Australian Government

Department of Health and Ageing

Aged Care Assessment Program

Minimum Data Set

Annual Report

Victoria
2005–2006

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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This report has been prepared as an aid for program managers in the Aged Care Assessment Program. It has been designed for use within the Australian Department of Health and Ageing and State and Territory health departments.
It describes the content of final datasets for the year 1 July 2005 to 30 June 2006 from Victorian ACASs. Care should be taken not to interpret the data contained in this report out of context.

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ABBREVIATIONS

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
ACAP	Aged Care Assessment Program
ACAS	Aged Care Assessment Service
ACAT	Aged Care Assessment Team
CACP	Community Aged Care Package
CALD	Culturally and Linguistically Diverse
DVA	Department of Veterans’ Affairs
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

This Annual Report analyses records with assessment end dates from July 1 2005 to June 30 2006, and is the second to comprise all MDS v2 data.

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

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.

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.

Summary of MDS data analysis

Assessment numbers and rates

Overall result:

- The total number of records reported in Victoria in 2005–06 was 55,716, including 50,403 (90.5% of the total) with face-to-face contact.

- Of the total records, 5.0% were referrals only, 9.1% were other incompletes, 15.7% were completed assessments (but not delegated), and 70.2% were delegated assessments.
- Across Victoria, 92.2% of completed assessments were of people in the target population. The overall assessment rate was 88.2 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 100.8 per 1000 target population.

Trends:

- Total referrals and completed assessment numbers were higher than in 2004–05—by 0.2% and 1.5% respectively.
- However, the number of assessments with face-to-face contact was 1.8% lower than the previous year—continuing a recent trend.
- Total assessment activity (face-to-face assessments and consultations recorded in the VAED) was 0.2% higher than in 2004–05 and showed a more stable historical trend.
- The proportion of target group assessments has increased from 87.1% in 1995–96 to the present 92.2%.

Rural metropolitan and inter-team comparison:

- Approximately a third (31.2%) 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 0.1% to 16.5%; and the proportion of complete/delegated assessments from 68.3% to 98.5%.

Reason for ending assessment

Overall result:

- The great majority of recorded assessments (85.8%) were completed or delegated.
- The most common reasons for incomplete assessments were the client choosing to withdraw (5.4%) and unstable functional status (3.1%).

Timeliness

Overall result:

- Response times to referrals varied considerably between hospital and non-hospital settings.
- On average (trimmed mean), the time from referral to first face-to-face contact took 2.0 calendar days in hospital settings and 20.0 calendar days in non-hospital settings.

- The average (trimmed mean) time from referral to end of assessment took 4.8 calendar days in hospital settings and 22.8 calendar days in non-hospital settings.
- Compared with the previous year, the time from referral to end of assessment increased in both hospital (4.8 days c.f. 4.4 days in 2004–05) and non-hospital settings (22.8 days c.f. 20.6 days in 2004–05).
- Victorian ACAS responded (referral to first intervention) to half of the referrals in hospital settings within one calendar day (median) and 90% of referrals within a week. In non-hospital settings the median response was 10 calendar days with 90% of referrals within 36 days. The respective trimmed means for hospital and non-hospital settings were 1.4 and 13.2 calendar days.
- From first intervention to first face-to-face date took, on average (trimmed mean), a further 0.6 days in hospital settings and 6.8 days in non-hospital settings.
- First face-to-face date to end of assessment date took, on average (trimmed mean), 2.8 calendar days in both hospital and non-hospital settings.
- For those assessments that went on to delegation, this took on average a further 2.8 days in hospital settings and 2.3 days in non-hospital settings.
- Overall, the great majority of both Priority 1 and Priority 2 referrals were seen "on time" (i.e., within 2 calendar days, and 14 calendar days respectively). In hospital settings 89.5% of Priority 1 and 83.0% of Priority 2 referrals were seen "on time"; in non-hospital settings the corresponding figures were 98.4% and 88.7%.

Trends:

- Further increases in the time taken to respond to a request for service, and the assessment process in 2005–06 were consistent with the long-term trend.
- In the period from 1999–00 to 2005–06 the time from referral date to face-to-face assessment date has increased from 1.7 to 2.0 calendar days in hospital settings, and from 11.8 to 20.0 calendar days in non-hospital settings.
- Maintaining the trend over the previous three years, the proportion of people seen "on time" in 2005–06 improved slightly compared with the previous year.

Rural metropolitan comparison:

- Response times in hospitals were shorter for metropolitan teams than rural teams.
- The proportion seen "on time" was higher in metropolitan than rural areas, particularly in non-hospital settings.

Range across teams:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.3 to 7.9 calendar days; non-hospital settings 5.5 to 23.7 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.4 to 11.3 calendar days; non-hospital settings 8.6 to 40.2 days.
- Response times from referral to end of assessment date: hospital settings, trimmed mean 1.4 to 17.7 calendar days; non-hospital settings 9.2 to 46.6 days.

- The proportion seen "on time" for Priority 1 ranged between 66.7% and 100.0% in hospital settings, and between 62.5% and 93.9% in non-hospital settings; and Priority 2 between 91.2% and 100.0% in hospital settings, and between 81.5% and 96.7% in non-hospital settings.

Location at assessment

Overall result:

- Nearly two-thirds of Victorian clients (65.0%) were assessed in a private residence/other community setting, 19.9% took place in acute hospitals, 8.3% in other inpatient settings and 6.4% in residential care.

Trend:

- A further decrease in the proportion of clients assessed this year in acute hospital/other inpatient settings in Victoria to the lowest recorded (28.2%).

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 12.5% to 46.1%.

Assessor profession

Overall result:

- The majority of assessments with face-to-face contact recorded (53.4%) were multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (69.5%).

Age of clients

Overall result:

- Two-thirds of clients accepted as referrals to Victorian ACAS were aged 80 years and over.
- Clients aged under 70 years comprised 8.1% of all referrals.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 66.7%.
- Since 1994–95 the proportion of assessments of clients aged under 70 years has decreased from 15.5% to 8.1% of total referrals.

Rural metropolitan comparison:

- Similar age distribution in rural and metropolitan areas.

Accommodation setting

Overall result:

- The great majority of Victorian clients lived in the community at assessment (private residence 80.7% or other community accommodation 9.5%).
- 8.2% lived in residential care (7.2% in low-level care; 1.0% 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 (84.0%) compared with metro areas (79.1%).
- Retirement village and supported community accommodation was relatively more common in metro areas.
- Similar proportions of clients in residential care.

Range across teams:

- The proportion of clients living in the community ranged from 86.9% to 92.5%.
- The proportion of clients living in low-level residential care ranged from 4.1% to 9.9%, and in high-level care from 0.3% to 1.7%.

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 (69.0%) of clients living in the community had a severe or profound core activity restriction at assessment.
- Non-target group clients were more likely to have a severe or profound core activity restriction (76.5%) than target group clients (68.4%).
- Proportionately more clients living in residential care were assessed as needing assistance than those living in the community. Over 90% needed assistance with self-care and health care tasks, and over 80% needed assistance with social and community participation, and transport.

Trends:

- In 2005–06 there was a further (small) increase (to 68.4%) in the proportion of target group clients living in the community with a severe or profound activity limitation at assessment (in 2004–05 it was 68.2% and in 2003–04 it was 65.0%).
- There was also a further increase (to 76.5%) in the proportion of non-target group clients living in the community with a severe or profound activity limitation at assessment (from 75.1% in 2004–05 and 66.9% in 2003–04).

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams in the proportion needing assistance at assessment, for example the need for assistance with domestic tasks among clients in the community ranged from 85.9% to 95.0%, meals from 69.1% to 85.4% of clients, transport 64.4% to 91.2%, and self-care 46.2% to 70.5%.
- The need for assistance among clients living in residential care ranged from 92.2% to 98.6% for self-care, from 85.9% to 100.0% for health, from 69.5% to 95.1% for transport, and from 67.1% to 95.1% for social participation.

Assistance with activities

Overall result:

- Just prior to assessment, the most common formal assistance was with domestic activities (36.9%), health care tasks (21.7%), meals (20.5%) and self-care (17.0%).
- The most commonly provided informal assistance was with transport (51.7%), meals (44.0%), social participation (41.6%), home maintenance (36.2%), and domestic tasks (30.3%).
- A small minority of clients (5.0%) received no assistance at assessment.

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranged between 44.5% and 63.7%, health tasks between 20.0% and 47.8%, and meals between 23.3% and 41.7%.
- Informal assistance with transport ranged from 43.4% to 77.5%, social participation from 32.5% to 73.7%, meals from 39.5% to 66.7%, and domestic tasks from 34.4% to 69.1%.

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 (19.8%).

Trends:

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

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 (21.0%) were of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS was lower than their representation in the target population.

Trends:

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

Rural metropolitan comparison:

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

Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.37% of all referrals involve people from Indigenous backgrounds while 0.70% of the target population are Indigenous.

Trends:

- The number of Indigenous clients has increased in most years since 1995–96 but has declined in the past two years.
- The number of Indigenous referrals in 2005–06 was 203, 21.0% fewer than the previous year.

Rural metropolitan comparison:

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

Range:

- The proportion of Indigenous to total referrals ranged from 0.0% to 1.8% across Victorian teams.

Clients with dementia

Overall result:

- Over a quarter (28.1%) 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.
- 19.2% of non-target group clients were diagnosed with dementia at the time of assessment.

Trends:

- A slight increase in the proportion of target group clients with dementia—28.1% in 2005–06 c.f. 27.7% in 2004–05 and 27.9% in 2003–04.

Rural metropolitan comparison:

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

Range:

- The proportion of target group clients with dementia ranged from 15.7% to 33.5%.
- The proportion of non-target group clients with dementia ranged from 11.2% to 26.1%.

Clients and carers

Overall result:

- The great majority of clients (81.3%) had carers.
- The majority of carers were co-resident.

Rural metropolitan comparison:

- Overall, the proportion of clients with carers was similar in rural and metropolitan areas.
- Co-resident carers were relatively more common in metropolitan areas, while non-resident carers were relatively more common in rural areas.

Client's "at risk"

Overall result:

- Overall, 10.1% of clients living in the community were "at risk" of admission to a residential care facility.
- "At risk" clients were more likely to receive a multi-disciplinary assessment than all clients—63.6% of "at risk" clients received a MDA compared with 53.5% of all clients living in the community.

Trends:

- The proportion of assessments of clients living in the community “at risk” of admission to a residential care facility has increased in the past three years (2003–04 9.1%; 2004–05 9.7%; 2005–06 10.1%).

Rural metropolitan comparison:

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

Recommendations for long-term care

Overall result:

- Nearly two-thirds of clients living in the community at assessment (65.6%) received a recommendation to continue living in the community.
- The great majority (83.6%) of clients living in low-level residential care at assessment were recommended to high-level care.
- The great majority (84.2%) of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care.
- However, a significant minority (9.9%) of clients living in high-level care were recommended to low-level care, and a further 4.5% received community recommendations.

Trends:

- 2005–06 continued 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 2005–06 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 52.3% to 84.9%.
- Low-level to high-level recommendations ranged from 67.5% to 92.0%.

Recommendations for government-funded care programs

Overall result:

- Of the assessments with a long-term care recommendation to the community, 54.0% had a recommendation for HACC service(s), 31.7% for a CACP, 17.5% to the National Respite for Carers Program, and 6% an EACH package.

- Over a tenth (10.6%) of assessments with a long-term care recommendation to the community had no recommendation for a government program (excludes respite care).

Rural metropolitan comparison:

- With the exception of the NRCP, average recommendations by rural and metropolitan teams were similar.

Range:

- There was considerable variation among the teams in recommendations for government-funded services, particularly for NRCP.
- HACC ranged between 40.0% and 75.9%; CACP between 19.7% and 45.5%; EACH package between 3.3% and 10.8%, and NRCP between 3.9% and 57.1% of complete assessments.

Recommendation for CACPs

Overall result:

- CACPs were recommended in a third of completed assessments of people recommended to the community—on-going 9.9% and new 21.7%.

Trends:

- Numbers of new and on-going CACPs in 2005–06 were similar to the previous year.

Rural metropolitan comparison:

- Newly recommended CACPs were more likely from 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 an on-going CACP recommendation ranged from 5.2% to 13.3%.
- The proportion of new recommendations ranged from 12.3% to 38.2%.

Recommendation for respite

Overall result:

- Nearly three-quarters of clients (72.0%) recommended to the community received a recommendation for residential respite in 2005–06, and 13.0% a recommendation for non-residential respite.

Trends:

- Consistent with the overall trend, recommendations for residential respite increased again in 2005–06.
- The number of recommendations for non-residential respite increased by 194 (5%) 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 45.0% and 92.4% of clients recommended to the community.
- For non-residential respite the range was between 2.2% and 31.0%.

Recommendation for clients not "at risk"

Overall result:

- The great majority of complete ACAS assessments were of clients (89.9%) not "at risk" of admission to residential care.
- Of those clients living in the community not "at risk", 68.9% were recommended to the community and 30.3% to residential care (16.1% to low-care and 14.2% to high-care).
- Clients not "at risk" were much less likely to receive a residential care recommendation than "at risk" clients.

Trends:

- Community recommendations for clients not "at risk" have increased in the past three years (2003–04 63.3%; 2004–05 66.9%; 2005–06 68.9%).

Rural metropolitan comparison:

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

Recommendations for "non-target" clients

Overall result:

- Two-thirds (66.7%) of "non-target" clients living in the community are recommended to remain in the community, 14.8% to low-level care and 17.2% to high-level care.
- Compared to all clients living in the community, the "non-target group" 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.

Trends:

- The proportion of "non-target" clients recommended to residential care was similar to the past three years (2003–04 65.9%; 2004–05 65.4%; 2005–06 66.7%).

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:

- There was a considerable range across the teams in the recommendations for "non-target group" clients: community ranged from 47.8% to 84.3%; low-level care from 4.3% to 31.3%; and high-level care from 9.9% to 29.6%.

Recommendations for clients with dementia

Overall result:

- The presence of dementia increases the likelihood of a residential care recommendation, particularly for high-level care.
- 44.4% of clients with dementia received a recommendation for residential care compared to 33.6% of all clients living in the community.
- Further, 23.4% clients with dementia receive a high-level care recommendation compared to 15.7% of all clients living in the community.

Trends:

- Increases each year since 2003–04 (49.0%) in the proportion of clients with dementia given a community recommendation to the present 55.2% (an increase of 1.7% compared with 2004–05).

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.

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.
- 24.7% of community clients assessed in an acute hospital received a recommendation to the community, 23.2% were recommended low-level care and 49.4% high-level care.
- For clients living in the community and assessed in the community the comparable recommendations were: community 80.7%, low-level care 14.5%, and high-level care 4.4%.

Trends:

- The proportion of clients assessed in hospital and given a community recommendation decreased by 2.0% compared with the previous year.

- The decrease in community recommendations from hospital assessments is consistent with the long-term trend; since 1995–96 the proportion has steadily decreased from 42.0% to the present 24.7%.
- There was a continuation of the long-term trend for decreasing proportions, and numbers, of assessments in acute hospitals.

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 1.9% to 40.7%.

"At risk" target group clients recommended a CACP

Overall result:

- Under 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, just under a half (49.3%) received a recommendation for a package, compared with 31.6% of all clients recommended to the community.

Trends:

- The proportion of "at risk" target group clients given a recommendation for a CACP was 0.3% higher than in 2004–05 but below the 19.1% reported in 2003–04).

Rural metropolitan comparison:

- Rural teams recommended a CACP 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 5.0% to 33.3%.

Conclusion

Assessment numbers

In 2005–06 there was a small increase (0.2%) in total referrals, and completed assessments (1.5%) over the previous year but Victorian teams reported 1.8% fewer assessments with face-to-face contact (i.e., MDS v1 comparable) than in 2004–05. However, if assessment activity in hospitals no longer reported in the national ACAP MDS (Victorian Admitted Episode Data on ACAS consultations in hospitals) is included, total assessment activity (face-to-face assessments and consultations recorded in the VAED) was slightly higher (0.2%) than in 2004–05. The decrease in assessments with face-to-face contact continues a trend evident from 2002–03, and appears to be due the introduction of MDS v2 and/or a change in criteria for what is included in the MDS. The historical trend is more stable if hospital consultations are included. Anecdotal evidence also suggests that a return to "core business" by teams may also be contributing to the continuing decline in face-to-face assessment numbers.

Access to assessment

Although total referrals and completed assessments were higher in 2005–06 than the previous year, assessment rates have steadily decreased in Victoria. The 2005–06 rates of 88.2 completed assessments and 100.8 assessments with face-to-face contact per 1000 target population were both lower than those for 2004–05 (89.1 and 107.0 respectively) and consistent with the longer-term trend (Lincoln Centre for Ageing and Community Care Research, 2006). However, the lower assessment rates in 2005–06 were partly attributable to a change in the target population figures used. Previous reports have used Estimated Resident Population data which is available only for the previous year. This report is based on population projections for the 2005–06 year.

Although assessment rates have declined, the ACAS in Victoria has become more focused on its target population. The proportion of target group (people aged 70 years and over and Indigenous people 50 to 69 years) assessments has steadily increased from 87.1% in 1995–06 to the present 91.9%.

Access to the ACAP by people of CALD background in 2005–06 was higher than the previous year. Referrals of people from CALD background were 4.3% higher than in 2004–05 and this increase was consistent with the longer term trend. However, the proportion of CALD to total referrals was below their representation in the population. As with overall assessment rates, this low representation was partly due to the change to projections for the target population.

Access to the ACAS of Indigenous people was lower than the previous year (by 54, a drop of 21.0%), particularly in metropolitan areas, and well below their representation in the target population. This continues a recent trend. Assessments of Indigenous people have declined since 2003–04 when there was a considerable increase over previous years.

Access to the ACAS by two particular groups, people with a severe or core activity restriction and people with dementia, increased slightly compared to the previous year. The increase in the proportion of people with a severe or core activity limitation in the target population continued the upward trend evident since this indicator became part of the MDS in 2002–03.

Timeliness of assessment

On average, Victorian ACAS take about a day and a half to respond to a need for a comprehensive assessment (referral to first intervention 5% trimmed mean) in acute hospital/other inpatient settings, and nearly two weeks in non-hospital settings (residential care/community). To complete the assessment process (first intervention to end of assessment) took an average of a further 3 days in hospital settings and 10 days in non-hospital settings.

Compared with the previous year, the time taken to respond to a request for service and the assessment process increased in 2005–06. The time between referral and first intervention, and from first intervention to the end of assessment increased in both hospital and non-hospital settings. These increases were consistent with the long-term trend of increasing assessment times. In the period from 1999–00 to 2005–06 the time from referral date to face-to-face assessment date (5% trimmed mean) has increased from 1.7 to 2.0 calendar days in hospital settings, and from 11.8 to 20.0 calendar days in non-hospital settings. Despite this trend, the proportion of people seen “on time” (First intervention within 48 hours for clients categorised as Priority 1 and 3–14 calendar days for Priority 2) has been maintained over the previous three years, and in 2005–06 improved slightly compared to the previous year. The proportion seen “on time” for Priority 1 clients was 89.6% in hospital settings and 83.2% in non-hospital settings; and for Priority 2 the corresponding figures were 98.6% and 88.7%. The higher proportions seen “on time” in hospital settings reflect the agreements many teams have with their auspice to respond to requests for assessment within a specified time (usually 48 hours).

Client characteristics

The complexity of clients continued to increase (albeit slightly) compared with previous years. The proportion of clients aged 80 years and over continued to increase (by 1.3% compared with 2004–05) and this was reflected in an increase in the proportion of clients reported with activity limitations and health conditions. The proportion of clients with an activity limitation was higher this year compared to last for all 8 of the 10 activities, and the proportion with no activity limitation decreased from 1.6% to 1.3%. The proportion of clients with one or more core activity limitation increased by 0.8% over the previous year. Relatively more clients were reported with many of the common health conditions, including dementia, compared to 2004–05. This continuing increase in client dependency may be a factor contributing to the lower assessment numbers compared to previous years.

Recommendations

The great majority of clients (90.1%) live in a community setting at the time of assessment, and 65.6% are recommended to continue living in the community, a small increase (1.6%) on the previous year. This increase is consistent with the long-term trend of increased proportions of community to community recommendations, from 58.9% to the present 65.5%. Over the same period, community recommendations for clients assessed in acute hospitals have decreased from 42.8% in 1995–96 to 24.7% in 2005–06. The decrease in the proportion of clients assessed in an acute hospital and given a community recommendation is off-set to some extent by the decreasing proportions, and numbers, of clients assessed in acute hospital (e.g., 9,833 community-dwelling assessments (23.2% of records with face-to-face contact) were assessed in hospital in 2003–04, compared with 7,066 assessments in 2005–06 (19.9% of records with face-to-face contact). This decrease indicates that assessments in acute hospitals are increasingly targeting people who need approval for residential care.

Recommendations of CACP for target group clients “at risk” of admission to residential care (those with any 4 of the following 5 characteristics: aged 80 years or over, or Indigenous and aged 60 years or over; having a severe or profound core activity restriction (needs assistance with one or more the tasks of self-care, mobility or communication)); having dementia; living alone; not having a carer) increased in 2005–06 by 0.3% over the previous year but were below the 19.1% reported in 2003–04. Long-term community recommendations for clients with dementia living in the community at assessment increased again in 2005–06 to 55.2%, an increase of 1.7% over the previous year.

Range across teams

As in previous years, there was considerable inter-team variation in assessment numbers, timeliness and recommendations. Variability in policy and practice (particularly intake procedures), recording practice, and the availability of services (particularly rehabilitation), impact on the assessment profile of teams. For example, the proportion of referrals that do not proceed further ranged from 0.1% to 16.5 %, and the proportion of completed (but not delegated) assessments from 5.9% to 42.4% and delegated assessments ranged from 43.4% to 88.8%. Taken together, complete and delegated assessments showed less variability (range 68.3% to 98.5%).

While there was a relatively narrow range in the proportion of completed assessments to all assessments (88.9% to 94.2%) across the teams, the rate of completed target group assessments per 1000 target population varied considerably (71.2 to 158.3). The high rates are due to local factors, for example, a metropolitan team with a relatively small catchment based at a hospital that draws people from a much wider area. However, 6 of the 18 teams reported rates between 70 and 80, and these relatively low rates may be due to a number of factors that vary from team to team.

Both rural and metropolitan teams reported a considerable range in timeliness in all settings. Response times (referral to face-to-face contact) ranged from 0.4 to 11.3 calendar days in hospital settings and from 8.6 to 40.2 calendar days in non-hospital settings (trimmed means). The assessment process (referral to end of assessment) ranged from 1.4 to 17.7 calendar days in hospital settings, and from 9.2 to 46.6 calendar days in non-hospital settings (trimmed means).

The outcomes of assessment (recommendations) also varied considerably across the teams. For example, the proportion of people living in the community and given a long-term care recommendations to the community ranged from 52.3% to 84.9%; and the proportion living in low-level care and recommended high-level care ranged from 67.5% to 92.0%.

Data quality

Victorian data quality in 2005–06 was good and there were improvements compared with the previous year. The National Data Repository aims for a missing or error rate of less than 1%. For records with face-to-face contact, and excluding date items, this level was achieved in Victoria for most items. Items with an error rate of more than 1% were: country of birth, Indigenous status, DVA entitlement, assistance with activities and respite care (use of and recommended). The error rate for all records in coding priority category was high (4.2%) because a few teams did not code it until there was face-to-face contact, when in almost all instances it should be coded as part of the intake process. The error rate for records with face-to-face contact was 0.3%. 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. The error rate for country of birth was 3.7% and due to a few teams with very high rates because of difficulties in linking with their hospital system. The error rates reported for the assistance with activities and respite care items were due in part to incorrect coding of “Not applicable”.

ACAP MINIMUM DATA SET AND PROGRAM EVALUATION

This Annual Report utilises records submitted to the Victorian Evaluation Unit with Assessment end dates between 1st July 2005 and 30th June 2006, and includes updated data from all four quarters of 2005–2006. With the exception of one section, the report uses accepted referrals or assessments (not individuals assessed), and most analyses are based on complete assessments (i.e., Reason for ending assessment is coded 1 = Assessment complete). In sections that compare current records with previous Victorian reports, an MDS v2 record is considered an assessment if there is a First Face-to-face Contact Date. This report 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, it also includes some trend analyses. Further information on the Aged Care Assessment Program, and the Minimum Data Set Version 2 can be found in Appendix 2.

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 2005-2006 a total of 55,716 records (rural 17,934; metropolitan 37,421) were submitted to the Evaluation Unit. Of these 50,403 (90.5%) included face-to-face contact and can be compared with MDSv1 data in previous years. Figure 1 on the next page presents the numbers and proportions of each of the levels of the total records submitted. [*]

Across Victoria the great majority (85.9%) of all referrals result in a recommended long-term living arrangement (completed or delegated assessments). Figure 1 shows that a relatively small proportion of all assessments (5.0%) go no further than the referral stage, 5.9% go beyond referral but don’t involve a comprehensive assessment, and 3.2% involve a comprehensive assessment with no resultant recommendation. The great majority of this latter group are referred to rehabilitation or further treatment.

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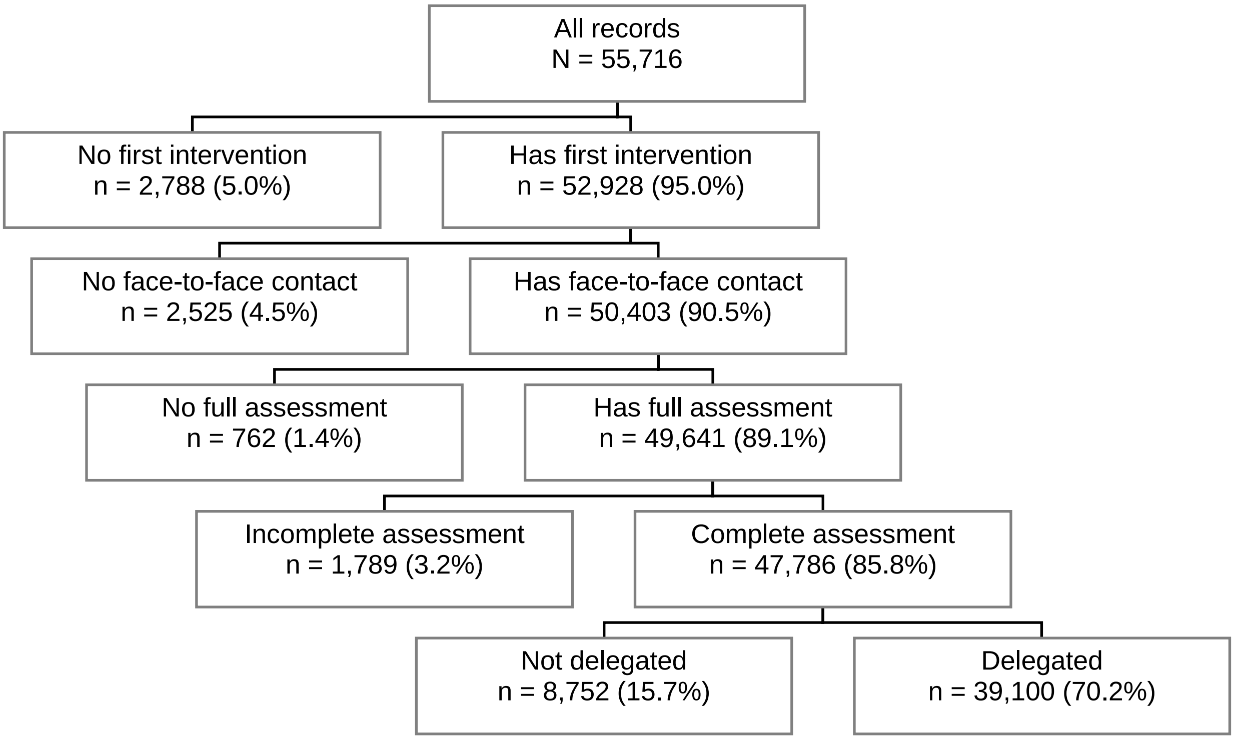
[*] See Appendix 2 for a description of the six levels of assessment.

Figure 1: Flowchart of MDS v2 records



There is considerable inter-team variation within the averages presented in Figure 1. The proportion of referrals only ranged from 0.1% to 16.5%, and the proportion of minimalist/simple assessments from 0.5% to 20.4%. The proportion of incomplete assessments involving a comprehensive assessment ranged from 0.0% to 12.5%. The proportion of completed from 5.9% to 42.4% and delegated assessments ranged from 53.4% to 88.8% (complete and delegated ranged from 68.3% to 98.5%). 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

The great majority of recorded assessments were completed (including delegated), that is a care plan developed with an effective referral (Table 1). Of the incomplete assessments, most were because the client withdrew or because the client's functional or medical condition required further rehabilitation or treatment.

Table 1: Reason for ending assessment, Victoria 2005–06 (%)

	Assessment complete[1] %	Client withdrew %	Client died %	Client transferred %	Medical condition unstable %	Functional status unstable %	Other reason/ missing %	Tota %
Rural	87.5	6.5	1.2	0.4	1.9	0.9	1.5	100.0
Metro	84.9	4.9	0.8	1.5	2.9	4.1	0.9	100.0
Total	**85.8**	**5.4**	**0.9**	**1.1**	**2.6**	**3.1**	**1.1**	**100.0**

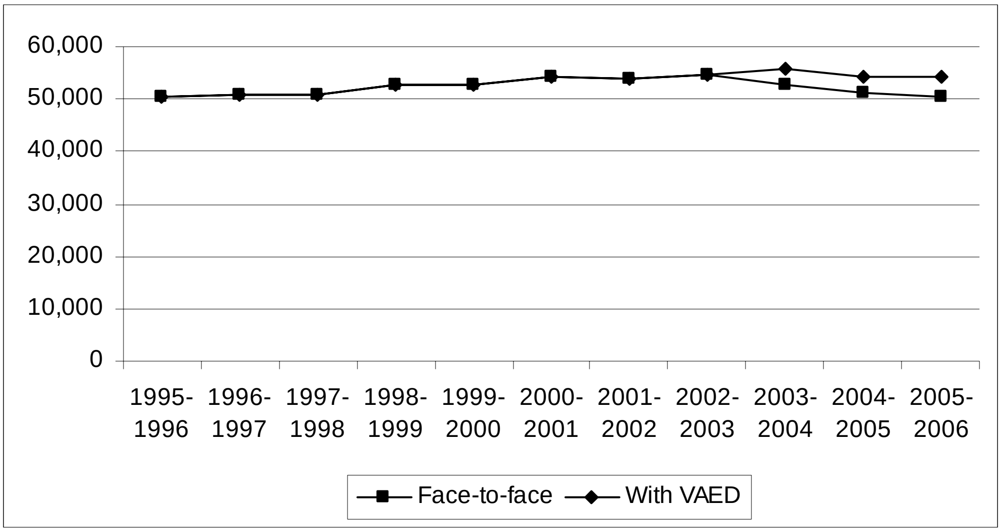
Note: [1] Includes complete and delegated assessments.

Trends in assessment numbers

Figure 2 shows change in total assessment numbers in the 10 years to 2005–2006. For comparability with previous years, only MDS v2 records with a valid First face-to-face contact date were included.

Assessment numbers increased in most years between 1995–96 and 2002–03, but the present year continues a recent trend of declining numbers. Victorian teams in 2005–06 reported 941 (1.8%) fewer "MDS v1 comparable" assessments than in 2004–05. However, in contrast to recent years there was a small increase in total referrals compared to the previous year, with 128 (0.2%) more referrals in 2005–06 than in 2004–05. The number of completed assessments was also higher than the previous year (by 1.5%).

Figure 2: Total assessment numbers, Victoria 1995-1996 to 2005–2006



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

In response 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 2005–06 it was estimated that 4,018 consultations were carried out in rural and metropolitan hospitals. This workload, when added to the ACAP MDS assessments results in an ACAS output of 54,421 face-to-face assessments and consultations—0.2% more than in 2004–05. Figure 2 shows that the variation in total assessment activity over the previous five years is lower if this hospital activity is taken into account.

Assessment rates

Table 2 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 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 2: Number of referrals, number of assessments, and assessment rates, Victoria 2005–06 (%)

	2006 Target Population[1]	Total Number of Accepted Referrals	Total Number of assessments with Face-to-face contact[2]	Total Number of Completed Assessments[3]	Total Number of Completed Target group Assessments[4]	Target group as % of Total Completed Assessments[5]	Rate[6]
Rural	156,130	17,934	16,454	15,701	14,420	91.8	92.4
Metro	343,698	37,782	33,949	32,085	29,658	92.4	86.3
Total	**499,828**	**55,716**	**50,403**	**47,786**	**44,078**	**92.2**	**88.2**

Note: [1] Population Projections based upon ABS Population Projections Australia, 2002 to 2101 Series B (supplied by the Department of Health and Ageing). Target group comprises people aged 70+ years and Indigenous people aged 50–69 years.

[2] Records with a valid face-to-face contact date (ACCR Question18).

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

[4] Target group records with assessment coded complete.

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

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

Overall, more than 90% of completed assessments were of the ACAP target group and there was little variation among the teams (88.9%–94.2%). However, the completed assessment rate varied considerably among the teams around the average (88.2) shown in Table 4 and ranged from 71.0 to 158.5 across the 18 Victorian teams. The highest rate was reported by a metropolitan team with a relatively small catchment based at a hospital that draws people from a much wider area. The overall assessment rate, based on the number of MDS v2 assessments with face-to-face contact in 2005–06 was 100.8 assessments/1000 target group (not shown in Table 4). This was lower than in 2004–05 (107.0), 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 2005–06 was 55,716, including 50,403 (90.5% of the total) with face-to-face contact.
- Of the total records, 5.0% were referrals only, 9.1% were other incompletes, 15.7% were completed assessments (but not delegated), and 70.2% were delegated assessments.
- Across Victoria, 92.2% of completed assessments were of people in the target population. The overall assessment rate was 88.2 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 100.8 per 1000 target population.

Trends:

- Total referrals and completed assessment numbers were higher than in 2004–05—by 0.2% and 1.5% respectively.
- The recent trend of declining numbers of assessments with face-to-face contact continued in 2005–06—they were 1.8% lower than the previous year.
- Total assessment activity (face-to-face assessments and consultations recorded in the VAED) was 0.2% higher than in 2004–05 and showed a more stable historical trend.

- The proportion of target group assessments has increased from 87.1% in 1995–96 to the present 92.2%.

Rural metropolitan and inter-team comparison:

- Approximately a third (31.2%) 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 0.1% to 16.5%; and the proportion of complete/delegated assessments from 68.3% to 98.5%.

Summary: Reason for ending assessment

Overall result:

- The great majority of recorded assessments (85.8%) were completed or delegated.
- The most common reasons for incomplete assessments were the client choosing to withdraw (5.4%) and unstable functional status (3.1%).

Timeliness

This section reports on the ACAS response to requests for assessment. Times from Referral date to First intervention date and First face-to-face contact date provide an indication of how long ACAS take to respond to requests for service. 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 private residence/other community) locations are provided. All times are calendar days.

Referral to First intervention

Table 3 presents the times between Referral and First intervention and shows the considerable differences in the response times between hospital and non-hospital settings for both rural and metropolitan teams. In hospital setting, the average response (trimmed mean) was about a day and a half, half of all referrals received a response on the same day, and almost all referrals (90%) were seen within a week. In non-hospital settings the average response was nearly two weeks, half of the referrals received a response within two weeks, and 90% received a response within 36 days. Response times in rural areas were longer than metropolitan areas in hospital settings but shorter in non-hospital settings.

Table 3: Referral to First intervention by First face-to-face contact setting, Victoria 2005–06 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	3,974	14	2.9 (1.8–7.9)	4.2 (2.3–9.4)	1 (0–6)	9 (6–27)
Metro	10,271	19	0.9 (0.3–1.9)	1.6 (0.8–2.7)	0 (0–1)	4 (2–7)
Total	**14,245**	**33**	**1.4**	**2.3**	**0**	**6**
Non-hospital**						
Rural	12,348	11	9.0 (5.5–20.1)	11.7 (6.5–21.1)	5 (1–20)	33 (15–48)
Metro	23,743	22	15.3 (6.7–23.7)	16.8 (7.7–24.9)	13 (5–23)	38 (17–51)
Total	**36,091**	**33**	**13.2**	**15.1**	**10**	**36**
Residential care						
Rural	1,352	4	5.6 (3.9–9.0)	7.8 (5.8–11.0)	3 (2–6)	21 (13–37)
Metro	1,902	4	9.3 (4.2–13.9)	10.6 (5.1–15.1)	7 (1–12)	26 (12–35)
Total	**3,254**	**8**	**7.7**	**9.4**	**5**	**25**
Private residence/other community						
Rural	10,996	7	9.5 (5.5–21.2)	12.2 (6.6–22.1)	5 (1–21)	34 (15–49)
Metro	21,841	18	15.9 (6.8–25.0)	17.4 (7.8–26.2)	14 (6–25)	38 (18–54)
Total	**32,837**	**25**	**13.7**	**15.6**	**11**	**37**

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

Both rural and metropolitan teams reported a considerable range in response times in all settings, but there was less variation in hospital settings than non-hospital settings—trimmed means ranged from 0.3 to 7.9 calendar days in hospital settings and 5.5 to 23.7 calendar days in non-hospital settings.

Referral to First face-to-face contact

Time from Referral date to First face-to-face contact date were shorter in hospital than non-hospital settings (Table 4). In hospital settings, the average response (trimmed mean) was two days, the assessment process had begun the day after referral for half of the referrals, and almost all referrals (90%) received face-to-face contact in just over a week. In non-hospital settings it was an average (trimmed mean) of nearly three weeks between referral and face-to-face contact, half of referrals received face-to-face contact within 17 days (median) and 90% within 48 days.

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 for community settings were shorter in metropolitan than rural areas. The ranges in response times varied considerably among both rural and metropolitan teams in all settings.

Table 4: Referral to First face-to-face contact by First face-to-face contact setting, Victoria 2005–06 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	3,962	26	5.3 (2.2–11.3)	7.1 (1–9)	4 (1–9)	16 (6–33)
Metro	10,247	43	1.0 (0.4–2.4)	(0–1)	0 (0–1)	5 (3–7)
Total	**14,209**	**69**	**2.0**	**3.3**	**1**	**8**
Non-hospital**						
Rural	12,340	19	20.8 (8.6–40.2)	23.4 (7–34)	15 (7–34)	57 (21–93)
Metro	23,623	142	19.8 (12.3–35.0)	21.2 (11–35)	18 (11–35)	43 (27–71)
Total	**35,963**	**161**	**20.0**	**22.0**	**17**	**48**
Residential care						
Rural	1,350	6	11.2 (7.4–20.4)	13.5 (7–15)	8 (7–15)	31 (19–54)
Metro	1,877	29	11.7 (4.7–16.5)	13.1 (4–14)	9 (4–14)	31 (14–40)
Total	**3,227**	**35**	**11.5**	**13.3**	**8**	**31**
Private residence/other community						
Rural	10,990	13	22.0 (8.8–43.3)	24.6 (7–38)	16 (7–38)	59 (21–96)
Metro	21,746	113	20.5 (12.6–37.3)	21.9 (11–39)	19 (11–39)	44 (27–72)
Total	**32,736**	**126**	**20.9**	**22.8**	**18**	**49**

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

Since 1999–00, the time between referral and first face-to-face contact has been increasing in all settings. In 2005–06, response times in hospital settings were similar to the previous year, but in residential care and community settings they were longer than the previous year (2004–05 residential trimmed mean 10.3 days; community settings 18.7 days).

Referral to Assessment end date

Times from Referral date to Assessment end date and Delegation date provide an indication of the duration of the assessment process. Table 5 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, and 23 days in non-hospital settings (14 in residential care and 24 in community settings). The median times for hospital and non-hospital settings were 3 and 20 days respectively, and to complete 90% of assessments it took 17 and 53 days respectively. As with the other measures of timeliness, there was considerable variation within settings among both rural and metropolitan teams.

Table 5: Referral to End of assessment by First face-to-face contact setting, Victoria 2005–06 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	3,988	0	8.0 (3.7–17.7)	10.3 (4.7–20.7)	6 (2–13)	24 (9–50)
Metro	10,287	3	3.6 (1.4–12.6)	5.2 (2.2–14.7)	2 (0–8)	14 (5–38)
Total	**14,275**	**3**	**4.8**	**6.6**	**3**	**17**
Non-hospital**						
Rural	12,356	3	23.0 (9.2–46.6)	25.7 (10.3–48.9)	18 (7–41)	61 (22–99)
Metro	23,761	4	22.8 (13.1–37.6)	24.4 (14.4–38.8)	21 (12–38)	49 (28–73)
Total	**36,117**	**7**	**22.8**	**24.9**	**20**	**53**
Residential care						
Rural	1,356	0	12.8 (8.8–24.3)	15.5 (10.5–27.8)	9 (7–20)	37 (24–63)
Metro	1,905	1	14.1 (5.8–18.1)	16.0 (7.2–21.1)	11 (4–15)	36 (17–49)
Total	**3,261**	**1**	**13.6**	**15.8**	**10**	**36**
Private residence/other community						
Rural	11,000	3	24.3 (9.2–49.9)	27.0 (10.2–51.9)	19 (7–46)	63 (22–101)
Metro	21,856	3	23.6 (13.5–40.0)	25.2 (14.6–40.9)	21 (12–41)	50 (29–74)
Total	**32,856**	**6**	**23.7**	**25.8**	**21**	**54**

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

Time from Referral to Delegation date

On average, the assessment process for Commonwealth approved services (referral to delegation) took nearly eight days in hospital settings and 25 days in non-hospital settings. The ranges in response times (calendar days) between teams in the various settings for the trimmed mean were: hospital/other inpatient 2.1 to 17.9; and non-hospital 10.6 to 46.1 (Table 8). Response times in hospital and non-hospital settings reported by metropolitan teams were shorter than rural teams.

Table 6: Referral to Delegation date by First face-to-face contact setting, Victoria 2005–06 (calendar days)

	Valid n*	Missing n	Trimmed mean (range) days	Mean (range) days	Median (range) days	90th %ile (range) days
Hospital/other inpatient						
Rural	3,183	0	9.4 (4.6–17.9)	11.7 (5.1–21.0)	7 (4–13)	27 (11–50)
Metro	7,745	6	6.8 (2.1–14.7)	8.5 (3.2–16.9)	5 (1–11)	20 (7–39)
Total	**10,928**	**6**	**7.6**	**9.4**	**6**	**22**
Non-hospital**						
Rural	9,324	7	26.3 (10.6–46.1)	28.8 (11.9–48.0)	21 (9–41)	65 (25–97)
Metro	18,795	4	24.7 (13.5–41.9)	26.3 (14.9–43.1)	22 (12–42)	51 (29–79)
Total	**28,119**	**11**	**25.1**	**27.1**	**22**	**56**
Residential care						
Rural	1,077	1	14.5 (9.1–26.2)	16.9 (9.9–29.2)	11 (8–21)	41 (24–64)
Metro	1,430	3	15.2 (7.1–23.3)	17.1 (9.9–24.1)	13 (6–21)	37 (18–51)
Total	**2,507**	**4**	**14.9**	**17.0**	**12**	**38**
Private residence/other community						
Rural	8,247	6	27.9 (10.8–49.0)	30.4 (12.2–50.7)	22 (9–44)	68 (26–99)
Metro	17,365	1	25.5 (14.0–44.3)	27.1 (15.3–45.2)	23 (13–44)	52 (29–80)
Total	**25,612**	**7**	**26.1**	**28.1**	**23**	**57**

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

Timeliness by stage

Figure 2 presents the aggregated time taken for each stage of the assessment process in hospital (acute hospital and other inpatient) and non-hospital (residential care and private residence/other community).[*] It highlights the considerable difference in time taken to complete the assessment process in hospital and non-hospital settings. It also shows that most of this difference occurs in the first stages of the assessment process between referral and first face-to-face contact. On average (trimmed mean), Victorian ACAS take just under a day and a half to respond to a request for service (referral to first intervention) in hospital settings, but nearly two weeks in non-hospital settings. Response times in rural areas were longer than metropolitan areas in hospital settings but shorter in non-hospital settings. The time from first intervention to face-to-face contact was within a day in hospital settings but took over four days in non-hospital settings. However, the time spent on the assessment process was similar in the two settings.

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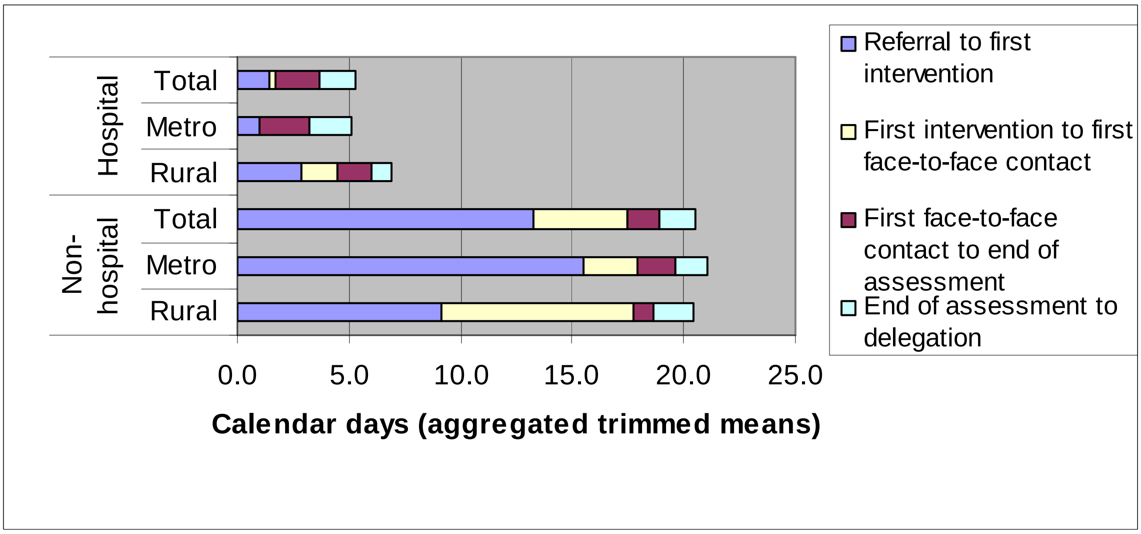
[*] These aggregated times differ from those in Tables 3–6 because of differences in the method of calculation and the cases included in each stage.

Figure 2: Aggregated time for the assessment process, Victoria 2005–06 (calendar days)



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

Timeliness and Priority category

Table 7 provides further information on response times for the three Priority categories in the various assessment settings. 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 hospital settings than non-hospital settings.

The data also indicates that the allocation of priority category continues to be influenced more by the assessment setting (auspice agreements etc) than client need. Of all referrals, 9.3% were allocated Priority 1, with three-quarter of these (7.0%) in hospital settings. Metropolitan teams were much more likely to categorise referrals as Priority 1 in hospital settings than rural teams. These figures are a small improvement on the previous year.

Table 7: Referral to First intervention by Priority category by Location at assessment, Victoria 2005–06 (calendar days)

	Priority category 1			Priority category 2			Priority category 3				
	% of total[1] (range)	% seen on time[2] (range)	Count	% of total[3] (range)	% seen on time[4] (range)	Count	% of total[5] (range)	% seen within 36 days[6] (range)	Count	Missing[7] %	Total number[8]
Acute hospital/other inpatient											
Rural	7.0 (0.1–59.1)	87.1 (66.7–100.0)	280	78.0 (40.0–98.5)	97.2 (91.2–100.0)	3,109	14.8 (0.9–44.1)	93.9 (90.0–100.0)	589	0.3	3,988
Metro	35.2 (0.5–70.4)	89.7 (78.2–100.0)	3,626	59.1 (28.7–93.3)	99.0 (97.9–100.0)	6,077	5.5 (0.7–66.2)	96.8 (71.4–100.0)	565	0.2	10,290
Total	**27.4**	**89.5**	**3,906**	**64.3**	**98.4**	**9,186**	**8.1**	**95.3**	**1,154**	**0.2**	**14,278**
Non-hospital (residential care and private residence/other community settings)											
Rural	2.9 (0.9–6.6)	79.0 (68.7–93.9)	357	45.6 (16.8–90.7)	87.9 (81.5–96.5)	5,636	51.1 (8.4–82.3)	86.4 (66.4–98.2)	6,319	0.4	12,359
Metro	3.5 (0.9–6.7)	84.7 (62.5–93.2)	823	26.7 (7.1–68.0)	94.9 (85.7–96.7)	6,343	69.7 (27.6–91.7)	85.0 (72.8–98.2)	16,557	0.2	23,765
Total	**3.3**	**83.0**	**1,180**	**33.2**	**88.7**	**11,979**	**63.3**	**85.4**	**22,876**	**0.2**	**36,124**
Residential care											
Rural	5.9 (0.0–13.0)	82.5 (57.1–100.0)	80	59.2 (36.8–92.3)	90.9 (80.3–98.0)	803	34.4 (7.7–60.7)	92.9 (73.3–98.4)	466	0.5	1,356
Metro	8.1 (1.3–14.5)	87.1 (66.7–100.0)	155	43.7 (12.7–71.7)	93.6 (80.9–98.0)	832	48.0 (15.5–84.3)	91.7 (85.1–100.0)	914	0.3	1,906
Total	**7.2**	**85.5**	**235**	**50.1**	**92.3**	**1,635**	**42.3**	**92.1**	**1,380**	**0.4**	**3,262**
Private residence/other community settings											
Rural	2.5 (0.7–6.0)	78.0 (64.2–100.0)	277	43.9 (14.0–90.5)	87.4 (81.7–96.1)	4,833	53.2 (15.5–84.3)	85.9 (85.1–100.0)	5,853	0.4	11,003
Metro	3.1 (0.9–6.1)	84.1 (60.6–96.6)	668	25.2 (6.4–67.9)	14.1 (84.2–96.5)	5,511	71.6 (28.2–92.7)	84.6 (71.0–98.2)	15,643	0.2	21,859
Total	**2.9**	**82.3**	**945**	**31.5**	**88.1**	**10,344**	**65.4**	**85.0**	**21,496**	**0.2**	**32,862**

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

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

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

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

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

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

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

[7] The number of records with invalid or missing referral date (ACCR Question 1), first intervention date (ACCR Question 7), Priority Category (ACCR Question 16).

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

Table 8 provides further information on the response times and presents the proportion of referrals given a response within the various timeframes. It shows that over 70% of referrals receive a response within two weeks and almost 90% within a month. In general, response times by rural teams were shorter than metropolitan teams. The table also shows considerable variability among the teams.

Table 8: Referral to First intervention and First face-to-face contact within given times, Victoria 2005–06 (calendar days)

	Referral to first intervention[1]					Referral to face-to-face contact[2]				
	0–14 days (range) %	15–28 days (range) %	29–42 days (range) %	43–56 days (range) %	57+ days (range) %	0–14 days (range) %	15–28 days (range) %	29–42 days (range) %	43–56 days (range) %	57+ days (range) %
Rural	79.1 (46.6–89.1)	11.1 (6.2–27.6)	4.6 (1.6–17.8)	2.4 (0.4–5.6)	2.8 (0.3–4.9)	59.2 (40.3–81.6)	17.6 (14.0–29.5)	9.5 (3.4–20.0)	5.8 (0.6–11.6)	7.9 (0.3–25.7)
Metro	67.8 (52.1–90.3)	18.4 (5.6–30.3)	8.9 (1.7–15.6)	3.1 (0.2–7.7)	1.8 (0.2–4.9)	59.2 (45.6–77.1)	22.4 (8.4–31.9)	10.9 (4.2–17.8)	4.3 (0.9–10.3)	3.2 (0.3–14.5)
Total	71.5	16.0	7.5	2.9	2.1	59.2	20.8	10.5	4.8	4.7

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

Summary: Timeliness

Overall result:

- Response times to referrals varied considerably between hospital and non-hospital settings.
- On average (trimmed mean), the time from referral to first face-to-face contact took 2.0 calendar days in hospital settings and 20.0 calendar days in non-hospital settings.
- The average (trimmed mean) time from referral to end of assessment took 4.8 calendar days in hospital settings and 22.8 calendar days in non-hospital settings.
- Compared with the previous year, the time from referral to end of assessment increased in both hospital (4.8 days c.f. 4.4 days in 2004–05) and non-hospital settings (22.8 days c.f. 20.6 days in 2004–05).
- Victorian ACAS responded (referral to first intervention) to half of the referrals in hospital settings within one calendar day (median) and 90% of referrals within a week. In non-hospital settings the median response was 10 calendar days with 90% of referrals within 36 days. The respective trimmed means for hospital and non-hospital settings were 1.4 and 13.2 calendar days.
- From first intervention to the beginning of the assessment process (first face-to-face date) took, on average (trimmed mean), a further 0.6 days in hospital settings and 6.8 days in non-hospital settings.
- The assessment process (first face-to-face date to end of assessment date) took, on average (trimmed mean), 2.8 calendar days in both hospital and non-hospital settings.
- For those assessments that went on to delegation, this took a further 2.8 days in hospital settings and 2.3 days in non-hospital settings.
- Overall, the great majority of both Priority 1 and Priority 2 referrals were seen "on time" (i.e., within 2 calendar days, and 14 calendar days respectively). In

hospital settings 89.5% of Priority 1 and 83.0% of Priority 2 referrals were seen "on time"; in non-hospital settings the corresponding figures were 98.4% and 88.7%.

Trends:

- Further increases in the time taken to respond to a request for service, and the assessment process in 2005–06 were consistent with the long-term trend.
- In the period from 1999–00 to 2005–06 the time from referral date to face-to-face assessment date has increased from 1.7 to 2.0 calendar days in hospital settings, and from 11.8 to 20.0 calendar days in non-hospital settings.
- Maintaining the trend over the previous three years, the proportion of people seen "on time" in 2005–06 improved slightly compared with the previous year.

Rural metropolitan comparison:

- Response times in hospitals were shorter for metropolitan teams than rural teams.
- The proportion seen "on time" was higher in metropolitan than rural areas, particularly in non-hospital settings.

Range across teams:

- Response times from referral to first intervention: hospital settings, trimmed mean 0.3 to 7.9 calendar days; non-hospital settings 5.5 to 23.7 days.
- Response times from referral to first face-to-face contact: hospital settings, trimmed mean 0.4 to 11.3 calendar days; non-hospital settings 8.6 to 40.2 days.
- Response times from referral to end of assessment date: hospital settings, trimmed mean 1.4 to 17.7 calendar days; non-hospital settings 9.2 to 46.6 days.
- The proportion seen "on time" for Priority 1 ranged between 66.7% and 100.0% in hospital settings, and between 62.5% and 93.9% in non-hospital settings; and Priority 2 between 91.2% and 100.0% in hospital settings, and between 81.5% and 96.7% 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). The great majority of clients live in a community setting or a residential care facility, but because of their medical or functional status, a significant minority are assessed in hospitals or other inpatient facilities. Assessments in hospital settings are often undertaken by staff with multiple roles, such as geriatricians. Assessments in “other hospital settings” are often undertaken by, or in conjunction with, staff who work in those settings, such as allied health professionals.

Nearly two-thirds of clients were assessed in a private residence or other community setting, a fifth in acute hospitals and a further 6% in residential care facilities (Table 9). Rural teams assessed relatively more clients in community or residential care settings than metropolitan teams. Clients in metropolitan areas were more likely to be assessed in hospitals or other inpatient settings.

Table 9: Location of assessment, Victoria 2005–06

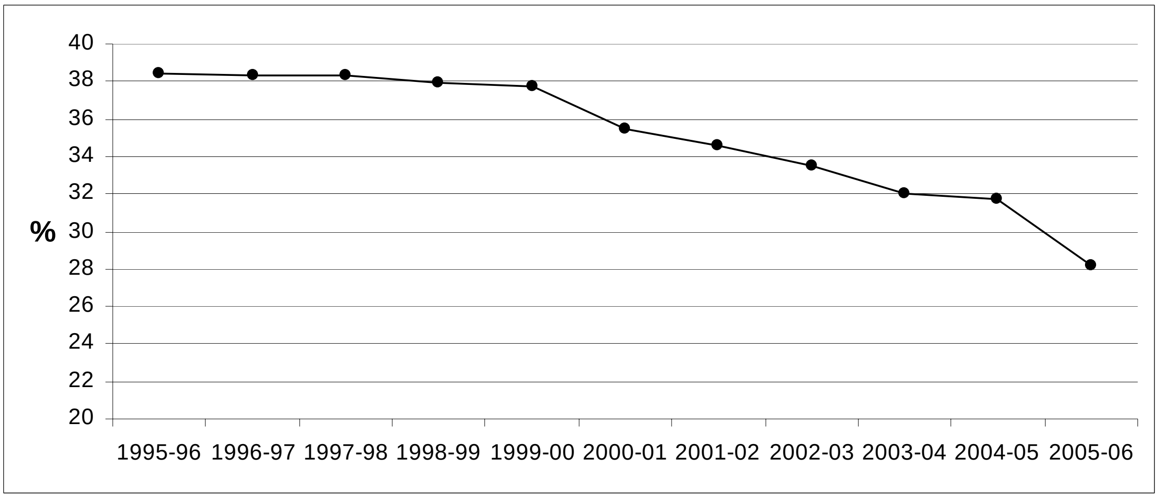
	Acute hospital %	Other inpatient setting %	Residential care setting %	Private residence/ Other community %	Missing %	Total %	Total n
Rural	18.4	5.7	8.2	66.9	0.8	100.0	16,444
Metrop	20.6	9.6	5.5	64.1	0.2	100.0	33,930
Total	**19.9**	**8.3**	**6.4**	**65.0**	**0.4**	**100.0**	**50,374**

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

The proportion of clients assessed in the various settings varied considerably among the 18 Victorian teams. Those assessed in hospital ranged from 6.1% to 29.0%; other inpatient from 0.2% to 23.7%; residential care from 3.4% to 9.8%; and private residence/other community 50.1% to 81.5%. 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—and particularly since 1999–00—the proportion of clients assessed in hospital settings in Victoria has decreased, and in 2005–06 there was a further decrease to the lowest recorded (28.2%).

Figure 4: Assessments in hospital/other inpatient settings, Victoria 1995-1996 to 2005–2006 (%)



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

Summary: Location at assessment

Overall result:

- Nearly two-thirds of Victorian clients (65.0%) were assessed in a private residence/other community setting, 19.9% took place in acute hospitals, 8.3% in other inpatient settings and 6.4% in residential care.

Trend:

- A further decrease in the proportion of clients assessed this year in acute hospital/other inpatient settings in Victoria to the lowest recorded (28.2%).

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 12.5% to 46.1%.

Assessor profession

Overall, one professional was involved in 46.6% of assessments (with face-to-face contact), two in 20.9%, three in 10.5%, and 21.2% involved four or more assessorss. Assessor profession was not recorded for 0.8% of cases. Overall, 53.0% of assessments were multidisciplinary, that is, two or more different professions were involved. Table 10 shows that nurses were most commonly involved in assessments, with other health professionals, medical professionals, and social professional (mainly social workers but also welfare workers, counsellors, psychologists and interpreters) represented fairly equally. Geriatricians were more likely to participate in assessments by metropolitan teams (31.8%) than rural teams (13.8%).

Table 10: Assessor profession involved in assessment, Victoria 2005–06 (%)

	Medical profession %	**Nursing profession %**	**Other health profession %**	**Social profession %**	**Other profession %**	**Interpreter %**	**None %**
Rural	32.9	73.8	30.9	23.4	1.6	<0.1	2.2
Metro	45.7	67.4	51.4	49.1	2.6	0.6	0.2
Total	**41.5**	**69.5**	**44.7**	**40.7**	**2.3**	**0.4**	**0.8**

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 (53.4%) were multidisciplinary (two or more different professions involved).
- Nursing was the most common profession involved in assessment (69.5%).

CLIENT CHARACTERISTICS AND ACCESS TO THE ACAP

This section of the report describes the characteristics of clients assessed by Victorian ACAS in 2005–06 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 of target group clients with a severe or profound core activity restriction and/or dementia, and decreasing assessment of non-target group clients with no severe or profound core activity restriction.

Age

The age distribution for 2005–06 (Table 11 following page) shows that two-thirds of ACAS clients were aged 80 years and over. Clients aged 60 years and under comprised 2.1% of all referrals. The age distribution in rural and metro areas was similar. Although the age distribution in 2005–06 was showed only small differences compared 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 2005–06, and shows the increase in the proportion of clients in the older age groups in that time. Since 1994–95, the proportion of clients aged 80 years and over has increased from 54.7% to 66.7%. In the same time the proportion of clients under 60 years has decreased from 5.9% to the present 2.1%.

Figure 5: Client age, Victoria 1994-1995 to 2005-2006

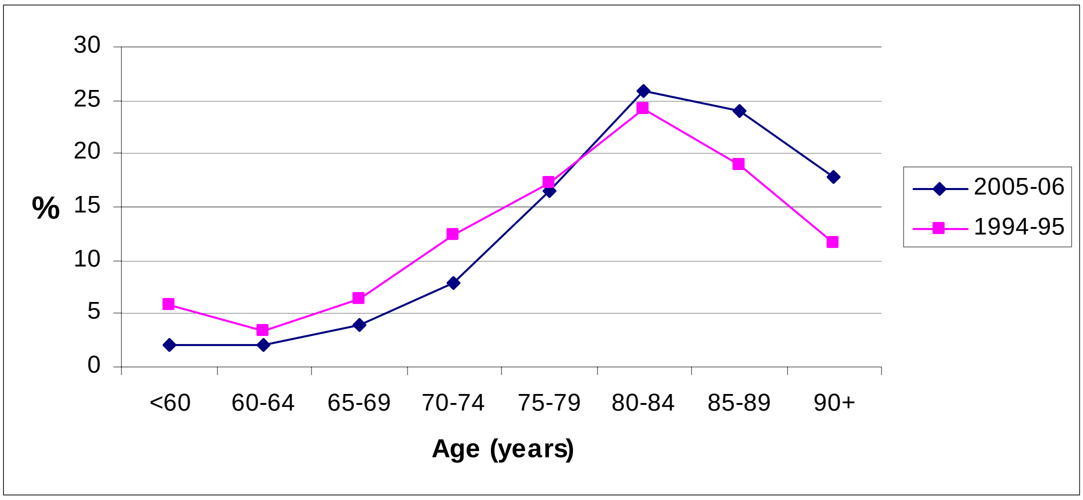


Table 11: Age, Victoria 2005–06 (%)

	< 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	2.4	1.9	4.3	8.1	16.5	26.0	23.7	13.4	3.5	<0.1	100.0	17,934
Metro	1.9	2.0	3.9	7.7	16.4	25.8	24.2	14.1	4.1	<0.1	100.0	37,782
Total	**2.1**	**2.0**	**4.0**	**7.8**	**16.4**	**25.8**	**24.0**	**13.9**	**3.9**	**<0.1**	**100.0**	**55,716**

Note: Table includes all records.

Summary: Client age

Overall result:

- Two-thirds of clients accepted as referrals to Victorian ACAS were aged 80 years and over.
- Clients aged under 70 years comprised 8.1% of all referrals.

Trend:

- Since 1994–95 the proportion of clients aged 80 years and over has increased from 54.7% to the present 66.7%.
- Since 1994–95 the proportion of assessments of clients under 70 years has decreased from 15.5% to 8.1% of total referrals.

Rural metropolitan comparison:

- Similar age distribution in rural and metropolitan areas.

Usual accommodation setting

The usual accommodation setting at assessment of the great majority of ACAS clients was a community setting, and the great majority of these lived in a private residence. A minority lived in residential care settings (Table 12 on the next page). While the proportion of clients living in the community was similar in rural and metropolitan areas, the proportion living in private residences was higher in rural than metropolitan areas. Residence in a retirement village or supported community accommodation was more common in metropolitan areas. There was a range across the teams in the proportion of clients usually living in residential care.

Summary: Accommodation setting

Overall result:

- The great majority of Victorian clients lived in the community at assessment (private residence 80.7% or other community accommodation 9.5%).
- 8.2% lived in residential care (7.2% in low-level care; 1.0% 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 (84.0%) compared with metro areas (79.1%).
- Retirement village and supported community accommodation was relatively more common in metro areas.
- Similar proportions of clients in residential care.

Range across teams:

- The proportion of clients living in the community ranged from 86.9% to 92.5%.
- The proportion of clients living in low-level residential care ranged from 4.1% to 9.9%, and in high-level care from 0.3% to 1.7%.

Table 12: Usual accommodation setting, Victoria 2005–06 (%)

	Private residence %	Other community %	Community total %	Low Care %	High Care %	Residential Total %	Other %	Unknown/ Missing %	Total %	Total N
Rural	84.0	6.3	90.3	6.8	1.1	7.9	1.5	0.4	100.0	16,444
Metro	79.1	11.0	90.1	7.3	0.9	8.3	1.5	0.1	100.0	33,930
Total	**80.7**	**9.5**	**90.1**	**7.2**	**1.0**	**8.2**	**1.5**	**0.2**	**100.0**	**50,374**

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

Table 14a: Usual accommodation setting—community settings, Victoria 2005–06 (%)

	Private residence - owned %	Private residence - owned by family/related person %	Private residence - private rent %	Private residence - public rent %	Private residence - Indigenous community settlement %	Retirement village (ILU) %	Boarding/ rooming house %	Crisis, emergency or transitional accomm. %	Supported community accomm. %	Total community %
Rural	67.3	3.4	7.5	5.8	<0.1	4.4	0.2	0.0	1.7	90.3
Metro	65.9	3.9	4.5	4.7	<0.1	7.3	0.3	0.1	3.3	90.1
Total	**66.3**	**3.8**	**5.5**	**5.1**	**<0.1**	**6.3**	**0.3**	**0.1**	**2.8**	**90.1**

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

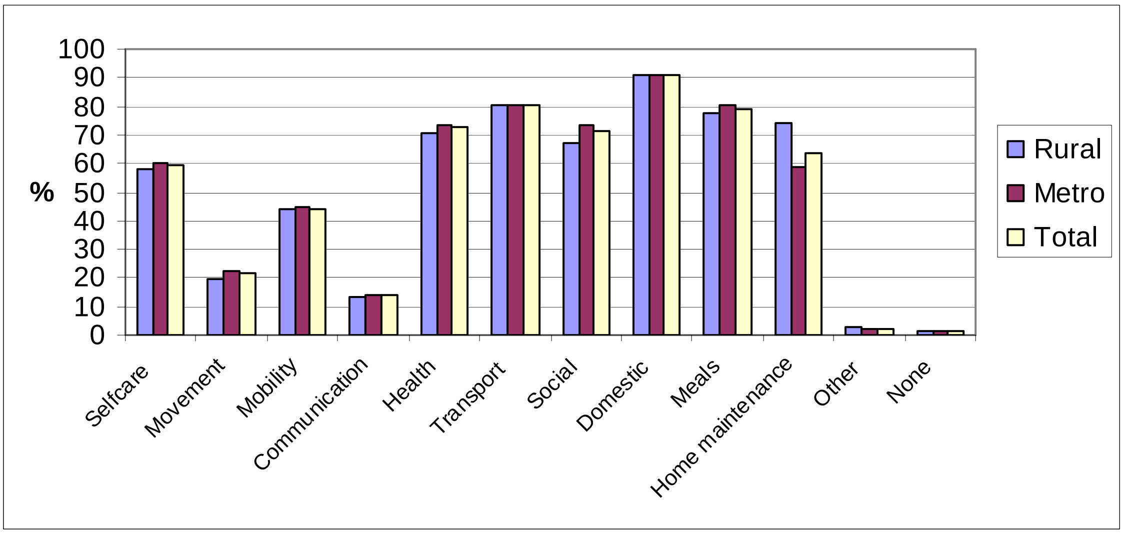
Functional profile and health conditions

Activity limitations

This section provides functional profiles—in terms of activity limitations—of clients usually living in the community and in residential care, and the formal and informal assistance they were receiving at assessment. Activity limitation is defined as whether the person needs the help or supervision of another individual in ten activities of daily living. 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).

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), transport (including using public transport, getting to and from places away from home and driving), and meals. Need for assistance with self-care was also relatively common. With the exception of home maintenance, 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 85.9% to 95.0% of clients, for transport 64.4% to 91.2%, for meals 69.1% to 85.4%, and for self-care 46.2% to 70.5%. Among Victorian clients living in the community, over two-thirds (69.0%) had a severe or profound core activity restriction, with a similar proportion across rural (68.3%) and metropolitan teams (69.4%). Non-target group clients were more likely to have a severe or profound core activity restriction (76.5%) than target group clients (68.4%).

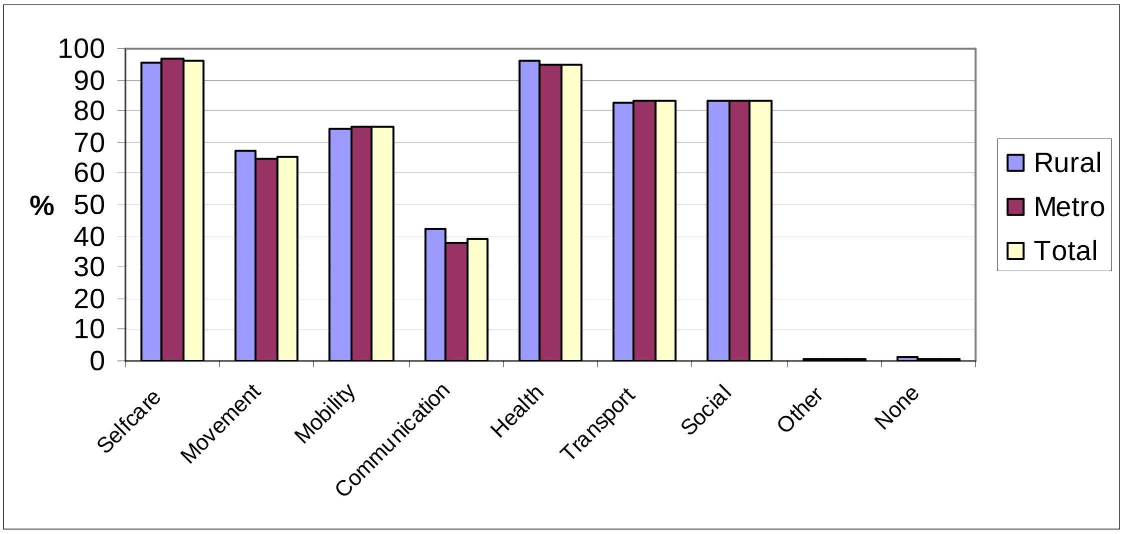
Figure 6: Activity limitations (clients living in the community), Victoria 2005–2006 (%)



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 80% received assistance with social and community participation (includes shopping, managing finances, and participation in recreational, cultural or religious activities) and transport (Figure 7).* The range across teams for self-care was 92.2% to 98.6% of clients, for health 85.9% to 100.0%, for transport 69.5% to 95.1%, and for social participation 67.1% to 95.1%.

Figure 7: Activity limitations (clients living in residential care), Victoria 2005–2006 (%)



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 (next page) shows the proportion of clients who received formal, informal, and both formal and informal assistance for each activity. The most common assistance at assessment was with domestic tasks (over 80%), with assistance with meals and transport (over 70%), and social participation, health care tasks and home maintenance (over 60%) were also relatively common. With the exception of domestic assistance, it was relatively rare (around 10% or less) for clients to receive assistance from both formal and informal sources. A small minority of clients (5.0%; rural 3.3%, metropolitan 5.8%) were not receiving any assistance at assessment. The level of formal assistance was similar to the previous year while the general level of informal assistance was slightly higher than in 2004–05.

Figures 8 shows the importance of informal assistance in supporting people in the community. With the exception of assistance with domestic tasks, the proportion of clients receiving informal assistance was higher than those receiving formal assistance. In particular, in the areas of communication, mobility, movement, transport and social participation, almost all the assistance was from informal sources.

In general, the level of formal assistance and informal assistance was similar in rural and metropolitan areas. However, there was a considerable range in the level of formal and informal assistance reported across the teams. For example, the proportion receiving formal assistance with domestic activities ranged from 44.5% to 63.7%; assistance with health tasks from 20.0% to 47.8%), meals from 23.3% to 41.7%, and assistance with self-care tasks from 20.7% to 38.8%. The proportion of clients receiving informal assistance with transport ranged from 43.4% to 77.5%, social participation from 32.5% to 73.7%, meals from 39.5% to 66.7%, and assistance with domestic tasks from 34.4% to 69.1%.

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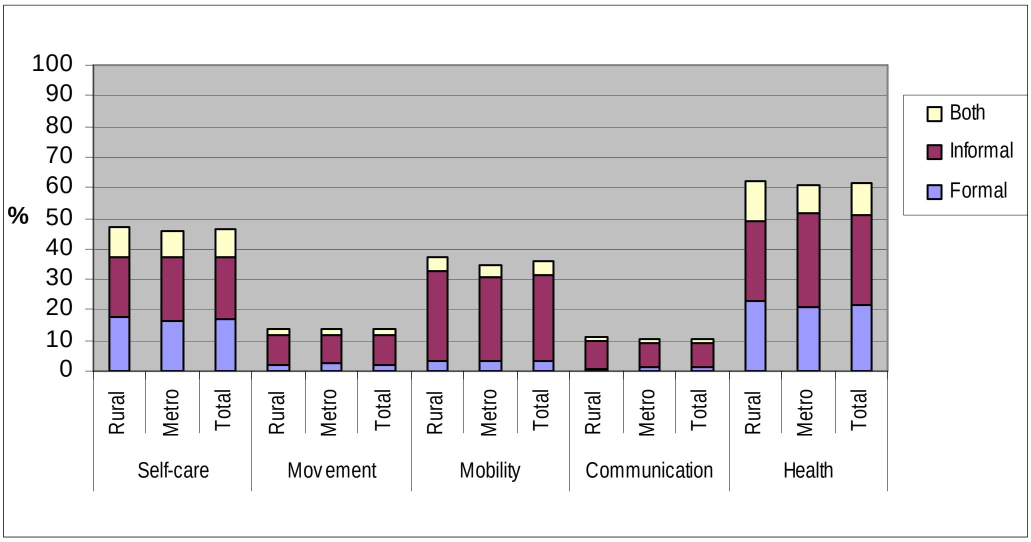
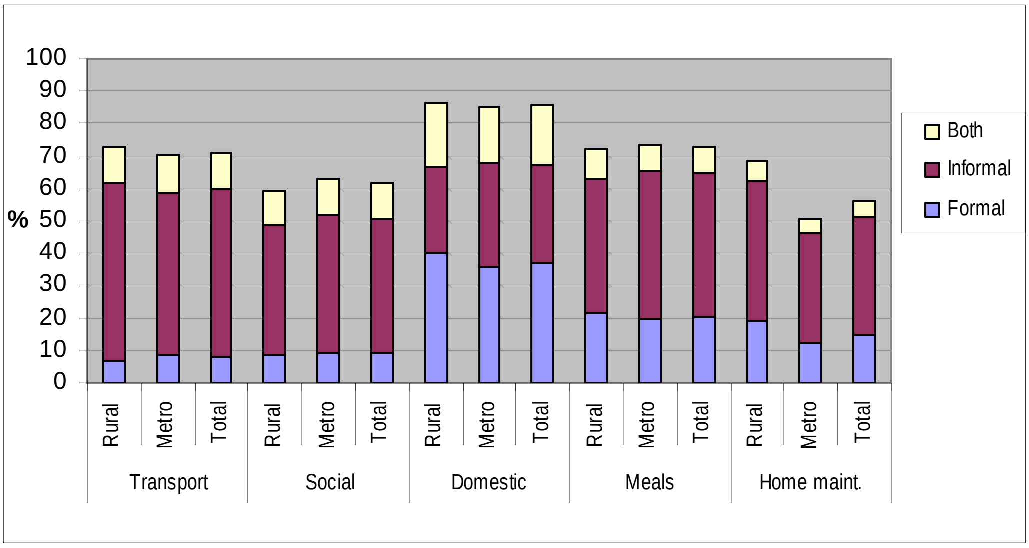
[*] Note that the need for assistance with domestic activities, meals and home maintenance is not recorded for people living in residential care, assistance with these activities is provided as part of the care.

Figure 8: Assistance with activities, Victoria 2005–2006 (%)



Note: Complete assessments of clients living in the community only.

Figure 8 cont.: Assistance with activities, Victoria 2005–2006 (%)



Note: Complete assessments of clients living in the community only.

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 (69.0%) of clients living in the community had a severe or profound core activity restriction.
- Non-target group clients were more likely to have a severe or profound core activity restriction (76.5%) than target group clients (68.4%).

- Proportionately more clients living in residential care were assessed as needing assistance than those living in the community. Over 90% needed assistance with self-care and health care tasks, and over 80% needed assistance with social and community participation, and transport.

Trends:

- In 2005–06 there was a further (small) increase (to 68.4%) in the proportion of target group clients living in the community with a severe or profound activity limitation at assessment (in 2004–05 it was 68.2% and in 2003–04 it was 65.0%).
- There was also a further increase (to 76.5%) in the proportion of non-target group clients living in the community with a severe or profound activity limitation at assessment (from 75.1% in 2004–05 and 66.9% in 2003–04).

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams in the proportion needing assistance at assessment, for example the need for assistance with domestic tasks among clients in the community ranged from 85.9% to 95.0%, meals from 69.1% to 85.4% of clients, transport 64.4% to 91.2%, and self-care 46.2% to 70.5%.
- The need for assistance among clients living in residential care ranged from 92.2% to 98.6% for self-care, from 85.9% to 100.0% for health, from 69.5% to 95.1% for transport, and from 67.1% to 95.1% for social participation.

Summary: Assistance with activities

Overall result:

- Just prior to assessment, the most common formal assistance was with domestic activities (36.9%), health care tasks (21.7%), meals (20.5%) and self-care (17.0%).
- The most commonly provided informal assistance was with transport (51.7%), meals (44.0%), social participation (41.6%), home maintenance (36.2%), and domestic tasks (30.3%).
- A small minority of clients (5.0%) received no assistance at assessment.

Rural metropolitan comparison:

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

Range:

- There was considerable range across the teams, for example formal assistance with domestic activities ranged between 44.5% and 63.7%, health tasks between 20.0% and 47.8%, and meals between 23.3% and 41.7%.

- Informal assistance with transport ranged from 43.4% to 77.5%, social participation from 32.5% to 73.7%, meals from 39.5% to 66.7%, and domestic tasks from 34.4% to 69.1%.

Health conditions

Tables 13 and 14 (following page) provide a profile of the Health conditions of clients who had a complete assessment. Table 13 provides the proportions of clients with the 12 most common diagnoses, and Table 14 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 13). The most common primary health condition was dementia (19.8%). The prevalence of dementia was slightly lower in rural areas. A comparison between Tables 13 and 14 provides an indication of the relative importance of the health conditions that lead to an assessment and the complexity of client conditions assessed by ACAS. In particular, the part played by dementia in precipitating an assessment. Dementia was not the most common among all listed conditions but was more than twice as frequent compared to other diagnoses reported for the primary health condition.

Summary: Health conditions

Overall result:

- Overall, heart conditions, arthritis, hypertension and dementia were the most common diagnoses among ACAS clients.
- The most common primary health condition was dementia (19.8%).

Trends:

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

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.

Table 13: Diagnosed diseases/disorder—all listed (12 most common conditions), Victoria 2005–06 (%)

	Heart %	Arthritis %	Hypertension %	Dementia %	Eye and vision %	CVA %	Diabetes %	Psycho-affective %	CLRD %	Osteoporosis %	Fracture %	Parkinson's %
Rural	47.3	36.6	31.3	23.7	23.8	17.3	17.4	14.7	15.6	12.4	10.2	4.7
Metro	46.4	35.0	36.6	29.6	23.4	17.6	17.5	16.1	13.8	13.9	11.9	5.1
Total	**46.7**	**35.5**	**34.9**	**27.7**	**23.5**	**17.5**	**17.5**	**15.7**	**14.4**	**13.4**	**11.3**	**5.0**

Note: Includes only complete records.

Table 14: Diagnosed diseases/disorder—primary condition listed (12 most common conditions), Victoria 2005–06 (%)

	Dementia %	Arthritis %	CVA %	Heart %	CLRD %	Diabetes %	Fracture %	Psycho-affective %	Parkinson's %	Eye and vision %	Hypertension %	Osteoporosis %
Rural	16.2	8.7	8.5	8.2	4.6	3.9	3.2	2.9	3.0	4.0	2.8	1.8
Metro	21.5	8.5	8.4	8.0	3.9	3.9	3.6	3.3	3.5	3.0	2.6	1.7
Total	**19.8**	**8.6**	**8.5**	**8.0**	**4.1**	**3.9**	**3.5**	**3.2**	**3.3**	**3.3**	**2.6**	**1.7**

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)

Access for special needs groups

Clients from Culturally and linguistically diverse backgrounds

Table 15 shows that a fifth of all accepted referrals were people of Culturally and Linguistically Diverse (CALD) backgrounds, with a higher proportion in metropolitan than rural areas. While the number of referrals of people of CALD background increased by 4.3%, access was below that expected from their representation in the target population. The index that compares the proportion of accepted referrals that involve clients from CALD backgrounds with the proportion of CALD people in the target population shows that access of people from CALD backgrounds was below that expected based on their representation in the 70+ years population.[*]

Table 15: Clients from CALD background, Victoria 2005–06

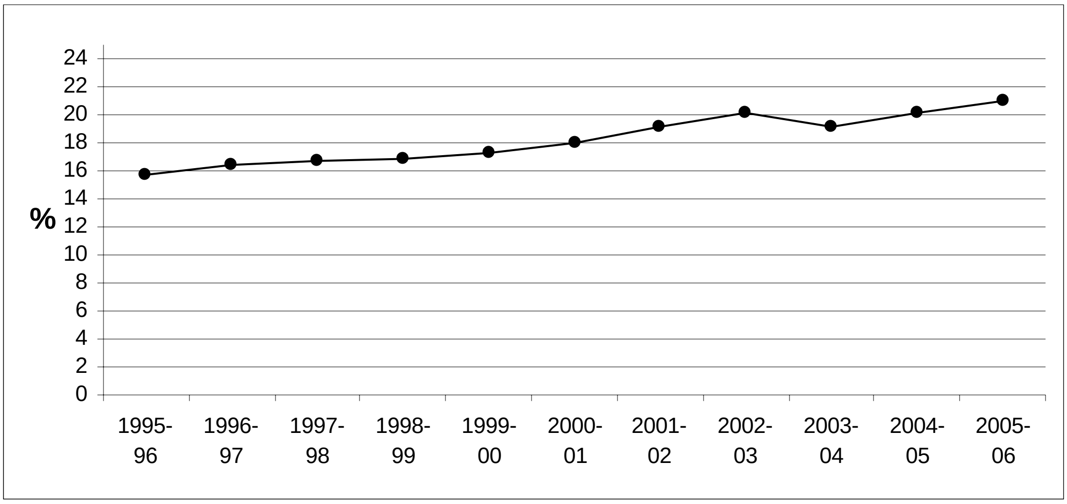
	CALD in population aged 70+ years [1] N	Proportion of target population is CALD [2] %	CALD referrals N	Proportion of CALD referrals [3] %	Index [4]
Rural	24,046	15.7	1,505	8.6	0.5
Metro	122,354	35.3	9,722	27.1	0.8
Total	**146,400**	**29.3**	**11,227**	**21.0**	**0.7**

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

[1] Population Projections based upon ABS Population Projections Australia, 2002 to 2101 Series B (assumptions agreed to by the Department of Health and Ageing).
[2] (Population count CALD background aged 70+) * 100/(Total population aged 70+).
[3] (Referrals with CALD background) * 100/(Total referrals with known country of birth).
[4] Column 5/column 3.

Figure 10 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 2005–06 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 2005–2006 (%)



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

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[*] The number of people of CALD background is based on ABS population projections for 2005-6, in previous reports the CALD target population was taken from the 2001 Census.

Summary: Clients from CALD backgrounds

Overall result:

- A fifth of Victorian assessments (21.0%) were of people from culturally and linguistically diverse backgrounds.
- Access of people from CALD backgrounds to both rural and metropolitan ACAS was lower than their representation in the target population.

Trends:

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

Rural metropolitan comparison:

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

Clients from Indigenous backgrounds

Table 16 presents the numbers of referrals of Indigenous clients and the number of referrals with face-to-face contact.

Table 16: Clients from Indigenous background, Victoria 2005–06 (count)

	Indigenous clients (referrals)	Total referrals*	Indigenous clients (referrals with face-to-face contact)	Total (referrals with face-to-face contact)*
Rural	114	17,452	102	16,316
Metro	89	36,976	83	33,269
Total	**203**	**54,428**	**185**	**49,585**

Note: * Records with valid code for Indigenous status.

Table 17 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 17). There were relatively more Indigenous referrals to rural than metropolitan teams, and rural teams assessed a higher proportion of Indigenous clients relative to their target population.

Table 17: Clients from Indigenous background, Victoria 2005–06

	Indigenous population aged 50+ years [1] N	Proportion of target population is Indigenous [2] %	Indigenous referrals N	Proportion of referrals are Indigenous [3] %	Index [4]
Rural	1,813	1.19	114	0.65	0.55
Metro	1,702	0.49	89	0.24	0.49
Total	**3,515**	**0.70**	**203**	**0.37**	**0.53**

Note: Includes all referrals with valid codes for Indigenous status.

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

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

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

[4] Column 5/column 3.

Figure 11 charts the numbers of Indigenous clients assessed in Victoria in the previous 10 years. Since the large increase in 2003–04 (corresponding to the introduction of MDS v2 in early/mid 2003), Indigenous referrals have decreased with a sharp decline of 21% in 2005–06 compared to the previous year.

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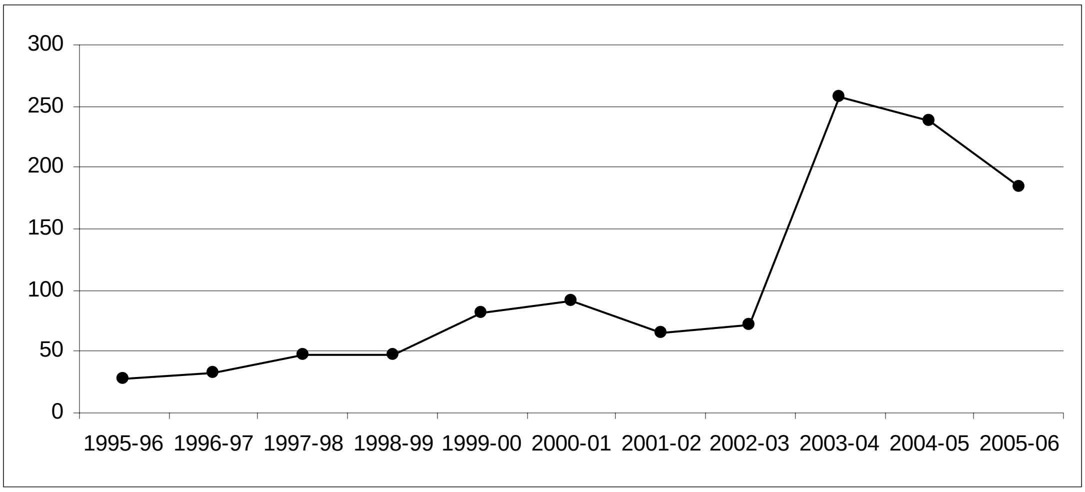
[*] In previous years the Indigenous target population was taken from the 2001 Census.

Figure 11: Assessments of Indigenous clients, Victoria 1995–06 to 2005–06 (counts)



Note: Referrals with face-to-face contact.

Summary: Clients from Indigenous backgrounds

Overall result:

- Over all teams, 0.37% of all referrals involve people from Indigenous backgrounds while 0.70% of the target population are Indigenous.

Trends:

- The number of Indigenous clients has increased in most years since 1995–96 but has declined in the past two years.
- The number of Indigenous referral in 2005–06 was 21.0% lower than the previous year.

Rural metropolitan comparison:

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

Range:

- The proportion of Indigenous to total referrals ranged from 0.0% to 1.8% across Victorian teams.

Clients with dementia

Table 18 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 clients reported with dementia was higher among metropolitan teams than rural teams. There was an increase over the previous year in the proportion of "non-target" clients assessed by metropolitan teams. There was also variation among the teams. The proportion of non-target group clients with dementia ranged from 11.2% to 26.1%, and the proportion of target group clients ranged from 15.7% to 33.5%.

Table 18: Clients with dementia, Victoria 2005–06 (%)

	"Non-target group" clients with dementia (%)	Target group clients with dementia (%)
Rural	16.9	24.0
Metropolitan	20.5	30.1
Total	**19.2**	**28.1**

Note: Complete assessments only.

Summary: Clients with dementia

Overall result:

- Over a quarter (28.1%) 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.
- 19.2% of non-target group clients were diagnosed with dementia at the time of assessment.

Trends:

- A slight increase in the proportion of target group clients with dementia—28.1% in 2005–06 c.f. 27.7% in 2004–05 and 27.9% in 2003–04.

Rural metropolitan comparison:

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

Range:

- The proportion of target group clients with dementia ranged from 15.7% to 33.5%.
- The proportion of non-target group clients with dementia ranged from 11.2% to 26.1%.

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

Clients and carers

Table 19 shows that the great majority of clients (81.3%) 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 19: Clients and carers, Victoria 2005–06 (%)

	Clients with no carer %	Clients with co-resident carer %	Clients with non-resident carer %	Not known %	Total %
Rural	16.9	43.3	37.6	2.2	100.0
Metropolitan	17.4	45.9	35.7	1.0	100.0
Total	**17.2**	**45.0**	**36.3**	**1.4**	**100.0**

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

Summary: Clients and carers

Overall result:

- The great majority of clients (81.3%) had carers.
- The majority of carers were co-resident.

Rural metropolitan comparison:

- Overall, the proportion of clients with carers was similar in rural and metropolitan areas.
- Co-resident carers were relatively more common in metropolitan areas, while non-resident carers were relatively more common in rural 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 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 as one profession and all nursing professionals as one profession).[*]

Table 20 shows that in 2005–06 a tenth of clients living in the community were "at risk" of admission to residential care facility. The proportion "at risk" was higher in metropolitan areas. Just over half 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, with a higher proportion in metropolitan than rural areas.

Table 20: Clients "at risk" of admission to residential care and given a multi-disciplinary assessment, Victoria 2005–06 (%)

	Community clients	Clients "at risk"		Clients get MDA		Clients "at risk" get MDA	
	n	n	%	n	%	n	%
Rural	13,680	1,183	8.6	6,472	47.3	628	53.1
Metro	27,608	2,980	10.8	15,618	56.6	2,018	67.7
Total	**41,288**	**4,163**	**10.1**	**22,090**	**53.5**	**2,646**	**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); a severe or profound core activity restriction; having dementia; living alone; no carer.
The table includes only complete assessments with valid values for the 5 risk factors.
MDA = Multi-disciplinary assessment.

Summary: Client's "at risk"

Overall result:

- Overall, 10.1% of clients living in the community were "at risk" of admission to a residential care facility.
- "At risk" clients were more likely to receive a multi-disciplinary assessment than all clients—63.6% of "at risk" clients received a MDA compared with 53.5% of all clients living in the community.

Trends:

- The proportion of assessments of clients living in the community "at risk" of admission to a residential care facility has increased in the past three years (2003–04 9.1%; 2004–05 9.7%; 2005–06 10.1%).

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[*] It is acknowledged that an ACAS member may be able to incorporate more than one dimension of care need into their comprehensive assessment.

Rural metropolitan comparison:

- The proportion “at risk” was higher in metropolitan than rural 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

Recommended long-term care setting

This sub-section provides an analysis of the recommendation patterns for clients living in the community, low-level care and high-level care at assessment. Table 21 shows that nearly two-thirds of clients living in the community at assessment receive a recommendation to continue living in the community. Overall, this was the same in rural and metropolitan areas but there was variation across the 18 teams—community to community recommendations ranged from 52.3% to 84.9%.

Table 21: Recommended long-term care setting by usual accommodation setting, Victoria 2005–06 (%)

	Community %	Low-level care %	High-level care %	Other/ Missing %	Total %
Clients living in the community at assessment					
Rural	65.7	18.5	15.2	0.6	100.0
Metropolitan	65.5	17.7	15.9	0.9	100.0
Total	**65.6**	**17.9**	**15.7**	**0.8**	**100.0**
Clients living in low-level residential care at assessment					
Rural	0.4	14.1	84.9	0.6	100.0
Metropolitan	1.1	15.0	83.0	0.9	100.0
Total	**0.8**	**14.8**	**83.6**	**0.8**	**100.0**
Clients living in high-level residential care at assessment					
Rural	4.7	10.1	83.4	1.8	100.0
Metropolitan	4.4	9.7	84.6	1.3	100.0
Total	**4.5**	**9.9**	**84.2**	**1.5**	**100.0**
Clients living in other settings (including missing) at assessment					
Rural	37.6	20.5	32.3	9.6	100.0
Metropolitan	36.0	28.1	25.3	10.7	100.0
Total	**36.5**	**25.7**	**27.5**	**10.4**	**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”.

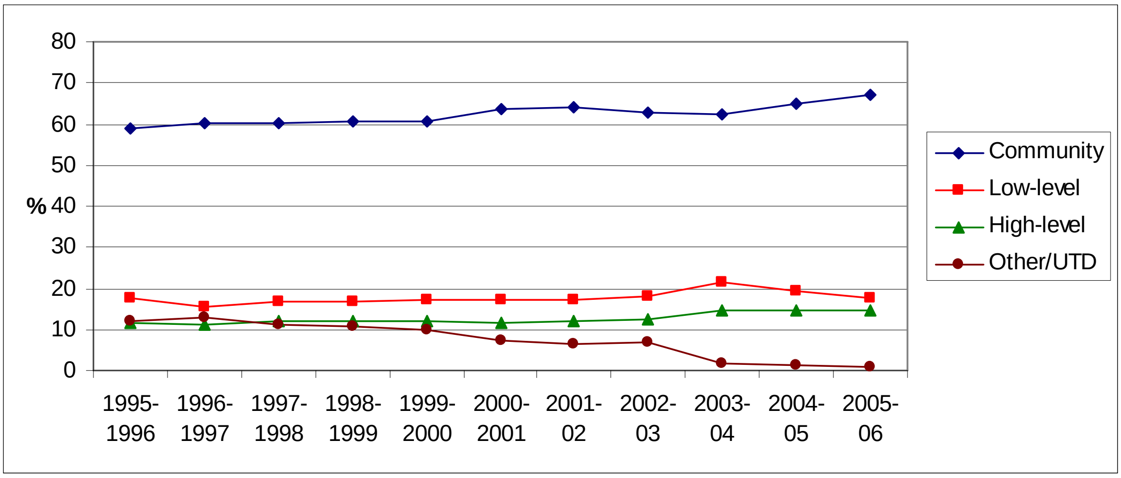
As would be expected, the great majority of clients living in low-level residential care at assessment (83.6%) were recommended to high-level care, with similar proportions in rural and metropolitan areas. Across the teams the proportion of low-level to high-level recommendations ranged from 67.5% to 92.0%.

While the great majority of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care, a significant minority (9.9%) were recommended to low-level care, and a further 4.5% 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 2005–06, 2.8% of completed assessments were of people living in supported community accommodation, with proportionally more in metropolitan (3.4%) than rural areas (1.7%). The recommendations resulting from these assessments were community 2.6%, supported community accommodation 18.1%, low-level care 33.0%, and high-level care 45.5%. 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 10% 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 (including supported community accommodation) at assessment the recommendations are as follows: community 1.3% (rural 1.1%; metropolitan 1.4%), low-level care 25.1% (rural 22.3%; metropolitan 26.2%), and high-level care 73.0% (rural 76.3%; metropolitan 71.7%).

Figures 12 and 13 compare recommendations for 2005–06 with previous years. For historical comparison, the analysis is based on referrals with a face-to-face contact date and clients living in supported community accommodation are considered to be living in low-level residential care. Figure 12 shows that 2005–06 continued 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.

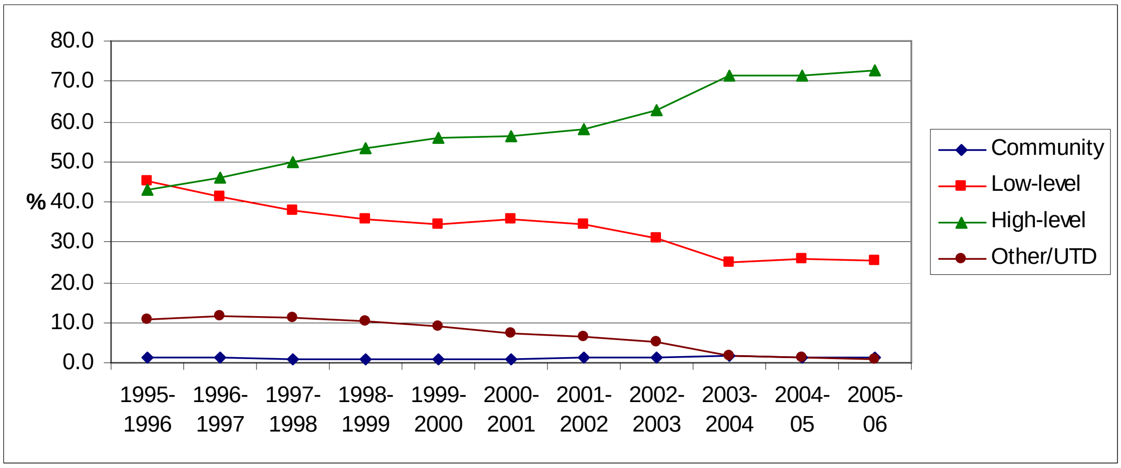
Figure 12: Recommendations—clients living in the community, Victoria 1995–06 to 2005–06 (%)



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

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 2005–06 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 to be low.

Figure 13: Recommendations—clients living in low-level residential care, Victoria 1995–96 to 2005–06 (%)



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 (65.6%) received a recommendation to continue living in the community.
- The great majority (83.6%) of clients living in low-level residential care at assessment were recommended to high-level care.
- The great majority (84.2%) of clients usually living in high-level residential care at assessment were recommended to continue living in high-level care.
- However, a significant minority (9.9%) of clients living in high-level care were recommended to low-level care, and a further 4.5% received community recommendations.

Trends:

- 2005–06 continued 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 2005–06 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 52.3% to 84.9%.

- Low-level to high-level recommendations ranged from 67.5% to 92.0%.

Recommended government-funded care programs

This section presents recommendations (both ongoing and new) for government program support for clients living in the community. Table 22 that over half of clients assessed were recommended a HACC service(s), nearly a third a CACP, nearly a fifth to the National Respite for Carers Program (NRCP), and 6% an EACH package. Just over a tenth were not recommended for any government program. With the exception of the NRCP, recommendations by rural teams were similar to metropolitan teams.

Table 22: Recommended government-funded care programs, Victoria 2005–06 (%)

	CACP	EACH	Transition care[1]	HACC	Veterans' Home Care	Day Therapy Centre	NRCP	Other	None	UTD	Missing[2]
	%	%	%	%	%	%	%	%	%	%	%
Rural	31.7	5.8	0.0	56.4	8.7	3.3	26.0	7.9	8.8	0.3	0.8
Metro	31.7	6.1	0.1	52.8	7.9	3.1	13.3	10.4	11.5	1.0	0.6
Total	31.7	6.0	0.1	54.0	8.2	3.2	17.5	9.6	10.6	0.8	0.7

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

Within the averages presented in Table 22 was considerable variation across the teams in their recommendations. For example, the proportion recommended HACC ranged between 40.0% and 75.9%; for a CACP between 19.7% and 45.5%; and for an EACH package between 3.3% and 10.8% of complete assessments. The variability of recommendations for the NRCP was particularly marked with a range between 3.9% and 57.1% of complete assessments.

Summary: Recommendation for government-funded programs

Overall result:

- Of the assessments with a long-term care recommendation to the community, 54.0% were recommended HACC service(s), 31.7% CACP, 17.5% the National Respite for Carers Program, and 6% an EACH package.
- Over a tenth (10.6%) of assessments with a long-term care recommendation to the community had no recommendation for a government program (excludes respite care).

Rural metropolitan comparison:

- With the exception of the NRCP, average recommendations by rural and metropolitan teams were similar.

Range:

- There was considerable variation among the teams in recommendations for government-funded services, particularly for NRCP.
- HACC ranged between 40.0% and 75.9%; CACP between 19.7% and 45.5%; EACH package between 3.3% and 10.8%, and NRCP between 3.9% and 57.1% of complete assessments.

Recommendations for CACPs

Of the complete assessments resulting in a community recommendation, nearly a third had a recommendations for CACPs—newly recommended or on-going (Table 23). 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 new CACPs recommendation ranged from 12.3% to 38.2%; and an ongoing recommendation from 5.2% to 13.3% of complete assessments with a community recommendation.

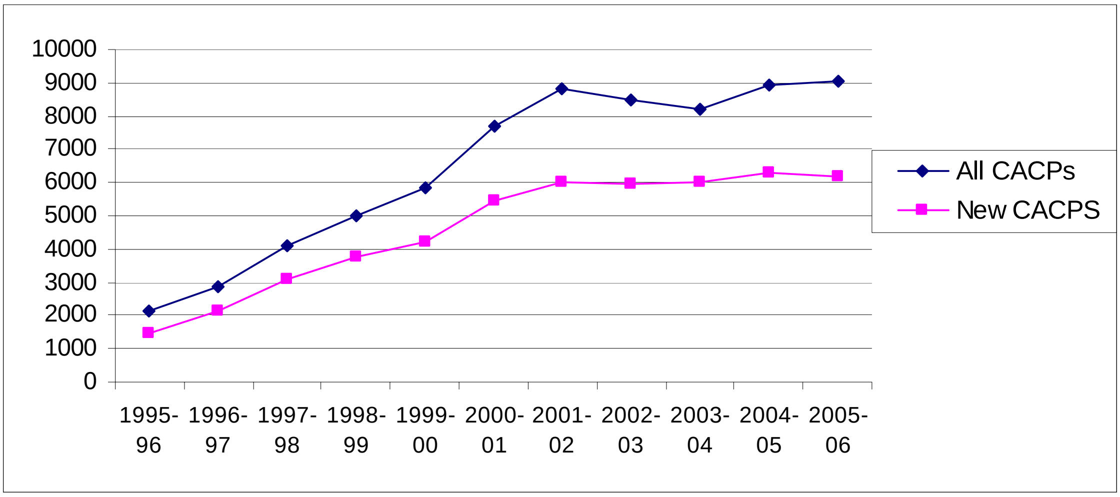
Table 23: Recommended for CACPs, Victoria 2005–06 (%)

	Newly-recommended CACPs		On-going CACPs		Total recommended CACPs		Total recommended to community
	n	%	n	%	n	%	N
Rural	2,172	23.0	822	8.7	2,994	31.7	9,455
Metropolitan	4,033	21.0	2,010	10.5	6,043	31.5	19,184
Total	**6,205**	**21.7**	**2,832**	**9.9**	**9,037**	**31.6**	**28,639**

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

Figure 14 shows that the number of CACPs recommended in Victoria increased markedly between 1995–96 and 2001–02, but in recent years has levelled off. Numbers of new and on-going CACPs in 2005–06 were similar to the previous year.

Figure 14: Recommendations for CACPs (clients recommended to the community), Victoria 1995–06 to 2005–06 (counts)



Summary: Recommendation for CACPs

Overall result:

- CACPs are recommended in a third of assessments of people recommended to the community—on-going 9.9% and 21.7%.

Trends:

- Numbers of new and on-going CACPs in 2005–06 were similar to the previous year.

Rural metropolitan comparison:

- Newly recommended CACPs were more likely from 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 an on-going CACP recommendation ranged from 5.2% to 13.3%.
- The proportion of new recommendations ranged from 12.3% to 38.2%.

Recommendations for respite

Nearly three-quarters of clients recommended to the community receive a recommendation for residential respite care, and over a tenth a recommendation for non-residential respite (these proportions include recommendations for both residential and non-residential). 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 45.0% and 92.4% of clients recommended to the community, and for non-residential respite between 2.2% and 31.0%.

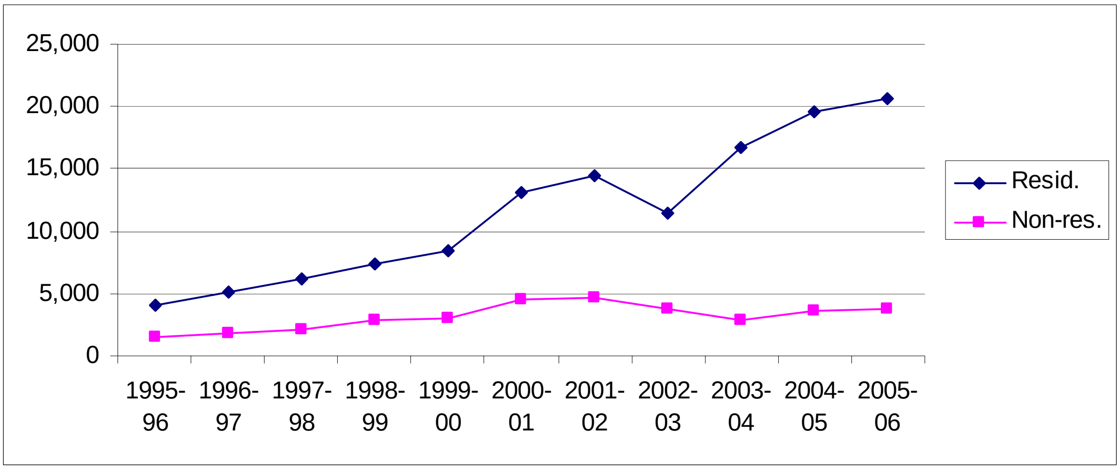
Table 24: Recommended for respite care, Victoria 2005–06 (%)

	Residential respite care*		Non-residential respite care*		Recommended to community
	n	%	n	%	N
Rural	6,482	68.6	1,413	14.9	9,455
Metropolitan	14,110	73.6	2,406	12.5	19,184
Total	**20,592**	**72.0**	**3,819**	**13.0**	**28,639**

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

Figure 15 shows that with the exception of 2002–03, the number of clients recommended for residential respite has increased steadily since 1995–96, and 2005–06 was consistent with the overall trend. The number of recommendations for non-residential respite was 5% higher than in 2004–05.

Figure 15: Recommendations for respite care (clients recommended to the community), Victoria 1995–06 to 2005–06 (counts)



Summary: Recommendation for respite

Overall result:

- Nearly three-quarters of clients (72.0%) recommended to the community received a recommendation for residential respite in 2005–06, and 13.0% a recommendation for non-residential respite.

Trends:

- Consistent with the overall trend, recommendations for residential respite increased again in 2005–06.

- The number of recommendations for non-residential respite increased by 194 (5%) 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 45.0% and 92.4% of clients recommended to the community.
- For non-residential respite the range was between 2.2% and 31.0%.

Recommendations for particular groups

Recommendations for clients not "at risk"

Clients living in the community are defined as being "at risk" of admission to residential care if they have any 4 of the following 5 characteristics: aged 80 years or over (or Indigenous and aged 60 years or over); having a severe or profound core activity restriction; having dementia; living alone; not having a carer. Table 25 presents recommendations for clients who are not "at risk".

Table 25: Recommendations for clients not "at risk", Victoria 2005–06

	Community		Low-level care		High-level care		Other/ missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	8,506	68.1	2,094	16.8	1,818	14.5	79	0.6	12,497	100.0
Metro	17,074	69.3	3,898	15.8	3,442	14.0	214	0.9	24,628	100.0
Total	**25,580**	**68.9**	**5,992**	**16.1**	**5,260**	**14.2**	**293**	**0.8**	**37,125**	**100.0**

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

The recommendation pattern was similar in rural and metropolitan areas. The corresponding recommendations for "at risk" clients were community 38.3%, low-level care 33.3%, and high-level care 27.2%. That is, "at risk" clients were twice as likely to receive a residential care recommendation as 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 coded as community clients. For the clients not "at risk" living in supported community accommodation at assessment (833), the recommendations were: 3.6% community; 21.4% to supported community accommodation; 37.2% to low-level care; 36.5% to high-level care; and 1.3% to other/missing.

Summary: Recommendation for clients not "at risk"

Overall result:

- The great majority of complete ACAS assessments were of clients (89.9%) not "at risk" of admission to residential care.
- Of those clients living in the community not "at risk", 68.9% were recommended to the community and 30.3% to residential care (16.1% to low-care and 14.2% to high-care).
- Clients not "at risk" were much less likely to receive a residential care recommendation than "at risk" clients.

Trends:

- Community recommendations for clients not "at risk" have increased in the past three years (2003–04 63.3%; 2004–05 66.9%; 2005–06 68.9%).

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. Table 26 shows that 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 21), "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 47.8% to 84.3%; low-level care from 4.3% to 31.3%; and high-level care from 9.9% to 29.6%.

Table 26: Recommendations for "non-target" clients, Victoria 2005–06

	Community		Low-level care		High-level care		Other / missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	840	72.2	125	10.7	186	16.0	13	1.1	1,164	100.0
Metro	1,408	63.9	372	16.9	394	17.9	30	1.4	2,204	100.0
Total	**2,248**	**66.7**	**497**	**14.8**	**580**	**17.2**	**43**	**1.3**	**3,368**	**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 (158), the recommendations were: 3.2% community; 22.2% to supported community accommodation; 36.7% to low-level care; 36.1% to high-level care; and 1.9% to other/missing.

Summary: Recommendations for "non-target" clients

Overall result:

- Two-thirds (66.7%) of "non-target" clients living in the community are recommended to remain in the community, 14.8% to low-level care and 17.2% to high-level care.
- Compared to all clients living in the community, the "non-target group" 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.

Trends:

- The proportion of "non-target" clients recommended to residential care was similar to the past three years (2003–04 65.9%; 2004–05 65.4%; 2005–06 66.7%).

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:

- There was a considerable range across the teams in the recommendations for "non-target group" clients: community ranged from 47.8% to 84.3%; low-level care from 4.3% to 31.3%; and high-level care from 9.9% to 29.6%.

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 (21.0% to low-level and 23.4% 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 27: Recommendations for clients with dementia, Victoria 2005–06 (%)

	Community		Low-level care		High-level care		Other/ missing		Total	
	n	%	n	%	n	%	n	%	N	%
Rural	1,691	54.9	684	22.2	696	22.6	11	0.4	3,082	100.0
Metropolitan	4,359	55.3	1,613	20.5	1,863	23.7	42	0.5	7,877	100.0
Total	**6,050**	**55.2**	**2,297**	**21.0**	**2,559**	**23.4**	**53**	**0.5**	**10,959**	**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 27 above shows that 44.4% of clients with dementia received a recommendation for residential care compared to 33.6% of all clients living in the community (Table 21). Further, a high-level care recommendation is more likely for clients with dementia (23.4%) than all clients living in the community (15.7%).

For the clients with dementia living in supported community accommodation at assessment (535), the recommendations were: 1.3% community; 12.7% to supported community accommodation; 27.1% to low-level care; 58.1% to high-level care; and 0.7% to other/missing.

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.
- 44.4% of clients with dementia received a recommendation for residential care compared to 33.6% of all clients living in the community.
- Further, 23.4% clients with dementia receive a high-level care recommendation compared to 15.7% of all clients living in the community.

Trends:

- Increases each year since 2003–04 (49.0%) in the proportion of clients with dementia given a community recommendation to the present 55.2% (an increase of 1.7% compared with 2004–05).

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 but usually living in the community were three times as likely to receive a recommendation for residential care (72.6%) than the community (24.7%), and were more likely to receive a recommendation for high-level care than low-level care (Table 28). Recommendations in rural and metropolitan areas were similar. The recommendation pattern evident in Table 28 was similar across all teams but there was a considerable range in the proportion recommended to the community (1.9% to 40.7%), with less variability in the range for low-level (14.7% to 31.8%) and high-level care (41.4% to 66.0%) recommendations. This reflects different policy and practice among the teams on the assessment of clients likely to continue to live in the community.

Table 28: Recommendations for clients assessed in acute hospital and usually living in the community, Victoria 2005–06

	Community		**Low-level care**		**High-level care**		**Other/ missing**		**Total**	
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**N**	**%**
Rural	622	25.7	570	23.5	1,186	49.0	44	1.8	2,422	100.0
Metro	1,125	24.2	1,067	23.0	2,302	49.6	150	3.2	4,644	100.0
Total	**1,747**	**24.7**	**1,637**	**23.2**	**3,488**	**49.4**	**194**	**2.7**	**7,066**	**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 28 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 80.7%, low-level care 14.5%, and high-level care 4.4%.

For the clients living in supported community accommodation and assessed in an acute hospital (368), the recommendations were: 0.8% community; 5.4% to supported community accommodation; 14.9% to low-level care; 78.3% to high-level care; and 0.5% to other/missing.

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.
- 24.7% of community clients assessed in an acute hospital received a recommendation to the community, 23.2% were recommended low-level care and 49.4% high-level care.
- For clients living in the community and assessed in the community the comparable recommendations were: community 80.7%, low-level care 14.5%, and high-level care 4.4%.

Trends:

- The proportion of clients assessed in hospital and given a community recommendation decreased by 2.0% compared with the previous year.
- The decrease in community recommendations from hospital assessments is consistent with the long-term trend; since 1995–96 the proportion has steadily decreased from 42.0% to the present 24.7%.
- There was a continuation of the long-term trend for decreasing proportions, and numbers, of assessments in acute hospitals.

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 1.9% to 40.7%.

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.

Under a fifth (17.9%) of "at risk" target group individuals living in the community received a recommendation for a CACP. This means that just under half of "at risk" target group individuals recommended to the community received a recommendation for a CACP. This was relatively more than the proportion (31.6%) of all assessments recommended to the community with a CACP (Table 23). Across the teams, the proportion of individuals recommended a CACP ranged between 5.0% and 33.3%.

Table 29: CACP recommendations for "at risk" target group clients, Victoria 2005–06 (%)

	Community with no CACP %	Community with CACP %	Low-level care %	High-level care %	Other / missing %	Total %
Rural	19.0	20.4	35.4	24.8	0.3	100.0
Metropolitan	18.2	16.9	32.3	31.7	1.0	100.0
Total	**18.4**	**17.9**	**33.2**	**29.8**	**0.8**	**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:

- Under 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, just under a half (49.3%) received a recommendation for a package, compared with 31.6% of all clients recommended to the community.

Trends:

- The proportion of "at risk" target group clients given a recommendation for a CACP was 0.3% higher than in 2004–05 but below the 19.1% reported in 2003–04).

Rural metropolitan comparison:

- Rural teams recommended a CACP 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 5.0% to 33.3%.

CONCLUSION

This Annual Report analyses records with assessment end dates from July 1 2005 to July 30 2006, and is the second to comprise all MDS v2 data.

Assessment numbers

In 2005–06 there was a small increase (0.2%) in total referrals, and completed assessments (1.5%) over the previous year but Victorian teams reported 1.8% fewer assessments with face-to-face contact (i.e., MDS v1 comparable) than in 2004–05. However, if assessment activity in hospitals no longer reported in the national ACAP MDS (Victorian Admitted Episode Data on ACAS consultations in hospitals) is included, total assessment activity (face-to-face assessments and consultations recorded in the VAED) was slightly higher (0.2%) than in 2004–05. The decrease in assessments with face-to-face contact continues a trend evident from 2002–03, and appears to be due the introduction of MDS v2 and/or a change in criteria for what is included in the MDS. The historical trend is more stable if hospital consultations are included. Anecdotal evidence also suggests that a return to “core business” by teams may also be contributing to the continuing decline in face-to-face assessment numbers.

Access to assessment

Although total referrals and completed assessments were higher in 2005–06 than the previous year, assessment rates have steadily decreased in Victoria. The 2005–06 rates of 88.2 completed assessments and 100.8 assessments with face-to-face contact per 1000 target population were both lower than those for 2004–05 (89.1 and 107.0 respectively) and consistent with the longer-term trend (Lincoln Centre for Ageing and Community Care Research, 2006). However, the lower assessment rates in 2005–06 were partly attributable to a change in the target population figures used. Previous reports have used Estimated Resident Population data which is available only for the previous year. This report is based on population projections for the 2005–06 year.

Although assessment rates have declined, the ACAS in Victoria has become more focused on its target population. The proportion of target group (people aged 70 years and over and Indigenous people 50 to 69 years) assessments has steadily increased from 87.1% in 1995–06 to the present 91.9%.

Access to the ACAP by people of CALD background in 2005–06 was higher than the previous year. Referrals of people from CALD background were 4.3% higher than in 2004–05 and this increase was consistent with the longer term trend. However, the proportion of CALD to total referrals was below their representation in the population. As with overall assessment rates, this low representation was partly due to the change to projections for the target population.

Access to the ACAS of Indigenous people was lower than the previous year (by 54, a drop of 21.0%), particularly in metropolitan areas, and well below their representation in the target population. This continues a recent trend. Assessments of Indigenous people have declined since 2003–04 when there was a considerable increase over previous years.

Access to the ACAS by two particular groups, people with a severe or core activity restriction and people with dementia, increased slightly compared to the previous year. The increase in the proportion of people with a severe or core activity limitation in the target population continued the upward trend evident since this indicator became part of the MDS in 2002–03.

Timeliness of assessment

On average, Victorian ACAS take about a day and a half to respond to a need for a comprehensive assessment (referral to first intervention 5% trimmed mean) in acute hospital/other inpatient settings, and nearly two weeks in non-hospital settings (residential care/community). To complete the assessment process (first intervention to end of assessment) took an average of a further 3 days in hospital settings and 10 days in non-hospital settings.

Compared with the previous year, the time taken to respond to a request for service and the assessment process increased in 2005–06. The time between referral and first intervention, and from first intervention to the end of assessment increased in both hospital and non-hospital settings. These increases were consistent with the long-term trend of increasing assessment times. In the period from 1999–00 to 2005–06 the time from referral date to face-to-face assessment date (5% trimmed mean) has increased from 1.7 to 2.0 calendar days in hospital settings, and from 11.8 to 20.0 calendar days in non-hospital settings. Despite this trend, the proportion of people seen "on time" (First intervention within 48 hours for clients categorised as Priority 1 and 3–14 calendar days for Priority 2) has been maintained over the previous three years, and in 2005–06 improved slightly compared to the previous year. The proportion seen "on time" for Priority 1 clients was 89.6% in hospital settings and 83.2% in non-hospital settings; and for Priority 2 the corresponding figures were 98.6% and 88.7%. The higher proportions seen "on time" in hospital settings reflect the agreements many teams have with their auspice to respond to requests for assessment within a specified time (usually 48 hours).

Client characteristics

The complexity of clients continued to increase (albeit slightly) compared with previous years. The proportion of clients aged 80 years and over continued to increase (by 1.3% compared with 2004–05) and this was reflected in an increase in the proportion of clients reported with activity limitations and health conditions. The proportion of clients with an activity limitation was higher this year compared to last for all 8 of the 10 activities, and the proportion with no activity limitation decreased from 1.6% to 1.3%. The proportion of clients with one or more core activity limitation increased by 0.8% over the previous year. Relatively more clients were reported with many of the common health conditions, including dementia, compared to 2004–05. This continuing increase in client dependency may be a factor contributing to the lower assessment numbers compared to previous years.

Recommendations

The great majority of clients (90.1%) live in a community setting at the time of assessment, and 65.6% are recommended to continue living in the community, a small increase (1.6%) on the previous year. This increase is consistent with the long-term trend of increased proportions of community to community recommendations, from 58.9% to the present 65.5%. Over the same period, community recommendations for clients assessed in acute hospitals have decreased from 42.8% in 1995–96 to 24.7% in 2005–06. The decrease in the proportion of clients assessed in an acute hospital and given a community recommendation is off-set to some extent by the decreasing proportions, and numbers, of clients assessed in acute hospital (e.g., 9,833 community-dwelling assessments (23.2% of records with face-to-face contact) were assessed in hospital in 2003–04, compared with 7,066 assessments in 2005–06 (19.9% of records with face-to-face contact). This decrease indicates that assessments in acute hospitals are increasingly targeting people who need approval for residential care.

Recommendations of CACP for target group clients "at risk" of admission to residential care (those with any 4 of the following 5 characteristics: aged 80 years or over, or

Indigenous and aged 60 years or over; having a severe or profound core activity restriction (needs assistance with one or more the tasks of self-care, mobility or communication)); having dementia; living alone; not having a carer) increased in 2005–06 by 0.3% over the previous year but were below the 19.1% reported in 2003–04. Long-term community recommendations for clients with dementia living in the community at assessment increased again in 2005–06 to 55.2%, an increase of 1.7% over the previous year.

Range across teams

As in previous years, there was considerable inter-team variation in assessment numbers, timeliness and recommendations. Variability in policy and practice (particularly intake procedures), recording practice, catchment size, and the availability of services (particularly rehabilitation), impact on the assessment profile of teams. For example, the proportion of referrals that do not proceed further ranged from 0.1% to 16.5 %, and the proportion of completed (but not delegated) assessments from 5.9% to 42.4% and delegated assessments ranged from 43.4% to 88.8%. Taken together, complete and delegated assessments showed less variability (range 68.3% to 98.5%).

While there was a relatively narrow range in the proportion of completed assessments to all assessments (88.9% to 94.2%) across the teams, the rate of completed target group assessments per 1000 target population varied considerably (71.2 to 158.3). The high rates are due to local factors, for example, a metropolitan team with a relatively small catchment based at a hospital that draws people from a much wider area. However, 6 of the 18 teams reported rates between 70 and 80, and these relatively low rates may be due to a number of factors that vary from team to team (see above).

Both rural and metropolitan teams reported a considerable range in timeliness in all settings. Response times (referral to face-to-face contact) ranged from 0.4 to 11.3 calendar days in hospital settings and from 8.6 to 40.2 calendar days in non-hospital settings (trimmed means). The assessment process (referral to end of assessment) ranged from 1.4 to 17.7 calendar days in hospital settings, and from 9.2 to 46.6 calendar days in non-hospital settings (trimmed means).

The outcomes of assessment (recommendations) also varied considerably across the teams. For example, the proportion of people living in the community and given a long-term care recommendations to the community ranged from 52.3% to 84.9%; and the proportion living in low-level care and recommended high-level care ranged from 67.5% to 92.0%.

Data quality

Victorian data quality in 2005–06 was good and there were improvements compared with the previous year. The National Data Repository aims for a missing or error rate of less than 1%. For records with face-to-face contact, and excluding date items, this level was achieved in Victoria for most items. Items with an error rate of more than 1% were: country of birth, Indigenous status, DVA entitlement, assistance with activities and respite care (use of and recommended). The error rate for all records in coding priority category was high (4.2%) because a few teams did not code it until there was face-to-face contact, when in almost all instances it should be coded as part of the intake process. The error rate for records with face-to-face contact was 0.3%. 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. The error rate for country of birth was 3.7% and due to a few teams with very high rates because of difficulties in linking with their hospital system. The error rates reported for the assistance with activities and respite care items were due in part to incorrect coding of “Not applicable”.

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APPENDIX 1: HOT ITEMS/ISSUES REVIEWED DURING THE YEAR

The following hot items were included in this year's quarterly reports.

Diagnosed diseases/disorders

Diagnosed diseases/disorders, Victoria 2005–06

	Average number of diagnoses/ completed assessment n	Proportion of complete assessments with one diagnosis only %	Proportion of complete assessments with no diagnosis[1] %	Proportion of complete assessments with missing diagnosis[2] %
Geelong	6.3	0.7	0.0	0.1
Warrnambool	3.6	11.0	0.0	0.0
Ballarat	4.5	4.6	0.0	0.1
Bendigo	5.0	8.5	0.0	0.1
Mildura	4.6	5.0	0.0	1.0
Shepparton	5.0	2.6	0.0	0.2
Wangaratta	3.3	20.2	0.0	1.0
Gippsland	5.5	7.3	0.0	0.0
NorthWest	4.0	17.0	0.0	0.0
Western	3.0	27.5	0.0	0.0
Bundoora	4.9	2.7	0.3	0.0
Heidelberg	4.3	3.2	0.0	0.0
Eastern	5.2	3.5	0.0	0.1
St Georges	6.4	2.8	0.0	0.2
Outer East	5.8	3.1	0.0	0.1
Mount Eliza	4.0	7.1	0.0	0.0
Kingston	5.1	2.7	0.0	0.3
Caulfield	4.7	5.2	0.1	0.0
Total	**4.8**	**7.4**	**<0.1**	**0.1**

Note: Complete assessments only (Reason for ending assessment (ACCR Question 32) code 1).
[1] Health condition codes 0000 and 9998.
[2] Health condition code missing.

Missing data

Table shows the proportion of records from each team that has missing or invalid data in selected fields

Missing data—selected items, Victoria 2005–06

	First intervention date[1] %	First face-to-face contact date[1] %	Assessment end date[1] %	Delegation date[1] %	Postcode[2] %	Country of birth[2] %	Usual accommodation[2] %
Geelong	0.0	0.0	0.0	0.0	0.0	1.0	0.1
Warrnambool	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Ballarat	0.0	0.0	0.0	0.0	0.0	2.0	0.0
Bendigo	0.1	0.1	0.0	0.0	0.1	0.9	0.1
Mildura	0.0	0.0	0.0	0.0	0.0	0.3	0.1
Shepparton	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Wangaratta	0.0	0.0	0.0	0.0	0.0	0.9	0.0
Gippsland	0.0	0.0	0.0	0.0	0.0	0.4	0.0
NorthWest	0.0	0.0	0.0	0.0	0.0	17.9	0.1
Western	0.1	0.1	0.0	0.0	0.1	11.6	0.0
Bundoora	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Heidelberg	0.0	0.0	0.0	0.0	0.0	0.1	0.0
Eastern	0.0	0.0	0.0	0.0	0.0	0.6	0.0
St Georges	0.0	0.0	0.0	0.0	0.0	15.9	0.3
Outer East	0.0	0.0	0.0	0.0	0.0	0.2	0.1
Mount Eliza	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Kingston	0.0	0.0	0.0	0.0	0.0	0.2	0.0
Caulfield	0.0	0.0	0.0	0.0	0.0	2.0	0.0
Total	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**3.6**	**0.1**

Note: [1] Invalid dates or dates out of sequence (e.g., first intervention before referral; assessment end date outside the quarter) as a proportion of records with the particular date.

[2] Proportion of invalid or missing codes as a proportion of completed assessments.

APPENDIX 2: THE AGED CARE ASSESSMENT PROGRAM AND DATA COLLECTION

The Aged Care Assessment Program

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

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

Assessment by an Aged Care Assessment Service (ACAS) is mandatory for admission to residential care and residential respite, to receive Australian Government funded community care (Community Aged Care Package) and flexible care (Extended Aged Care at Home, Transition Care). ACAS also refer people to community services provided under the Home and Community Care Program, to Linkages[9] (which provides intensive community care packages), to rehabilitation services—both inpatient and community-based—and to general community services.

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

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

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[9] Known as Community Options in other states.

- 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[10] 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.

MDS v1 and MDS v2

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

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[10] Now the Lincoln Centre for Ageing.

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.

The Aged Care Client Record

At the 18 November 2004 meeting of ACAP Officials it was agreed that the Department of Health and Ageing (DoHA) was to revise the current Aged Care Client Record (ACCR) in line with the ACAP MDSv2. The changes were necessary in order to:

- address requests for improvements from users of the current form;
- prepare for program initiatives announced in the 2004-2005 Budget (transition care and improved case management) or foreshadowed in the Government's Election commitments (EACH Dementia); and
- prepare for forthcoming pilot study of electronic capture and transmission of assessment data (the eACCR project).

The revised ACCR was developed to address the needs listed above. Members of the ACAP Data Working Group and stakeholders within DoHA were consulted on the changes proposed and ACAP Officials advised of the release of the revised ACCR at their meeting on 17 May 2005.

The changes made to the ACCR included no additional questions but extra options were added to some questions, and some formats and wording changed to make the ACCR more useable and decrease data entry errors. The more noticeable of the changes were the inclusion of items to record recommendations to transition care and the expansion of items related to flexible care.