Aged Care Assessment Program

Minimum Data Set

Annual Report

Victoria
2004–2005

Report by the Victorian ACAP Evaluation Unit,
Lincoln Centre for Ageing and Community Care Research
on behalf of the Victorian Department of Human Services

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Aged Care Assessment Program

Victoria

July 2004–June 2005

Report structure

Executive summary

The ACAP Minimum Data Set and Program evaluation

Chapter 1: Introduction

Chapter 2: Program throughput and characteristics of the assessment process

Chapter 3: Client characteristics and access to ACAP

Chapter 4: ACAP Recommendations

CONTENTS

LIST OF TABLES

LIST OF FIGURES

ABBREVIATIONS

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

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

The Aged Care Assessment Program

This Annual Report for the Aged Care Assessment Program in Victoria reports on MDS v2 records with assessment end dates from 1st July 2004 and 30th June 2005.

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

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

The ACAP Minimum Data Set

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

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

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

Differences between MDS v1 and MDS v2

The number of data items and their complexity are greater in MDS v2 than in MDS v1. Further, criteria for inclusion as a record are quite different in MDS v2 from what they were in MDS v1. In Victoria, MDS v1 records were included if they were defined as “assessments”, that is if a face-to-face meeting with the client had taken place. Hence, the dataset included completed assessments and some incomplete records (e.g., cancellations, clients who died before a complete assessment etc).

MDS v2 includes all referrals that are accepted for a comprehensive assessment. Cases are included if there are data on 6 items: client ID number, adequate information to form a Statistical Linkage Key (name, sex, and date of birth), referral date, reason for ending the assessment, and assessment end date.

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

Program throughput and characteristics of the assessment process

Assessment numbers and rates

Overall result:

- The total number of records reported in Victoria in 2004–05 was 55,588, including 51,344 (92.4% of the total) with face-to-face contact.
- Of the total records, 4.6% were referrals only, 10.7% were other incompletes, 16.6% were completed assessments (but not delegated), and 68.2% were delegated assessments.
- Across Victoria, 91.7% of completed assessments were of people in the target population. The overall assessment rate was 89.9 completed assessments per 1000 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) was 107.0 per 1000 target population.

Trends:

- The recent trend of declining numbers of assessments with face-to-face contact continued in 2004–05—they were 2.6% lower than the previous year.
- Although showing a more stable historical trend, total assessment activity (face-to-face assessments and consultations recorded in the VAED) was also lower than in 2003–04 (by 2.7%).
- Total referrals and completed assessment numbers were also lower than in 2003–04—by 0.7% and 3.2% respectively.

Rural metropolitan and inter-team comparison:

- Approximately a third (32.7%) of all referrals were to teams in rural areas.
- The assessment rate was higher in rural than metropolitan areas.

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 were referrals only ranged from 0% to 12.9%; and the proportion of complete/delegated assessments from 60.1% to 98.0%.

Reason for ending assessment

Overall result:

- The great majority of recorded assessments (84.8%) were completed or delegated.

- The most common reasons for incomplete assessments were unstable functional status (4.9%) and the client choosing to withdraw (4.8%).

Timeliness of assessment

Overall result:

- Response times to referrals varied considerably between hospital and non-hospital settings.
- On average, Victorian ACAS responded to half of the referrals (referral to first intervention) in hospital settings within one calendar day (trimmed mean 1.2 calendar days) and 90% of referrals within a week. In non-hospital settings the median response was 8 calendar days (trimmed mean 11.8 days) with 90% of referrals within 34 days.
- From first intervention to the beginning of the assessment process (first face-to-face date) took, on average (trimmed mean), a further 0.2 days in hospital settings and 3.7 days in non-hospital settings.
- The assessment process (first face-to-face date to end of assessment date) took, on average (trimmed mean), 1.7 calendar days in hospital settings and 1.4 days in non-hospital settings.
- For those assessments that went on to delegation, this took a further 2.0 days in hospital settings and 1.6 days in non-hospital settings.
- On average (trimmed mean), the time from referral to end of assessment took 5.1 calendar days in hospital settings and 18.5 calendar days in non-hospital settings.
- Overall, the great majority of referrals (91.0%) were seen “on time” (i.e., priority 1 within 2 calendar days, and priority 2 within 14 calendar days).

Rural metropolitan comparison:

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

Range across teams:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.0 to 8.2 calendar days; non-hospital settings 1.8 to 21.0 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.0 to 10.9 calendar days; non-hospital settings 3.5 to 32.3 days.
- Response times from referral to end of assessment date: hospital settings, trimmed mean 0.6 to 26.2 calendar days; non-hospital settings 4.0 to 34.6 days.
- The proportion seen “on time” for Priority 1 ranged between 66.7% and 98.9% in hospital settings, and between 60.6% and 96.3% in non-hospital settings; and Priority 2 between 93.3% and 99.8% in hospital settings, and between 75.7% and 98.3% in non-hospital settings.

Location at assessment

Overall result:

- The majority of Victorian clients (61.9%) were assessed in community settings (mainly the person's home), 23.1% took place in acute hospitals, 8.6% in other inpatient settings and 5.9% in residential care.

Rural metropolitan comparison:

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

Range:

- The proportion of assessments carried out in acute hospital/other inpatient settings ranged considerably across the Victorian teams—from 14.6% to 52.5%.

Trend:

- Since 1995–96, the proportion of clients assessed in acute hospital/other inpatient settings in Victoria has decreased, and in 2004–05 there was a further small decrease compared with the previous year.

Assessor profession

Overall result:

- The majority of assessments with face-to-face contact recorded (54.2%) were multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (67.5%).

Client characteristics and access to ACAP

Age

Overall result:

- Two-thirds of clients assessed by Victorian ACAS were aged 80 years and over
- Non-target group clients comprised 8.9% of all assessments.

Rural metropolitan comparison:

- Similar age distribution.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 66.4%.
- The proportion of non-target group assessments has decreased from 15.5% to 8.9% of total assessments.

Accommodation setting

Overall result:

- The great majority of Victorian clients (80.0%) lived in the community or other community setting (9.4%) at assessment.
- 8.2% lived in residential care (7.4% in low-level care; 0.8% in high-level care).

Rural metropolitan comparison:

- Overall, similar proportions of clients live in the community in rural and metro areas, but there were relatively more in private residences in rural compared with metro areas.
- Similar proportions of clients in residential care.

Range:

- The proportion of clients living in the community ranged from 85.3% to 92.7%.

Activity limitations

Overall result:

- The great majority of Victorian ACAS clients living in the community were assessed as needing assistance with domestic activities, meals and transport just prior to their assessment. Assistance with self-care was also relatively common.
- Over two-thirds (68.2%) of clients had a severe or profound core activity restriction.
- Proportionately more clients living in residential care were assessed as needing assistance than those living in the community. Over 80% needed assistance with self-care and health care tasks, and the majority needed assistance with social and community participation, and transport.

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams, for example the need for domestic assistance among clients in the community ranged from 73.0% to 95.7% of clients, meals 59.9% to 85.8%, transport 53.6% to 88.7%, and self-care 42.9% to 66.7%.
- The need for assistance among clients living in residential care ranged from 83.7% to 100.0% for self-care, from 83.8% to 100.0% for health, from 73.5% to 100.0% for transport, and from 65.1% to 97.6% for social participation.

Assistance with activities

Overall result:

- Just prior to assessment, most clients were receiving formal assistance with domestic activities (53.9%), self-care (26.2%) or health tasks (30.5%).

- The most commonly provided informal assistance was with transport (59.7%), meals (48.7%), social participation (47.0%), mobility (29.3%), and domestic tasks (46.8%).
- There appears to be a considerable degree of complementarity between formal and informal assistance in that there was a greater level of informal assistance for those activities with a low level of formal assistance.

Health conditions

Overall result:

- Overall, heart conditions, arthritis, hypertension and dementia were the most common diagnoses among ACAS clients.
- The most common primary health condition was dementia (19.6%).

Rural metropolitan comparison:

- The prevalence of dementia was slightly lower in rural areas.

Other comments

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

Clients from CALD backgrounds

Overall result:

- A fifth of Victorian assessments (20.1%) were of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS approximated their representation in the 70+ years population.

Rural metropolitan comparison:

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

Trend:

- The proportion of referrals from people of CALD backgrounds was higher than the previous year and consistent with the overall trend.

Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.47% of all referrals involve people from Indigenous backgrounds while 0.67% of the target population are Indigenous.

Rural metropolitan comparison:

- Indigenous referrals to both rural and metropolitan teams were less than expected from the proportion in the population.

Range:

- The proportion of Indigenous to total referrals ranged from 0.2% to 2.5%.

Trend:

- The number of Indigenous clients has increased in most years since 1994–95.
- While the number in 2004–05 was 7.6% lower than 2003–04, Indigenous referrals since the introduction of MDS v2 in early/mid 2003 are much higher than previous years.

Clients with dementia

Overall result:

- Over a quarter (27.7%) of target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) were diagnosed with dementia at the time of assessment.
- 17.6% of non-target group clients were diagnosed with dementia at the time of assessment.

Rural metropolitan comparison:

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

Range:

- The proportion of target group clients with dementia ranged from 10.9% to 34.8%.
- The proportion of non-target group clients with dementia ranged from 8.9% to 26.5%.

Clients and carers

Overall result:

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

Rural metropolitan comparison:

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

Client’s “at risk”

Overall result:

- Overall, 9.7% of clients living in the community were “at risk” of admission to a residential care facility.

- “At risk” clients were more likely to receive a multidisciplinary assessment than all clients—63.6% of “at risk” clients received a MDS compared with 40.5% of all clients.

Rural metropolitan comparison:

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

Recommendations

Long-term care by accommodation setting

Overall result:

- Nearly two-thirds of clients living in the community at assessment (64.0%) received a recommendation to continue living in the community.
- The great majority (82.2%) of clients living in low-level residential care at assessment were recommended to high-level care.
- The great majority (77.8%) of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care.
- However, a significant minority (14.1%) of clients living in high-level care were recommended to low-level care, and a further 6.4% received community recommendations.

Trends:

- 2004–05 saw a return to the long-term trend (reversed between 2001-02 and 2003–04) of an increase in the proportion of community-dwelling clients recommended to remain in the community.
- In 2004–05 the proportion of clients living in low-level residential care and recommended to high-care was similar to the previous year.

Rural metropolitan comparison:

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

Range:

- Across the teams the proportion of community to community recommendations ranged from 47.8% to 82.1%.
- Low-level to high-level recommendations ranged from 69.1% to 91.5%.

Recommendation for CACPs

Overall result:

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

Trends:

- After a decline over the previous three years (following marked increases since 1995–96) the number of CACPs recommended increased in 2004–05

Rural metropolitan comparison:

- Newly recommended CACPs were relatively higher by rural than metropolitan teams, whereas an on-going recommendation was more likely from a metropolitan team.

Range:

- Across the teams the proportion of assessments with a CACPs recommendation (new and ongoing) ranged from 18.2% to 49.2%.
- The proportion of new recommendations ranged from 11.7% to 39.4%.

Recommendation for respite

Overall result:

- Over two-thirds of clients (70.9%) recommended to the community receive a recommendation for residential respite and 13.2% a recommendation for non-residential respite.

Trends:

- Consistent with the trend between 1995–96 and 2001–02, recommendations for residential respite increased in 2004–05.
- After several years of decreasing proportions of recommendations for non-residential respite, there was an increase in 2004–05 over the previous year.

Rural metropolitan comparison:

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

Range:

- Recommendations for residential respite ranged between 45.8% and 89.1% of clients recommended to the community.
- For non-residential respite the range was between 6.4% and 35.5%.

Recommendation for clients not "at risk"

Overall result:

- Of those clients living in the community not "at risk", 66.9% were recommended to the community and 32.3% to residential care (17.7% to low-care and 14.6% to high-care).
- "At risk" clients were twice as likely to receive a residential care recommendation than clients not "at risk".
- Recommendations for "at risk" clients were community 36.8%, low-level care 35.2%, and high-level care 27.1%.

Rural metropolitan comparison:

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

Recommendations for non-target clients

Overall result:

- Nearly two-thirds (65.4%) of non-target group clients living in the community are recommended to remain in the community, 15.0% to low-level care and 17.8% to high-level care.
- Compared to all clients living in the community, non-target group clients were slightly more likely to be recommended to the community, less likely to be recommended low-level residential care and more likely to be recommended to high-level care.

Rural metropolitan comparison:

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

Range:

- The proportion of non-target group clients recommended to remain in the community ranged from 41.4% to 88.9%.

Recommendations for clients with dementia

Overall result:

- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 46.0% of clients with dementia received a recommendation for residential care compared to 35.2% of all clients living in the community.
- Further, 23.6% clients with dementia receive a high-level care recommendation compared to 15.8% of all clients living in the community.

Rural metropolitan comparison:

- Clients assessed by metropolitan teams were less likely to be recommended to low-level residential care and more likely to receive a recommendation for high-level care than those assessed by rural teams.

Recommendations for clients assessed in an acute hospital

Overall result:

- Clients usually living in the community and assessed in an acute hospital were more likely to receive a recommendation for residential care (particularly high-level care) than clients living in the community and assessed in another setting.
- 26.7% of community clients assessed in an acute hospital received a recommendation to the community, 23.0% were recommended low-level care and 48.1% high-level care.
- For clients living in the community and assessed in the community the comparable recommendations were: community 78.5%, low-level care 16.2%, and high-level care 4.9%.

Rural metropolitan comparison:

- Recommendations in rural and metropolitan areas were similar.

Range:

- The recommendation pattern was similar across all teams but there was a considerable range in the proportion recommended to the community—from 3.4% to 48.2%.

“At risk” target group clients recommended a CACP

Overall result:

- Nearly a fifth of “at risk” target group clients received a recommendation for a CACP.
- Of the “at risk” target group clients recommended to the community, over half (55%) received a recommendation for a package, compared with 32% of all clients recommended to the community.

Rural metropolitan comparison:

- Rural teams recommended a CACP slightly more often than metropolitan teams.

Range:

- The proportion of “at risk” target group clients living in the community who received a recommendation for a CACP ranged from 5.9% to 44.9%.

Conclusion

This is the first Annual Report to analyse MDS v2 data only. With the additional information recorded in MDS v2, further historical comparisons and trends can be analysed.

Victorian data quality in 2004–05 was reasonably good. The National Data Repository aims for a missing or error rate of less than 1%. For records coded assessment complete, and excluding date items, this level was achieved in Victoria for over half of the items. However, some teams reported high missing rates for some items, in particular, priority category, the carer items, Indigenous status and DVA entitlement. There were also problems with date sequencing, particularly with the Delegation date preceding the Assessment end date. However, changes to the ACE software introduced in 2005 are helping to improve this problem. There also were indications that for some teams the coding of Priority category (particularly in hospitals) reflected the requirements of the facility rather than client need.

Inter-team variation across most areas continued. For example, the proportion of referrals only ranged from 0% to 12.9%, and the proportion of completed assessments from 7.3% to 42.4% and delegated assessments ranged from 49.6% to 90.4%. Both rural and metropolitan teams reported a considerable range in response times in all settings, s—trimmed means ranged from 0.0 to 8.2 calendar days in acute settings; 0.0 to 7.2 in other inpatient settings; 1.8 to 13.9 in residential care; and 3.3 to 21.0 calendar days in community settings. These variations are the result of a number of factors, including team policy and practice, recording practice, and the availability of services such as rehabilitation.

In contrast to the recent trend, timeliness of assessment improved in 2004–05. The aggregated time between referral and end of assessment was lower than the previous year in both hospital and non-hospital settings. Response times also improved with the time between referral and first face-to-face contact lower than in 2003–04 in all settings. The proportion of referrals seen "on time" was 91%, an increase of 2% over the previous year.

Assessment rates have steadily decreased in Victoria since 1995–96 and the 2004–05 rate of 107 assessments per 1000 target population was consistent with this trend (Lincoln Centre for Ageing and Community Care Research, 2004). Access to the ACAP by people of CALD background improved and was comparable to their representation in the population. While access of Indigenous people was higher among rural teams, it was lower overall than their representation, and down on the previous year.

Although assessment numbers increased in most years between 1994–05 and 2002–03, the present year continues a recent trend of declining numbers. Total reported referrals in 2004–5 were 0.7% lower than 2003–04, and the number of completed assessments was 2.4% lower. Victorian teams also reported 2.6% lower "MDS v1 comparable" assessments (those with face-to-face contact) than in 2003–04. Lower numbers may be due the introduction of MDS v2 and/or a change in criteria for what is included in the MDS. Anecdotal evidence also suggests that a return to "core business" by teams may have contributed to reduced assessment numbers. Future years will show whether this is a longer-term trend.

To account for assessment activity in hospitals no longer reported in the national ACAP MDS, Victoria also measures ACAS consultations in hospitals through the Victorian Admitted Episode Data (VAED). Although showing a more stable historical trend, total assessment activity (face-to-face assessments and consultations recorded in the VAED) was also lower than in 2003–04 (by 2.7%)

One factor that may be contributing to the lower assessment numbers was the increase in client dependency in 2004–05 compared with 2003–04. The proportion of clients aged 80 years and over continued to increase and this was reflected in an increase in the proportion of clients reported with activity limitations. The proportion of clients with an activity limitation was higher this year compared to last for all 10 activities. In particular, the proportion with one or more core activity limitations increased by 3.2%. The proportion of clients reported with the most common health conditions, particularly dementia, was also higher than in 2003–04. Given these increases in client complexity the increase in the proportion of clients given community recommendations is a positive outcome for clients and shows that the ACAP is continuing to deliver on one of its most important objectives—assisting older people to continue living in the community.

THE ACAP MINIMUM DATA SET AND PROGRAM EVALUATION

INTRODUCTION

This Victorian Annual Report is the first to comprise only Minimum Data Set Version 2 (MDS v2) data.[*] It utilises data collected by the Victorian Evaluation Unit on records with Assessment end dates between 1st July 2004 and 30th June 2005, and includes updated data sets from all four quarters of 2004-2005.

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

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

The Aged Care Assessment Program

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

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

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

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

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

[†] Known as Community Options in other states.

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.

Introduction of the ACAP Minimum Data Set Version 2.0

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

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

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

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

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

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

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

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

MDS v1 and MDS v2

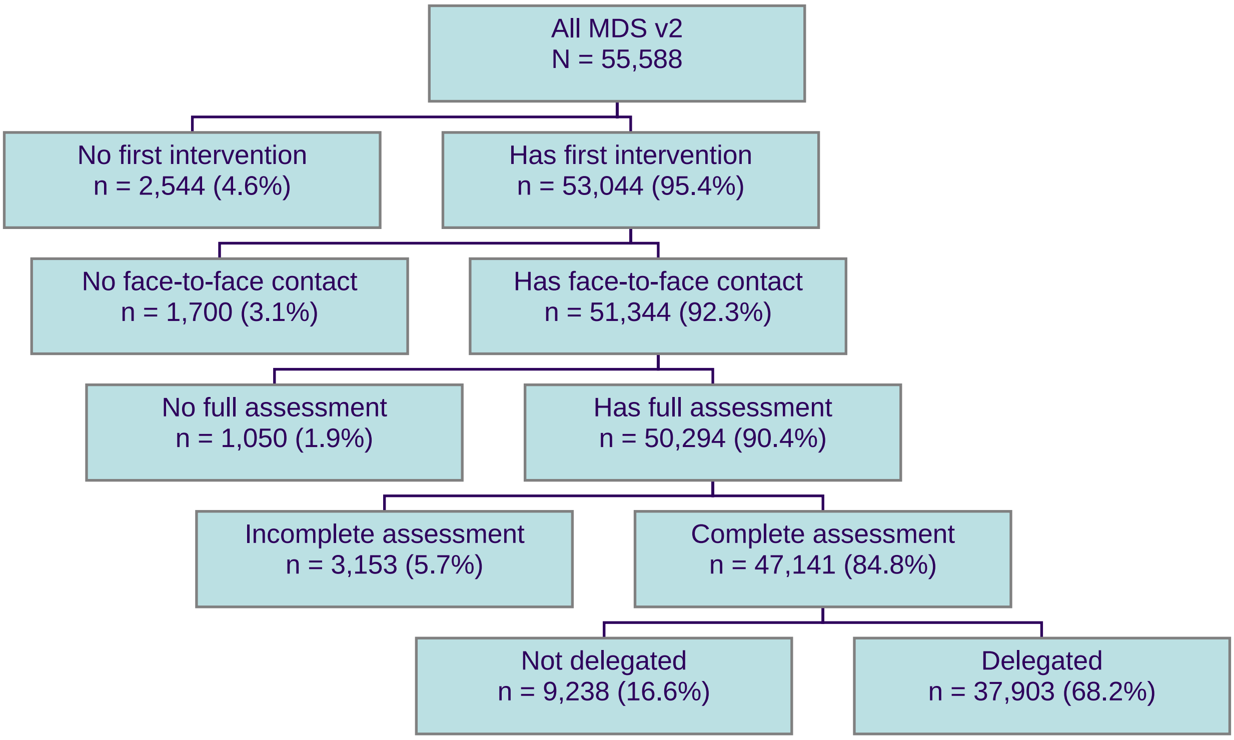
The previous Victorian Annual Report (2003–04) contains a detailed discussion on the changes resulting from the introduction of MDS v2. The main differences are an increase in the number of data items and their complexity and the criteria for inclusion as a record. In particular, the different criteria 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 1 below and Figure 1 on the following page.

Table 1: 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.

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

Figure 1: Flowchart of MDS v2 records



Content of this report

All 2004–05 data was compiled from MDS v2 records. Wherever possible, analyses in this report conform to the standards set out in the Aged Care Assessment Program Data Dictionary Version 1 (AIHW, 2002). Analyses are based on accepted referrals or assessments (not individuals assessed), except for the section on CACPs recommended to clients “at risk” (see AIHW, 2002). Many analyses are restricted to complete assessments (i.e., Reason for ending assessment is coded 1 = Assessment complete). In 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 (i.e., Levels 3–6 in Table 1 above).

PROGRAM THROUGHPUT AND THE ASSESSMENT PROCESS

Assessment numbers and rates

Definition

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

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

Number and types of records

During 2003-2004 a total of 55,588 records (rural 18,167; metropolitan 37,421) were submitted to the Evaluation Unit. Of these 51,344 (92.4%) were Level 3–6 and can be compared with previous years. Table 2 presents the proportion of each of the levels of the total records submitted.

Table 2: Records at each level of completion, Victoria 2004–05 (%)

	Level 1: Referral only %	Level 2: Minimalist %	Level 3: Simple %	Level 4: Compre-hensive %	Level 5: Complete %	Level 6: Delegated %	Total n
Rural	3.8	5.6	1.8	2.2	20.9	65.7	18,167
Metropolitan	5.0	1.8	1.9	7.4	14.5	69.4	37,421
Total	**4.6**	**3.1**	**1.9**	**5.7**	**16.6**	**68.2**	**55,588**

Across Victoria the great majority (84.8%) of all referrals result in a recommended long-term living arrangement (completed or delegated assessments). Table 2 above shows that a relatively small proportion of all assessments (4.6%) go no further than the referral stage, 5% go beyond referral but don’t involve a comprehensive assessment, and nearly 6% involve a comprehensive assessment with no resultant recommendation. The great majority of this latter group are referred to rehabilitation or further treatment.

There is considerable inter-team variation within the averages presented in Table 2. The proportion of referrals only ranged from 0% to 12.9%, and the proportion of minimalist/simple assessments from 0.0% to 19.1%. The proportion of incomplete assessments involving a comprehensive assessment (level 4) ranged from 0.1% to 24.8%. The proportion of completed from 7.3% to 42.4% and delegated assessments ranged from 49.6% to 90.4%. These variations are the result of a number of factors, including team policy and practice, recording practice, and the availability of services such as rehabilitation.

Reason for Ending Assessment

Table 3 provides a breakdown on reason for ending assessment. The great majority of recorded assessments were completed (including delegated), that is a care plan developed with an effective referral. Completed assessments correspond to Levels 5 and 6 in Table 2 above. Of the incomplete assessments (Levels 1 to 4 in Table 2), most were because the client's functional or medical condition required further rehabilitation or treatment, or because the client withdrew.

Table 3: Reason for ending assessment, Victoria 2004–05 (%)

	Assess-ment complete %	Client withdrew %	Client died %	Client trans-ferred %	Medical condition unstable %	Func-tional status unstable %	Other reason/ missing %	Tota %
Rural	86.5	6.4	1.3	0.5	2.1	1.4	1.9	100.0
Metro	83.7	4.1	0.6	1.7	2.3	6.6	1.0	100.0
Total	84.6	4.8	0.9	1.3	2.2	4.9	1.3	**100.0**

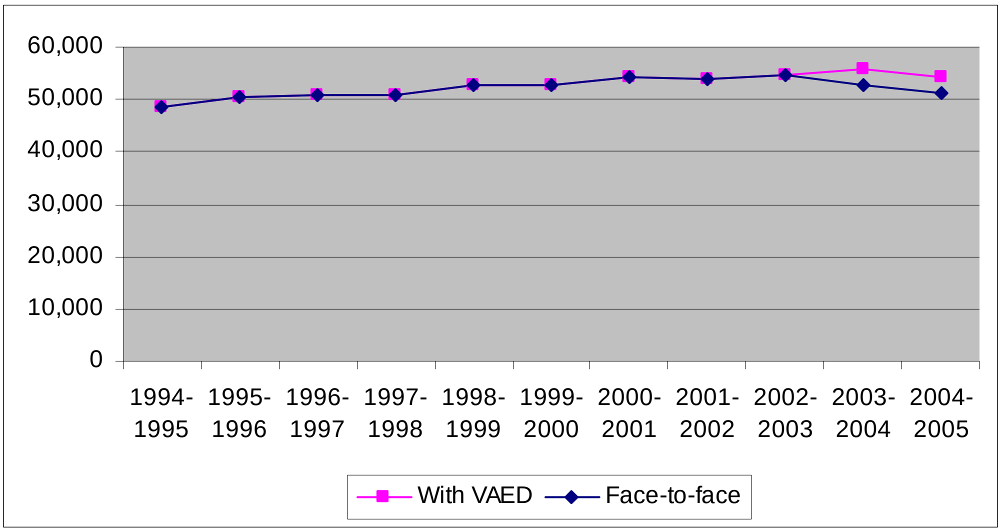
Trends in assessment numbers

Figure 2 shows change in total assessment numbers from 1994-1995 to 2004-2005. For comparability with previous years, only MDS v2 records with a valid First face-to-face contact date were included.

Victorian teams in 2004–05 reported 1,360 (2.6%) fewer "MDS v1 comparable" assessments than in 2003–04. Although assessment numbers increased in most years between 1994–05 and 2002–03, the present year continues a recent trend of declining numbers. There was also a small decrease in total referrals compared to the previous year, with 415 (0.7%) fewer referrals in 2004–05 than in 2003–04. The number of completed assessments was 2.4% lower than the previous year.

Due to the tightening in definitions of an ACAS assessment for national ACAP MDS v2, Victoria introduced an ACAS data collection item into the state-wide hospital data collection—Victorian Admitted Episode Data (VAED). This collection—initiated in 2003–04—allows ACAS to identify workload in the form of consultations that are no longer reported in the national ACAP MDS because they do not comply with the national ACAP definition of a comprehensive assessment. In 2004–05 it was estimated that 2,967 consultations were carried out in metropolitan hospitals. This workload, when added to the ACAP MDS assessments results in an ACAS output of 54,311 face-to-face assessments and consultations—2.7% less than in 2003–04. However, Figure 2 shows that the variation in total assessment activity over the previous five years is lower if the hospital activity is taken into account.

Figure 2: Total assessment numbers, Victoria 1994-1995 to 2004-2005



Note: 1994–95 to 2001–02 includes MDS v1 records only, 2002–03 and 2003-04 include MDS v1 and MDS v2 records, 2004–05 includes MDS v2 records only. For comparison with MDS v1 data, only MDS v2 records with a First face-to-face contact date were included.

Assessment rates

Table 4 shows the number of referrals and assessments reported for the year, and estimates of rates. 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 population figures were obtained from the Australian Bureau of Statistics. The assessment rate represents the number of assessments of clients in the target group per 1000 target group population in the catchment area.[*] In accordance with the standards set out in the Data Dictionary (AIHW, 2002), rates are estimated on complete assessments only.

Table 4: Number of referrals, number of assessments, and assessment rates, Victoria 2004–05 (%)

	2004 Estimated Target Population [1]	Total Number of Accepted Referrals	Total Number of assess-ments with Face-to-face contact	Total Number of Completed Assess-ments	Total Number of Completed Target group Assess-ments	Target group as % of Total Completed Assess-ments	Rate [2]
Rural	153,216	18,167	16,466	15,716	14,367	91.4	93.8
Metro	326,512	37,421	34,878	31,325	28,762	91.8	88.1
Total	479,728	55,588	51,344	47,041	43,129	91.7	89.9

Note: [1] ABS Estimated Resident Population at June 2004 provided to the Lincoln Centre for Ageing and Community Care Research by Victorian Department of Human Services. Target group comprises people aged 70+ years and Indigenous people aged 50–69 years).
[2] Rate = (Total completed target group assessments/target population) x 1000.

Overall, more than 90% of completed assessments were of the ACAP target group and there was little variation among the teams (89.7–93.9). However, the completed assessment rate varied considerably among the teams around the average (89.9) shown in Table 4 (77.5–156.7).

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[*] Rates should be interpreted with some caution, for example counts of Indigenous people are not updated annually and hence the target populations are likely to be underestimates.

The overall assessment rate, based on the number of MDS v2 assessments with face-to-face contact in 2004–05 was 107.0 assessments/1000 target group (not shown in Table 4). This was lower than in 2003–04 (112.0), and consistent with the declining trend since 1995–96.

Summary: Assessment numbers and rates

Overall result:

- The total number of records reported in Victoria in 2004–05 was 55,588, including 51,344 (92.4% of the total) with face-to-face contact.
- Of the total records, 4.6% were referrals only, 10.7% were other incompletes, 16.6% were completed assessments (but not delegated), and 68.2% were delegated assessments.
- Across Victoria, 91.7% of completed assessments were of people in the target population. The overall assessment rate was 89.9 completed assessments per 1000 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) was 107.0 per 1000 target population.

Trends:

- The recent trend of declining numbers of assessments with face-to-face contact continued in 2004–05—they were 2.6% lower than the previous year.
- Although showing a more stable historical trend, total assessment activity (face-to-face assessments and consultations recorded in the VAED) was also lower than in 2003–04 (by 2.7%).
- Total referrals and completed assessment numbers were also lower than in 2003–04—by 0.7% and 3.2% respectively.

Rural metropolitan and inter-team comparison:

- Approximately a third (32.7%) of all referrals were to teams in rural areas.
- The assessment rate was higher in rural than metropolitan areas.

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 were referrals only ranged from 0% to 12.9%; and the proportion of complete/delegated assessments from 60.1% to 98.0%.

Summary: Reason for ending assessment

Overall result:

- The great majority of recorded assessments (84.8%) were completed or delegated.
- The most common reasons for incomplete assessments were unstable functional status (4.9%) and the client choosing to withdraw (4.8%).

Timeliness

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

Referral to First intervention

Table 5 presents the times between Referral and First intervention for the four face-to-face contact settings (acute hospital, other inpatient, residential care and community). Table 5 shows considerable differences in the response times between hospital and non-hospital settings for both rural and metropolitan teams. On average (trimmed mean), Victorian ACAS take about a day and a half to respond to a request for service in hospital settings, but nearly two weeks in non-hospital settings. Median and 90th percentile responses showed a similar pattern. Response times in rural areas were longer than metropolitan areas in hospital settings but shorter in non-hospital settings. Both rural and metropolitan teams reported a considerable range in response times in all settings, but there was less variation in acute hospital and

Table 5: Time from Referral to First intervention by First face-to-face contact setting, Victoria 2004–05 (calendar days)

	Valid n	Missing n	Trimmed mean (range) days	Median (range) days	90th %ile (range) days
Acute hospital					
Rural	3,275	15	3.0 (1.2–8.2)	1 (0–6)	11 (3–21)
Metro	8,620	6	0.8 (0.0–1.7)	0 (0–1)	4 (0–6)
Total	11,895	21	1.3	0	6
Other inpatient					
Rural	713	2	2.7 (0.8–7.2)	1 (0–5)	9 (4–35)
Metro	3,680	0	0.7 (0.0–3.4)	0 (0–2)	4 (0–11)
Total	4,393	2	1.0	0	6
Residential care					
Rural	1,315	0	5.0 (1.8–8.6)	3 (0–6)	19 (9–41)
Metro	1,712	2	8.3 (3.2–13.9)	6 (1–10)	24 (14–34)
Total	3,027	2	6.9	5	21
Other*					
Rural	11,140	1	9.1 (3.3–18.7)	5 (1–14)	34 (11–101)
Metro	20,704	40	14.2 (7.3–21.0)	13 (1–20)	35 (20–43)
Total	31,844	41	12.4	9	35

Note: Missing values include cases that did not proceed to First intervention, or cases with negative times, times over 364 days, or without a valid contact setting.
* Community settings, mainly the client’s home.

inpatient settings than non-hospital settings—trimmed means ranged from 0.0 to 8.2 calendar days in acute settings; 0.0 to 7.2 in other inpatient settings; 1.8 to 13.9 in residential care; and 3.3 to 21.0 calendar days in community settings.

Referral to First face-to-face contact

Table 6 provides response times between Referral and First face-to-face contact by First face to-face contact setting. In general, response times from referral to beginning the assessment process were shorter in hospital and other inpatient settings than residential care or other settings. Response times in hospital settings reported by metropolitan teams were shorter than rural teams. Response times in residential care were similar for rural and metropolitan teams while times community settings were shorter in rural areas than metropolitan areas. The ranges in response times varied considerably among both rural and metropolitan teams in the various settings.

Since 1999–00, the time between referral and first face-to-face contact has been increasing in all settings. In 2004–05, response times in hospital settings were slightly shorter than the previous year, and in residential care and in the community they were shorter than previous years.

Table 6: Referral to First face-to-face contact by First face-to-face contact setting, Victoria 2004–05 (calendar days)

	Valid n	Missing n	Trimmed mean (range) days	Median (range) days	90th %ile (range) days
Acute hospital					
Rural	3,263	27	5.1 (1.5–10.6)	4 (1–9)	15 (5–26)
Metro	8,604	22	0.9 (0.1–1.9)	0 (0–1)	4 (1–6)
Total	11,867	49	1.9	1	7
Other inpatient					
Rural	713	2	4.7 (2.7–10.9)	4 (1–10)	14 (8–36)
Metro	3,677	3	1.0 (0.0–4.1)	0 (0–3)	5 (0–13)
Total	4,390	5	1.5	0	7
Residential care					
Rural	1,302	13	9.8 (3.5–18.6)	7 (3–13)	27 (13–54)
Metro	1,707	7	10.6 (6.3–15.1)	8 (5–13)	28 (18–40)
Total	3,009	20	10.3	8	27
Other*					
Rural	11,115	26	19.4 (7.3–32.3)	14 (6–29)	57 (18–117)
Metro	20,645	99	18.7 (13.2–31.0)	16 (12–30)	41 (27–64)
Total	31,760	125	18.7	15	44

Note: Missing values include cases with negative times, or times over 364 days, or without a valid contact setting.
* Community settings, mainly the client's home.

Time from 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. Table 7 presents total time from the date of Referral to the Assessment end date. On average (trimmed mean), the assessment process from referral to the end of assessment takes about 5 days in hospital settings, 13 days in residential care settings and 21 days in the community. The assessment process (difference in trimmed means from face-to-face contact to end of assessment) took between two and four days according to the setting. As with the other measures of timeliness, there was considerable variation within settings among both rural and metropolitan teams.

Table 7: Referral to End of assessment by First face-to-face contact setting, Victoria 2004–05 (calendar days)

	Valid n	Missing n	Trimmed mean (range) days	Median (range) days	90^{th} %ile (range) days
Acute hospital					
Rural	3,290	0	7.0 (2.8–14.3)	5 (1–11)	21 (8–43)
Metro	8,626	0	2.9 (0.8–7.6)	1 (0–6)	11 (5–22)
Total	11,916	0	4.0	2	14
Other inpatient					
Rural	714	1	9.6 (5.7–12.6)	7 (5–11)	27 (13–36)
Metro	3,680	0	4.8 (0.6–26.2)	2 (0–24)	20 (3–53)
Total	4,394	1	5.6	3	21.6
Residential care					
Rural	1,315	0	11.6 (4.0–22.4)	8 (3–19)	33 (14–63)
Metro	1,714	0	13.2 (7.7–20.8)	10 (6–19)	35 (19–47)
Total	3,029	0	12.5	9	34
Other*					
Rural	11,141	0	21.3 (8.0–34.6)	15 (7–31)	61 (20–119)
Metro	20,744	0	21.7 (15.4–34.1)	20 (13–34)	46 (34–67)
Total	31,885	0	21.4	19	49

Note: Missing values include cases with negative times or times over 364 days, or without a valid contact setting.
* Community settings, mainly the client's home.

Time from Referral to Delegation date

On average (trimmed mean), approval for services (end of assessment to delegation date) takes from one to three days depending on the setting. Approval following assessment in residential care and acute hospitals was quicker than in other settings (Table 8). Response times from referral to approval for services were shorter in hospital and other inpatient settings than residential care or other (community-based) settings. Response times in hospital settings reported by metropolitan teams were shorter than rural teams, while response times in residential care settings were shorter in rural areas than metropolitan areas. The ranges in response times (calendar days) between teams in the various settings for the trimmed mean were: hospital—1.3 to 14.1; other inpatient—0.7 to 26.6; residential care—7.2 to 23.6; other—9.2 to 38.4.

Table 8: Referral to Delegation date by First face-to-face contact setting, Victoria 2004–05 (calendar days)

	Valid n	Missing n	Trimmed mean (range) days	Median (range) days	90th %ile (range) days
Acute hospital					
Rural	2,448	4	8.1 (4.0–14.1)	6 (4–11)	22 (9–39)
Metro	4,641	0	6.6 (1.3–13.3)	5 (1–11)	19 (5–30)
Total	7,089	4	7.1	6	20
Other inpatient					
Rural	522	0	10.0 (6.0–12.2)	8 (5–13)	28 (14–34)
Metro	3,529	1	8.5 (0.7–26.6)	6 (0–24)	26 (4–54)
Total	4,051	1	8.7	7	26
Residential care					
Rural	966	1	12.9 (7.2–23.6)	10 (4–21)	34 (19–61)
Metro	1,325	2	13.9 (8.4–19.1)	11 (7–15)	36 (21–53)
Total	2,291	3	13.5	11	35
Other*					
Rural	7,981	6	24.4 (9.2–35.9)	19 (8–33)	64 (22–118)
Metro	16,427	2	23.9 (14.8–38.4)	22 (13–39)	49 (34–71)
Total	24,408	8	23.8	21	52

Note: Missing values include cases with negative times, times over 364 days, or without a valid contact setting.
* Community settings, mainly the client's home.

Timeliness and Priority category

Tables 9 and 10 present response times in the three Priority categories for hospital (acute hospital and inpatient) and non-hospital (residential care and community) settings. The mean (rather than the trimmed mean), the median, the 90th percentile, the proportion of clients who are seen "on time", and the ranges across the teams are presented. These tables provide further information on response times in terms of settings and Priority categories. A large difference between the mean and the median indicates that there is a considerable spread of response times within the particular category.

As indicated in the tables above, response times in hospital settings were shorter than in non-hospital settings, and this was so for all Priority categories. Overall, the great majority of referrals were seen "on time" (i.e., Priority 1 within 2 calendar days, and Priority 2 within 14 calendar days), with metropolitan teams seeing a higher proportion of clients "on time" than rural teams. The proportion seen "on time" was higher in non-hospital settings than hospital settings.

Table 9: Referral to First intervention by Priority category—hospital settings, Victoria 2004–05 (calendar days)

	Valid n	Missing n	Mean (range) days	Median (range) days	90^{th} %ile (range) days	Seen "on time" * (range) %
Priority = 1, < 48 hours						
Rural	396	0	2.0 (0.8–20.7)	0 (0–1)	3 (2–8)	87.9 (66.7–96.8)
Metro	4,371	1	1.2 (0.3–1.8)	0 (0–1)	2 (0–4)	90.5 (81.6–98.9)
Total	4,767	1	1.2	0	2	90.3
Priority = 2, 3–14 days						
Rural	3,079	16	3.5 (1.7–6.7)	1 (1–5)	8 (4–13)	97.2 (93.0–99.7)
Metro	7,075	5	1.5 (0.6–3.6)	0 (0–3)	5 (2–8)	98.9 (97.1–99.8)
Total	10,154	21	2.1	0	6	98.4
Priority = 3, more than 14 days						
Rural	503	1	10.5 (0.5–27.6)	6 (1–13)	26 (23–30)	NA
Metro	812	0	3.3 (3.9–19.5)	0 (0–9)	10 (9–64)	NA
Total	1,315	1	6.0	1	20	NA

Note: Missing values include cases with negative times, times over 364 days, or without a valid contact setting or priority category.
* % of clients whose priority category was 48 hours and had an intervention within 48 hours; % of clients whose priority category was 3-14 days and had an intervention within 14 days.

The data also indicates considerable variability in the coding of priority category and that coding may be influenced by the location of assessment. Overall, 12.2% of referrals were categorised as Priority 1, but in hospital settings 29.4% were categorised as Priority 1 compared to 4.2% in non-hospital settings. Metropolitan teams (35.7%) were much more likely to categorise referrals as Priority 1 in hospital settings than rural teams (9.9%). The range in the proportion of referrals given a Priority 1 category was almost as variable among rural teams (0.4%–30.8%) as metropolitan teams (0.0%–72.9%). These proportions are an improvement on the previous year (i.e., relatively fewer clients are reported as Priority 1 in hospitals) but they remain high.

Table 10: Referral to First intervention by Priority category—non-hospital settings, Victoria 2004–05 (calendar days)

	Valid n	Missing n	Mean (range) days	Median (range) days	90th %ile (range) days	Seen “on time” * (range) %
Priority = 1, < 48 hours						
Rural	523	0	3.9 (0.7–6.9)	0 (0–1)	12 (1–58)	78.0 (60.6–96.3)
Metro	938	0	2.0 (0.7–4.3)	1 (0–1)	4 (1–16)	84.0 (70.0–94.7)
Total	1,461	0	2.7	1	6	81.9
Priority = 2, 3–14 days						
Rural	6,483	0	7.1 (3.4–9.7)	4 (0–6)	18 (9–34)	86.7 (75.7–96.9)
Metro	6,676	8	7.7 (3.3–9.9)	6 (1–7)	16 (9–22)	86.5 (78.8–98.3)
Total	13,159	8	7.4	5	17	86.6
Priority = 3, more than 14 days						
Rural	5,418	1	20.5 (7.4–47.6)	8 (1–18)	60 (22–134)	NA
Metro	14,714	16	19.5 (12.4–26.3)	17 (4–24)	39 (25–49)	NA
Total	20,132	17	19.8	15	41	NA

Note: Missing values include cases with negative times, times over 364 days, or without a valid contact setting or priority category.

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

Timeliness by stage

Figure 3 provides an overall picture of the time taken for each stage of the assessment process in hospital and non-hospital settings. It highlights some of the points discussed above.

Figure 3: Aggregated time for the assessment process, Victoria 2004–05 (calendar days)

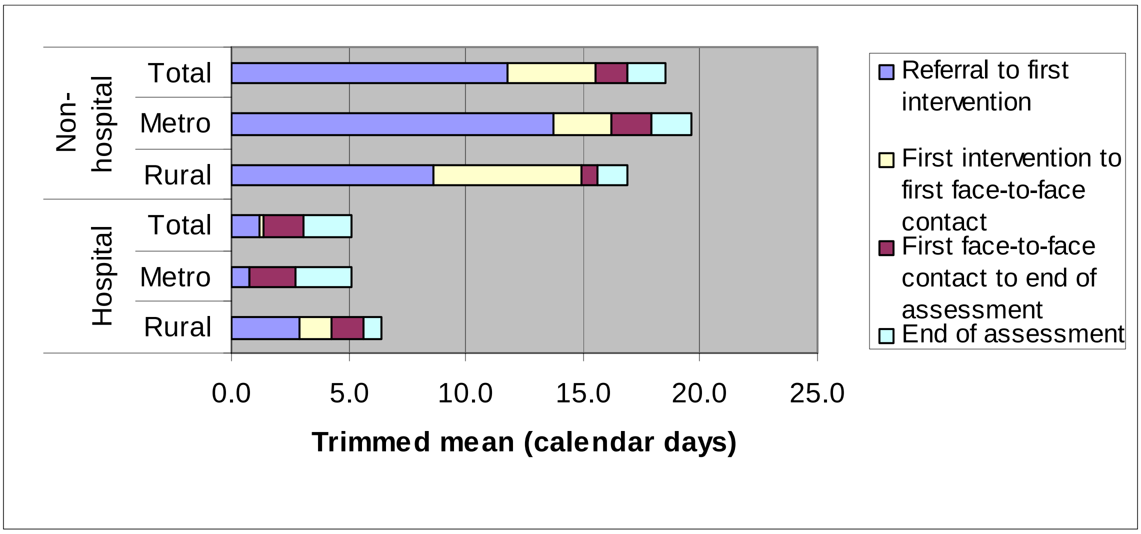


Figure 3 shows the considerable difference in total time between hospital and non-hospital settings. It also shows that most of this difference occurs in the first stage of the assessment process, the much shorter response times between referral and first intervention, and the shorter period between first intervention and face-to-face contact in hospital settings.

Summary: Timeliness of assessment

Overall result:

- Response times to referrals varied considerably between hospital and non-hospital settings.
- On average, Victorian ACAS responded to half of the referrals (referral to first intervention) in hospital settings within one calendar day (trimmed mean 1.2 calendar days) and 90% of referrals within a week. In non-hospital settings the median response was 8 calendar days (trimmed mean 11.8 days) with 90% of referrals within 34 days.
- From first intervention to the beginning of the assessment process (first face-to-face date) took, on average (trimmed mean), a further 0.2 days in hospital settings and 3.7 days in non-hospital settings.
- The assessment process (first face-to-face date to end of assessment date) took, on average (trimmed mean), 1.7 calendar days in hospital settings and 1.4 days in non-hospital settings.
- For those assessments that went on to delegation, this took a further 2.0 days in hospital settings and 1.6 days in non-hospital settings.
- On average (trimmed mean), the time from referral to end of assessment took 5.1 calendar days in hospital settings and 18.5 calendar days in non-hospital settings.
- Overall, the great majority of referrals (91.0%) were seen “on time” (i.e., priority 1 within 2 calendar days, and priority 2 within 14 calendar days).

Rural metropolitan comparison:

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

Range across teams:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.0 to 8.2 calendar days; non-hospital settings 1.8 to 21.0 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.0 to 10.9 calendar days; non-hospital settings 3.5 to 32.3 days.
- Response times from referral to end of assessment date: hospital settings, trimmed mean 0.6 to 26.2 calendar days; non-hospital settings 4.0 to 34.6 days.
- The proportion seen “on time” for Priority 1 ranged between 66.7% and 98.9% in hospital settings, and between 60.6% and 96.3% in non-hospital settings; and Priority 2 between 93.3% and 99.8% in hospital settings, and between 75.7% and 98.3% in non-hospital settings.

Location of assessment

Whenever possible, clients should be assessed in their usual accommodation setting (Commonwealth Department of Health and Ageing, 2002, p.27). For the majority of clients this will be a community setting or a residential care facility. Because of their medical or functional status, a significant minority of clients are assessed in hospitals or other inpatient facilities. Assessments in hospital settings are often undertaken by staff with multiple roles, such as geriatricians. Assessments in "other hospital settings" are often undertaken by, or in conjunction with, staff who work in those settings, such as allied health professionals.

The majority of clients were assessed in a community ("other") setting, more than a fifth in acute hospitals and a further 6% in residential care facilities (Table 11). Rural teams assessed relatively more clients in community or residential care settings than metropolitan teams. Clients in metropolitan areas were more likely to be assessed in hospitals or other inpatient settings. The decline in the proportion of clients assessed in residential care in 2004–05 (5.9%) compared with the previous year (10.2%) follows the removal in July 2004 by the Australian Government of the requirement for ACATs to reassess a resident before moving from low to high-level care.

Table 11: Location of assessment, Victoria 2004–05

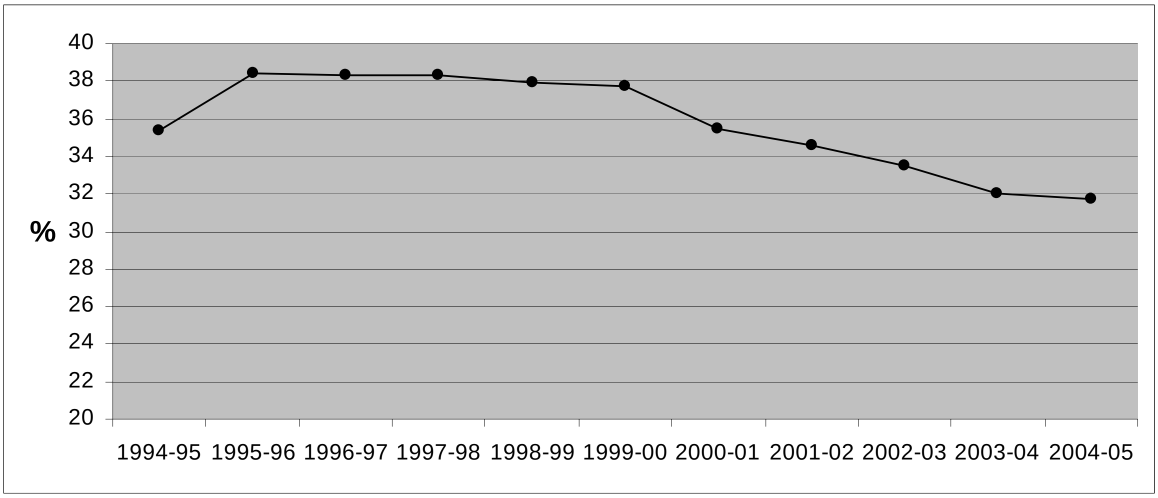
	Acute hospital %	Other inpatient setting %	Residential care setting %	Other* %	Missing %	Total %	Total n
Rural	19.8	4.3	7.9	67.5	0.4	100.0	16,456
Metrop	24.7	10.6	4.9	59.3	0.6	100.0	34,841
Total	23.1	8.6	5.9	61.9	0.5	100.0	51,297

Note: Table includes only records with a valid face-to-face contact date.
* Community settings, mainly the client's home.

The proportion of clients assessed in the various settings varied considerably among the 18 Victorian teams. Those assessed in hospital ranged from 7.2% to 40.7%; other inpatient from 1.4% to 22.5%; residential care from 3.9% to 9.9%; and "other" 41.4% to 80.0%. 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 4 illustrates change over time in the proportion of assessments that take place in hospital settings (acute hospital and other inpatient settings). Since 1995–96, the proportion of clients assessed in hospital settings in Victoria has decreased (Figure 4), and in 2004–05 there was a further decrease to the lowest recorded (31.7%).

Figure 4: Assessments in hospital settings, Victoria 1994-1995 to 2004-2005 (%)



Note: Assessments in hospital settings includes other inpatient.
Includes only records with a First face-to-face contact date.

Summary: Location at assessment

Overall result:

- The majority of Victorian clients (61.9%) were assessed in community settings (mainly the person's home), 23.1% took place in acute hospitals, 8.6% in other inpatient settings and 5.9% in residential care.

Rural metropolitan comparison:

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

Range:

- The proportion of assessments carried out in acute hospital/other inpatient settings ranged considerably across the Victorian teams—from 14.6% to 52.5%.

Trend:

- Since 1995–96, the proportion of clients assessed in acute hospital/other inpatient settings in Victoria has decreased, and in 2004–05 there was a further small decrease compared with the previous year.

Assessor profession

Overall, one professional was involved in 45.8% of assessments (with face-to-face contact), two in 20.3%, three in 12.8%, and 21.0% involved four or more assessments with assessor profession recorded. Overall, 54.2% of assessments were multidisciplinary, that is, two or more different professions were involved. Table 12 shows that over two thirds of assessments with face-to-face contact recorded involved a nurse, over 40% a medical professional, over 40% an other health professional, and 40% a social professional (mainly social workers but also welfare workers, counsellors, psychologists and interpreters). Geriatricians were more likely to participate in assessments by metropolitan teams (41.2%) than rural teams (13.5%). The proportion of all assessments with no profession recorded was 1.9%.

Table 12: Assessor profession involved in assessment, Victoria 2004–05 (%)

	Medical Profession %	Nursing Profession %	Other health profession %	Social profession %	Other profession %	None %
Rural	28.7	69.3	28.3	22.8	1.4	5.0
Metro	53.1	66.6	49.8	52.9	2.5	0.4
Total	45.3	67.5	42.9	43.2	2.1	1.9

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:

- The majority of assessments with face-to-face contact recorded (54.2%) were multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (67.5%).

CLIENT CHARACTERISTICS AND ACCESS TO ACAP

This section of the report describes the characteristics of clients assessed by Victorian ACAS in 2004–05 and examines access to the ACAP by clients who may experience difficulty in doing so. The Data Dictionary (AIHW, 2002) specifies that the proportion of older ACAT clients belonging to a special needs group (such as those from culturally and linguistically diverse backgrounds, those who are Aboriginal and/or Torres Strait Islanders, and people living in rural and remote areas) should be consistent with the proportion of older people in the population belonging to these groups. Further, it specifies maintaining or increasing assessment among older population with a severe or profound core activity restriction and older clients with dementia, and decreasing assessment among younger clients with no severe or profound core activity restriction.

Age

The age distribution for 2004–05 in Table 13 (following page) shows that two-thirds of ACAS clients were aged 80 years and over. Clients aged 60 years and under comprised 2.6% of total assessments. The age distribution in rural and metro areas was similar. Although the age distribution in 2004–05 was similar to the previous year, the age distribution has been steadily becoming older since 1994–95. Figure 5 below compares the age distribution in 1994–95 with that in 2004–05, and shows the increase in the proportion of clients in the older age groups in that time. In the ten years since 1994–95, the proportion of clients aged 80 years and over has increased from 54.7% to 66.4%. In the same time the proportion of clients under 60 years has decreased from 5.9% to the present 2.6%.

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

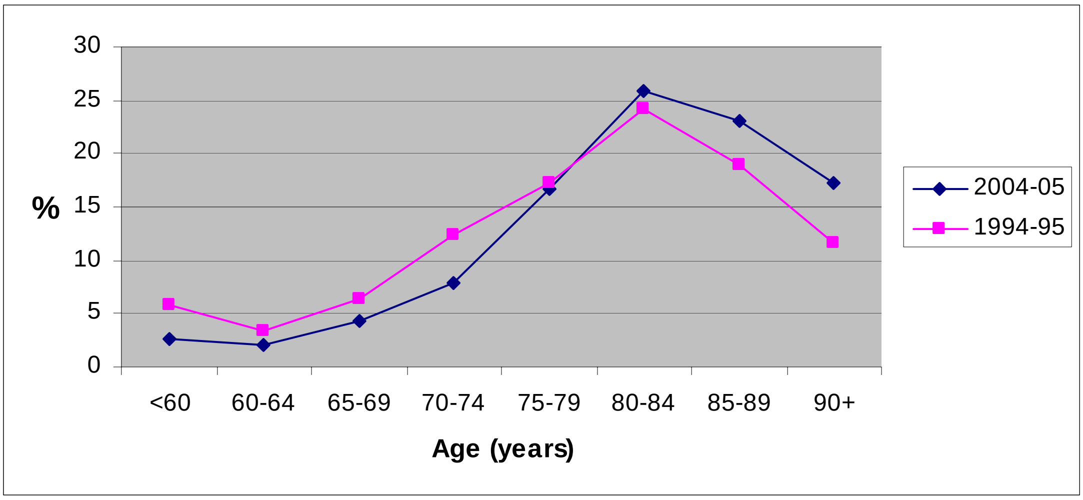


Table 13: Age, Victoria 2004–05 (%)

	< 60 years %	60-64 years %	65-69 years %	70-74 years %	75-79 years %	80-84 years %	85-89 years %	90-94 years %	95+ years %	Unknown %	Total %	Total n
Rural	3.0	2.1	4.3	7.8	16.5	26.3	23.5	13.0	3.6	0.0	100.0	18,167
Metro	2.4	2.2	4.2	8.0	16.8	25.8	23.0	14.0	3.7	0.0	100.0	37,421
Total	**2.6**	**2.1**	**4.2**	**7.9**	**16.7**	**25.9**	**23.1**	**13.7**	**3.6**	**0.0**	**100.0**	**55,588**

Note: Table includes all records.

Summary: Client age

Overall result:

- Two-thirds of clients assessed by Victorian ACAS were aged 80 years and over
- Non-target group clients comprised 8.9% of all assessments.

Rural metropolitan comparison:

- Similar age distribution.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 66.4%.
- The proportion of non-target group assessments has decreased from 15.5% to 8.9% of total assessments.

Usual accommodation setting

The usual accommodation setting at assessment of the great majority of ACAS clients was a private residence (80.0% of assessments with face-to-face contact) or other community setting (9.4% of assessments with face-to-face contact). A further 8.2% lived in residential care settings. Table 14 (overleaf) compares the rural with metropolitan teams on client usual accommodation setting. The proportion of clients living in the community ranged from 85.3% to 92.7%, including the range in the proportion living in a private residence from 70.4% to 89.2%. The proportion of clients usually living in low-level residential care ranged from 3.9% to 9.6%; and those in high-level care from 0.4% to 1.9%.

Summary: Accommodation setting

Overall result:

- The great majority of Victorian clients (80.0%) lived in the community or other community setting (9.4%) at assessment.
- 8.2% lived in residential care (7.4% in low-level care; 0.8% in high-level care).

Rural metropolitan comparison:

- Overall, similar proportions of clients live in the community in rural and metro areas, but there were relatively more in private residences in rural compared with metro areas.
- Similar proportions of clients in residential care.

Range:

- The proportion of clients living in the community ranged from 85.3% to 92.7%.

Table 14: Usual accommodation setting, Victoria 2004–05 (%)

	Private residence %	Other community %	Community total %	Low Care %	High Care %	Residential Total %	Other %	Unknown/ Missing %	Total %	Total n
Rural	83.4	6.4	89.8	6.7	1.0	7.7	2.1	0.4	100.0	16,456
Metro	78.4	10.8	89.2	7.7	0.8	8.4	2.1	0.3	100.0	34,841
Total	**80.0**	**9.4**	**89.4**	**7.4**	**0.8**	**8.2**	**2.1**	**0.3**	**100.0**	**51,297**

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

Table 14a: Usual accommodation setting—community settings, Victoria 2004–05 (%)

	Private residence - owned %	Private residence - private rent %	Private residence - public rent %	Retirement village (ILU) %	Boarding/ rooming house %	Crisis, emergency or transitional accomm. %	Supported community accomm. %	Total community %
Rural	70.0	7.7	5.7	4.3	0.2	0.0	1.9	89.8
Metro	68.9	4.7	4.8	7.0	0.4	0.1	3.4	89.2
Total	**69.2**	**5.6**	**5.1**	**6.1**	**0.3**	**0.1**	**2.9**	**89.4**

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

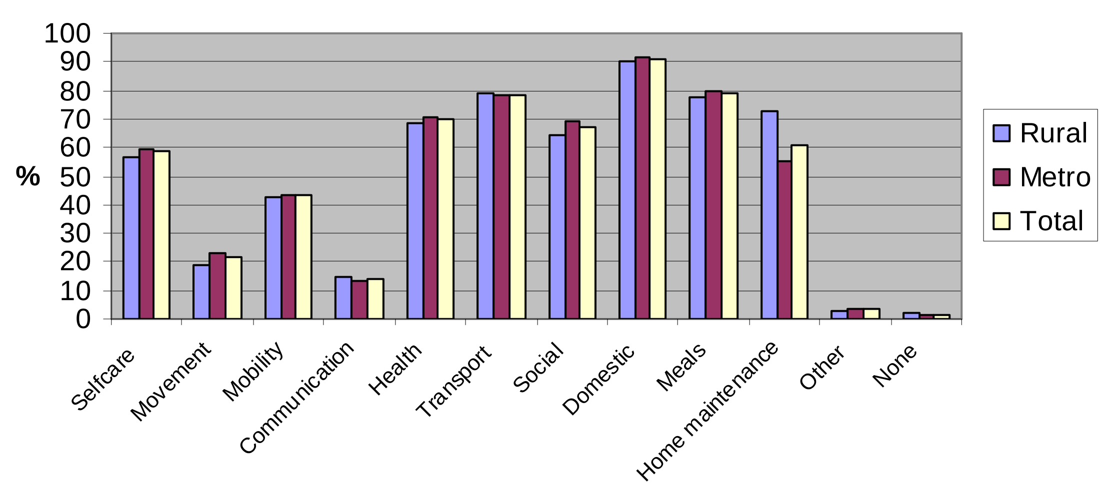
Functional profile and health conditions

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

Activity limitations

Figure 6 below shows that the great majority of Victorian ACAS clients living in the community were assessed as needing assistance with domestic activities (including washing, ironing, cleaning), meals and transport (including using public transport, getting to and from places away from home and driving) just prior to their assessment. Need for assistance with self-care was also relatively common. The level of the need for assistance was similar in rural and metropolitan areas. The range across teams for the need for domestic assistance was 73.0% to 95.7% of clients, for meals 59.9% to 85.8%, for transport 53.6% to 88.7%, and for self-care 42.9% to 66.7%. Among Victorian clients, over two-thirds (68.2%) had a severe or profound core activity restriction, with a similar proportion across rural (67.2%) and metropolitan teams (68.6%).

Figure 6: Activity limitations (clients living in the community), Victoria 2004-2005 (%)



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

As expected, proportionately more clients living in residential care needed assistance than those living in the community. Over 90% received assistance with self-care and health care tasks (including taking medication, dressing wounds), and three-quarters received assistance with social and community participation (includes shopping, managing finances, and participation in recreational, cultural or religious activities) and transport (Figure 7).* The

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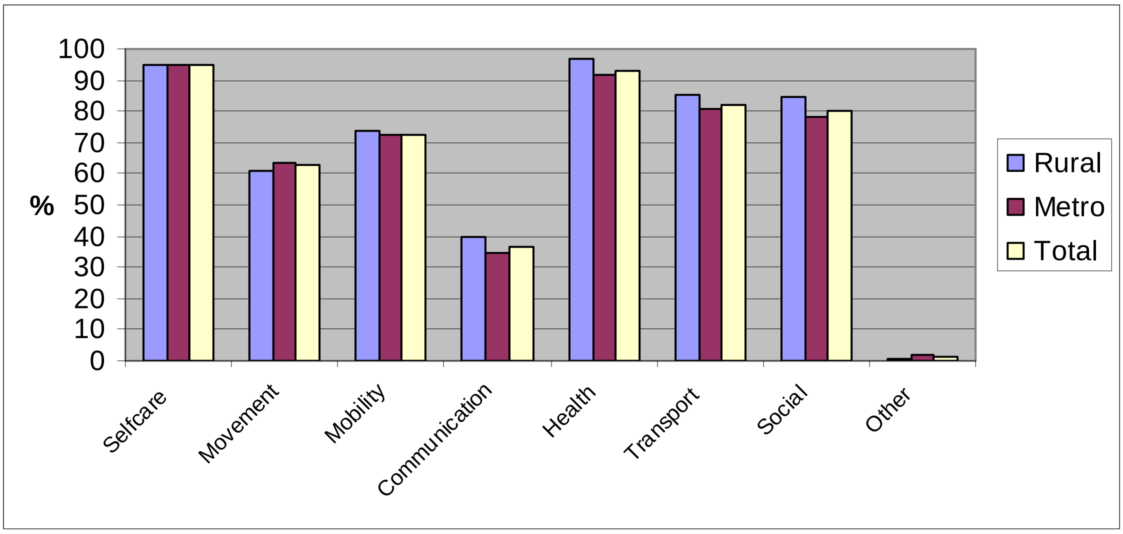
[*] Note that the need for assistance with domestic activities, meals and home maintenance is not recorded for people living in residential care, assistance with these activities is provided as part of the care.

range across teams for self-care was 83.7% to 100.0% of clients, for health 83.8% to 100.0%, for transport 73.5% to 100.0%, and for social participation 65.1% to 97.6%.

Figure 7: Activity limitations (clients living in residential care), Victoria 2004-2005 (%)



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 8 shows the proportion of clients who received formal assistance (or formal and informal assistance) with each activity. Just prior to assessment, most clients were receiving formal assistance with domestic activities (53.9%; range 42.7%–66.9%). Assistance with health tasks (30.5%; range 18.1%–48.8%), meals (29.3%; range 22.6%–47.0%), and/or self-care (26.2%; range 20.3%–40.9%) was also relatively common.[*] Overall, the level of formal assistance prior to assessment was slightly higher in rural than metropolitan areas.

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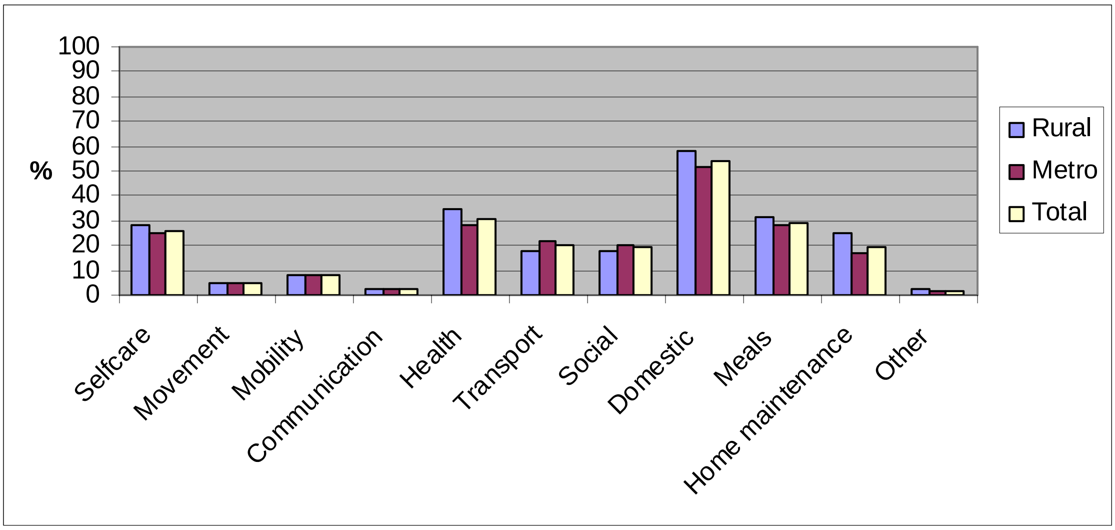
[*] Proportions of assistance are presented differently to other reports. Previously the proportion of formal and informal assistance was calculated only on the sub-group of assessments where the client received assistance; in this report proportions are lower as total complete assessments of clients in the community was used as the denominator.

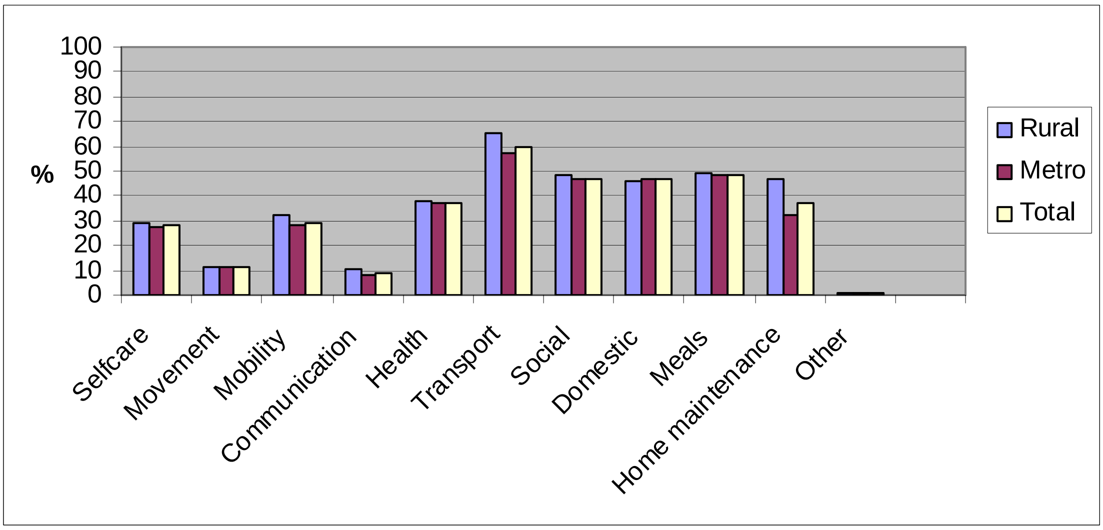
Figure 8: Formal assistance (clients living in the community), Victoria 2004-2005 (%)



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

Figure 9 shows the proportion of clients who received informal assistance (or formal and informal assistance) with each activity. Just prior to assessment, about half of clients received informal assistance with transport (59.7%; range 41.3%–74.8%), meals (48.7%; range 32.3%–68.7%), social participation (47.0%; range 34.4%–70.3%), domestic tasks (46.8%; range 29.7%–66.8%). Informal assistance with home maintenance, health care tasks, mobility and self-care was also relatively common. The level of informal assistance for most activities was higher in rural areas than metropolitan areas.

Figure 9: Informal assistance (clients living in the community), Victoria 2004-2005 (%)



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

There appears to be a considerable degree of complementarity between formal and informal assistance for a number of types of assistance, that is a relatively high level of informal assistance for some activities with a low level of formal assistance. For example, a comparison of Figures 8 and 9 shows that formal assistance with transport, social participation and mobility was relatively low but informal assistance was relatively high for these activities.

Summary: Activity limitations

Overall result:

- The great majority of Victorian ACAS clients living in the community were assessed as needing assistance with domestic activities, meals and transport just prior to their assessment. Assistance with self-care was also relatively common.
- Over two-thirds (68.2%) of clients had a severe or profound core activity restriction.
- Proportionately more clients living in residential care were assessed as needing assistance than those living in the community. Over 80% needed assistance with self-care and health care tasks, and the majority needed assistance with social and community participation, and transport.

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams, for example the need for domestic assistance among clients in the community ranged from 73.0% to 95.7% of clients, meals 59.9% to 85.8%, transport 53.6% to 88.7%, and self-care 42.9% to 66.7%.
- The need for assistance among clients living in residential care ranged from 83.7% to 100.0% for self-care, from 83.8% to 100.0% for health, from 73.5% to 100.0% for transport, and from 65.1% to 97.6% for social participation.

Summary: Assistance with activities

Overall result:

- Just prior to assessment, most clients were receiving formal assistance with domestic activities (53.9%), self-care (26.2%) or health tasks (30.5%).
- The most commonly provided informal assistance was with transport (59.7%), meals (48.7%), social participation (47.0%), mobility (29.3%), and domestic tasks (46.8%).
- There appears to be a considerable degree of complementarity between formal and informal assistance in that there was a greater level of informal assistance for those activities with a low level of formal assistance.

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranged between 42.7% and 66.9%, health tasks between 39.4% and 81.0%, and meals between 22.6% and 47.0%.
- Informal assistance with transport ranged from 41.3% to 74.8%, meals from 32.3% to 68.7%, social participation from 34.4% to 70.3%), and domestic tasks from 29.7% to 66.8%.

Health conditions

Tables 15 and 16 (overleaf) provide a profile of the Health conditions of clients who had a complete assessment. Table 15 provides the proportions of clients with the 12 most common diagnoses, and Table 16 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, arthritis, hypertension and dementia were the most common diagnoses among ACAS clients (Table 15). The most common primary health condition was dementia (19.6%). The prevalence of dementia was slightly lower in rural areas. A comparison between Tables 15 and 16 provides an indication of the relative importance of the health conditions that lead to an assessment and the complexity of client conditions assessed by ACAS. In particular, the part played by dementia in precipitating an assessment. Dementia was not the most common among all listed conditions but was more than twice as frequent compared to other diagnoses reported for the primary health condition.

Table 15: Diagnosed diseases/disorder—all listed (12 most common conditions), Victoria 2004–05 (%)

	Heart %	Arthritis %	Hypertension %	Dementia %	Eye and vision %	CVA %	Diabetes %	Psycho-affective %	CLRD %	Osteoporosis %	Fracture %	Parkinson's %
Rural	43.6	35.4	29.5	24.3	19.1	16.0	16.0	13.6	15.0	10.9	8.8	4.1
Metro	42.1	32.9	32.0	28.5	20.1	17.0	16.1	14.5	13.4	12.0	10.6	4.2
Total	**42.6**	**33.7**	**31.2**	**27.1**	**19.8**	**16.7**	**16.1**	**14.2**	**13.9**	**11.6**	**10.0**	**4.2**

Note: Includes only complete records.

Table 16: Diagnosed diseases/disorder—primary condition listed (12 most common conditions), Victoria 2004–05 (%)

	Dementia %	Arthritis %	CVA %	Heart %	CLRD %	Diabetes %	Fracture %	Psycho-affective %	Parkinson's %	Eye and vision %	Hypertension %	Osteoporosis %
Rural	16.8	10.0	8.1	9.2	5.1	3.6	3.2	3.0	2.9	3.4	2.9	1.9
Metro	21.0	8.7	8.7	8.0	4.2	4.1	3.5	3.5	3.4	3.0	3.2	1.8
Total	**19.6**	**9.1**	**8.5**	**8.4**	**4.5**	**3.9**	**3.4**	**3.3**	**3.3**	**3.1**	**3.1**	**1.8**

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)

Summary: Health conditions

Overall result:

- Overall, heart conditions, arthritis, hypertension and dementia were the most common diagnoses among ACAS clients.
- The most common primary health condition was dementia (19.6%).

Rural metropolitan comparison:

- The prevalence of dementia was slightly lower in rural areas.

Other comments

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

Section 8: Access for special needs groups

Clients from Culturally and linguistically diverse backgrounds

Table 17 shows that 20.1% of all accepted referrals were people of Culturally and Linguistically Diverse (CALD) backgrounds, with a higher proportion in metropolitan than rural areas. An index that compares the proportion of accepted referrals that involve clients from CALD backgrounds with the proportion of CALD people in the target population shows that access of people from CALD backgrounds was close to that expected based on their representation in the 70+ years population. It should also be noted that the proportion of people from CALD backgrounds probably is an underestimate because it is based on counts from the 2001 ABS Census.

Table 17: Clients from CALD background, Victoria 2004–05 (%)

	CALD in population aged 70+ N (2001 Census)	Proportion of target population is CALD (%) [1]	CALD referrals N	Proportion of CALD referrals (%)[2]	Index (proportion of referrals/ proportion of target population) [3]
Rural	12,164	8.1	1,497	8.4	1.04
Metro	84,064	26.2	9,266	26.0	0.99
Total	**96,228**	**20.4**	**10,763**	**20.1**	**0.99**

Note: Includes records with valid codes for country of birth.

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

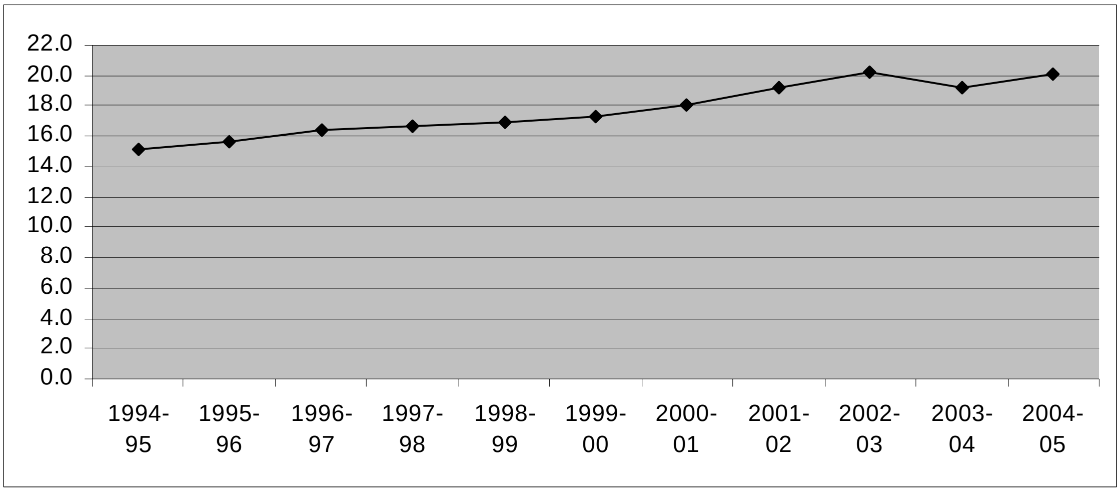
[2] (Referrals with CALD background) * 100/(Total referrals with known country of birth).

[3] Column 5/column 3.

Source: 2001 ABS Census.

Figure 10 (next page) presents the proportion of total assessments of people of CALD backgrounds over the previous ten years (for comparison with previous years only assessments with face-to-face contact were included). In 2004–05 the proportion of assessments of people of CALD backgrounds was higher than the previous year and consistent with a trend of increasing proportions of people of CALD backgrounds.

Figure 10: Assessments of clients of CALD background, Victoria 2004-2005 (%)



Note: Records with face-to-face contact and valid country of birth.

Summary: Clients from CALD backgrounds

Overall result:

- A fifth of Victorian assessments (20.1%) were of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS approximated their representation in the 70+ years population.

Rural metropolitan comparison:

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

Trend:

- The proportion of referrals from people of CALD backgrounds was higher than the previous year and consistent with the overall trend.

Clients from Indigenous backgrounds

Table 18 presents the numbers of referrals of Indigenous clients and the number of referrals with face-to-face contact.

Table 18: Clients from Indigenous background, Victoria 2004–05 (count)

	Indigenous clients (referrals)	Total referrals*	Indigenous clients (referrals with face-to-face contact)	Total (referrals with face-to-face contact)*
Rural	115	17,869	103	16,398
Metro	142	36,442	135	33,925
Total	**257**	**54,311**	**238**	**50,323**

Note: * Records with valid code for Indigenous status.

Table 19 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.

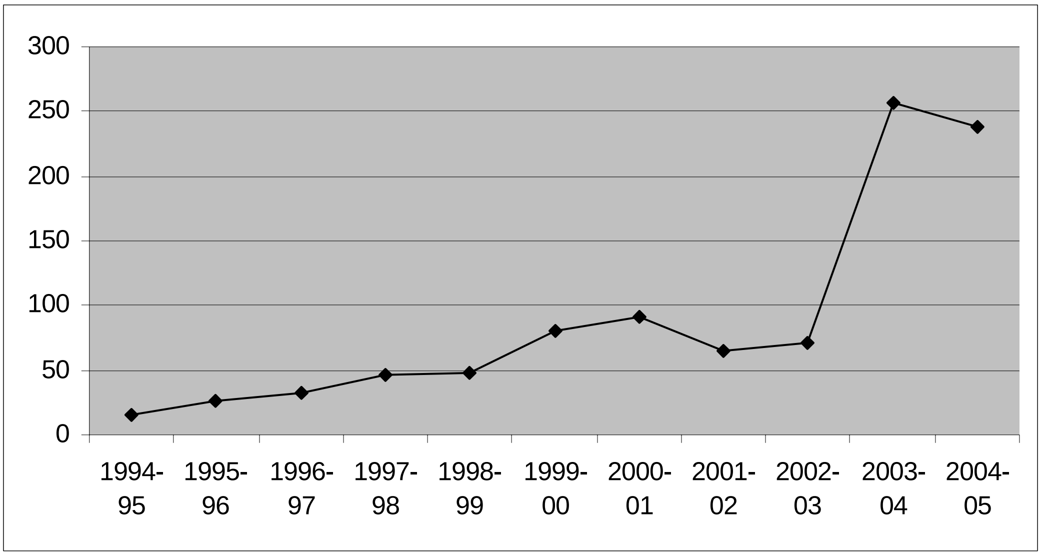
Less than 1% of all referrals involve people from Indigenous backgrounds (Table 19). There were relatively more Indigenous referrals to metropolitan teams than rural teams. It is likely that the size of the Indigenous population is underestimated because the available data is from the 2001 Census counts, and there are large proportions of missing data in the Census on this item. (Also, people who did not state Indigenous status are included in the target population, thus reducing the proportion of people with Indigenous status.)

Table 19: Clients from Indigenous background, Victoria 2004–05

	Indigenous population aged 50+ (2001 Census)	Proportion of target population is Indigenous	Indigenous referrals	Proportion of referrals are Indigenous	Index (proportion of referrals/ proportion of target population)
	N	%	N	%	
Rural	1,427	1.14	115	0.64	0.56
Metro	1,248	0.46	142	0.39	0.85
Total	**2,675**	**0.67**	**257**	**0.47**	**0.71**

Figure 11 charts the numbers of Indigenous clients assessed in Victoria since 1994–95. While the number in 2004–05 (257) was 7.6% lower than 2003–04, Indigenous referrals since the introduction of MDS v2 in early/mid 2003 are much higher than previous years.

Figure 11: Assessments of Indigenous clients, Victoria 1994–05 to 2004–05 (counts)



Note: Referrals with face-to-face contact.

Summary: Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.47% of all referrals involve people from Indigenous backgrounds while 0.67% of the target population are Indigenous.

Rural metropolitan comparison:

- Indigenous referrals to both rural and metropolitan teams were less than expected from the proportion in the population.

Range:

- The proportion of Indigenous to total referrals ranged from 0.2% to 2.5%.

Trend:

- The number of Indigenous clients has increased in most years since 1994–95.
- While the number in 2004–05 was 7.6% lower than 2003–04, Indigenous referrals since the introduction of MDS v2 in early/mid 2003 are much higher than previous years.

Clients with dementia

Table 20 shows that over a quarter of complete assessment of target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) and nearly a fifth of "non-target group" clients were diagnosed with dementia at the time of assessment.* The proportion of target group clients reported with dementia was higher among metropolitan teams than rural teams. There was also variation among the teams. The proportion of non-target group clients with dementia ranged from 8.9% to 26.5%, and the proportion of target group clients ranged from 10.9% to 34.8%.

Table 20: Clients with dementia, Victoria 2004–05 (%)

	"Non-target group" clients with dementia (%)	Target group clients with dementia (%)
Rural	17.7	24.6
Metropolitan	17.6	29.2
Total	**17.6**	**27.7**

Note: Complete assessments only.

Summary: Clients with dementia

Overall result:

- Over a quarter (27.7%) of target group clients (Indigenous aged 50 years and over, and other clients aged 70 years and over) were diagnosed with dementia at the time of assessment.
- 17.6% of non-target group clients were diagnosed with dementia at the time of assessment.

Rural metropolitan comparison:

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

Range:

- The proportion of target group clients with dementia ranged from 10.9% to 34.8%.
- The proportion of non-target group clients with dementia ranged from 8.9% to 26.5%.

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

Clients and carers

Table 21 shows that the great majority of clients (81.1%) had carers, and that the majority of carers were co-resident. The proportion of clients with carers was slightly higher, and non-resident carers were slightly more common, in rural areas than metropolitan areas. These figures were similar to the previous year.

Table 21: Clients and carers, Victoria 2004–05 (%)

	Clients with no carer %	Clients with co-resident carer %	Clients with non-resident carer %	Not known %	Total %
Rural	17.8	42.5	37.6	2.1	100.0
Metropolitan	19.4	45.3	33.1	2.2	100.0
Total	**18.9**	**44.3**	**34.6**	**2.2**	**100.0**

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

Summary: Clients and carers

Overall result:

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

Rural metropolitan comparison:

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

Clients “at risk” of admission to residential care

Clients are defined as being “at risk” of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 years or over (or Indigenous and aged 60 years or over); having a severe or profound core activity restriction (needs assistance with one or more the tasks of self-care, mobility or communication); having dementia; living alone; not having a carer. A multidisciplinary assessment (MDA) is defined as involving more than one profession (all medical practitioners are considered one profession and all nursing professionals one profession). It is acknowledged that one ACAS member may be able to incorporate more than one dimension of care need into their assessment of a client’s care needs.

Table 22 shows that in 2004–05 a tenth of clients living in the community were “at risk” of admission to residential care facility. The proportion “at risk” was higher in rural areas. About 40% of all assessments of people living in the community were multi-disciplinary but this was more likely if the client was assessed by a metropolitan team. Nearly two-thirds of “at risk” clients received a MDA.

Table 22: Clients "at risk" of admission to residential care and given a multi-disciplinary assessment, Victoria 2004–05 (%)

	Community clients	Clients "at risk"		Clients get MDA		Clients "at risk" get MDA	
	n	n	%	n	%	n	%
Rural	14,144	1,215	8.6	5,364	37.9	559	46.0
Metro	28,069	2,864	10.2	15,951	56.8	2,036	71.1
Total	**42,213**	**4,079**	**9.7**	**21,315**	**50.5**	**2,595**	**63.6**

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); having a severe or profound core activity restriction; having dementia; living alone; and having no carer.
The table includes only complete assessments with valid values for the 5 risk factors.
MDA = Multi-disciplinary assessment.

Summary: Client's "at risk"

Overall result:

- Overall, 9.7% of clients living in the community were "at risk" of admission to a residential care facility.
- "At risk" clients were more likely to receive a multidisciplinary assessment than all clients—63.6% of "at risk" clients received a MDS compared with 40.5% of all clients.

Rural metropolitan comparison:

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

RECOMMENDATIONS

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

Recommendations—general

This section of the report examines recommendation patterns for ACAP-delegated services, namely residential care, and CACPs and residential respite.

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 23 shows that nearly two-thirds of clients living in the community at assessment (64.0%) receive a recommendation to continue living in the community. Overall, this was the same in rural and metropolitan areas but there was more variation across the 18 teams—community to community recommendations ranged from 47.8% to 82.1%.

Table 23: Recommended long-term care setting by usual accommodation setting, Victoria 2004–05 (%)

	Community %	Low-level care %	High-level care %	Other/ Missing %	Total %
Clients living in the community at assessment					
Rural	64.0	20.4	14.7	0.8	100.0
Metropolitan	64.0	18.9	16.4	0.8	100.0
Total	64.0	19.4	15.8	0.8	100.0
Clients living in low-level residential care at assessment					
Rural	0.9	17.4	80.7	1.1	100.0
Metropolitan	0.7	15.8	82.8	0.6	100.0
Total	0.8	16.3	82.2	0.7	100.0
Clients living in high-level residential care at assessment					
Rural	4.0	15.2	78.1	2.6	100.0
Metropolitan	7.9	13.4	77.6	1.2	100.0
Total	6.4	14.1	77.8	1.7	100.0
Clients living in other settings (including missing) at assessment					
Rural	45.2	28.1	22.2	4.5	100.0
Metropolitan	38.5	25.1	27.2	9.2	100.0
Total	40.9	26.2	25.4	7.5	100.0

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

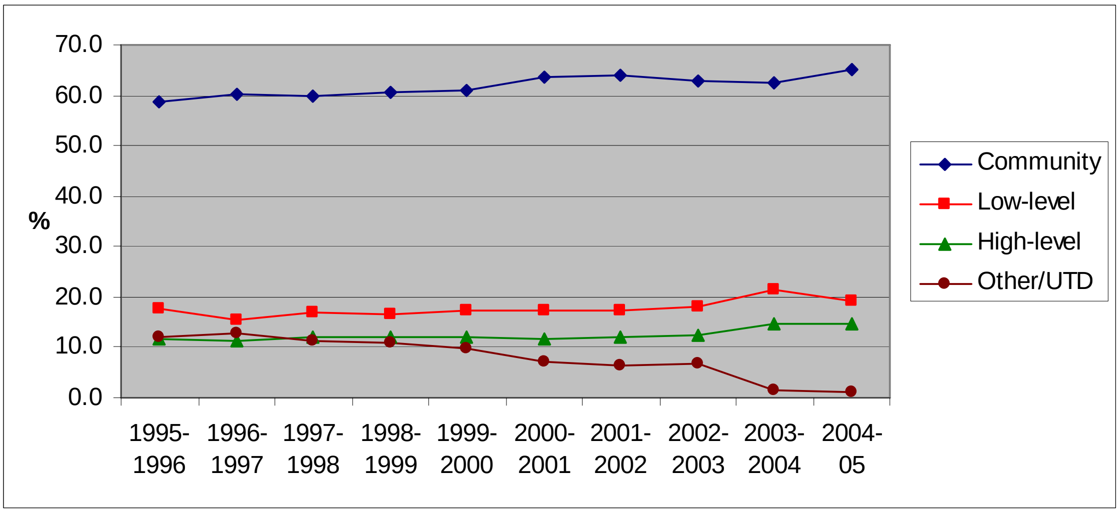
As would be expected, the great majority of clients living in low-level residential care at assessment (82.2%) were recommended to high-level care, with similar proportions in rural and metropolitan areas. Across the teams the proportion of low-level to high-level recommendations ranged from 69.1% to 91.5%.

The great majority of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care in 2004–05. However, a significant minority (14.1%) were recommended to low-level care, and a further 6.4% received community recommendations. (Ranges across the teams are not meaningful because of small cell numbers.)

Under MDS v1 coding, supported residential services were categorised as low-level residential care. In 2004–05, 2.9% of completed assessments were of people living in a SRS, with proportionally more in metropolitan (3.4%) than rural areas (1.9%). The recommendations resulting from these assessments were community 2.2%, supported community accommodation (SRS) 16.4%, low-level care 30.6%, and high-level care 49.6%. If clients living in supported community accommodation are coded with low-level care, the main impact on Table 23 is to increase the proportion of low-level residential care recommendations for those clients usually living in low-level residential care by about 9% and decrease the proportion of low-level to high-level care recommendations by about the same amount. Other outcomes were within 2% of those in Table 23. For clients living in low-level care at assessment the recommendations are as follows: community 1.1% (rural 1.2%; metropolitan 1.1%), low-level care 25.3% (rural 26.5%; metropolitan 24.9%), and high-level care 72.9% (rural 73.4%; metropolitan 72.9%).

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

Figure 12: Recommendations—clients living in the community, Victoria 1994–05 to 2004–05 (%)

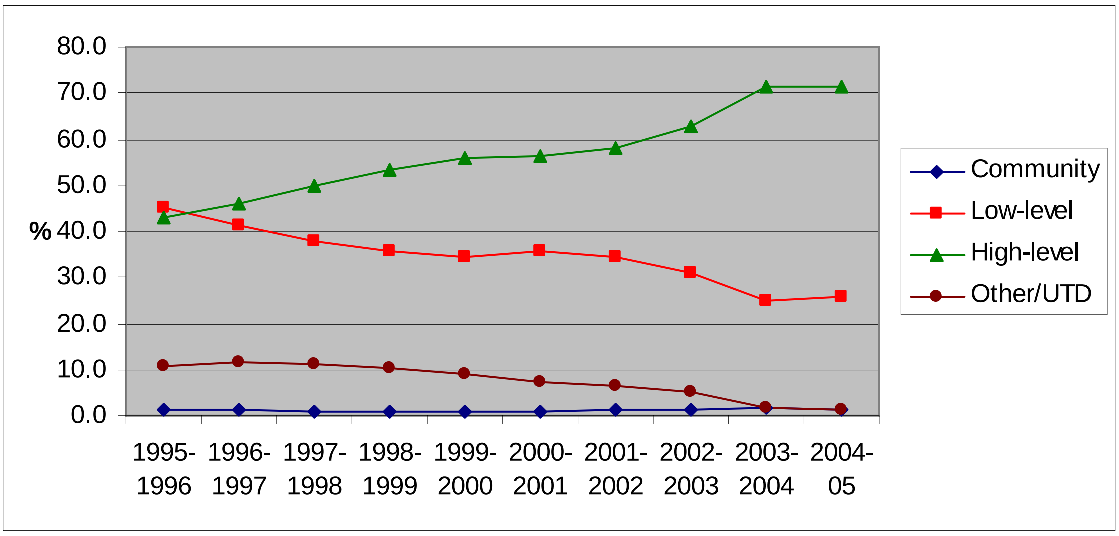


Note: Clients living in the community with a face-to-face assessment date recorded.
Clients living in SRS included in low-level care.

2004–05 saw a return to the long-term trend (reversed between 2001-02 and 2003–04) of an increase in the proportion of community-dwelling clients recommended to remain in the community. There has also been a consistent decrease in the proportion of other/unable to determine category that has accelerated with the introduction of MDSv2.

Since 1995–96, the proportion of clients living in low-level residential care and recommended to high-care has steadily increased, with a corresponding decrease in recommendations to remain in low-level care and in the proportions of other/UTD. In 2004–05 recommendations from low-level care to high-level and to remain in low-level care were similar to the previous year (Figure 13). The proportion of other/unable to determine also continued at its recent low level.

Figure 13: Recommendations—clients living in low-level residential care, Victoria 1994–05 to 2004–05 (%)



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:

- Nearly two-thirds of clients living in the community at assessment (64.0%) received a recommendation to continue living in the community.
- The great majority (82.2%) of clients living in low-level residential care at assessment were recommended to high-level care.
- The great majority (77.8%) of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care.
- However, a significant minority (14.1%) of clients living in high-level care were recommended to low-level care, and a further 6.4% received community recommendations.

Trends:

- 2004–05 saw a return to the long-term trend (reversed between 2001-02 and 2003–04) of an increase in the proportion of community-dwelling clients recommended to remain in the community.
- In 2004–05 the proportion of clients living in low-level residential care and recommended to high-care was similar to the previous year.

Rural metropolitan comparison:

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

Range:

- Across the teams the proportion of community to community recommendations ranged from 47.8% to 82.1%.
- Low-level to high-level recommendations ranged from 69.1% to 91.5%.

Recommendations for CACPs

Of the 27,497 complete assessments resulting in a community recommendation in 2004–05, nearly a third had a recommendations for CACPs—23.0% newly recommended and 9.6% on-going (Table 24). The proportion of newly recommended CACPs recommended was higher by rural than metropolitan teams, whereas an on-going recommendation was more likely from a metropolitan team. Across the teams the proportion of assessments with a CACPs recommendation (new and ongoing) ranged from 18.2% to 49.2%. The proportion of new recommendations ranged from 11.7% to 39.4% of complete assessments with a community recommendation.

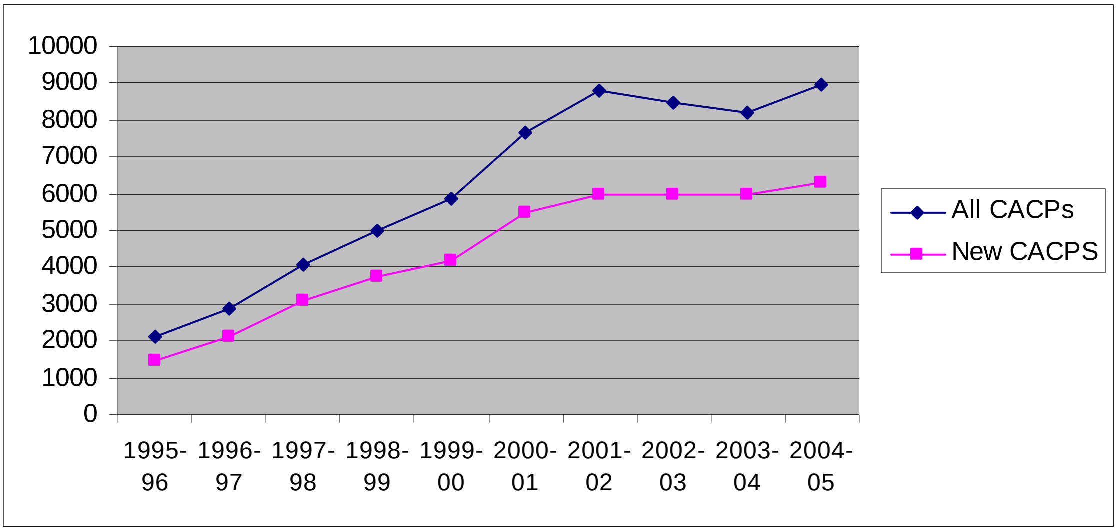
Table 24: Recommended for CACPs, Victoria 2004–05 (%)

	Newly-recommended CACPs		On-going CACPs		Total recommended CACPs		Total recommended to community
	n	%	n	%	n	%	N
Rural	2,274	24.6	721	7.8	2,995	32.4	9,243
Metropolitan	4,040	22.1	1,915	10.5	5,955	32.6	18,254
Total	**6,314**	**23.0**	**2,636**	**9.6**	**8,950**	**32.5**	**27,497**

Note: Community-recommended clients with complete assessments only.
The percentages in this table are the proportions of community-recommended clients who are recommended CACPs.

Figure 14 shows that the number of CACPs recommended increased markedly between 1995–96 and 2001–02. After a decline over the previous three years the number of CACPs recommended increased in 2004–05.

Figure 14: Recommendations for CACPs (clients recommended to the community), Victoria 1994–05 to 2004–05 (count)



Summary: Recommendation for CACPs

Overall result:

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

Trends:

- After a decline over the previous three years (following marked increases since 1995–96) the number of CACPs recommended increased in 2004–05

Rural metropolitan comparison:

- Newly recommended CACPs were relatively higher by rural than metropolitan teams, whereas an on-going recommendation was more likely from a metropolitan team.

Range:

- Across the teams the proportion of assessments with a CACPs recommendation (new and ongoing) ranged from 18.2% to 49.2%.
- The proportion of new recommendations ranged from 11.7% to 39.4%.

Recommendations for respite

Over two-thirds of clients recommended to the community receive a recommendation for residential respite care, and over a tenth a recommendation for non-residential respite. Clients in rural areas were less likely to receive a recommendation for residential respite and more likely to receive a recommendation for non-residential respite. Recommendations for residential respite ranged between 45.8% and 89.1% of clients recommended to the community, and for non-residential respite between 6.4% and 35.5%.

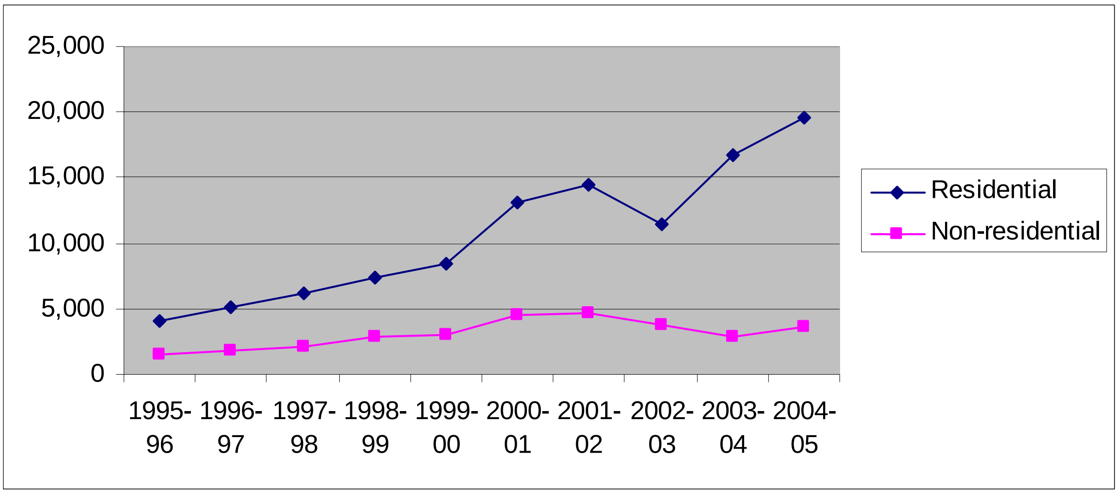
Table 25: Recommended for respite care, Victoria 2004–05 (%)

	Residential respite care		Non-residential respite care		Total recommended to community
	n	%	n	%	N
Rural	6,139	66.4	1,542	16.7	9,243
Metropolitan	13,370	73.2	2,083	11.4	18,254
Total	**19,509**	**70.9**	**3,625**	**13.2**	**27,497**

Note: Community-recommended clients with complete assessments only.
The percentages in this table are the proportions of community-recommended clients who are recommended respite care.

Figure 15 shows that with the exception of 2002–03, the number of clients recommended for residential respite has increased steadily since 1995–96. Recommendations increased again in 2004–05 and were consistent with the overall trend. Recommendations for non-residential respite increased between 1995–96 and 2000–01 and declined between 2001–02 and 2003–04. This year saw an increase over 2003–04.

Figure 15: Recommendations for respite care (clients recommended to the community), Victoria 1994–05 to 2004–05 (count)



Summary: Recommendation for respite

Overall result:

- Over two-thirds of clients (70.9%) recommended to the community receive a recommendation for residential respite and 13.2% a recommendation for non-residential respite.

Trends:

- Consistent with the trend between 1995–96 and 2001–02, recommendations for residential respite increased in 2004–05.
- After several years of decreasing proportions of recommendations for non-residential respite, there was an increase in 2004–05 over the previous year.

Rural metropolitan comparison:

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

Range:

- Recommendations for residential respite ranged between 45.8% and 89.1% of clients recommended to the community.
- For non-residential respite the range was between 6.4% and 35.5%.

Recommendations for particular groups

Recommendations for clients not "at risk"

Clients living in the community are defined as being "at risk" if they have any 4 of the following 5 characteristics: aged 80 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. Table 26 presents recommendations for clients who are not "at risk".

Table 26: Recommendations for clients not "at risk", Victoria 2004–05 (%)

	Community		Low-level care		High-level care		Other/ missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	8,569	66.3	2,407	18.6	1,847	14.3	106	0.8	12,929	100.0
Metropolitan	16,942	67.2	4,350	17.3	3,729	14.8	184	0.7	25,205	100.0
Total	**25,511**	**66.9**	**6,757**	**17.7**	**5,576**	**14.6**	**290**	**0.8**	**38,134**	**100.0**

Note: Table includes assessments of clients living in the community and complete assessments.

Two-thirds of clients not "at risk" were recommended to remain living in the community in 2004–05, nearly a fifth were recommended to low-level residential care and 15% to high-level care. The recommendation pattern was similar in rural and metropolitan areas. The corresponding recommendations for "at risk" clients were community 36.8%, low-level care 35.2%, and high-level care 27.1%. That is, "at risk" clients were twice as likely to receive a residential care recommendation than clients not "at risk".

Previously (under MDS v1 coding) people living in supported community accommodation (SRS) were included in low-level care but in MDS v2 are included in community clients. For the clients not "at risk" living in supported community accommodation at assessment (837), the recommendations were: 2.6% community; 19.6% to supported community accommodation; 36.2% to low-level care; 40.4% to high-level care; and 1.2% to other.

Summary: Recommendation for clients not "at risk"

Overall result:

- Of those clients living in the community not "at risk", 66.9% were recommended to the community and 32.3% to residential care (17.7% to low-care and 14.6% to high-care).
- "At risk" clients were twice as likely to receive a residential care recommendation than clients not "at risk".
- Recommendations for "at risk" clients were community 36.8%, low-level care 35.2%, and high-level care 27.1%.

Rural metropolitan comparison:

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

Recommendations for residential care for non-target group clients

Non-target group clients include Indigenous clients aged 49 years and under and non-Indigenous clients aged 69 years and under at assessment. Table 27 shows that about two-thirds of non-target clients living in the community are recommended to remain in the community, with the other third evenly split between low-level and high-level care recommendations. Compared to all clients living in the community (Table 23), non-target group clients were slightly more likely to be recommended to the community, less likely to be recommended low-level residential care and more likely to be recommended to high-level care. Non-target group clients living in rural areas were more likely to receive a community recommendation than those in metropolitan areas. Across the teams, the proportion of non-target group clients recommended to remain in the community ranged from 41.4% to 88.9%.

Table 27: Recommendations for non-target clients, Victoria 2004–05 (%)

	Community		Low-level care		High-level care		Other / missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	860	69.5	153	12.4	204	16.5	21	1.7	1,238	100.0
Metropolitan	1,489	63.3	385	16.4	436	18.5	43	1.8	2,353	100.0
Total	**2,349**	**65.4**	**538**	**15.0**	**640**	**17.8**	**64**	**1.8**	**3,591**	**100.0**

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.

For the non-target group clients living in supported community accommodation at assessment (176), the recommendations were: 1.7% community; 21.0% to supported community accommodation; 37.5% to low-level care; 36.4% to high-level care; and 3.4% to other.

Summary: Recommendations for non-target clients

Overall result:

- Nearly two-thirds (65.4%) of “younger” clients living in the community are recommended to remain in the community, 15.0% to low-level care and 17.8% to high-level care.
- Compared to all clients living in the community, non-target group clients were slightly more likely to be recommended to the community, less likely to be recommended low-level residential care and more likely to be recommended to high-level care.

Rural metropolitan comparison:

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

Range:

- The proportion of non-target group clients recommended to remain in the community ranged from 41.4% to 88.9%.

Recommendations for clients with dementia

Just under half of clients with dementia living in the community at assessment were recommended to move to residential care (a quarter to low-level and a quarter to high-level).[*] Compared with rural teams, clients assessed by metropolitan teams were less likely to be recommended to low-level residential care and more likely to receive a recommendation for high-level care.

Table 28: Recommendations for clients with dementia, Victoria 2004–05 (%)

	Community		Low-level care		High-level care		Other/ missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	1,692	53.7	781	24.8	665	21.1	15	0.5	3,153	100.0
Metropolitan	3,965	53.5	1,584	21.4	1,826	24.6	37	0.5	7,412	100.0
Total	**5,657**	**53.5**	**2,365**	**22.4**	**2,491**	**23.6**	**52**	**0.5**	**10,565**	**100.0**

Note: Table includes complete assessments of clients with dementia living in the community at assessment.

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 28 above shows that 46.0% of clients with dementia received a recommendation for residential care compared to 35.2% of all clients living in the community (Table 23). Further, a high-level care recommendation is more likely for clients with dementia (23.6%) than all clients living in the community (15.8%).

For the clients with dementia living in supported community accommodation at assessment (569), the recommendations were: 1.4% community; 10.2% to supported community accommodation; 22.8% to low-level care; 65.2% to high-level care; and 0.4% to other.

Summary: Recommendations for clients with dementia

Overall result:

- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 46.0% of clients with dementia received a recommendation for residential care compared to 35.2% of all clients living in the community.
- Further, 23.6% clients with dementia receive a high-level care recommendation compared to 15.8% of all clients living in the community.

Rural metropolitan comparison:

- Clients assessed by metropolitan teams less likely to be recommended to low-level residential care and more likely to receive a recommendation for high-level care than those assessed by rural teams.

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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).

Recommendations for clients living in the community and assessed in hospital

Clients assessed in an acute hospital (i.e., their face-to-face contact setting was acute hospital) but usually living in the community were nearly three times as likely to receive a recommendation for residential care (71.1%) than the community (26.7%), and were more likely to receive a recommendation for high-level care (48.1%) than low-level care (23.0%). Recommendations in rural and metropolitan areas were similar. The recommendation pattern evident in Table 29 was similar across all teams but there was a considerable range in the proportion recommended to the community—from 3.4% to 48.2%. This reflects different policy and practice among the teams on the assessment of clients likely to continue to live in the community.

Table 29: Recommendations for clients assessed in acute hospital and usually living in the community, Victoria 2004–05 (%)

	Community		Low-level care		High-level care		Other/ missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	678	26.5	633	24.7	1,187	46.4	61	2.4	2,559	100.0
Metropolitan	1,236	26.8	1,020	22.1	2,262	49.0	99	2.1	4,617	100.0
Total	**1,914**	**26.7**	**1,653**	**23.0**	**3,449**	**48.1**	**160**	**2.2**	**7,176**	**100.0**

Note: Table includes complete assessments of clients usually living in the community and assessed in an acute hospital.

The association between assessment in an acute hospital and a recommendation for residential care is evident through a comparison of the proportions in Table 29 above and the recommendations for clients living in the community and assessed in the community. Clients usually living in the community and assessed in an acute hospital were more likely to receive a recommendation for residential care—particularly high-level care—than clients living in the community and assessed in the community. For these latter clients the comparable recommendations were: community 78.5%, low-level care 16.2%, and high-level care 4.9%.

For the clients living in supported community accommodation and assessed in an acute hospital (382), the recommendations were: 0.8% community; 3.4% to supported community accommodation; 11.5% to low-level care; 83.2% to high-level care; and 1.0% to other.

Summary: Recommendations for clients assessed in an acute hospital

Overall result:

- Clients usually living in the community and assessed in an acute hospital were more likely to receive a recommendation for residential care (particularly high-level care) than clients living in the community and assessed in another setting.
- 26.7% of community clients assessed in an acute hospital received a recommendation to the community, 23.0% were recommended low-level care and 48.1% high-level care.
- For clients living in the community and assessed in the community the comparable recommendations were: community 78.5%, low-level care 16.2%, and high-level care 4.9%.

Rural metropolitan comparison:

- Recommendations in rural and metropolitan areas were similar.

Range:

- The recommendation pattern was similar across all teams but there was a considerable range in the proportion recommended to the community—from 3.4% to 48.2%.

Percentage "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. 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.

Nearly a fifth (19.1%) of "at risk" target group clients living in the community received a recommendation for a CACP. This means that over half of "at risk" target group clients recommended to the community received a recommendation for a CACP. This was relatively more than the corresponding proportion (32.5%) of all clients recommended to the community who received a CACPs recommendation (Table 24). Across the teams, the proportion recommended a CACP ranged between 5.9% and 44.9%.

Table 30: CACP recommendations for "at risk" target group clients, Victoria 2004–05 (%)

	Community with no CACP %	Community with CACP %	Low-level care %	High-level care %	Other / missing %	Total %
Rural	16.8	20.9	40.1	21.4	0.7	100.0
Metropolitan	15.1	18.3	32.8	33.1	0.7	100.0
Total	**15.6**	**19.1**	**34.9**	**29.7**	**0.7**	**100.0**

Note: Table includes complete assessments of target group clients (aged 70+ years and Indigenous aged 50–69 years) usually living in the community.

Summary: "At risk" target group clients recommended a CACP

Overall result:

- Nearly a fifth of "at risk" target group clients received a recommendation for a CACP.
- Of the "at risk" target group clients recommended to the community, over half (55%) received a recommendation for a package, compared with 32% of all clients recommended to the community.

Rural metropolitan comparison:

- Rural teams recommended a CACP slightly more often than metropolitan teams.

Range:

- The proportion of “at risk” target group clients living in the community who received a recommendation for a CACP ranged from 5.9% to 44.9%.

CONCLUSION

This is the first Annual Report to analyse MDS v2 data only (though MDS v1 data comprised a very small proportion of the data in 2003–04). With the additional information recorded in MDS v2, further historical comparisons and trends can be analysed.

Victorian data quality in 2004–05 was reasonably good. The National Data Repository aims for a missing or error rate of less than 1%. For records coded assessment complete, and excluding date items, this level was achieved in Victoria for over half of the items. However, some teams reported high missing rates for some items, in particular, priority category, the carer items, Indigenous status and DVA entitlement. There were also problems with date sequencing, particularly with the Delegation date preceding the Assessment end date. However, changes to the ACE software introduced in 2005 are helping to improve this problem. There also were indications that for some teams the coding of Priority category (particularly in hospitals) reflected the requirements of the facility rather than client need.

In contrast to the recent trend, timeliness of assessment improved in 2004–05. The aggregated time between referral and end of assessment was lower than the previous year in both hospital and non-hospital settings. Response times also improved with the time between referral and first face-to-face contact lower than in 2003–04 in all settings. The proportion of referrals seen “on time” was 91%, an increase of 2% over the previous year.

Inter-team variation across most areas continued. For example, the proportion of referrals only ranged from 0% to 12.9%, and the proportion of completed assessments from 7.3% to 42.4% and delegated assessments ranged from 49.6% to 90.4%. Both rural and metropolitan teams reported a considerable range in response times in all settings, s—trimmed means ranged from 0.0 to 8.2 calendar days in acute settings; 0.0 to 7.2 in other inpatient settings; 1.8 to 13.9 in residential care; and 3.3 to 21.0 calendar days in community settings. These variations are the result of a number of factors, including team policy and practice, recording practice, and the availability of services such as rehabilitation.

Although assessment numbers increased in most years between 1994–05 and 2002–03, the present year continues a recent trend of declining numbers. Total reported referrals were 0.7% lower than 2003–04, and the number of completed assessments was 2.4% lower. Victorian teams also reported 2.6% lower “MDS v1 comparable” assessments (those with face-to-face contact) than in 2003–04. Lower numbers may be due the introduction of MDS v2 and/or a change in criteria for what is included in the MDS. Anecdotal evidence also suggests that a return to “core business” by teams may have contributed to reduced assessment numbers. Future years will show whether this is a longer-term trend.

To account for assessment activity in hospitals no longer reported in the national ACAP MDS, Victoria also measures ACAS consultations in hospitals through the Victorian Admitted Episode Data (VAED). Although showing a more stable historical trend, total assessment activity (face-to-face assessments and consultations recorded in the VAED) in 2004–05 was also lower than in 2003–04 (by 2.7%)

Assessment rates have steadily decreased in Victoria since 1995–96 and the 2004–05 rate of 107 assessments per 1000 target population was consistent with this trend (Lincoln Centre for Ageing and Community Care Research, 2004). Access to the ACAP by people of CALD background improved and was comparable to their representation in the population. While access of Indigenous people was higher among rural teams, it was lower overall than their representation, and down on the previous year.

One factor that may be contributing to the lower assessment numbers was the increase in client dependency in 2004–05 compared with 2003–04. The proportion of clients aged 80 years and over continued to increase and this was reflected in an increase in the proportion of clients reported with activity limitations. The proportion of clients with an activity limitation was higher this year compared to last for all 10 activities. In particular, the proportion with one or more core activity limitations increased by 3.2%. The proportion of clients reported with the most common health conditions, particularly dementia, was also higher than in 2003–04. Given these increases in client complexity the increase in the proportion of clients given community recommendations is a positive outcome for clients and shows that the ACAP is continuing to deliver on one of its most important objectives—assisting older people to continue living in the community.

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