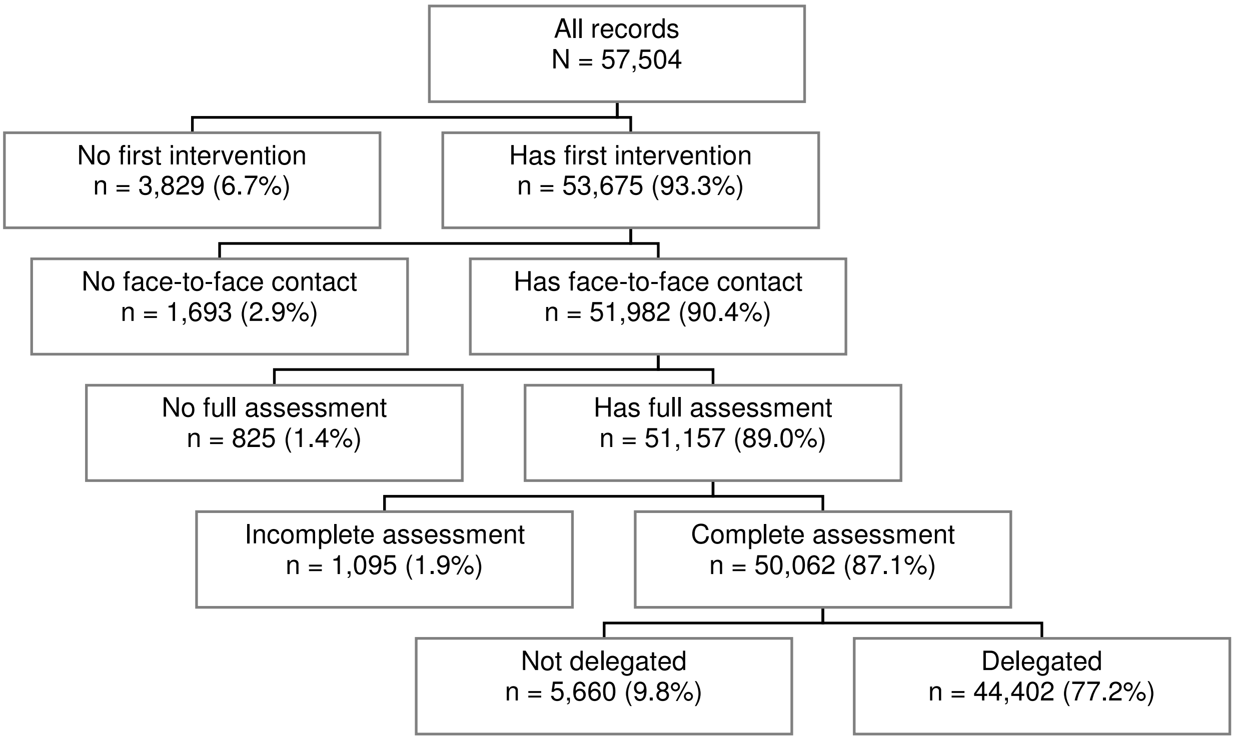
ACAS are required to conduct a holistic assessment of the client's care needs; taking into account the physical, medical, psychiatric and social needs of frail older people, including their rehabilitation potential, in order to help them choose the most appropriate services to meet their needs.[*] Records are included in the MDS if the ACAS considered that the client needs a comprehensive assessment.

Assessment numbers and rates

Number and types of records

During 2009–2010 a total of 57,504 records were accepted by the Evaluation Unit. Of these 51,982 (90.4%) include face-to-face contact and can be compared with MDSv1 data from previous years. Figure 1 presents the numbers and proportions of each of the levels of the total records submitted.[†] Across Victoria, the great majority (87.1%) of all referrals result in a recommended long-term living arrangement (completed or delegated assessments). Figure 1 shows that a relatively small proportion of all assessments (6.7%) go no further than the referral stage, 4.3% go beyond referral but don't involve a comprehensive assessment, and 1.9% involve a comprehensive assessment with no resultant recommendation. The great majority of this latter group are referred to rehabilitation or further treatment.

Figure 1: Flowchart of MDS v2 records



There is considerable inter-team variation within the averages presented in Figure 1. The proportion of referrals with no first intervention ranges from 0.3% to 20.5%, and the proportion of assessments with face-to-face contact from 79.5% to 99.0%. Completed (but not delegated) assessments range from 0.3% to 32.2% and delegated assessments from 60.9% to 91.5% (complete and delegated range from 74.5% to 97.5%). These variations have persisted over the previous five years, and are the result of a number of factors, including team intake policy and practice, recording practice, and the availability of services such as rehabilitation.

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[*] Department of Health and Ageing (2002) op. cit., p.9.

[†] See Appendix 2 for a description of the six levels of assessment.

Reason for Ending Assessment

The great majority of recorded assessments are completed (including delegated), that is a care plan is developed with an effective referral (Table 1). Of the incomplete assessments, most are because the client withdrew (4.6%; range 0.6% to 15.8%) or because the client's medical (3.4%; range 0.2% to 6.3%) or functional condition (1.5%; range 0.0% to 12.2%) required further treatment or rehabilitation.

Table 1: Reason for ending assessment, Victoria 2009–10 (%)

	Assessment complete[1] %	Client withdrew %	Client died %	Client transferred %	Medical condition unstable %	Functional status unstable %	Other reason/ missing %	Total %
Rural	88.4	5.6	1.0	0.2	2.6	0.7	1.6	100.0
Metro	86.5	4.1	0.6	0.6	3.8	1.8	2.6	100.0
Total	**87.1**	**4.6**	**0.7**	**0.5**	**3.4**	**1.5**	**2.3**	**100.0**

Note: [1] Includes complete and delegated assessments.

Assessments and rates

This section provides further information on access to the Victorian ACAP during 2009–10. It details the number of referrals and assessments reported for the year, and estimates of rates of access relative to the ACAP target population. This section also reports on the following Performance Indicator (PI):[*]

- % older people assessed by ACATs (PI: 2.2).
  Desired outcome: to maintain or increase the proportion of older population comprehensively assessed.

The target population for the ACAP program is all people aged 70 years and over, together with people from Indigenous backgrounds aged 50–69 years. The measure PI 2.2, the assessment rate, is the number of completed assessments of clients in the target group per 1,000 target group population in the catchment area.

Overall, the ACAP is well targeted with more than 90% of completed assessments of the target group and little variation among the teams (90.2%–95.4%). The completed assessment rate (PI 2.2) in 2009–10 is 95.1, an increase of 6.0 over the previous year. However, there is considerable variation in the completed assessment rate across the across the 18 Victorian teams. While two teams were considerably higher than the others—the highest rate (152.1) was reported by a metropolitan team with a relatively small catchment based at a hospital that draws people from a much wider area and the next highest (147.5) a small rural team— the remaining teams range from 73.1 to 112.7. The assessment rate based on the number of assessments with face-to-face contact is 95.1 assessments/1000 target group in 2009–10—a decrease of 3.7 on the previous year.

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[*] AIHW (2002). op. cit. Section 4, p. 139–140.

Table 2: Number of referrals, number of assessments, and assessment rates, Victoria 2009–10 (%)

	2010 Target Population[1]	Total Number of Accepted Referrals	Total Number of assessments with Face-to-face contact[2]	Total Number of Completed Assessments[3]	Total Number of Completed Target group Assessments[4]	Target group as % of Total Completed Assessments[5]	Rate[6]
Rural	169,138	17,469	15,856	15,435	14,358	93.0	84.9
Metro	377,695	40,035	36,126	34,627	32,274	93.2	85.4
Total	**546,833**	**57,504**	**51,982**	**50,062**	**46,632**	**93.1**	**85.3**

Note: [1] Population Projections based upon ABS Population Projections Australia, 2002 to 2010 Series B (supplied by the Department of Health and Ageing). Target group comprises people aged 70+ years and Indigenous people aged 50–69 years.

[2] Records with a valid face-to-face contact date (ACCR Q. 8).

[3] Records coded assessment complete (i.e., Reason for ending assessment (ACCR Q. 32) code 1).

[4] Target group records with assessment coded complete.

[5] (Number of completed assessments of target group/total completed assessments) x 100, i.e., (5)/(4) x 100.

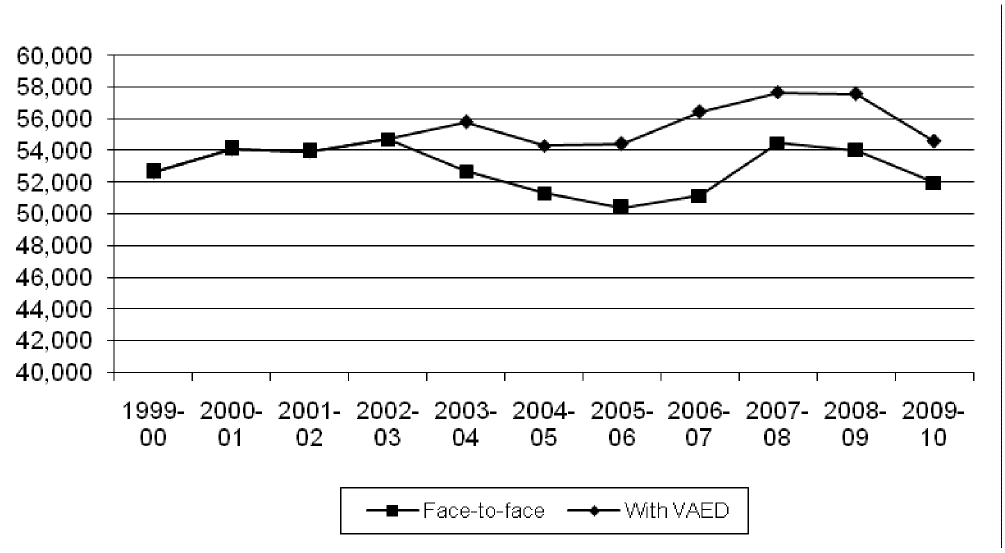
[6] Rate = (Number of completed target group assessments/target population) x 1000, i.e., (5)/(1) x 1000

Trends in assessment numbers

Figure 2 shows change in total assessment numbers in the 10 years to 2009–10. For comparability with previous years, only MDS v2 records with a valid First face-to-face contact date are included.

Assessment numbers increased in most years to 2002–03, declined between 2002–03 and 2005–06, before increasing in the next two years. Victorian teams in 2009–10 reported 2,881 (4.77%) less referrals, and 2,408 (4.59%) less completed assessments than in 2008–09. If the 2,612 hospital consultations (no longer reported in the national ACAP MDS because they do not comply with the national ACAP definition of a comprehensive assessment but collected in the Victorian Admitted Episode Data) are included in the workload, the ACAS output of face-to-face assessments and consultations for 2009–10 is 54,594—5.2% fewer than in 2008–09.

Figure 2: Assessment numbers, Victoria 1999-00 to 2009–10



Note: The years to 2001–02 include MDS v1 records only, 2002–03 and 2003-04 include MDS v1 and MDS v2 records, the years from 2004–05 comprise MDS v2 records only. For comparison with MDS v1 data, only MDS v2 records with a First face-to-face contact date are included.

Summary: Assessment numbers and rates

Overall result:

- The total number of records accepted by the Victorian Evaluation Unit in 2009–10 was 57,504, including 51,982 (90.4% of the total) with face-to-face contact.
- Of the total records, 6.7% are referrals only, 6.2% other incompletes, 9.8% completed assessments (but not delegated), and 77.2% delegated assessments.
- Across Victoria, 93.1% of completed assessments are of people in the target population.
- The completed assessment rate (PI 2.2) is 85.3 completed assessments per 1,000 people aged 70+ years and Indigenous people aged 50–69 years.
- The rate of assessments with face-to-face contact (i.e., comparable with previous years) is 95.1 per 1,000 target population.

Trends:

- Total referrals and completed assessments are lower (by 4.77% and 4.59% respectively) than in 2008–09.
- The number of assessments with face-to-face contact decreased by 3.83% over the previous year.
- Total assessment activity (face-to-face assessments and consultations recorded in the VAED) is 5.2% lower than in 2008–09.
- The proportion of target group assessments (93.1%) is the same as the previous year.
- The completed assessment rate (PI 2.2) decreased by 3.7 compared to the previous year (2009–10 85.3; 2008–09 89.1; 2007–08 93.9; 2006–07 90.6; 2005–06 92.2; 2004–05 89.9; 2003–04 94.9).

Rural metropolitan and inter-team comparison:

- Approximately a third (30.4%) of all referrals is to teams in rural areas.
- The assessment rate is slightly higher in metropolitan (85.4) than rural areas (84.9).

Range across teams:

- 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 are referrals only ranges from 0.3% to 20.5%; and the proportion of complete/delegated assessments from 74.5% to 97.5%.

Summary: Reason for ending assessment

Overall result:

- The great majority of recorded assessments (87.1%) are completed or delegated.
- The most common reasons for incomplete assessments are the client choosing to withdraw (4.5%) and unstable medical (3.4%) or functional status (1.4%).

Access for particular groups

Key objectives of the ACAP are to ensure that all groups of older people have equitable access, and that access to ACAP services is based on need.[*] This section of the report examines access to the ACAP by clients who may experience difficulty in doing so, such as those who are Aboriginal and/or Torres Strait Islanders, people from culturally and linguistically diverse backgrounds, and groups with particular needs including people with a severe or profound core activity restriction and/or dementia. In particular this section reports on the following Performance Indicators: [†]

- % older ACAT clients who are of Aboriginal and/or Torres Strait Islander origin (PI: 1.1)
  Desired outcome: that older Aboriginal and/or Torres Strait Islander peoples are represented as clients of the ACAP in proportions consistent with their representation in the general population.
- % older ACAT clients from culturally and linguistically diverse backgrounds (PI: 1.2)
  Desired outcome: that older from culturally and linguistically diverse backgrounds are represented as clients of the ACAP in proportions consistent with their representation in the general population.
- % older people with severe or profound core activity restriction assessed by ACATs (PI: 2.3)
  Desired outcome: to maintain or increase the proportion of the older population with a severe or profound core activity restriction assessed.
- % younger clients with severe or profound core activity restriction (PI: 2.4)
  Desired outcome: to reduce the proportion of younger clients who do not have a severe or profound core activity restriction.
- % older ACAT clients with dementia (PI: 2.5)
  Desired outcome: to maintain or increase the proportion of the older clients with dementia.

Clients from Indigenous backgrounds

Less than 1% of all referrals involve people from Indigenous backgrounds, and, as indicated by the index in Table 3, have relatively lower representation among ACAS referrals than their target population (PI 1.1). Table 3 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.

There are relatively more Indigenous referrals to rural than metropolitan teams, and rural teams assess a higher proportion of Indigenous clients relative to their target population.

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[*] Department of Health and Ageing (2002) op. cit. p. 5.

[†] AIHW (2002) op. cit. p. 127–149.

Table 3: Clients from Indigenous background, Victoria 2009–10

	Indigenous population aged 50+ years [1] N	Indigenous population aged 50+ years [2] %	Indigenous referrals N	Indigenous referrals [3] %	Index [4]
Rural	2,038	1.20	171	0.98	0.81
Metro	1,868	0.49	117	0.29	0.59
Total	**3,905**	**0.71**	**288**	**0.50**	**0.70**

Note: Includes all referrals with valid codes for Indigenous status (ACCR Q. 12).

[1] Population Projections based upon ABS Population Projections Australia, 2002 to 2101 Series B (supplied by the Department of Health and Ageing).

[2] (Population count Indigenous aged 50+) * 100/(Total population aged 70+ and Indigenous 50–69 years).

[3] (Referrals of Indigenous background) * 100/(Total referrals with known Indigenous status).

[4] Proportion of referrals that are Indigenous/proportion of target population that is Indigenous.

Table 4 presents the numbers of referrals of Indigenous clients and the number of referrals with face-to-face contact.

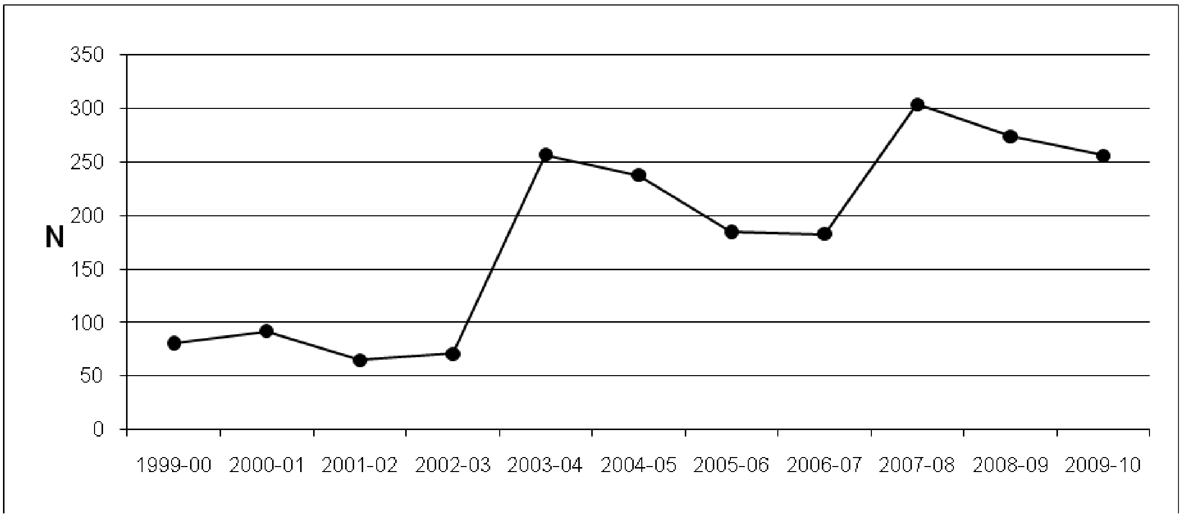
Table 4: Referrals of Indigenous clients, Victoria 2009–10 (count)

	Indigenous clients (referrals)	Total referrals*	Indigenous clients (referrals with face-to-face contact)	Total (referrals with face-to-face contact)*
Rural	171	17,469	150	15,856
Metro	117	40,035	106	36,126
Total	**288**	**57,504**	**256**	**51,982**

Note: * Records with valid code for Indigenous status (ACCR Q. 12).

Figure 3 charts the numbers of Indigenous clients assessed in Victoria in the previous 10 years. After the large increase in 2003–04 (corresponding to the introduction of MDS v2 in early/mid 2003), Indigenous referrals decreased sharply over the following two years, stabilised and increased to 2007–08 but decreased by 15.8% in 2009–10.

Figure 3: Assessments of Indigenous clients, Victoria 1999–00 to 2009–10 (count)



Note: Referrals with face-to-face contact.

Summary: Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.50% of all referrals and 0.49% of referrals that go on to face-to-face contact involve people from Indigenous backgrounds while 0.71% of the target population are Indigenous.
- Decreased access of Indigenous clients in 2009–10.

Trends:

- The number of Indigenous clients referred to ACAS decreased in 2009–10, compared to recent years.
- The index that compares the proportion of Indigenous clients with their representation in the general population (PI 1.1) remains less than 1.0 and but is higher than the previous year (2009–10 0.70; 2008–09 0.64; 2007–08 0.80; 2006–07 0.51; 2005–06 0.53; 2004–05 0.71).

Rural metropolitan comparison:

- Indigenous referrals to both rural and metropolitan teams are less than expected from the proportion in the population.
- Rural teams received relatively more Indigenous referrals than metropolitan teams and are slightly higher in the proportion relative to their target population.

Range:

- The proportion of Indigenous to total referrals ranges from 0.1% to 2.4% across Victorian teams.

Clients from Culturally and linguistically diverse backgrounds

Table 5 shows that just under a quarter of all accepted referrals are people of Culturally and Linguistically Diverse (CALD) backgrounds. Referrals of CALD background people are more likely in metropolitan than rural areas, and the range across teams was considerable, from 2.3% to 45.5%. The Index that compares the proportion of accepted referrals that involve clients from CALD backgrounds with the proportion of CALD people in the target population (PI 1.2) shows that access of people from CALD backgrounds is below that expected based on their representation in the 70+ years population.* Access of people from CALD background is relatively higher in metropolitan areas than rural areas with a considerable range across both (rural 0.20 to 0.78; metropolitan 0.74 to 1.05).

Table 5: Clients from CALD background, Victoria 2009–10

	CALD in population aged 70+ years [1] N	Proportion of target population is CALD [2] %	CALD referrals N	Proportion of CALD referrals [3] %	Index [4]
Rural	26,672	15.8	1,629	9.4	0.60
Metro	134,921	35.7	12,101	31.3	0.88
Total	**161,593**	**29.6**	**13,730**	**24.5**	**0.83**

Note: Includes records with valid codes for country of birth (ACCR Q. 10).

[1] Population Projections based upon ABS Population Projections Australia, 2002 to 2101 Series B (assumptions agreed to by the Department of Health and Ageing).

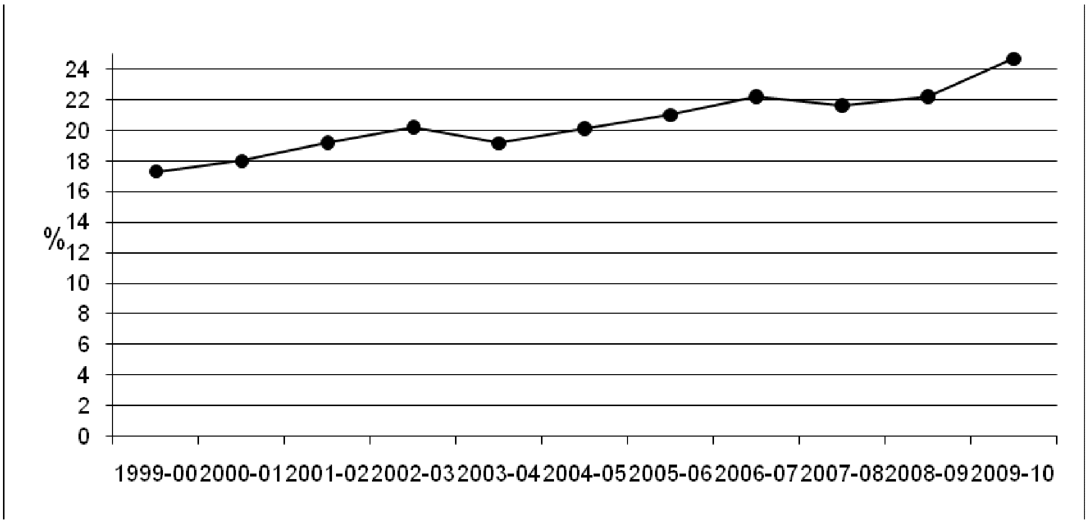
[2] (Population count CALD background aged 70+) * 100/(Total population aged 70+).

[3] (Referrals with CALD background) * 100/(Total referrals with known country of birth).

[4] Proportion CALD referrals/proportion of CALD in target population.

Figure 4 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 are included). Consistent with the overall trend, the proportion of assessments of people of CALD backgrounds in 2009–10 is higher than the previous year.

Figure 4: Assessments of clients of CALD background, Victoria 1999–00 to 2009–10 (%)



Note: Records with face-to-face contact date (ACCR Q. 18) and valid country of birth (ACCR Q. 10).

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* Based on ABS Population Projections Australia, 2002 to 2010 Series B.

Summary: Clients from CALD backgrounds

Overall result:

- Nearly a quarter of Victorian referrals (24.5%) are of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS is lower than their representation in the target population.

Trends:

- Consistent with the overall trend, the proportion of referrals from people of CALD backgrounds is higher than the previous year.
- The index (PI 1.2) that compares the proportion of CALD clients with their representation in the general population is higher than the previous year but remains less than 1.0 (2009–10 0.83; 2008–09 0.8; 2007–08 0.7; 2006–07 0.8; 2005–06 0.7; 2004–05 0.1.0; 2003–04 0.9).

Rural metropolitan comparison:

- Considerably more CALD clients are assessed by metropolitan than rural teams.

Range:

- The proportion of CALD people among accepted referrals ranges from 2.1% to 45.5%.
- The index comparing the proportion of accepted referrals involving CALD people relative to their representation in the target population ranges from 0.20 to 1.05.

Clients with severe or profound core activity limitation

An objective of the ACAP is to ensure that access is based on need and a measure is the proportion of assessments of people with a severe or profound activity limitation (PIs 2.3 and 2.4). Performance indicator 2.3 is based on the number of older ACAT clients assessed as a proportion of the total number with a severe or profound core activity limitation living in households in the community. As the population estimates for the denominator are not available, this section presents a proxy measure (the number of assessments of target group clients with a severe or profound core activity limitation as a proportion of the total number of target group assessments). Activity limitation is defined as whether the person needs the help or supervision of another individual in ten activities of daily living. A person with a severe or profound core activity restriction is one who sometimes, or always, needs assistance with one or more of the tasks of self-care, movement, mobility, or communication.*

More than two-thirds of Victorian clients living in the community have a severe or profound core activity restriction (Table 6). Non-target group (younger) clients are more likely to have a severe or profound core activity restriction than target group (older) clients.

Table 6: Clients with severe or profound core activity limitation, Victoria 2009–10 (%)

	"Non-target group" clients with severe or profound core activity limitation (%)	Target group clients with severe or profound core activity limitation (%)	Total (%)
Rural	78.7	71.5	72.0
Metropolitan	75.8	71.0	71.4
Total	**76.7**	**71.2**	**71.6**

Note: Table includes clients living in the community at assessment (complete assessments) only.

While rural and metropolitan teams reported similar overall proportions of clients with a severe or profound core activity limitation, there is considerable variation across teams. The proportion with a severe or profound core activity limitation among non-target group clients ranges from 53.5% to 88.7% among rural teams and from 64.6% to 94.4% among metropolitan teams. The corresponding proportions for target group clients were 53.2% to 82.4% among rural teams and 56.5% to 90.7% among metropolitan teams.

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* AIHW (2002) op. cit.

Summary: Clients with severe or profound core activity limitation

Overall result:

- Over two-thirds (71.2%) of target group (older) clients living in the community have a severe or profound core activity limitation.
- Over three-quarters (76.7%) of non-target group (younger) clients living in the community have a severe or profound core activity limitation.

Trends:

- In 2009–10 there was small increase (to 71.2%) in the proportion of target group clients living in the community with a severe or profound activity limitation at assessment (PI 2.3) (in 2008-09 it was 70.3%; 2007–08 68.3%; 2006–07 70.0%; 2005–06 68.4%; 2004–05 67.5%; 2003–04 60.9%).
- There was a small increase (to 76.7%) in the proportion of non-target group clients living in the community with a severe or profound activity limitation at assessment (PI 2.4) (75.9% in 2008-09; 6.1% in 2007–08; 77.3% in 2006–07, 76.5% in 2005–06, 75.1% in 2004–05 and 65.3% in 2003–04).

Rural metropolitan comparison:

- A similar proportion of target and non-target clients with a severe or profound core activity limitation reported by rural and metropolitan teams.

Range:

- The proportion of target group clients with a severe or profound core activity limitation ranges from 53.2% to 82.4% among rural teams and 56.5% to 90.7% among metropolitan teams.
- The proportion of non-target group clients with a severe or profound core activity limitation ranges from 53.5% to 88.7% among rural teams and from 64.6% to 94.4% among metropolitan team.

Clients with dementia

Table 7 shows that under a quarter of complete assessments are of clients diagnosed with dementia at the time of assessment.* The prevalence of dementia was higher among target group clients (clients aged 70 years and over, and Indigenous clients aged 50 years and over) and than of "non-target group" (younger) clients. The proportion of clients reported with dementia is higher among metropolitan teams than rural teams, and there is considerable variation across both in the proportion of clients reported with dementia. The proportion of non-target group clients with dementia ranges from 2.8% to 20.7% among rural teams and from 13.9% to 27.1% among metropolitan teams; and the proportion of target group clients with dementia ranges from 13.8% to 28.0% among rural teams and from 21.6% to 30.3% among metropolitan teams.

Table 7: Clients with dementia, Victoria 2009–10 (%)

	"Non-target group" clients with dementia (%)	Target group clients with dementia (%)	Total (%)
Rural	14.9	19.9	19.5
Metropolitan	20.1	26.0	25.6
Total	**18.5**	**24.1**	**23.7**

Note: Complete assessments only.

The range across the teams in the proportion of clients reported with diagnosed dementia is considerable and may be due to several factors, including variation in the team catchment population, variations in the diagnosis of dementia due to lack of availability of geriatricians, and recording practice. However, it appears that the main factor in this variability is recording practice. The range in rates of diagnosed dementia/1000 target population of 11.9 to 32.8 (average 20.5/1000 target population) was wider than the proportional rates above. Inclusion of clients with symptoms and signs of dementia reported (i.e., can be coded by ACAS clinicians independently of a diagnosis from a medical practitioner) increases the average rate to 35.7/1000 target population and increases the range (26.7 to 52.9) to some degree.†‡

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* ACAP health condition codes 0500 to 0532 (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)).

† Ranges exclude the rates for one team based at a large hospital but with a small catchment.

‡ Symptoms and signs included were disorientation (ACAP health condition code 1716), amnesia (code 1717), restlessness and agitation (code 1719), and hostility (code 1722).

Summary: Clients with dementia

Overall result:

- 23.7% of ACAS assessments involve clients with a diagnosis of dementia.
- Target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) are more likely (24.1%) to have a diagnosis of dementia than non-target group (younger) clients (18.5%).

Trends:

- For PI 2.5, the proportion of target group clients with dementia (24.1%) is lower compared to previous years (2008-09 26.6%; 2007–08 27.1%; 2006–07 28.1%; 2005–06 28.1%; 2004–05 27.7%; 2003–04 27.9%).
- The proportion of non-target group clients with dementia (18.5%) is similar to previous years (2008-09 17.9%; 2007–08 16.5%; 2006–07 18.8%; 2005–06 19.2%; 2004–05 17.6%; 2003–04 15.2%).

Rural metropolitan comparison:

- Diagnosed dementia is more common among metropolitan than rural clients.

Range:

- The proportion of target group clients with dementia ranges from 13.8% to 30.3%.
- The proportion of non-target group clients with dementia ranges from 2.8% to 27.1%.

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. This section also reports on the following Performance Indicator:[*]

- % ACAT clients receiving timely assistance (PI: 2.1).
  Desired outcome: all clients are assisted within the timeframe specified by the Priority category allocated to the client's assessment.

Times from Referral date 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 private residence/other community) locations are provided. All times are calendar days.

Referral to First intervention

Table 8 presents the times between Referral and First intervention in the different assessment settings.

Table 8: Referral to First intervention by First face-to-face contact setting, Victoria 2009–10 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	4,257	17	3.9 (1.3–7.0)	5.2 (2.0–8.0)	2 (1–7)	12 (3–18)
Metro	10,763	6	0.9 (0.4–1.8)	1.4 (0.9–2.5)	0 (0–1)	4 (2–6)
Total	**15,020**	**23**	**1.6**	**2.5**	**1**	**7**
Non-hospital**						
Rural	11,555	28	19.4 (7.5–41.2)	24.1 (8.7–45.9)	14 (6–20)	55 (20–138)
Metro	25,202	15	16.8 (10.3–31.0)	19.1 (10.9–33.8)	14 (9–26)	41 (21–90)
Total	**36,757**	**43**	**17.5**	**20.7**	**14**	**45**
Residential care						
Rural	1,207	5	9.6 (5.7–11.8)	11.6 (7.7–13.9)	7 (4–10)	28 (20–34)
Metro	1,936	0	8.3 (4.4–13.9)	10.0 (5.7–15.8)	7 (2–10)	23 (14–43)
Total	**3,143**	**5**	**8.8**	**10.6**	**7**	**25**
Private residence/other community						
Rural	10,348	23	20.8 (7.6–44.3)	25.5 (8.7–48.8)	15 (7–22)	58 (20–140)
Metro	23,266	15	17.6 (10.6–32.2)	19.9 (11.2–34.6)	15 (10–28)	42 (21–91)
Total	**33,614**	**38**	**18.4**	**21.6**	**15**	**47**
TOTAL	**51,777**	**66**	**12.2**	**15.4**	**8**	**37**

Note: *Records with valid referral and first intervention dates (ACCR Questions 1 and 17). Missing includes cases with negative times, times over 364 days, or records without a valid contact setting.
** Residential care and private residence/other community settings.

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[*] AIHW (2002). op. cit. Section 4, p. 136–138.

Table 8 shows the considerable differences in the response times between hospital and non-hospital settings for both rural and metropolitan teams. In hospital settings the average response (trimmed mean) is under two days, half of all referrals receive a response within a day, and almost all referrals (90%) are seen within one week. In non-hospital settings the average response is over two weeks, half of the referrals receive a response within two weeks, and 90% receive a response within 45 days.

Response times in rural areas are longer than metropolitan areas in hospital settings but similar in non-hospital settings. This difference reflects the location of the team and team practice. Most metropolitan teams are located within acute hospitals/other inpatient facilities and have auspice arrangements to respond to referrals in the facility within two days, while most rural teams are located within Community Health Centres. In addition, for those teams located within acute hospitals/other inpatient facilities some of the work of assessment is done by staff within the facility.

Both rural and metropolitan teams reported a considerable range in response times in all settings, but there is less variation in hospital settings than non-hospital settings—trimmed means range from 0.4 to 7.0 calendar days in hospital settings and 7.5 to 31.0 calendar days in non-hospital settings.

Referral to First face-to-face contact

Times from Referral date to First face-to-face contact date are also shorter in hospital than non-hospital settings (Table 9). In hospital settings, the average response (trimmed mean) is two days, the assessment process begun within a day after referral for half of the referrals, and almost all referrals (90%) receive face-to-face contact in a week. In non-hospital settings the average time (trimmed mean) between referral and face-to-face contact is just under three weeks, half of referrals receive face-to-face contact within 16 days (median) and 90% within 51 days.

Table 9: Referral to First face-to-face contact by First face-to-face contact setting, Victoria 2009–10 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	4,249	25	4.7 (1.3–8.6)	6.1 (2.1–10.1)	3 (1–7)	14 (4–23)
Metro	10,748	21	1.0 (0.5–2.0)	1.5 (1.0–2.6)	0 (0–1)	4 (2–7)
Total	**14,997**	**46**	**1.9**	**2.8**	**1**	**7**
Non-hospital**						
Rural	11,551	32	22.4 (7.7–46.6)	27.1 (8.9–51.0)	16 (6–24)	63 (20–141)
Metro	25,180	37	19.3 (10.6–50.3)	21.9 (11.2–51.7)	16 (10–44)	48 (21–101)
Total	**36,731**	**69**	**20.1**	**23.5**	**16**	**51**
Residential care						
Rural	1,207	5	11.2 (7.5–13.0)	13.3 (8.8–14.6)	9 (5–11)	29 (21–36)
Metro	1,934	2	9.6 (4.5–25.7)	11.5 (5.8–28.5)	7 (3–20)	27 (14–66)
Total	**3,141**	**7**	**10.3**	**12.2**	**8**	**28**
Private residence/other community						
Rural	10,344	27	23.9 (7.8–50.1)	28.7 (8.9–54.3)	18 (7–27)	69 (20–145)
Metro	23,246	35	20.2 (10.9–51.4)	22.7 (11.5–52.7)	17 (10–45)	49 (21–102)
Total	**33,590**	**62**	**21.1**	**24.6**	**17**	**54**
TOTAL	**51,728**	**115**	**14.1**	**17.5**	**10**	**42**

Note: Records with valid referral and first face-to-face contact dates (ACCR Questions 1 and 18). Missing includes cases with negative times, times over 364 days, or records without a valid contact setting.
** Residential care and private residence/other community settings.

Response times in hospital settings reported by metropolitan teams are shorter than rural teams. Response times in residential care and community settings are similar for rural and metropolitan teams. The range in response times varies considerably among both rural and metropolitan teams in all settings.

Since 1999–00, the time between referral and first face-to-face contact has been increasing in all settings. However, times in 2009–10 are not consistent with the long-term trend. Response times in non-hospital, residential care and community settings are shorter than the previous year (2008–09 non-hospital trimmed mean 23.0; residential 12.6 days; community settings 24.2 days).

Referral to Assessment end date

Times from Referral date to Assessment end date and Delegation date provide an indication of the duration of the assessment process. On average (trimmed mean), the assessment process from referral to the end of assessment takes between three and four days in hospital settings, and 23 days in non-hospital settings (12 in residential care and 24 in community settings) (Table 10). The median times for hospital and non-hospital settings are 2 and 19 days respectively, and to complete 90% of assessments took 12 and 56 days respectively. As with the other measures of timeliness, there is considerable variation within settings among both rural and metropolitan teams.

Table 10: Referral to End of assessment by First face-to-face contact setting, Victoria 2009–10 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	4,016	0	5.9 (1.9–9.7)	7.4 (2.8–11.1)	5 (1–8)	16 (5–25)
Metro	9,800	2	2.5 (0.7–5.7)	3.6 (1..2–7.7)	1 (0–3)	8 (3–20)
Total	**13,816**	**2**	**3.4**	**4.7**	**2**	**12**
Non-hospital**						
Rural	11,401	5	24.2 (8.2–50.4)	28.9 (9.6–54.7)	18 (7–28)	67 (21–146)
Metro	24,793	8	22.7 (14.1–52.0)	25.3 (14.7–53.6)	20 (14–46)	52 (26–105)
Total	**36,194**	**13**	**23.0**	**26.4**	**19**	**56**
Residential care						
Rural	1,190	2	12.6 (8.3–14.9)	14.8 (9.5–17.7)	10 (6–12)	32 (25–43)
Metro	1,897	0	11.7 (6.3–26.4)	13.7 (8.0–29.2)	9 (5–20)	31 (18–66)
Total	**3,087**	**2**	**12.0**	**14.1**	**9**	**31**
Private residence/other community						
Rural	10,211	3	25.8 (8.3–54.2)	30.6 (9.6–58.2)	20 (7–31)	72 (21–148)
Metro	22,896	8	23.7 (14.4–53.0)	26.2 (15.0–54.6)	21 (14–47)	54 (26–105)
Total	**33,107**	**11**	**24.1**	**27.6**	**20**	**58**
TOTAL	**50,010**	**15**	**17.0**	**20.4**	**13**	**47**

Note: *Records of complete assessments with valid referral and end of assessment dates (ACCR Questions 1 and 33). Missing values include cases with negative times, times over 364 days, or records without a valid contact setting.
** Residential care and private residence/other community settings.

Time from Referral to Delegation date

On average, the assessment process for Commonwealth approved services (referral to delegation) takes five days in hospital settings and 27 days in non-hospital settings. The ranges in response times (calendar days) between teams in the various settings for the trimmed mean are: hospital/other inpatient 1.0 to 13.1; and non-hospital 11.0 to 54.9 (Table 11).

Table 11: Referral to Delegation date by First face-to-face contact setting, Victoria 2009–10 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	3,752	0	8.2 (3.1–13.1)	9.8 (4.1–14.6)	7 (2–12)	21 (7–29)
Metro	8,880	1	3.9 (1.0–8.3)	5.1 (1.7–10.4)	3 (1–6)	12 (4–24)
Total	**12,632**	**1**	**5.1**	**6.5**	**4**	**15**
Non-hospital**						
Rural	10,095	2	29.4 (11.0–54.4)	34.2 (12.3–58.7)	23 (9–32)	77 (26–150)
Metro	21,635	7	26.2 (16.1–54.9)	28.7 (16.8–56.7)	22 (15–49)	59 (29–106)
Total	**31,730**	**9**	**27.0**	**30.5**	**22**	**63**
Residential care						
Rural	1,080	0	15.4 (10.3–17.5)	17.4 (11.2–20.3)	13 (9–15)	36 (25–50)
Metro	1,637	0	14.5 (10.1–27.0)	16.6 (10.9–29.7)	12 (8–20)	35 (21–67)
Total	**2,717**	**0**	**14.9**	**16.9**	**13**	**35**
Private residence/other community						
Rural	9,015	2	31.4 (11.0–58.3)	36.2 (12.2–62.3)	24 (9–36)	84 (26–154)
Metro	19,998	7	27.2 (16.4–56.3)	29.7 (17.1–58.0)	23 (15–50)	60 (29–107)
Total	**29,013**	**9**	**28.2**	**31.8**	**23**	**65**
TOTAL	**44,362**	**10**	**20.1**	**23.7**	**16**	**53**

Note: *Records with valid referral and delegation dates. Missing values include cases with negative times, times over 364 days, or records without a valid contact setting.
** Residential care and private residence/other community settings.

Timeliness by stage

Figure 5 presents the aggregated time taken for each stage of the assessment process in hospital (acute hospital and other inpatient) and non-hospital (residential care and private residence/other community).* It highlights the considerable difference in time taken to complete the assessment process in hospital and non-hospital settings. It also shows that most of this difference occurs in the first stages of the assessment process, between referral and first face-to-face contact. On average (trimmed mean), Victorian ACAS take under two days to respond to a request for service (referral to first intervention) in hospital settings, but over two weeks in non-hospital settings. Response times in rural areas were longer than metropolitan areas in both hospital and non-hospital settings. The time from first intervention to face-to-face contact is a few hours in hospital settings but almost a day in non-hospital settings. The time spent on the assessment process was one day longer in non-hospital than hospital settings.

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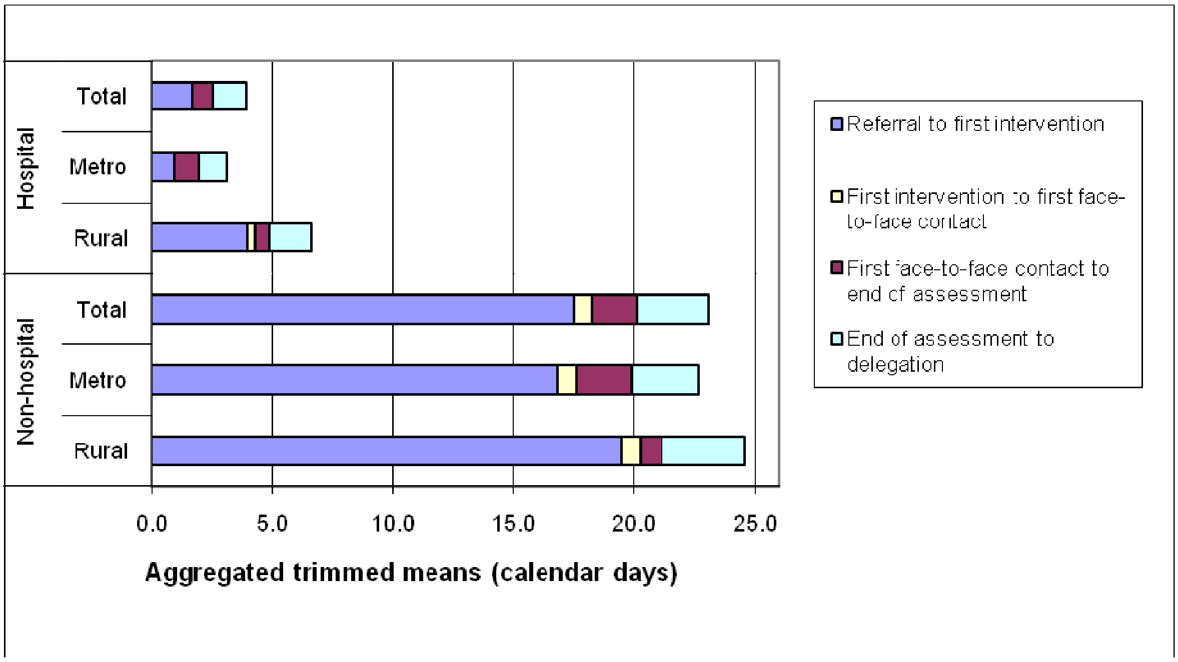
* These aggregated times differ from those in Tables 3–6 because of differences in the method of calculation and the cases included in each stage.

Figure 5: Aggregated time for the assessment process, Victoria 2009–10 (calendar days)



Note: The figure includes records of complete assessments with valid dates at the various stages of the assessment process.

Timeliness and Priority category

This sub-section provides further information on response times for the three Priority categories in the various assessment settings, and specifically reports on Performance Indicator 2.1 on “timely assistance”. Overall, 92.5% of referrals received timely assistance (i.e., Priority 1 within 2 calendar days, and Priority 2 within 14 calendar days), with a higher proportion of timely assistance in hospital settings than non-hospital settings. Timely assistance is more likely among metropolitan teams (95.3%) than rural teams (86.4%) with the range from 77.7% to 99.2% across all teams.

The coding of Priority category improved in 2009–10. Overall, only 4.6% of clients in hospital settings were categorised as Priority 1 compared to 9.0% in the previous year. However, a number of teams still reported a high proportion (up to 18.5%) of Priority 1 clients in hospital settings. There should be very few people allocated Priority 1 in these settings, as any clinical intervention is immediately available and the person should not be referred to ACAS until they are medically stable. This reflects the involvement of non-ACAS clinicians in the assessments, as some, but not all, of these teams are based in large metropolitan hospitals. The allocation of Priority 1 in non-hospital settings is slightly lower (1.4%) than previously (2.1%). In addition, there is considerable variation across the teams in their allocation of Priority category. Referrals categorised as Priority 1 range between 0.0% and 6.3%; Priority 2 between 8.5% and 68.0%; and Priority 3 between 30.6% and 91.2%.

Table 12: Referral to First intervention by Priority category by Location at assessment, Victoria 2009–10 (calendar days)

	Priority category 1			Priority category 2			Priority category 3			
	% of total[1] (range)	% seen on time[2] (range)	Count	% of total[3] (range)	% seen on time[4] (range)	Count	% of total[5] (range)	% seen within 36 days[6] (range)	Count	Total number[7]
Acute hospital/other inpatient										
Rural	2.5	93.5	107	87.0	96.0	3,719	10.1	92.1	433	4,274
	(0.3–6.5)	(72.7–100.0)		(57.9–98.7)	(91.9–98.3)		(1.0–39.9)	(75.0–100.0)		
Metro	5.4	93.3	579	92.8	99.4	9,998	1.7	98.3	178	10,769
	(0.5–18.5)	(70.0–100.0)		(79.5–98.7)	(98.5–99.9)		(0.5–5.4)	(85.7–100.0)		
Total	**4.6**	**93.3**	**686**	**91.2**	**98.5**	**13,717**	**4.1**	**93.9**	**611**	**15,043**
Non-hospital (residential care and private residence/other community settings)										
Rural	1.0	86.1	115	32.9	76.7	3,807	66.1	75.8	7,651	11,583
	(0.1–3.1)	(76.9–100.0)		(17.0–68.0)	(62.3–95.5)		(30.6–81.9)	(35.5–94.0)		
Metro	1.6	92.7	410	22.9	88.5	5,775	75.4	83.8	19,023	25,217
	(0.0–6.3)	(0.0–100.0)		(8.5–36.1)	(75.3–94.9)		(57.6–91.2)	(51.6–98.4)		
Total	**1.4**	**91.2**	**525**	**26.0**	**83.8**	**9,582**	**72.5**	**81.5**	**26,674**	**36,800**
Residential care										
Rural	1.8	86.4	22	58.4	84.9	708	39.7	90.0	481	1,212
	(0.0–6.7)	(75.0–100.0)		(29.6–79.8)	(72.4–100.0)		(17.9–68.5)	(73.3–94.6)		
Metro	3.9	94.7	76	51.5	94.8	997	44.5	91.4	861	1,936
	(0.0–9.2)	(86.4–100.0)		(26.3–77.1)	(86.2–100.0)		(18.8–7.3.7)	(71.6–100.0)		
Total	**3.1**	**92.9**	**98**	**54.2**	**90.7**	**1,705**	**42.6**	**90.9**	**1,342**	**3,148**
Private residence/other community settings										
Rural	0.9	86.0	93	29.9	74.8	3,099	69.1	74.9	7,170	10,371
	(0.1–2.6)	(72.7–100.0)		(10.7–70.7)	(60.8–95.6)		(28.0–88.6)	(34.2–93.9)		
Metro	1.4	92.2	334	20.5	87.2	4,778	78.0	83.5	18,162	23,281
	(0.0–6.1)	(63.4–100.0)		(7.7–35.6)	(72.8–94.7)		(58.4–92.2)	(50.8–98.3)		
Total	**1.3**	**90.9**	**427**	**23.4**	**82.4**	**7,877**	**75.3**	**81.1**	**25,332**	**33,652**

Note: Priority Category (ACCR Question 16) is the length of time within which the person needs contact of a clinical nature based on the urgency of the person's need as assessed by the ACAT at referral.
Priority Category 1: the person needs contact of a clinical nature within 48 hrs.
Priority Category 2: the person needs contact of a clinical nature between 3 and/ 14 calendar days.
Priority Category 3: the person needs contact of a clinical nature after 14 calendar days.

[1] The proportion of records allocated a Priority Category that are Priority Category 1.

[2] The proportion of records coded Priority Category 1with referral to first intervention within 48 hrs.

[3] The proportion of records allocated a Priority Category that are Priority Category 2.

[4] The proportion of records coded Priority Category 2 with referral to first intervention within 14 calendar days.

[5] The proportion of records allocated a Priority Category that are Priority Category 3.

[6] The proportion of records coded Priority Category 3 with referral to first intervention within 36 calendar days. The value 36 days is the national average for 90% of assessments to have reached first intervention for the 2003/04 assessment year. It should be noted that this is a measure, not performance indicator, which compares team performance to national performance.

[7] All records with a valid code for Location at assessment (ACCR Q. 19).

Missing (numbers not included) are those records with invalid or missing referral date (ACCR Q. 1), first intervention date (ACCR Question 7), or Priority Category (ACCR Q. 16).

Table 13 provides further information on the response times and presents the proportion of referrals given a response within the various timeframes. It shows that approximately two-thirds of referrals receive a response within two weeks and 84% within a month—similar proportions as the previous year. In general, response times by rural teams were shorter than metropolitan teams. The table also shows considerable variability among the teams.

Table 13: Referral to First intervention and First face-to-face contact within given times, Victoria 2009–10 (calendar days)

	Referral to first intervention[1]					Referral to face-to-face contact[2]				
	0–14 days (range) %	15–28 days (range) %	29–42 days (range) %	43–56 days (range) %	57+ days (range) %	0–14 days (range) %	15–28 days (range) %	29–42 days (range) %	43–56 days (range) %	57+ days (range) %
Rural	62.7	18.3	8.2	3.6	7.2	58.1	20.3	9.1	4.1	8.4
	(55.1–84.6)	(11.6–26.7)	(2.3–12.2)	(1.3–6.2)	(0.1–21.2)	(52.6–83.2)	(12.6–27.1)	(2.8–13.1)	(1.3–6.2)	(0.1–23.8)
Metro	65.3	20.4	7.3	3.0	4.1	62.2	21.1	8.1	3.5	5.0
	(47.0–79.0)	(12.5–34.4)	(1.9–12.1)	(0.3–8.4)	(0.1–15.2)	(43.0–78.2)	(7.9–34.9)	(2.1–14.5)	(0.6–9.6)	(0.1–25.0)
Total	64.5	19.8	7.5	3.2	5.0	60.9	20.9	8.4	3.7	6.1

Note: [1] Includes records with valid referral (ACCR Q. 1) and first intervention (ACCR Q. 17) dates only.
[2] Includes records with valid referral (ACCR Q. 1) and face-to-face contact (ACCR Q. 18) dates only.

Summary: Timeliness

Overall result:

- Assessment times vary considerably between hospital and non-hospital settings.
- The average (trimmed mean) time from referral to end of assessment is 3.4 calendar days in hospital settings and 23.0 calendar days in non-hospital settings.
- Most of the difference in assessment times between hospital and non-hospital settings is in the initial stages.
- Victorian ACAS respond (referral to first intervention) to half of the referrals in hospital settings within one calendar day (median) and 90% of referrals within 7 days. In non-hospital settings the median response is 14 calendar days, with 90% of referrals seen within 45 days. The respective trimmed means for hospital and non-hospital settings are 1.6 and 17.5 calendar days.
- From first intervention to the beginning of the assessment process (first face-to-face date) takes, on average (trimmed mean), there is a further 0.8 days in non-hospital settings. The trimmed mean is 0 days for hospital settings
- The assessment process (first face-to-face date to end of assessment date) takes a similar time in hospital settings (trimmed mean 0.9 calendar days) and non-hospital settings (trimmed mean 1.8 calendar days).
- For those assessments that went on to delegation, this takes a further 1.3 days in hospital settings and 3.0 days in non-hospital settings.

- Overall, the great majority of referrals (92.5%) receive “timely assistance” (PI 2.1), (Priority 1 within 2 calendar days, and Priority 2 within 14 calendar days).
- A higher proportion of referrals in hospital settings receive “timely assistance” (93.3% of Priority 1 and 98.5% of Priority 2 referrals), than in non-hospital settings (91.2% of Priority 1 and 83.8% of Priority 2 referrals).

Trends:

- The time from referral to end of assessment is lower in both hospital settings (3.4 days c.f. 3.9 days in 2008–09) and in non-hospital settings (23.0 days c.f. 25.6 days in 2008–09).
- The proportion of people who receive “timely assistance” is similar to the previous five years (2009–10 92.5%; 2008–09 93.0%; 2007–08 91.8%; 2006–07 92.0%; 2005–06 91.9%; 2004–05 91.0%).

Rural metropolitan comparison:

- Response times in hospitals are shorter for metropolitan teams than rural teams.
- The average proportion seen “on time” by metropolitan teams is higher than rural teams in both hospital and non-hospital settings.

Range across teams:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.4 to 7.0 calendar days; non-hospital settings 7.5 to 41.2 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.5 to 8.6 calendar days; non-hospital settings 7.7 to 50.3 days.
- Response times from referral to end of assessment date: hospital settings, trimmed mean 0.7 to 9.7 calendar days; non-hospital settings 8.2 to 52.0 days.
- The proportion seen “on time” for Priority 1 ranged between 70.0% and 100.0% in hospital settings, and between 71.4% and 100.0% in non-hospital settings; and Priority 2 between 91.9% and 99.9% in hospital settings, and between 62.3% and 95.5% in non-hospital settings.

Location of assessment

Whenever possible, clients should be assessed in their usual accommodation setting.[*] The great majority of clients live in a community setting or a residential care facility, but because of their medical or functional status, a significant minority 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.

Nearly two-thirds of clients are assessed in a private residence or other community setting, over a quarter in acute hospitals and other inpatient facilities, and a further 6.0% in residential care facilities (Table 14). Reflecting the availability of facilities, clients in metropolitan areas are more likely to be assessed in other inpatient settings than those in rural areas. Rural teams assessed relatively more clients in residential care settings than metropolitan teams.

Table 14: Location of assessment, Victoria 2009–10

	Acute hospital %	Other inpatient setting %	Residential care setting %	Private residence/ Other community %	Missing %	Total %	Total n
Rural	18.7	8.1	7.6	65.3	0.3	100.0	15,856
Metro	17.5	12.3	5.4	64.4	0.5	100.0	36,126
Total	**17.9**	**11.0**	**6.0**	**64.6**	**0.5**	**100.0**	**51,982**

Note: Table includes only records with a valid face-to-face contact date.

The proportion of clients assessed in the various settings varies considerably among the 18 Victorian teams. Those assessed in hospital ranged from 5.6% to 33.9%; other inpatient from 0.3% to 32.2%; residential care from 2.7% to 9.7%; and private residence/other community 41.7% to 79.1%. These differences are influenced considerably by the team catchment and the number of acute hospitals in it, the availability of other inpatient facilities, and individual team/auspice policy and practice.

Figure 6 illustrates change over time in the proportion of assessments that take place in hospital settings (acute hospital and other inpatient settings). Prior to 1999–00 the proportion of clients assessed in hospital settings in Victoria was fairly stable around 38%. Since 1999–00 there has been a steady decline in the proportion of clients assessed in hospital settings, until 2007–08, when the proportion of client began to increase. Consistent with the increasing trend over the past few years, the proportion in 2009–10 (28.9%) was slightly higher than the previous year (27.2%).

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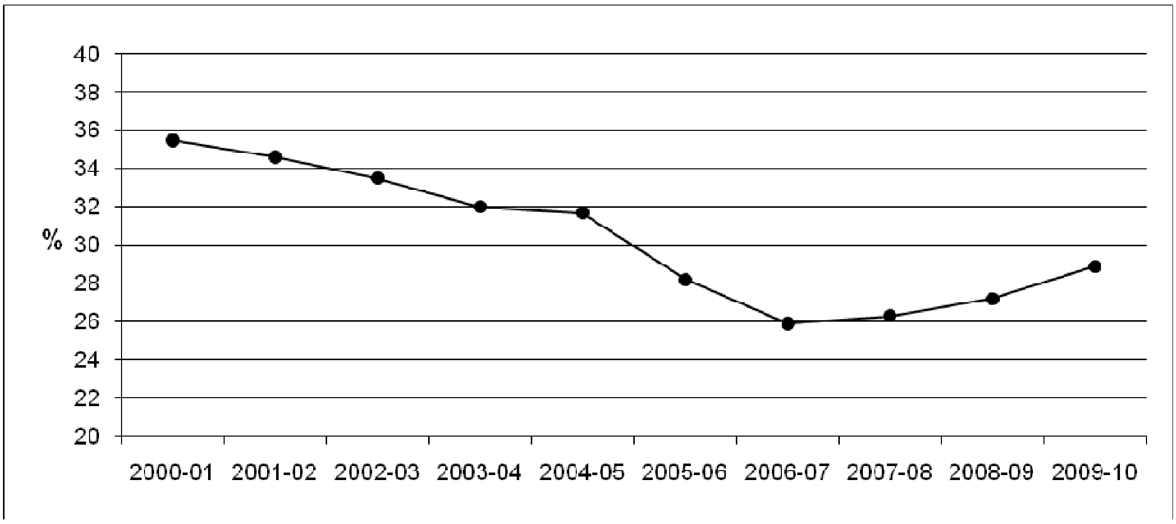
[*] Department of Health and Ageing, 2002, op. cit. p.27.

Figure 6: Assessments in hospital/other inpatient settings, Victoria 1999-00 to 2009–10 (%)



Note: Includes only records with a First face-to-face contact date.

Summary: Location at assessment

Overall result:

- Nearly two-thirds of Victorian clients (64.6%) are assessed in a private residence/other community setting, 17.9% in acute hospitals, 11.0% in other inpatient settings and 6.0% in residential care.

Trend:

- Consistent with the increasing trend over the past few years, the proportion in 2009–10 (28.9%) was slightly higher than the previous year (27.2%).

Rural metropolitan comparison:

- Relatively more clients were assessed in acute hospital setting in rural areas than metropolitan areas. However, more clients were assessed in other inpatient settings in metropolitan areas than rural areas.

Range:

- The proportion of assessments carried out in acute hospital/other inpatient settings ranged considerably across the Victorian teams—from 15.8% to 50.2%.

Assessor profession

Overall, one professional was involved in 45.4% of assessments (with face-to-face contact), two in 15.5%, three in 11.6%, and 27.0% involved four or more assessors. Assessor profession was not recorded for 0.4% of cases with face-to-face contact. Overall, 54.2% of assessments were multidisciplinary, that is, two or more different professions were involved. Table 15 shows that nurses were most commonly involved in assessments, with other health professionals, social professionals (mainly social workers but also welfare workers, counsellors, and psychologists), and medical professionals represented fairly equally. Geriatricians were more likely to participate in assessments by metropolitan teams (43.5%) than rural teams (19.3%).

Table 15: Assessor profession involved in assessment, Victoria 2009–10 (%)

	Medical profession %	Nursing profession %	Other health profession %	Social welfare profession %	Other profession %	Interpreter %	None %
Rural	19.3	82.1	33.7	18.6	1.4	0.4	0.6
Metro	43.5	73.9	60.5	55.6	2.4	4.0	0.4
Total	**36.1**	**76.4**	**52.4**	**44.3**	**2.1**	**2.9**	**0.4**

Note: Includes only records with a First face-to-face contact date.
Rows across professions add to more than 100%—multiple response.

Summary: Assessor profession

Overall result:

- Over half of assessments (54.2%) with face-to-face contact recorded are multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (76.4%).
- Interpreters were involved in a small minority of assessments.

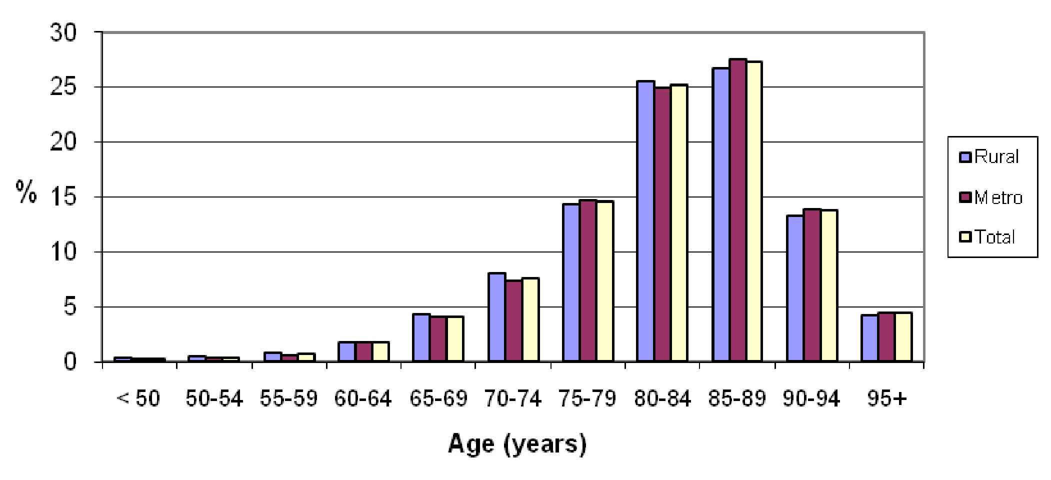
CLIENT CHARACTERISTICS

This section of the report describes the characteristics of clients assessed by Victorian ACAS in 2009–10.

Age

The mean age of people referred to ACAS in 2009-10 is 82.5 years. The age distribution (Figure 7) shows that 70% of ACAS referrals are of people aged 80 years and over. People under 60 years of age comprise less than 2% of all referrals. The age distribution in rural and metropolitan areas is similar. The proportion of target group referrals is 92.7% (rural 92.2%; metropolitan 92.9%).

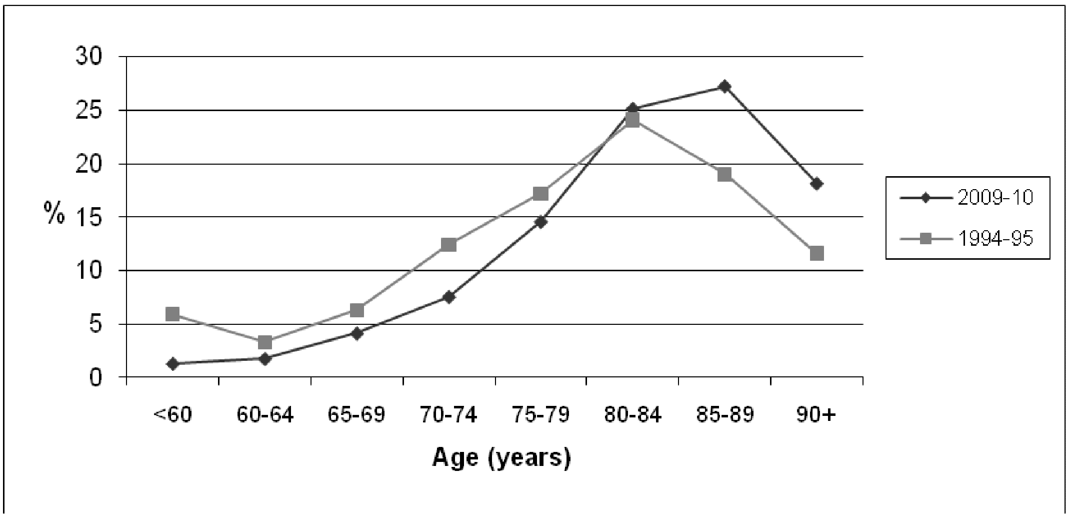
Figure 7: Client age, Victoria 2009–10



Note: Includes all records.

Although the age distribution in 2009–10 shows only small differences compared to the previous year, the age profile of ACAS clients has steadily become older over time. Figure 8 (following page) compares the age distribution in 1994–95 with that in 2009–10, and shows the increase in the proportion of clients in the older age groups in that time. Since 1994–95, the proportion of clients aged 80 years and over has increased from 54.7% to 70.6%, and the proportion of clients aged 85 years and over has increased from 30.6% to 45.4%. In the same time the proportion of clients under 60 years has decreased from 5.9% to the present 1.3%.

Figure 8: Client age, Victoria 1994-1995 to 2009–10



Summary: Client age

Overall result:

- The profile of Victorian ACAS clients continues to age.
- The mean age of clients in 2009–10 is 82.5 years.
- 70% of accepted referrals are of people aged 80 years and over.
- Referrals from people aged 85 years and over comprise 45.4% of the total.
- Clients aged under 70 years comprise 7.3% of all referrals.
- A small minority of clients (1.3%) are aged under 60 years.
- People from the ACAP target population comprise 92.7% of total referrals.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 70.6%; and the proportion 85 years and over has increased from 30.6% to 45.4%.
- Since 1994–95 the proportion of assessments of clients under 70 years has decreased from 15.5% to 7.3% of total referrals.

Rural metropolitan comparison:

- Similar age distribution in rural and metropolitan areas.
- Similar proportions of target group referrals accepted in rural (92.2%) and metropolitan teams (92.9%).

Usual accommodation setting

The usual accommodation setting at assessment of the great majority of ACAS clients was a community setting, and the great majority of these lived in a private residence. A minority lived in residential care settings (Table 16 on the next page). While the proportion of clients living in the community was similar in rural and metropolitan areas, the proportion living in private residences was higher in rural than metropolitan areas. Residence in a retirement village or supported community accommodation was more common in metropolitan areas. There was a range across the teams in the proportion of clients usually living in residential care.

Summary: Usual accommodation setting

Overall result:

- The great majority of Victorian clients lived in the community at assessment (private residence 84.1% or other community accommodation 10.1%).
- 5.3% lived in residential care (4.8% in low-level care; 0.5% in high-level care).

Rural metropolitan comparison:

- Overall, similar proportions of clients live in the community in rural and metropolitan areas, but there are relatively more in private residences in rural (86.4%) compared with metropolitan areas (83.1%).
- Retirement village and supported community accommodation is relatively more common in metropolitan areas.
- Similar proportions of clients in residential care.

Range across teams:

- The proportion of clients living in the community ranged from 72.2% to 89.6%.
- The proportion of clients living in low-level residential care ranged from 2.9% to 9.0%, and in high-level care from 0.2% to 1.2%.

Table 16: Usual accommodation setting, Victoria 2009–10 (%)

	Private residence %	Other community* %	Community total %	Low Care %	High Care %	Residential Total %	Hospital/ other institutional care %	Unknown/ Missing %	Total %	Total N
Rural	86.4	7.3	93.7	5.4	0.5	5.9	0.2	0.2	100.0	15,856
Metro	83.1	11.3	94.4	4.5	0.5	5.1	0.2	0.3	100.0	36,126
Total	**84.1**	**10.1**	**94.2**	**4.8**	**0.5**	**5.3**	**0.2**	**0.3**	**100.0**	**51,982**

Note: Includes only records with a First face-to-face contact date.
* Includes boarding house/rooming house/private hotel, short-term, crisis or transitional accommodation, supported community accommodation, public place/temporary shelter, other.

Table 16a: Usual accommodation setting—community settings, Victoria 2009–10 (%)

	Private residence - owned %	Private residence - owned by family/related person %	Private residence - private rent %	Private residence - public rent %	Private residence - Indigenous community settlement %	Retirement village (ILU) %	Boarding/ rooming house %	Crisis, emergency or transitional accom. %	Supported community accom. %	Other community* %	Total community %
Rural	67.7	8.2	5.8	4.6	0.1	5.0	0.0	0.1	1.6	0.6	93.7
Metro	63.2	10.5	4.4	5.0	0.0	8.0	0.3	0.1	2.5	0.5	94.4
Total	**64.6**	**9.8**	**4.9**	**4.9**	**0.0**	**7.1**	**0.2**	**0.1**	**2.2**	**0.5**	**94.2**

Note: Includes only records with a First face-to-face contact date.
* Includes public place/temporary shelter, other.

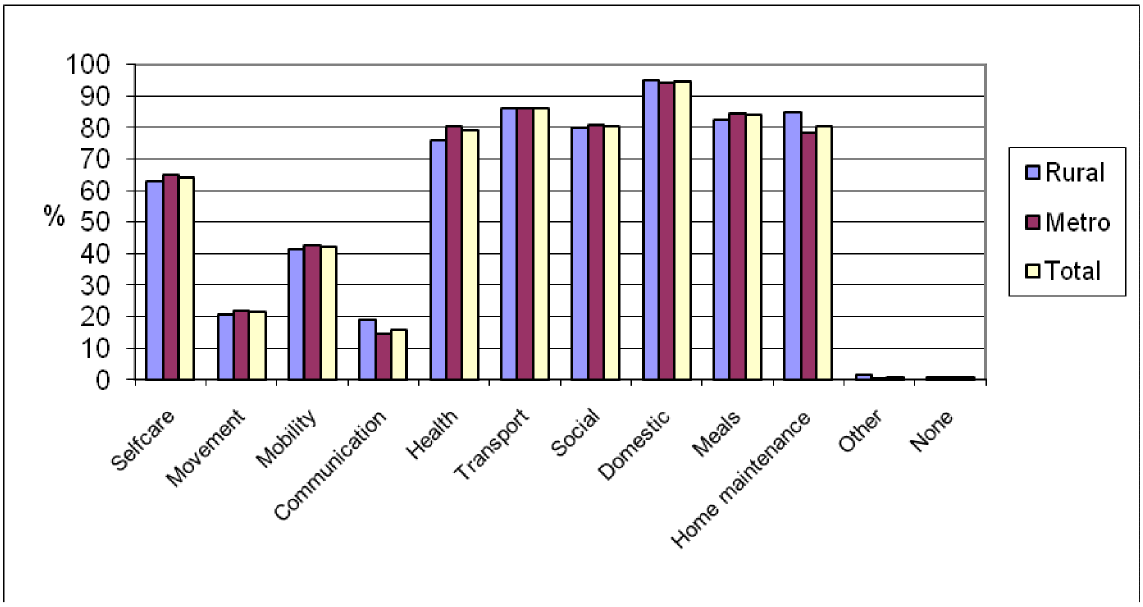
Functional profile

Activity limitations

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. A severe or profound core activity restriction, is 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.

Figure 9 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), transport (including using public transport, getting to and from places away from home and driving), and meals. Need for assistance with self-care is also relatively common. The level of the need for assistance is similar in rural and metropolitan areas. The range across teams for the need for domestic assistance is 89.2% to 97.2% of clients, for transport 77.4% to 93.6%, for meals 71.5% to 91.3%, and for self-care 44.9% to 89.3%.

Figure 9: Activity limitations (clients living in the community), Victoria 2009–10 (%)



Note: Includes only complete records of clients living in the community at assessment.
Multiple response—clients may have more than one activity limitation.

Among Victorian clients living in the community, 71.6% have a severe or profound core activity restriction, with a similar proportion across rural (72.0%) and metropolitan teams (71.4%).

As expected, proportionately more clients living in residential care need assistance than those living in the community. Almost all (96.5%) receive assistance with self-care and health care tasks (including taking medication, dressing wounds), and 90% receive assistance with social and community participation (includes shopping, managing finances, and participation in recreational, cultural or religious activities) and transport (Figure 10).*

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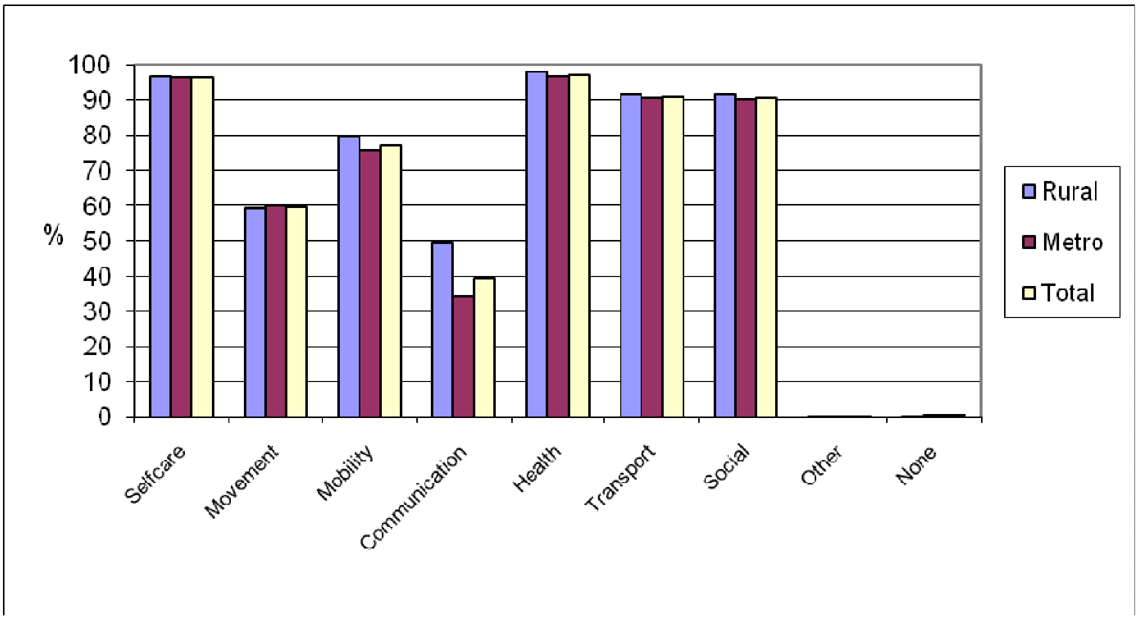
* Note that the need for assistance with domestic activities, meals and home maintenance is not recorded for people living in residential care, assistance with these activities is provided as part of the care.

The range across teams for self-care is 91.6% to 99.3% of clients, for health 88.2% to 100.0%, for transport 81.6% to 98.4%, and for social participation 80.5% to 99.0%.

Figure 10:Activity limitations (clients living in residential care), Victoria 2009–10 (%)



Note: Includes only complete records of clients living in residential care at assessment.
Multiple response—clients may have more than one activity limitation.

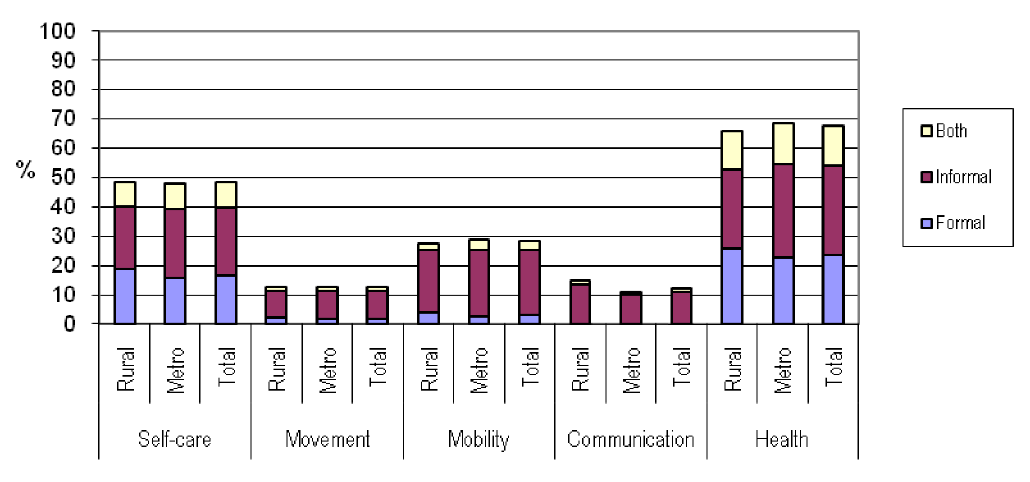
Assistance with activities

Figure 11 (next page) shows the proportion of clients living in the community who receive formal, informal, and both formal and informal assistance prior to assessment for each activity. The most common assistance at assessment is with domestic tasks (nearly 90%), with assistance with meals and transport (over 75%), and social participation, health care tasks and home maintenance (70%) also relatively common. A proportion of clients receive both formal and informal assistance (10% or more) with domestic assistance, health care tasks, social participation, and transport. A small minority of clients (3.9% for metropolitan and 3.8% for rural) were not receiving any assistance at assessment. In general, the level of formal assistance is lower than the previous year. The level of formal assistance for eight of the ten activities decreased by between 0.1% to 1.7% and the level of informal assistance for four of the ten activities decreased by between 0.5% and 1.4%. The level of informal assistance for communication, social participation, transport, domestic assistance, meals and home maintenance increased.

Figures 11 shows the importance of informal assistance in supporting people in the community. With the exception of assistance with domestic tasks, the proportion of clients receiving informal assistance is higher than those receiving formal assistance. In particular, in the areas of communication, mobility, movement, transport and social participation, almost all the assistance is from informal sources.

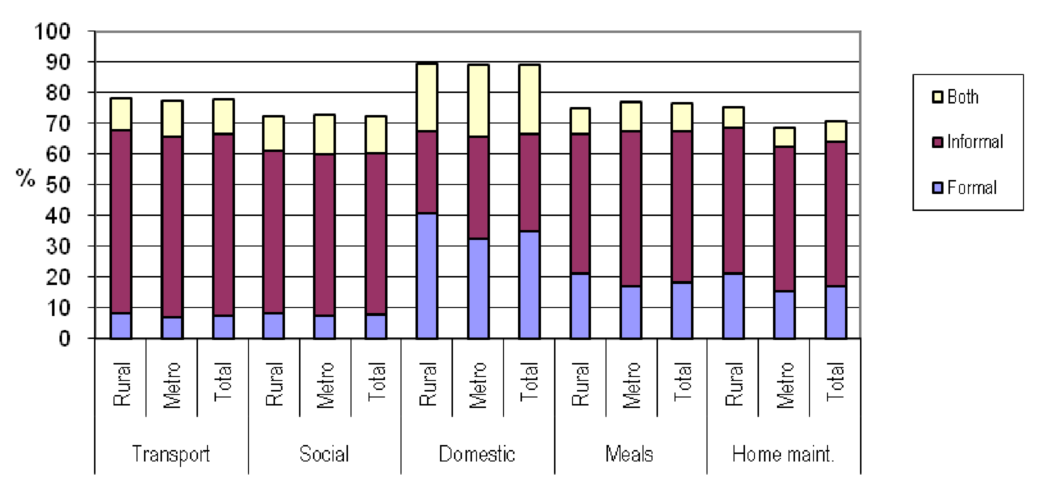
In general, the level of formal assistance and informal assistance is similar in rural and metropolitan areas. However, there is a considerable range in the level of formal and informal assistance reported across the teams. For example, the proportion receiving formal assistance with domestic activities ranges from 44.0% to 68.2%; assistance with health tasks from 17.4% to 51.1%, meals from 20.8% to 45.2%, and assistance with self-care tasks from 18.2% to 41.9%. The proportion of clients receiving informal assistance with transport ranges from 52.6% to 78.1%, social participation from 34.0% to 76.4%, meals from 40.8% to 68.5%, and assistance with domestic tasks from 27.8% to 71.2%.

Figure 11: Assistance with activities, Victoria 2009–10 (%)



Note: Percentage of clients living in the community receiving assistance (complete assessments).

Figure 11 cont.: Assistance with activities, Victoria 2009–10 (%)



Note: Percentage of clients living in the community receiving assistance (complete assessments).

Summary: Activity limitations

Overall result:

- The great majority of Victorian ACAS clients living in the community are assessed as needing assistance with domestic activities, meals and transport just prior to their assessment. Assistance with self-care is also relatively common.
- Over two-thirds (71.6%) of clients living in the community have a severe or profound core activity restriction.
- Proportionately more clients living in residential care are assessed as needing assistance than those living in the community. Almost all (96.4%) need assistance with self-care and health care tasks, and 90% need assistance with social and community participation, and transport.

Trends:

- In 2009–10 there was small increase (to 71.6%) in the proportion of clients living in the community with a severe or profound activity limitation at assessment.

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 in the proportion needing assistance at assessment, for example the need for assistance with domestic tasks among clients in the community ranged from 89.2% to 97.2% of clients, for transport 77.4% to 93.6%, for meals 71.5% to 91.3%, and for self-care 44.9% to 89.3%.
- The need for assistance among clients living in residential care ranged from 91.6% to 99.3% of clients for self care, for health 88.2% to 100.0%, for transport 81.6% to 98.4%, and for social participation 80.5% to 99.0%.

Summary: Assistance with activities

Overall result:

- Just prior to assessment, the most common formal assistance (including clients who receive both formal and informal) is with domestic activities (57.9%), health care tasks (37.5%), meals (27.5%) and self-care (25.5%).
- The most commonly provided informal assistance (including clients who receive both formal and informal) is with transport (70.5%), meals (58.2%), social participation (64.8%), home maintenance (53.8%), and domestic tasks (54.1%).
- A small minority of clients (3.9%) receive no assistance at assessment.

Trends:

- In general, the level of formal assistance is lower than the previous year. The level of formal assistance for eight of the ten activities decreased by between 0.1% to 1.7% and the level of informal assistance for four of the ten activities decreased by between 0.5% and 1.4%. The level of informal assistance for communication, social participation, transport, domestic assistance, meals and home maintenance increased.

Rural metropolitan comparison:

- Overall, the level of formal and informal assistance was similar in rural and metropolitan areas.

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranges from 44.0% to 68.2%; assistance with health tasks from 17.4% to 51.1%, meals from 20.8% to 45.2%, and assistance with self-care tasks from 18.2% to 41.9%.
- Informal assistance with transport ranged from 52.6% to 78.1%, social participation from 34.0% to 76.4%, meals from 40.8% to 68.5%, and assistance with domestic tasks from 27.8% to 71.2%.

Health conditions

Tables 17 and 18 (following page) provide a profile of the Health conditions of clients who had a complete assessment. Table 17 provides the proportions of clients with the 12 most common diagnoses, and Table 18 provides the same figures for 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, hypertension, arthritis, eye and vision, and dementia are the most common diagnoses among ACAS clients (Table 17). No diagnosis is recorded for less than 0.1% of completed assessments, and for 0.2% of cases the data is missing. The most common primary health condition (Table 18) is dementia (18.1%). The prevalence of dementia is lower in rural areas. A comparison between Tables 17 and 18 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 is not the most common among all listed conditions but is reported more than twice as frequently as diagnoses as the primary health condition.

Summary: Health conditions

Overall result:

- Overall, heart conditions, hypertension, arthritis and dementia are the most common diagnoses among ACAS clients.
- The most common primary health condition is dementia (18.1%).

Trends:

- A further increase in the prevalence of most of the common health diseases/disorders.

Rural metropolitan comparison:

- The prevalence of dementia is lower in rural areas.

Range:

- The range across the teams in the proportion of clients reported with diagnosed dementia is considerable and the inclusion of clients with symptoms and signs of dementia reported (i.e., can be coded by ACAS clinicians independently of a diagnosis from a medical practitioner) increases the average rate/1000 target population and decreases the range to some degree but it is still significant.

Other comments

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

Table 17: Diagnosed diseases/disorder—all listed (12 most common conditions), Victoria 2009–10 (%)

	Heart %	Hypertension %	Arthritis %	Vision %	Dementia %	Diabetes %	Psycho-affective %	CVA %	CLRD %	Osteoporosis %	Fracture %	Parkinson's %
Rural	59.9	43.9	43.1	28.8	19.7	20.9	20.1	17.0	18.3	15.8	14.0	4.6
Metro	57.9	47.2	40.3	28.0	25.7	21.6	21.5	18.5	16.2	16.8	15.3	4.7
Total	**58.5**	**46.2**	**41.2**	**28.3**	**23.9**	**21.4**	**21.0**	**18.0**	**16.9**	**16.5**	**14.9**	**4.7**

Note: Includes only complete records.

Table 18: Diagnosed diseases/disorder—primary condition listed (12 most common conditions), Victoria 2009–10 (%)

	Dementia %	Heart %	CVA %	Arthritis %	Fracture %	CLRD %	Diabetes %	Psycho-affective %	Vision %	Parkinson's %	Hypertension %	Osteoporosis %
Rural	14.8	9.1	6.7	6.6	3.9	4.8	3.9	3.0	3.1	2.5	2.2	1.2
Metro	19.6	8.0	7.2	6.5	4.8	3.7	3.7	3.3	2.7	2.9	1.9	1.0
Total	**18.1**	**8.3**	**7.0**	**6.5**	**4.5**	**4.1**	**3.7**	**3.2**	**2.8**	**2.8**	**2.0**	**1.1**

Note: Includes only complete records.

Arthritis	Includes Rheumatoid arthritis (1301), osteoarthritis and other arthritis (1302)
CLRD	Chronic lower respiratory disease, Code 1005 (includes emphysema, COAD, asthma)
CVA	Includes codes for cerebrovascular disease and stroke (codes 0910 to 0916)
Dementia	Includes all dementias (codes 0500 to 0532)
Diabetes	Includes Type 1 (code 0402), Type 2 (code 0403) and Unspecified (code 0404)
Eye and vision	Includes all diseases of the eye and adnexa (codes 0701 to 0799)
Fracture	Includes all codes for fractures (codes 1606 to 1612)
Heart	Includes angina, heart attack, heart disease, heart failure and other heart diseases (codes 0900 to 0907)
Hypertension	Code 0921
Osteoporosis	Code 1306
Parkinson’s disease	Code 0604
Psycho-affective	Includes all affective disorders (codes 0550 to 0553)

Clients and carers

Table 19 shows that the great majority of clients (88.1%) have carers, and that over half of carers are co-resident. The proportion of clients with carers is similar among rural and metropolitan teams, with non-resident carers slightly more prevalent among rural clients and co-resident carers slightly more prevalent in metropolitan areas.

Table 19: Clients and carers, Victoria 2009–10 (%)

	Clients with no carer %	Clients with co-resident carer %	Clients with non-resident carer %	Not known %	Total %
Rural	12.8	43.8	43.2	0.2	100.0
Metropolitan	11.1	47.0	41.7	0.2	100.0
Total	**11.6**	**46.0**	**42.1**	**0.2**	**100.0**

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

Summary: Clients and carers

Overall result:

- The great majority of clients (88.1%) have carers.
- The majority of carers are co-resident.

Rural metropolitan comparison:

- Overall, the proportion of clients with carers is similar in rural and metropolitan areas.
- Co-resident carers are relatively more common in metropolitan areas.

Clients “at risk” of admission to residential care

Comprehensive assessment is the core objective of the ACAP, and input to the assessment from a range of clinical expertise contributes to this objective (i.e., multidisciplinary). This section reports on the assessments of those clients at risk of admission to residential care, in particular Performance Indicator 6.1:[*]

- % multidisciplinary client assessments for “at risk” clients (PI: 6.1)
  Desired outcome: 100% comprehensive assessments of people “at risk” of admission to residential care involve input from more than one discipline.

Clients are defined as being “at risk” of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 years or over (or Indigenous and aged 60 years or over); a severe or profound core activity restriction (needs assistance with one or more of self-care, mobility or communication); dementia; live alone; no carer. A multidisciplinary assessment (MDA) is defined as involving more than one profession (all medical practitioners are considered as one profession and all nursing professionals as one profession).

Table 20 shows that in 2009–10 about a tenth of clients living in the community were “at risk” of admission to residential care facility. The proportion “at risk” is higher in metropolitan areas. Over half (54.1%) of all assessments of people living in the community are multi-disciplinary and this was more likely if the client is assessed by a metropolitan team. Over 60% of “at risk” clients receive a MDA, with a higher proportion in metropolitan than rural areas. This is lower than the desired outcome for PI 6.1 but whether clients receive a MDA depends on a number of factors. The measure used is a proxy for a multidimensional assessment and it is acknowledged that an ACAS member may be able to incorporate more than one dimension of care need into their comprehensive assessment. Whether a client receives a MDA also depends on the availability of a range of clinical expertise (within the team and outside) and this may be limited, particularly in rural areas.

Table 20: Clients “at risk” of admission to residential care and given a multi-disciplinary assessment, Victoria 2009–10 (%)

	Community clients	Clients “at risk”		Clients get MDA		Clients “at risk” get MDA	
	n	n	%	n	%	n	%
Rural	13,095	980	7.5	5,292	40.4	424	43.3
Metro	28,933	2,552	8.8	17,451	60.3	1,859	72.8
Total	**42,028**	**3,532**	**8.4**	**22,743**	**54.1**	**2,283**	**64.6**

Note: Clients “at risk” of entering residential care if they are living in the community and have at least 4 of the following 5 risk factors; aged 80+ years (or Indigenous aged 60+ years); a severe or profound core activity restriction; having dementia; living alone; no carer.
The table includes only complete assessments with valid values for the 5 risk factors and Assessor profession (ACCR Q. 34).
MDA = Multi-disciplinary assessment.

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[*] AIHW (2002) op. cit. p. 168–170.

Summary: Clients “at risk”

Overall result:

- Overall, 8.4% of clients living in the community are “at risk” of admission to a residential care facility.
- “At risk” clients are more likely to receive a multi-disciplinary assessment than all clients—64.6% of “at risk” clients received a MDA compared with 54.1% of all clients living in the community.

Trends:

- The proportion of assessments of clients living in the community “at risk” of admission to a residential care facility in 2009–10 is slightly lower than the previous years (2008–09 9.1%; 2007–08 9.2%; 2006–07 9.9%; 2005–06 10.1%; 2004–05 9.7%; 2003–04 9.1%).
- The proportion of assessments of clients living in the community “at risk” of admission to a residential care facility who receive a MDA (PI 6.1) increased compared with previous years (2009–10 64.6%; 2008–09 63.3%; 2007–08 58.1%; 2006–07 63.8%; 2005–06 63.6%; 2004–05 63.6%; 2003–04 61.7%).

Rural metropolitan comparison:

- The proportion “at risk” is higher in metropolitan than rural areas.
- A MDA is more likely if the client is assessed by a metropolitan team.

RECOMMENDATIONS

Assessment recommendations are an indicator of the movements of ACAS clients within the aged care system.

Recommendations—general

Recommended long-term care setting

This sub-section provides an analysis of the recommendation patterns for clients living in the community, low-level care and high-level care at assessment. Table 21 shows that over two-thirds of clients living in the community at assessment receive a recommendation to continue living in the community. The rural and metropolitan averages are similar but there is variation across the 18 teams—community to community recommendations ranges from 54.0% to 85.0%; community to low care from 5.6% to 24.8%; and community to high care from 9.4% to 24.3%.

Table 21: Recommended long-term care setting by usual accommodation setting, Victoria 2009–10 (%)

	Community %	Low-level care %	High-level care %	Other institutional %	Total %
Clients living in the community at assessment					
Rural	74.3	10.8	14.8	0.1	100.0
Metropolitan	68.6	14.3	17.0	0.1	100.0
Total	70.3	13.2	16.4	0.1	100.0
Clients living in low-level residential care at assessment					
Rural	0.2	14.7	84.7	0.4	100.0
Metropolitan	1.0	15.7	83.1	0.2	100.0
Total	0.8	15.4	83.6	0.3	100.0
Clients living in high-level residential care at assessment					
Rural	5.8	10.1	84.1	0.0	100.0
Metropolitan	7.5	8.1	84.4	0.0	100.0
Total	7.1	8.6	84.3	0.0	100.0
Clients living in other institutional settings at assessment					
Rural	0.0	21.9	71.9	6.3	100.0
Metropolitan	8.9	16.1	71.4	3.6	100.0
Total	5.7	18.2	71.6	4.6	100.0

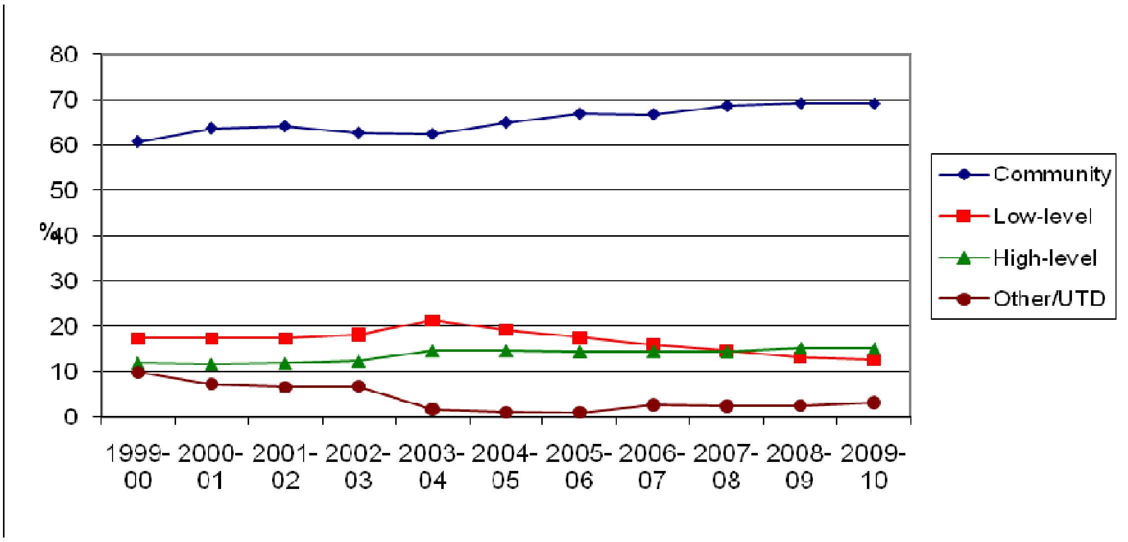
Note: Complete assessments only.
Counts are very low in some cells (see Table D1 in Appendix B).
Accommodation setting—usual (ACCR Q. 14): community includes private residence, retirement village (independent living), boarding house/rooming house/private hotel, short-term, emergency or transitional accommodation, supported community accommodation (SRS), public place/temporary shelter and “other”; other institutional includes hospital, and other institutional care.
Recommended long-term care (ACCR Q. 31): community includes private residence, retirement village (independent living), boarding house/rooming house/private hotel, supported community accommodation and “other”; other institutional includes hospital and other institutional care.

As would be expected, the great majority of clients living in low-level residential care at assessment (83.6%) are 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 ranges from 69.3% to 90.6%.

While the great majority of clients usually living in high-level residential care at assessment are recommended to continue living in high-level care, a significant minority (8.6%) are recommended to low-level care, and a further 7.1% receive community recommendations (ranges across the teams are not meaningful because of small cell numbers).

Figures 12 and 13 compare recommendations for 2009–10 with previous years. 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. The proportion of community-dwelling clients recommended to remain in the community in 2009–10 is similar to the previous year, and consistent with the long-term trend of increasing proportions of community to community recommendations (Figure 12). Consistent with the trend since 2003–04, there is also a further decrease in the proportion of community to low-level residential care recommendations in 2009–10.

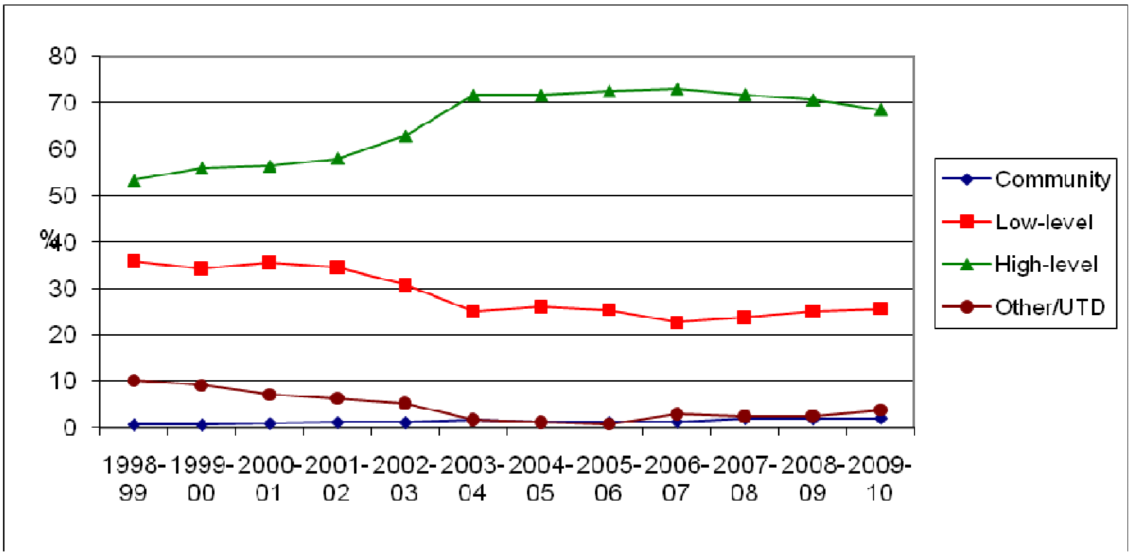
Figure 12: Recommendations—clients living in the community, Victoria 1999–00 to 2009–10 (%)



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

The proportion of clients living in low-level residential care and recommended to high-care decreased slightly in 2009–10, and the proportion of clients recommended to remain in low-level care remained unchanged (Figure 13).

Figure 13: Recommendations (clients living in low-level residential care), Victoria 1999–00 to 2009–10 (%)



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

Summary: Long-term care by accommodation setting

Overall result:

- Over two-thirds of clients living in the community at assessment (70.3%) receive a recommendation to continue living in the community.
- The great majority (83.6%) of clients living in low-level residential care at assessment are recommended to high-level care.
- The great majority (84.3%) of clients usually living in high-level residential care at assessment are recommended to continue living in high-level care.
- A minority (8.6%) of clients living in high-level care are recommended to low-level care, and a further 7.1% received community recommendations.

Trends:

- 2009–10 is consistent with the long-term trend of an increase in the proportion of community-dwelling clients recommended to remain in the community.
- In 2009–10 the proportion of clients living in low-level residential care and recommended to high-care is slightly lower than the previous year.

Rural metropolitan comparison:

- The proportion of community to community recommendations is slightly higher in rural than metropolitan areas.
- The proportion of low-level to high-level recommendations is similar in rural and metropolitan areas.

Range:

- Across the teams the proportion of community to community recommendations range from 54.0% to 85.0%; community to low care from 5.6% to 24.8%; and community to high care from 9.4% to 24.3%.
- Low-level to high-level recommendations range from 69.3% to 90.6%.

Recommended government-funded care programs

This section presents recommendations (both ongoing and new) for government program support for clients living in the community. Table 22 shows that over half of clients assessed were recommended a HACC service(s), nearly a third a CACP, nearly a fifth to the National Respite for Carers Program (NRCP), and a tenth an EACH or EACH-D package. Under a tenth of clients were not recommended for any government program (excluding respite care).

Table 22: Recommended government-funded care programs, Victoria 2009–10 (%)

	CACP	EACH	EACH-D	HACC	Veterans' Home Care	Day Therapy Centre	NRCP	Other	None	UTD	Missing[1]
	%	%	%	%	%	%	%	%	%	%	%
Rural	31.0	7.5	2.9	59.8	9.0	2.0	30.8	17.4	5.2	0.4	0.1
Metro	29.5	6.3	2.5	52.4	7.3	2.4	9.1	14.6	10.1	1.2	0.0
Total	**29.9**	**6.7**	**2.7**	**54.8**	**7.8**	**2.3**	**16.1**	**15.5**	**8.5**	**0.9**	**0.0**

Note: Records with a community recommendation (ACCR Q. 31 coded 1–3) only.
Multiple response—clients may receive recommendations for more than one program.
Does not include recommendations for Transition Care or respite.
[1] Includes missing or invalid codes (including Not applicable) for Recommended government services (ACCR Q. 29).

Within the averages presented in Table 22 there is considerable variation across the teams in their recommendations. For example, the proportion recommended HACC range between 39.6% and 73.5%; CACP between 22.2% and 41.1%; EACH package between 4.2% and 11.3%; and EACH-D between 1.1% and 5.1%, of complete assessments. The variability of recommendations for the NRCP was particularly marked with a range between 4.1% and 56.8% of complete assessments.

In addition to the services in Table 22, clients can be recommended a Transition Care Package (TCP). A tenth (10.8%) of all completed assessments resulted in a TCP in 2009–10 (range 0.1%–26.7%).

Summary: Recommended for government-funded programs

Overall result:

- Of the assessments with a long-term care recommendation to the community, 54.8% are recommended HACC service(s), 29.9% CACP, 16.1% the National Respite for Carers Program, and 6.7% an EACH package.
- Under a tenth (8.5%) of assessments with a long-term care recommendation to the community have no recommendation for a government program (excludes respite care).
- A tenth (10.8%) of completed assessments result in a recommendation for a Transition Care Package.

Rural metropolitan comparison:

- Average recommendations by rural and metropolitan teams are similar for most government-funded programs, but there are differences for HACC and the National Respite for Carers Program.

Range:

- There was considerable variation among the teams in recommendations for government-funded services, particularly for NRCP.
- HACC ranged between 39.6% and 73.5%; CACP between 22.2% and 41.1%; EACH package between 4.2% and 11.3%; and EACH-D between 1.1% and 5.1%, and NRCP between 4.1% and 56.8% of complete assessments for clients give a community recommendation.
- Recommendations for a TCP range between 0.1% and 26.7% of completed assessments.

Recommendations for CACPs

Of the complete assessments resulting in a community recommendation, nearly a third are given a recommendation for CACPs—new or on-going (Table 23). The proportion of newly recommended and on-going CACPs is similar among rural and metropolitan teams. Across the teams the proportion of assessments with a new CACPs recommendation range from 14.1% to 33.0%; and an ongoing recommendation from 3.7% to 11.8% of complete assessments with a community recommendation.

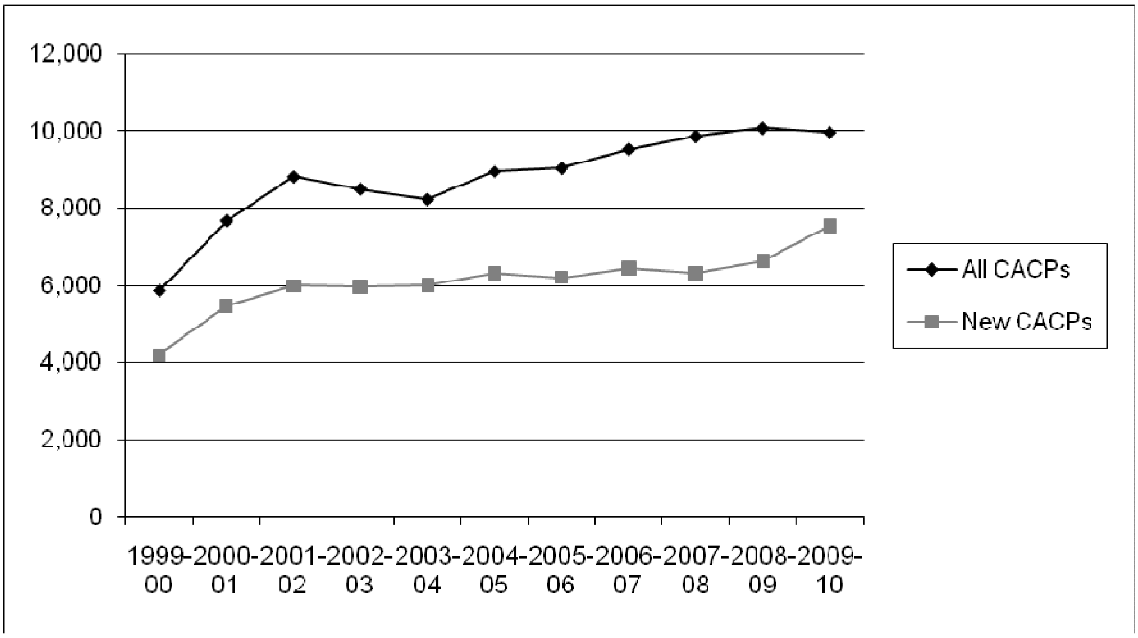
Table 23: CACPs recommendations, Victoria 2009–10 (%)

	Newly-recommended CACPs		On-going CACPs		Total recommended CACPs		Total recommended to community
	n	%	n	%	n	%	N
Rural	2,561	23.8	770	7.2	3,331	31.0	10,759
Metropolitan	4,979	22.1	1,658	7.4	6,637	29.5	22,535
Total	**7,540**	**22.6**	**2,428**	**7.3**	**9,968**	**29.9**	**33,294**

Note: Includes complete assessments of clients recommended to the community.

Figure 14 shows that the number of CACPs recommended in Victoria increased markedly in the years up to 2001–02, declined in the next two years, and increased after 2003–04. Consistent with the recent trend, the number of CACPs recommended in 2009–10 is higher than the previous year.

Figure 14: CACPs recommendations, Victoria 1999–00 to 2009–10 (counts)



Note: Includes complete assessments of clients recommended to the community.

Summary: Recommendation for CACPs

Overall result:

- CACPs are recommended for nearly a third of assessments (29.9%) of people recommended to the community on-going 7.3% and new 22.6%.

Trends:

- The total number of CACPs recommended increased compared with the previous year.

Rural metropolitan comparison:

- The proportion of newly and on-going recommended CACPs is similar among rural and metropolitan teams.

Range:

- Across the teams the proportion of assessments with an on-going CACP recommendation ranged from 3.7% to 11.8%.
- The proportion of new recommendations ranged from 14.1% to 33.0%.

Recommendations for respite

Nearly three-quarters of clients recommended to the community receive a recommendation for residential respite care, and over a tenth a recommendation for non-residential respite (these proportions include recommendations for both residential and non-residential). Recommendations for residential respite range between 53.0% and 91.0% of clients recommended to the community, and between 6.8% and 31.7%.for non-residential respite.

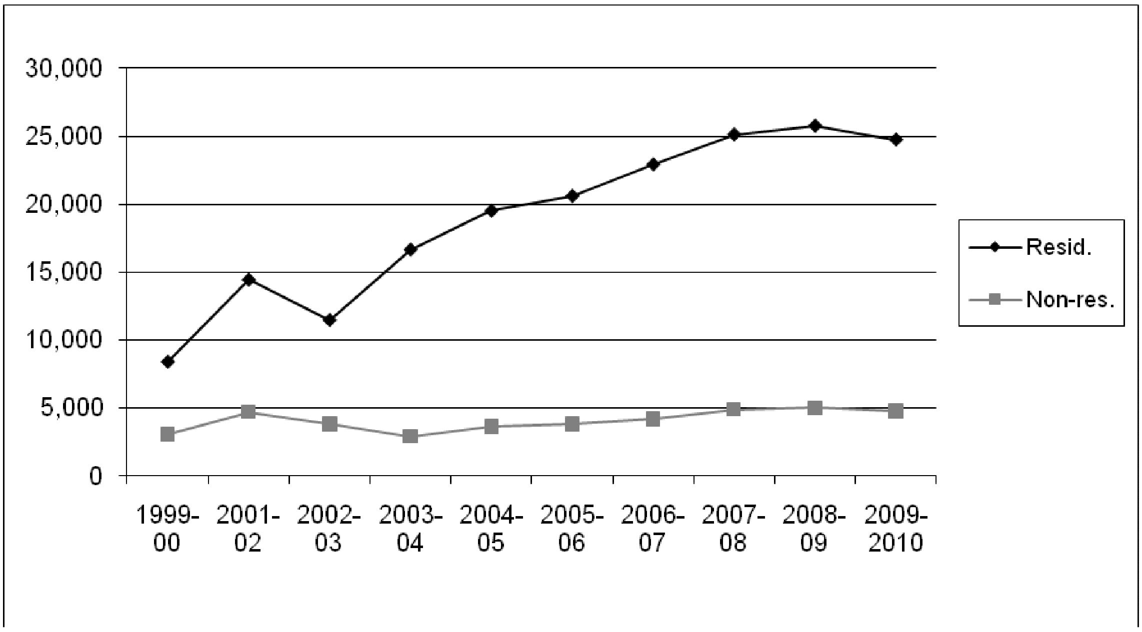
Table 24: Recommendations for respite care, Victoria 2009–10 (%)

	Residential respite care*		Non-residential respite care*		Recommended to community
	n	%	n	%	N
Rural	8,175	76.0	1,894	17.6	10,759
Metropolitan	16,577	73.6	2,879	12.8	22,535
Total	**24,752**	**74.3**	**4,773**	**14.3**	**33,294**

Note: Includes complete assessments of clients recommended to the community.
* Includes clients recommended both residential and non-residential respite.

Figure 15 shows that with the exception of 2002–03, the number of clients recommended for residential respite has increased steadily over the past 10 years, however, 2009–10 is not consistent with the overall trend. The number of recommendations for residential respite is 3.9% lower, and non-residential respite 4.5% lower in 2009–10 compared to the previous year.

Figure 15: Recommendations for respite care, Victoria 1999–00 to 2009–10 (counts)



Note: Includes complete assessments of clients recommended to the community.
Includes clients recommended both residential and non-residential respite.

Summary: Recommendations for respite

Overall result:

- Nearly three-quarters of clients (74.3%) recommended to the community receive a recommendation for residential respite in 2009–10, and 14.3% a recommendation for non-residential respite.

Trends:

- 2009–10 is not consistent with the overall increasing trend. The number of recommendations for residential respite is 3.9% lower, and non-residential respite 4.5% lower in 2009–10 compared to the previous year.

Rural metropolitan comparison:

- Recommendations for respite are similar in rural and metropolitan areas.

Range:

- Recommendations for residential respite range between 53.0% and 91.0% of clients recommended to the community
- For non-residential respite the range is between 6.8% and 31.7%.

Recommendations for particular groups

An important objective of the ACAP is to prevent premature or inappropriate admission to residential aged care services. This section reports on the effectiveness of the ACAP in this objective for a number of particular groups of ACAP clients. In particular, this section reports on the following Performance Indicators:[*]

- % ACAT recommendations for long-term residential care for clients not "at risk" (PI: 3.1)
  Desired outcome: to maintain or reduce the proportion of recommendations for long-term care in residential aged care services.
- % ACAT recommendations for long-term residential care for younger clients (PI: 3.2)
  Desired outcome: to reduce over time the proportion of recommendations for long-term care in residential aged care services for younger clients.
- % older ACAT clients with dementia recommended for long-term care in community settings (PI: 4.1)
  Desired outcome: to maintain or increase the proportion of older clients with dementia who are recommended for long-term care in community settings.
- % older ACAT clients "at risk" recommended for a Community Aged Care Package (PI: 4.2)
  Desired outcome: to maintain or increase the proportion of older clients at risk of admission to residential care who are recommended for long-term care in community settings.
- % ACAT recommendations for long-term care in community settings for clients assessed in community settings (PI: 4.3)
  Desired outcome: to maintain or reduce the proportion of clients who are comprehensively assessed in community settings and are recommended for long-term care in community settings.
- % ACAT recommendations for long-term care in community settings for clients assessed in hospital (PI: 4.4)
  Desired outcome: to maintain or reduce the proportion of clients comprehensively assessed in hospital who are recommended for long-term care in community settings.

Clients not "at risk"

Clients living in the community are defined as being "at risk" of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 years or over (or Indigenous and aged 60 years or over); a severe or profound core activity restriction; diagnosed dementia; live alone; no carer. Table 25 presents recommendations for clients who are not "at risk".

Table 25: Recommendations for clients not "at risk", Victoria 2009–10

	Community %	Low-level care %	High-level care %	Other instit.* %	Missing %	Total %	Total n
Rural	76.3	9.8	13.7	0.1	0.1	100.0	12,132
Metro	72.2	12.8	14.8	0.1	0.0	100.0	26,388
Total	**73.5**	**11.9**	**14.5**	**0.1**	**0.1**	**100.0**	**38,520**

Note: Includes complete assessments of clients living in the community.
* Includes hospital and other institutional care.

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[*] AIHW (2002) op. cit. Section 4, p. 150–167.

In 2009–10 the great majority of clients (91.6%) were not "at risk" of admission to residential care. Of those not "at risk", nearly three-quarters are given community recommendations and over a quarter (11.9% low-level and 14.5% high-level) recommended to residential care. The corresponding recommendations for "at risk" clients are community 44.5%, low-level care 24.6%, and high-level care 30.8%. That is, clients not "at risk" are half as likely to receive a residential care recommendation as those "at risk".

Summary: Clients not "at risk"

Overall result:

- The great majority of complete ACAS assessments are of clients (91.6%) not "at risk" of admission to residential care.
- Of those clients living in the community not "at risk", 73.5% are recommended to the community and 26.4% to residential care (11.9% to low-care and 14.5% to high-care).
- Clients not "at risk" are half as likely to receive a recommendation to residential care than "at risk" clients.

Trends:

- In line with Performance Indicator 3.1, recommendations to residential care for clients not "at risk" have remained lower compared to previous years (2009–10 26.4%; 2008–09 26.3%; 2007–08 27.4%; 2006–07 28.3%; 2005–06 30.3%; 2004–05 32.3%; 2003–04 35.9%).

Rural metropolitan comparison:

- Rural clients not "at risk" are less likely to receive a recommendation to residential care than metro clients.

Residential care for non-target group clients

Non-target group ("younger") clients include Indigenous clients aged 49 years and under and non-Indigenous clients aged 69 years and under. Table 26 shows that almost 70% of non-target clients living in the community are recommended to remain in the community. Compared to all clients living in the community (Table 21), non-target group clients are slightly more likely to be recommended to high level and less likely to be recommended low-level care.

Table 26: Recommendations for non-target clients, Victoria 2009–10

	Community %	Low-level care %	High-level care %	Other institution* %	Missing %	Total %	Total n
Rural	75.9	7.8	15.9	0.3	0.0	100.0	1,035
Metro	65.6	14.4	19.4	0.4	0.2	100.0	2,201
Total	**68.9**	**12.3**	**18.3**	**0.4**	**0.1**	**100.0**	**3,236**

Note: Table includes complete assessments of Indigenous clients aged 49 years and under and non-Indigenous clients aged 69 years and under living in the community at assessment.
* Includes hospital and other institutional care.

Non-target group clients living in rural areas are more likely to receive a community recommendation and less likely to receive a recommendation for residential care than those in metropolitan areas. Across the teams, the proportion of non-target group clients recommended to remain in the community ranged from 52.8% to 87.5%; low-level care from 4.2% to 21.8%; and high-level care from 7.8% to 30.6%.

Summary: Non-target ("younger") clients

Overall result:

- 68.9% of non-target clients living in the community are recommended to remain in the community, 12.3% to low-level care and 18.3% to high-level care.
- Compared to all clients living in the community, non-target group clients are slightly more likely to be recommended to the high-level care and less likely to be recommended low-level care.

Trends:

- The proportion of non-target clients recommended to residential care is higher than previous years, going against the desired outcome of Performance Indicator 3.2 (2009–10 30.6%; 2008–09 26.8%; 2007–08 28.9%; 2006–07 28.3%; 2005–06 32.0%; 2004–05 32.8%; 2003–04 32.0%).

Rural metropolitan comparison:

- Non-target group clients living in rural areas are more likely to receive a community recommendation and less likely to receive a recommendation for residential care than those in metropolitan areas.

Range:

- There was a considerable range across the teams in the recommendations for non-target group clients: community ranged from 52.8% to 87.5%; low-level care from 4.2% to 21.8%; and high-level care from 7.8% to 30.6%.

Target group clients with dementia

This section examines recommendations for target group clients with dementia.[*] Note that the analysis is concerned with individuals rather than assessments. If clients were assessed more than once in the year the most recent assessment was used for the analysis.

Over 40% of ACAP clients with dementia living in the community at assessment are recommended to move to residential care (14.8% to low-level and 25.6% to high-level). Compared with rural teams, clients assessed by metropolitan teams are less likely to be recommended to the community and more likely to receive a recommendation for residential care.

Table 27: Recommendations for ACAP clients with dementia, Victoria 2009–10

	Community %	Low-level care %	High-level care %	Other institution* %	Missing %	Total %	Total n
Rural	67.0	12.4	20.5	0.0	0.1	100.0	2,465
Metro	57.0	15.6	27.3	0.1	0.0	100.0	7,522
Total	**59.4**	**14.8**	**25.6**	**0.1**	**0.0**	**100.0**	**9,987**

Note: Table includes ACAP clients (aged 70+ years or Indigenous aged 50+ years) with dementia living in the community at assessment (complete assessments).
* Includes hospital and other institutional care.

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 27 above shows that 40.4% of clients with dementia received a recommendation for residential care compared to 29.6% of all clients living in the community (Table 21). Further, a high-level care recommendation is more likely for clients with dementia (25.6%) than all clients living in the community (16.4%).

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[*] Dementia includes health condition codes 0500 to 0532—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).

Summary: Target group clients with dementia

Overall result:

- The proportion of target group clients with dementia and living in the community given a community recommendation is 59.4%.
- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 40.4% of ACAP clients with dementia receive a recommendation for residential care compared to 29.6% of all clients living in the community.
- Further, 25.6% ACAP clients with dementia receive a high-level care recommendation compared to 16.4% of all clients living in the community.

Trends:

- In line with Performance Indicator 4.1, there was a further increase in the proportion of target group clients with dementia given a community recommendation compared with previous years (2009–10 59.4%; 2008–09 57.2%; 2007–08 56.9%; 2006–07 55.3%; 2005–06 52.7%; 2004–05 51.4%; 2003–04 46.6%).

Rural metropolitan comparison:

- Compared with rural teams, clients assessed by metropolitan teams are less likely to be recommended to the community and more likely to receive a recommendation for residential care.

“At risk” target group clients recommended a CACP

This section examines recommendations for target group clients “at risk” (defined in previous sections) of residential care. The analysis is of individual clients rather than assessments, with the most recent assessment used for the analysis. Nearly a fifth of “at risk” target group clients living in the community receive a recommendation for a CACP. In addition, 2.5% receive a recommendation for EACH and 1.2% an EACH-D, that is, more than half of “at risk” target group individuals recommended to the community receive a recommendation for a package (Table 28). However, “at risk” target clients are less likely to be recommended a CACP and more likely to be recommended residential care than other clients. Nearly a third (29.9%) all assessments with a community recommendation include a recommendation for a CACP (Table 23). Across the teams, the proportion of individuals recommended a CACP ranges between 9.0% and 39.3%, between 0.4% and 7.9% for an EACH package, and between 0.4% and 3.5% for EACH-D packages.

Table 28: Recommendations for “at risk” target group clients, Victoria 2009–10 (%)

	Community without package %	CACP %	EACH %	EACH-D %	Low-level care %	High-level care %	Other instit.* %	Missing %	Total %
Rural	24.3	25.0	3.3	2.2	19.6	25.7	0.0	0.0	100.0
Metro	21.9	16.4	2.2	0.8	26.1	32.6	0.1	0.0	100.0
Total	**22.5**	**18.8**	**2.5**	**1.2**	**24.3**	**30.7**	**0.1**	**0.0**	**100.0**

Note: Table includes ACAP clients (aged 70+ years or Indigenous aged 50+ years) living in the community at assessment “at risk” of admission to residential care (complete assessments).
* Includes hospital and other institutional care.

Summary: “At risk” target group clients recommended a CACP

Overall result:

- Nearly a fifth of “at risk” target group individual clients receive a recommendation for a CACP.
- Of the “at risk” target group clients recommended to the community, nearly a fifth (18.8%) receive a recommendation for a CACP, compared with 29.9% of all clients recommended to the community.

Trends:

- The proportion of “at risk” target group clients given a recommendation for a CACP (PI 4.2) is higher than the previous year (2009–10 18.8; 2008–09 17.7%; 2007–08 19.5%; 2006–07 19.5%; 2005–06 17.4%; 2004–05 19.0%; 2003–04 17.5%).

Rural metropolitan comparison:

- Rural teams recommend a CACP more often than metropolitan teams.

Range:

- The proportion of “at risk” target group individuals recommended a CACP ranges between 9.0% and 39.3%, between

0.4% and 7.9% for an EACH package, and between 0.4% and 3.5% for EACH-D packages.

Clients assessed in community settings

The great majority of assessments (86.4%) in community settings result in a recommendation for long-term care in the community, with a tenth to low-care and less than 4% to high care. Community recommendations are higher than previous years and consistent with KPI 4.3. The recommendations are similar for rural and metropolitan teams but there is considerable variation across the teams. The proportion of community recommendations range from 65.5% to 96.7%, low-level care from 1.8% to 23.7%, and high-level care from 1.3% to 10.9%.

Table 29: Recommendations for clients assessed in community settings, Victoria 2009–10

	Community %	Low-level care %	High-level care %	Other institution* %	Missing %	Total %	Total n
Rural	89.8	7.3	2.7	0.0	0.1	100.0	10,189
Metro	84.9	10.5	4.5	0.1	0.0	100.0	22,857
Total	**86.4**	**9.5**	**3.9**	**0.1**	**0.0**	**100.0**	**33,046**

Note: Table includes assessments conducted in community settings (Contact setting (Q19) = 4) (complete assessments).
* Includes hospital and other institutional care.

Summary: Recommendations for clients assessed in community settings

Overall result:

- The great majority of assessments (86.4%) in community settings result in a recommendation for long-term care in the community.

Trends:

- In line with Performance Indicator 4.3, the proportion of clients assessed in a community setting and whose usual accommodation was in the community increased by 1.9% compared with 2009–10 and is higher than all previous years (2008–09 86.1%; 2007–08 84.0%; 2006–07 82.1%; 2005–06 80.7%; 2004–05 78.4%; 2003–04 74.9%).

Rural metropolitan comparison:

- Overall, rural and metropolitan teams recommended similar proportions of clients to long-term care in the community.

Range:

- There was a considerable range across the teams in the recommendations of people assessed in the community—to the community from 65.5% to 96.7%, low-level care from 1.8% to 23.7%, and high-level care from 1.3% to 10.9%.

Clients usually living in the community and assessed in hospital

Clients assessed in an acute hospital and usually living in the community were nearly three times as likely to receive a recommendation for residential care (67.7%) than the community (31.9%), and were more likely to receive a recommendation for high-level care than low-level care (Table 30). Recommendations to the community are more likely in rural than metropolitan areas, while the reverse is true for high-level care. The recommendation pattern evident in Table 30 is similar across all teams but there is a considerable range in the proportion recommended to the community (11.2% to 58.7%), low-level (11.4% to 30.1%) and high-level care (28.3% to 66.9%). This reflects different policy and practice among the teams on the assessment of clients in hospital that are likely to continue to live in the community.

Table 30: Recommendations for clients assessed in acute hospital (living in the community), Victoria 2009–10

	Community %	Low-level care %	High-level care %	Other institution* %	Missing %	Total %	Total n
Rural	36.2	16.4	46.7	0.5	0.2	100.0	2,614
Metro	29.7	18.9	51.1	0.2	0.0	100.0	4,947
Total	**31.9**	**18.1**	**49.6**	**0.3**	**0.1**	**100.0**	**7,561**

Note: Table includes assessments conducted in acute hospitals (Contact setting (Q.19) = 1) of clients usually living in the community (Usual accommodation (Q.14 = 1–7, 12–15)) (complete assessments).
* Includes hospital and other institutional care.

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 assessed in the community (Table 29). Clients usually living in the community and assessed in an acute hospital are more likely to receive a recommendation for residential care—particularly high-level care—than clients assessed in the community. For these latter clients the comparable recommendations were: community 86.4%, low-level care 9.5%, and high-level care 3.9%.

Summary: Clients assessed in an acute hospital

Overall result:

- Clients usually living in the community and assessed in an acute hospital are more likely to receive a recommendation for residential care (particularly high-level care) than clients assessed in a community setting.
- 31.9% of community clients assessed in an acute hospital receive a recommendation to the community, 18.1% are recommended low-level care and 49.6% high-level care.
- For clients assessed in the community the comparable recommendations are: community 86.4%, low-level care 9.5%, and high-level care 3.9%.

Trends:

- The proportion of clients assessed in hospital and given a community recommendation (PI 4.4) is higher than the previous year (2009–10 31.9%; 2008–9 26.8%; 2007–08 27.2%; 2006–07 23.7%; 2005–06 25.3%; 2004–05 27.2%; 2003–04 30.2%).
- Note that year-to-year changes in PI 4.4 is confounded by team practice to wait till post-discharge to assess clients likely to return to the community (also reflected in the long-term trend of decreasing numbers of assessments in acute hospitals).
- The increase in community recommendations from hospital assessments is not consistent with the long-term trend; since 1995–96 the proportion has steadily decreased from 42.0% to the 26.8% in 2008–09.
- There was a continuation of the long-term trend for decreasing proportions, and numbers, of assessments in acute hospitals.

Rural metropolitan comparison:

- Recommendations to the community were more likely in rural than metropolitan areas, while the reverse was true for low-level and high-level care.

Range:

- There is a considerable range across the teams in the recommendations of people assessed in hospital—to the community (11.2% to 58.7%), low-level (11.4% to 30.1%) and high-level care (28.3% to 66.9%).

CARE COORDINATION

Care coordination—type and duration

Collection of data on care coordination was introduced in Victoria in Quarter 4 of 2005–06. Care coordination is activity that ensures that the care plan is implemented by: monitoring the implementation of the care plan and assisting clients access services (Level 1); and/or helping clients who require close monitoring or active assistance from the ACAS, such as those with complex needs, or who are in an unstable or dangerous situation (Level 2).[*]

Table 31 below shows that in 2009–10 under a tenth of clients (8.5%) received care coordination, and that it was mainly Level 1. Overall, the proportion of clients receiving care coordination is similar among rural and metropolitan teams but there is a considerable range within both rural and metropolitan teams. For example, the proportion of clients who receive any care coordination ranges between 0.1% and 17.3% among rural teams, and between 0.0% and 12.1% among metropolitan teams. The corresponding ranges for Level 1 care coordination are 2.0% to 17.3% for rural teams and 0.4% to 12.1% for metropolitan teams; and for Level 2 care coordination 0.1% to 2.8% for rural teams and 0.0% to 2.5% for metropolitan teams.

Table 31: Care coordination, Victoria 2009–10 (%)

	Level 1 %	Level 2 %	Levels 1 & 2 %	None %	Missing %	Total %	Total n
Rural	7.9	1.0	1.0	85.1	5.0	100.0	16,895
Metro	5.8	0.7	1.2	84.8	7.4	100.0	38,127
Total	**6.5**	**0.8**	**1.2**	**84.9**	**6.7**	**100.0**	**55,022**

Note: Complete assessments only.

Table 31 also shows a relatively high level of missing data for care coordination, and this is higher than the previous year (2.7% missing). The high proportion of records with the duration of zero days, that is the care coordination was provided before the care plan was finalised or on the same day, continues. Of complete assessments with some level of care coordination recorded, almost a third (26.3%; rural 41.5%, metro 17.7%) were reported with zero days duration. As care coordination is aimed at supporting the client to implement the care plan, care coordination should occur after the end of assessment. It should be remembered that routine referrals arising from the care plan are not care coordination, they are part of the assessment/care plan process.

Table 32 (next page) shows that the average duration for care coordination (of any level) is 11.8 calendar days, and that half of all care coordination episodes were closed within a week. The duration of care coordination is shorter among rural teams, but both rural and metropolitan teams show considerable variation in the duration of the care coordination they provided.

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[*] Department of Health and Ageing, *Aged Care Client Record User Guide*. Canberra: Department of Health and Ageing, 2007.

Table 32: Duration of care coordination, Victoria 2009–10 (calendar days)

	Mean (days) (range)	Median (days) (range)	90^{th} %ile (days) (range)	Total n
Rural	7.6 (3.1–16.6)	1 (0–11)	23 (9–39)	1,672
Metro	14.1 (5.1–19.9)	7 (3–22)	36 (19–51)	2,969
Total	**11.8**	**6**	**33**	**4,641**

Note: Complete assessments with Level 1, Level 2 or Level 1 & 2 care coordination recorded.
Excludes negative times and times over 365 days.

Care coordination—characteristics of assessment

Table 33 presents a selection of MDS variables that may influence the likelihood of care coordination occurring. In general, the likelihood of care coordination is similar across the selected variables, with the likelihood of care coordination slightly more for clients aged between 50 and 69 years than other ages, for clients with a co-resident carer, and for assessments with a recommendation to the community compared to those to residential care.

Table 33: Care coordination by characteristics of assessment, Victoria 2009–10 (%)

	Level 1 %	Level 2 %	Levels 1 & 2 %	None %	Total %	Total n
Age *						
Less than 50 years	8.3	1.7	0.0	90.1	100.0	121
50-69 years	8.3	1.4	2.0	88.3	100.0	3,193
70+ years	6.8	0.8	1.2	91.2	100.0	43,910
Total	6.9	0.9	1.2	91.0	100.0	47,226
Carer availability **						
No carer	6.2	0.9	1.3	91.6	100.0	5,129
Co-resident carer	7.6	1.0	1.2	90.2	100.0	20,573
Non-resident carer	6.7	0.8	1.3	91.3	100.0	18,875
Total	6.9	0.9	1.2	91.0	100.0	47,226
Dementia diagnosis *						
No dementia diagnosis	6.9	0.9	1.2	91.1	100.0	36,069
Dementia diagnosis	7.0	0.8	1.4	90.8	100.0	11,157
Total	6.9	0.9	1.2	91.0	100.0	47,226
Severe core or profound disability *						
No core/profound disability	7.7	0.8	1.2	90.3	100.0	12,692
Core/profound disability	6.6	0.9	1.2	91.3	100.0	34,376
Total	6.9	0.9	1.2	91.0	100.0	47,068
Recommended long-term care setting *						
Community	8.1	1.0	1.3	89.6	100.0	31,441
Residential care	4.5	0.6	1.1	93.8	100.0	15,693
Other	11.9	0.0	10.2	78.0	100.0	59
Total	6.9	0.9	1.2	91.0	100.0	47,193

Note: * Complete assessments with valid codes.
** Complete assessments of clients living in the community with valid codes.

Summary: Care coordination

Overall result:

- In 2009–10 under a tenth of clients (8.5%) received care coordination.
- Level 1 care coordination was much more common (6.5% of complete assessments) than Level 2 (0.8%) or both (1.2%).
- The average duration for care coordination (of any level) is 11.8 calendar days, and half of all care coordination episodes are closed within a week.
- In general, the care coordination provided is similar across a number of selected variables that might influence the likelihood of care coordination (age, availability of carer, presence of dementia, profound disability and recommended long-term care setting), with the likelihood of care coordination slightly more for clients aged between 50 and 69 years than other ages, for clients with a co-resident carer, and for assessments with a recommendation to the community compared to those to residential care.
- The level of missing data for care coordination (6.7%) increased compared to the previous year and is still higher than other items.

Rural metropolitan comparison:

- Overall, the proportion of clients receiving care coordination is similar among rural and metropolitan teams.
- The average duration of care coordination provided by rural teams is shorter than metropolitan teams.

Range:

- The proportion of clients who received any care coordination ranges between 0.1% and 17.3% among rural teams, and between 0.0% and 12.1% among metropolitan teams.
- The corresponding ranges for Level 1 care coordination are 2.0% to 17.3% for rural teams and 0.4% to 12.1% for metropolitan teams; and for Level 2 care coordination 0.1% to 2.8% for rural teams and 0.0% to 2.5% for metropolitan teams.
- Across all teams, the mean duration of care coordination ranged between 3.1 and 19.9 calendar days, and the median between 0 and 22 calendar days.

CONCLUSION

This Annual Report analyses records with assessment end dates from July 1 2009 to July 30 2010, and is the sixth to comprise all MDS v2 data.

Assessment numbers

In contrast to the previous year, assessment numbers are higher in 2009–10. Total referrals are 4.7% lower and completed assessments are 4.6% lower than 2008–09. Total assessments with face-to-face contact are 3.8% lower and total assessment activity (face-to-face assessments and consultations recorded in the VAED) is 5.2% lower than the previous year.

Access to assessment

Consistent with the decrease in numbers, the completed assessment rate (Performance Indicator 2.2) of 85.3 per 1,000 target population decreased by 3.8 compared to 2008–09, and the face-to-face contact rate of 95.1 is also lower. The proportion of target group assessments has steadily increased since 1995–96, and 2009–10 (93.1%) is similar to the previous year.

A small minority (0.50%) of all referrals to the ACAS involve people from Indigenous backgrounds. Referrals of Indigenous clients increased in 2009–10 but continued to be below their representation in the target population. The index (PI 1.1) of Indigenous referrals compared to their representation in the target population (0.71) is higher than 2008–09 and still below 1.0 (an index of 1.0 indicates that referrals of Indigenous people are commensurate with their representation in the target population).

In 2009–10 just under a quarter (24.5%) of referrals were of people of culturally and linguistically diverse (CALD) backgrounds. While access to the ACAP is higher than the previous year (referrals of people from CALD background are 11.17% higher than the previous year and consistent with the longer term trend), the proportion of CALD referrals continues to be below their representation in the population. The index comparing the representation of CALD referrals to their representation in the target population (PI 1.2) is 0.83, slightly higher than 2008–09 (an index of 1.0 indicates that referrals of people from CALD background are commensurate with their representation in the target population).

Over two-thirds (71.2%) of complete assessments involve people with a severe or profound core activity limitation, a small increase compared to 2008–09. A severe or profound core activity limitation was more likely among non-target group (younger) clients (76.7%) than among target group (older) clients (71.2%). The proportion of target group clients (PI 2.3) is slightly higher and the proportion of non-target group clients (PI 2.4) with a severe or profound core activity limitation slightly higher than the previous year.

Almost a quarter (23.7%) of complete ACAS assessments involve clients with a diagnosis of dementia, with a higher prevalence among target group clients (24.1%) than non-target group clients (18.5%). The proportion of target group clients with dementia (PI 2.5) is slightly lower than the previous year.

Timeliness of assessment

There is a considerable difference in time taken to complete the assessment process in hospital and non-hospital settings. However, most of this difference occurs in the first stages of the assessment process, between referral and first face-to-face contact. On average, Victorian ACAS take 1.7 calendar days to respond to a need for a comprehensive assessment (referral to first intervention 5% trimmed mean) in acute hospital/other inpatient settings, and 17.5 days in non-hospital settings (residential care/community), with a further 0.3 days in hospital settings and 0.8 days in non-hospital settings to face-to-face contact. To complete the assessment process (face-to-face contact to end of assessment) takes on average a further 0.9 days in hospital settings and 1.8 days in non-hospital settings; and delegation 1.3 days in hospital settings (end of assessment to delegation) and 3.0 days in non-hospital settings.

Overall, the time taken to complete the assessment process decreased in 2009–10 compared to previous years. Times in hospital settings decreased (referral to end of assessment decreased by an average of 3.4 days), and the assessment time (referral to end of assessment) in other settings also decreased from an average of 25.6 days to the present 23.0 days.

The proportion of clients (92.5%) who receive "timely assistance" (PI 2.1) is similar to previous years.[*] Timely assistance was relatively more common in hospital settings (98.2%) than in non-hospital settings (84.2%). The higher proportion of timely assistance in hospital settings reflects the agreements many teams have with their auspice to respond to requests for assessment within a specified time (usually 48 hours).

Client characteristics

The complexity of clients continued to increase (albeit slightly) compared with previous years. The proportion of clients aged 80 years and over continued to increase (by 0.4% compared with 2008–09) and this is reflected in increases in the proportion of clients reported with activity limitations and health conditions. The proportion of clients with an activity limitation is slightly higher (by between 0.6% and 3.2%) this year compared to 2008–09 for nine of the ten activities, and the proportion with no activity limitation decreased by 0.1%. In addition, relatively more clients were reported with many of the common health conditions compared to 2008–09.

Support at assessment

The level of support reported for clients living in the community is lower than the previous year—reported formal support for eight of the ten activities decreased by between 0.1% to 1.7% and the level of informal assistance for four of the ten activities decreased by between 0.5% and 1.4%.

The data also shows the importance of informal assistance in supporting people in the community. With the exception of assistance with domestic tasks, the proportion of clients receiving informal assistance is higher than those receiving formal assistance. In particular, in the areas of communication, mobility, movement, transport and social participation, almost all the assistance is from informal sources.

Recommendations

The great majority of clients (94.2%) live in a community setting at the time of assessment, and 70.3% are recommended to continue living in the community, a small increase (0.3%) on the previous year. This increase is consistent with the long-term trend of increased proportions of community to community recommendations, from 58.9% in 1995–96 to the present 70.3%. It is also consistent with Performance Indicator 4.3 (the proportion of clients assessed in the community and given a long-term recommendation for a community

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[*] Timely assistance is the number of clients categorised as Priority 1 who were seen within 48 hours (i.e., referral to first intervention) and the number of Priority 2 clients seen within 14 days, as a proportion of all Priority 1 and Priority 2 clients.

setting). Over the same period, community recommendations for clients assessed in acute hospitals (PI 4.4) decreased from 42.8% to the present 31.9% (an increase of 5.1% compared to 2008–09). The decrease in the proportion of clients assessed in an acute hospital and given a community recommendation is off-set to some extent by the decreasing proportions, and numbers, of clients assessed in acute hospital (e.g., 9,833 community-dwelling assessments—23.2% of records with face-to-face contact—were assessed in hospital in 2003–04, compared with 7,561 assessments in 2009–10—14.0% of records with face-to-face contact). This decrease indicates that assessments in acute hospitals are increasingly targeting people who need approval for residential care.

An important objective of the ACAP is to prevent premature or inappropriate admission to residential care, particularly groups of clients such as those not "at risk" of admission to residential care (PI 3.1), non-target group (younger) clients (PI 3.2), clients with dementia (PI 4.1), and target group (older) clients (PI 4.2).[*] In line with PI 3.1 recommendations to residential care for clients not "at risk" have decreased over the past four years from 35.9% in 2002–03 to 26.4% in 2009–10. The proportion of non-target clients recommended to residential care (30.6%) is higher than the previous year. The proportion of long-term community recommendations for target group clients with dementia living in the community at assessment (59.4%) is slightly higher than the previous year and consistent with an increasing trend (PI 4.1). The proportion of target group clients "at risk" of admission to residential care given a recommendations for a CACP (18.8%) is higher than the previous year (PI 4.2).

Range across teams

As in previous years, there is considerable inter-team variation in assessment numbers, timeliness and recommendations. For example, the proportion of referrals that do not proceed further ranged from 0.3% to 20.5 %, and the proportion of completed (but not delegated) assessments from 0.3% to 32.2% and delegated assessments ranged from 60.9% to 91.5%. Taken together, complete and delegated assessments showed less variability (range 79.5% to 99.0%). There is also considerable variation in the allocation of priority category in both hospital and non-hospital settings. Referrals in hospital settings categorised as Priority 1 range across teams from 0.3% to 18.5%; Priority 2 between 57.9% and 98.7%; and Priority 3 between 0.5% and 39.9%. The corresponding proportions in non-hospital settings are: Priority 1 0.0% and 6.3%; Priority 2 8.5% and 68.0%; and Priority 3 30.6% and 91.2%. Variability in policy and practice (particularly intake procedures), recording practice, catchment size, and the availability of services (particularly rehabilitation), impact on the assessment profile of teams.

While there was a relatively narrow range in the proportion of completed target group assessments to all assessments (90.2% to 95.4%) across the teams, the rate of completed target group assessments per 1,000 target population varies considerably (73.1 to 152.1). If the two highest rates (a metropolitan team with a relatively small catchment based at a hospital that draws people from a much wider area, and a small rural team) are removed the rates range from 73.1 to 112.7 completed assessments/1000 target population, still a considerable range.

Both rural and metropolitan teams reported a considerable range in timeliness in all settings. Average response times (referral to face-to-face contact) ranged from 0.5 to 8.6 calendar days in hospital settings and from 7.7 to 50.3 calendar days in non-hospital settings (5% trimmed means). The assessment process (referral to end of assessment) ranged from 0.7 to

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[*] "At risk" clients are those with any 4 of the following 5 characteristics: aged 80 years or over, or Indigenous and aged 60 years or over; having a severe or profound core activity restriction; having dementia; living alone; not having a carer)

9.7 calendar days in hospital settings, and from 8.2 to 52.0 calendar days in non-hospital settings (trimmed means).

The outcomes of assessment (recommendations) also varied considerably across the teams. For example, the proportion of people living in the community and given a long-term care recommendations to the community ranged from 54.0% to 85.0%; and the proportion living in low-level care and recommended high-level care ranged from 69.3% to 90.6%.

Care coordination

Care coordination is activity that ensures that the care plan is implemented by: monitoring the implementation of the care plan and assisting clients access services (Level 1); and/or helping clients who require close monitoring or active assistance from the ACAS, such as those with complex needs, or who are in an unstable or dangerous situation (Level 2). Data on care coordination activity provided to ACAP clients was introduced to further document team activity.

In 2009–10 just under a tenth of clients (8.5%) received care coordination, and over two-thirds (76.5%) of these clients received Level 1 care coordination. The average duration for care coordination (of any level) was 11.8 calendar days, and half of all care coordination episodes were closed within a week. There is considerable variation across the teams in the proportion of clients who receive care coordination and the duration of the care coordination provided.

In general, the care coordination provided is similar across a number of selected variables that might influence the likelihood of care coordination (age, availability of carer, presence of dementia, profound disability and recommended long-term care setting). However, care coordination slightly more likelihood for clients aged between 50 and 69 years than other ages, for clients with a co-resident carer, and for assessments with a recommendation to the community compared to those to residential care.

Data quality

Victorian data quality in 2009–10 is very good and there were improvements compared with the previous year. The National Data Repository aims for a missing or error rate of less than 1%. For records with face-to-face contact, and excluding date items, this level was achieved in Victoria for almost all items. Items with an error rate of more than 1% are: country of birth, care coordination and priority category.

There continues to be a high level of missing data for care coordination (6.7% c.f. 2.7% in 2008–09). In addition to the missing data, there are a high proportion of records with the duration of zero days, that is the care coordination was provided before the care plan was finalised or on the same day. Of complete assessments with some level of care coordination recorded, nearly a third (26.3%) show a duration of zero days. As care coordination is aimed at supporting the client to implement the care plan, most care coordination should occur after the end of assessment. It should be remembered that routine referrals arising from the care plan are not care coordination, they are part of the assessment/care plan process.

The continuing and considerable, inter-team variation in assessment numbers, timeliness and recommendations is noted in a previous section. In addition to this variation there appears to be considerable variation in the coding of some items. The ACAP target population is older people and there is limited variation across the teams in the age and sex profile of clients—the largest difference in any age group across the 18 teams is 7.8% and in the proportion of women 6.1%. However, a number of items vary considerable more than this, for example, activity limitations and health conditions. Across the teams the proportion of clients reported with a severe or profound activity limitation ranges between 53.2% and 90.7%; the need for domestic assistance between 89.3% and 97.3%; transport between 77.4% and 93.7%; meals between 71.5% and 91.3%, and self-care between 44.9% and 89.3%. The proportion recorded with a heart condition or disease ranges from 39.4% to 66.4%; diabetes from 18.5% to 26.4% and cerebrovascular disease/stroke from 13.8% to 25.2%.

APPENDIX: THE AGED CARE ASSESSMENT PROGRAM AND DATA COLLECTION

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 and residential respite, to receive Australian Government funded community care (Community Aged Care Package) and flexible care (Extended Aged Care at Home, Extended Aged Care at Home–Dementia, Transition Care). ACAS also refer people to community services provided under the Home and Community Care Program, to Linkages[26] (which provides intensive community care packages), to rehabilitation services—both inpatient and community-based—and to general community services.

"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".[27] 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.

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 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.

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[26] Known as Community Options in other states.

[27] Department of Health and Ageing. *Aged Care Assessment Program Operational Guidelines*, Canberra: Department of Health and Ageing, 2002, p.12.

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[28] 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.

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[28] Now the Lincoln Centre for Research on Ageing.

MDS v1 and MDS v2

A previous Victorian Annual Report (2003–04) contains a detailed discussion on the changes resulting from the introduction of MDS v2. The main differences are an increase in the number of data items and their complexity and the criteria for inclusion as a record. In particular, the different criteria for inclusion in the MDS must be kept in mind when making historical comparisons between MDS v1 and v2 data. In Victoria, records were included in MDS v1 if a face-to-face meeting with the client occurred. MDS v2 includes all referrals that are accepted for a comprehensive assessment, and hence the MDS includes records of clients who were accepted for comprehensive assessment and received an assessment and care plan, as well as cases where the assessment process was incomplete for one reason or another (coded incomplete). Six categories (or levels) of records can be differentiated in MDS v2—see table below and following page.

Categories of cases in MDSV2 defined by data included in the dataset

Level	Data included
Level 1. Referral only. Denotes cases where referrals are accepted but do not result in any ACAS intervention.	• Client ID • Record linkage key • Referral date • Reason for ending assessment • Assessment completion date
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.	• Client ID • Record linkage key • Referral date • First intervention date • Reason for ending assessment, • Assessment completion date Other information is likely to be minimal
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).	• Client ID • Referral date • Record linkage key • First intervention date • First face-to-face assessment date • Reason for ending assessment • Assessment completion date Other information will be patchy, depending on how far the assessment proceeded.
Level 4. Comprehensive. Denotes assessments that involve substantial assessment activity but are defined in the MDS as "incomplete".	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.

Level 5. Complete. Denotes comprehensive assessments where recommendations are made and included in the MDS.	Full information on the client should be included in the MDS record.
Level 6. Delegated. Assessments are complete and also approvals are made.	Full information on the client should be included in the MDS record and Parts 5 and 6 of the ACCR completed.