Changing assessment processes in Older Person's Health:

Some Canterbury Tales

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ABSTRACT

A central challenge in building effective and comprehensive assessment processes in health services for older people lies in all the players communicating with each other, and trusting the reliability and significance of these communications. Drawing on the classical approach of Chaucer's *Canterbury Tales*, (and Bate's application of this analogy to a UK-NHS emerging 'community of practice') this paper describes some of the experiences of The Elder Care Canterbury Project in developing more effective sector-wide communication. It offers an update on the current pilot implementation of an increasingly common international language of comprehensive geriatric assessment, known as the interRAI suite of tools, from which Canterbury District Health Board is starting with a trial of the MDS-HC (Minimum Data Set – Home Care); implications of this process for primary care are also outlined.

Introduction

In the late 1990s a local demonstration project known as The Elder Care Canterbury Project grew, with a mission *'to integrate and improve the health of older people'*.[1] A key process from the early days in 1997 entailed all the key stakeholders committing to talk to each other and, in particular, to talk with older people (particularly through the mechanism of the Community Stakeholders Group), about how this mission might be achieved.[2]

A comparable whole systems change process is described by Bate[3] who presents this communicative breakthrough process through the voices of, and tales told by, the multiple players in a UK-NHS scenario, in these terms: *'stories and storytelling and the communities of practice lie at the very heart of the change process – in both a literal and metaphorical sense.'*[4]

Tales from the Elder Care Canterbury Project

Nigel Millar[2] has attributed the initial impetus behind the formation of this project to innovation arising from the local Independent Practitioners' Association communicating effectively with secondary and tertiary services, and agreeing to work with the community in an inclusive and collaborative way to develop the best possible service for Canterbury's older people. These early meetings, as well as a series of focus groups

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with older people and community service providers, generated several 'legendary tales' as Box 1 presents.

These tales share a common element of communication breakdown, either through several service providers asking the same question repeatedly, or describing situations when parties within the continuum of care are not communicating effectively.

In the early phases priority projects emerged, identified by all the stakeholders as having significant opportunities to improve and integrate services: Broken Hip, Stroke, Discharge Planning, Delirium, COSE – Coordinator of Services for the Elderly.[1] Each generated small scale pilots, and most made an attempt to record and describe processes and outcomes. In the period 1999–2000, an Evaluation Team was formed to develop and explore associated outcome measures, and to make considered before and after comparisons. Published results from aspects of the Broken Hip[5] and Stroke[6] projects are available, and COSE (a model of community care, needs assessment and service coordination involving a key worker based initially in primary care settings) continues to participate in a national RCT evaluating 'ageing in place' initiatives.[7] The Project website[1] made initial project design documents, working reports, and several interim evaluation reports widely accessible.

Finding a language in which to express costs and benefits, and to identify outcome measures, along with locally and nationally relevant benchmarking, remained a continuing challenge in evaluating these early projects, as components of the wider system (community organisations, primary care, acute or specialist services) had limited opportunity to develop integrative communication systems.[8] There were also delays as well as contact and consent difficulties in complying with ethical protocols required to permit contact with older people for service evaluation purposes. Following older people as they moved between 'consent to treat' borders was an equal challenge to integrating service delivery, and to quality audit when providers were accountable only for their part of the 'continuum of care'.

Box 1. Some Canterbury Tales

An older person's tale: If one more person asks me who the Prime Minister is today, I am likely to thump them.

A rural general practitioner's tale: Two of my older patients this month have been discharged from hospital late on a Friday afternoon with a prescription for changed medication which can't be filled locally until Monday.

A carer's tale: I had to become a traffic controller in my own driveway, as the van delivering my husband's new walking frame had to back up to allow the van (driving off with the returned ACC walking frame) to turn. Don't these people talk to each other?

Box 2. Translating the InterRAI language into service relevance

InterRAI assessments offer:

- Individual needs assessment in multiple domains, using validated measures
- Reliable information for care planning

When aggregated, an InterRAI database offers:

- Measures of case mix and resource utilisation
- Outcome measures for service development and evaluation
- Quality indicators on a service or population basis
- Research capacity based on clinically accurate measures in older person's health

Box 3. Some primary care questions which the interRAI assessment language can help us answer

1. What's worth knowing about the older people in your practice?
2. Is continence a problem for your patients?
3. How can you pre-empt crisis and reduce acute admissions?
4. How can you help your older patients remain at home?
5. How does the prevalence and management of incontinence in your practice compare with others locally or nationally?
6. Have acuity levels risen within your practice?

By 2001–2, the experience of the Elder Care Canterbury Project was however significantly acknowledged and incorporated in several objectives within the national Health of Older People Strategy;[9] in particular, this strategy required the Ministry of Health to *'develop an implementation plan and guidelines for comprehensive integrated assessment for older people and their carers. An integrated assessment system for accessing health and disability support services needs to cover physical, mental health, social, cultural and spiritual needs. It also needs to include assessment of whether functional limitations can be reversed by treatment and/or rehabilitation. The assessment process therefore needs to be integrated with treatment and rehabilitation services...[and should] map out potential trigger points for an assessment, the type of*

assessment that may be appropriate for given circumstances and the competencies required to undertake that assessment.' (Objective 3.2).

Other Elder Care Canterbury 'slogans' promoting *'the right service, in the right place, at the right time'* similarly became national goals, included within this Strategy.

Assessment processes for older people

The first step towards Objective 3.2 was the formation in late 2001 of the Assessment Processes for Older People Guideline Development Team, initially supported by the Ministry of Health and ACC and, by early 2002, under contract to the New Zealand Guidelines Group.

Linking these goals for integrated care of older people to an international evidence base, the New Zealand Guidelines Group[10,11] and its associated Tools Review focussed on exploring what 'best practice' meant in terms of how 'right' was to be assessed, in terms of matching services to need, as well as location, setting and timeliness of assessment. The inextricable linkage between assessing the health and social needs of older people, and the services designed and delivered to meet these needs, was acknowledged throughout. Accordingly, assessing needs in a way that leads to improving the outcomes for older people by improving the fit between assessed needs and service effectiveness, requires agreement on *'outcomes that matter to older people.'*[10]

Comprehensive geriatric assessment plus appropriate services to meet identified needs offers benefits for older people and is cost effective within a well integrated health service

The emerging consensus within the Guidelines Development Team, and from the systematic and critical appraisal of the strongest international evidence is clear: comprehensive geriatric assessment plus appropriate services to meet identified needs offers benefits for older people and is cost effective within a well integrated health service. The timeframes within which benefit is observed in the literature vary, depending on the point of needs assessment and types of intervention. However, the Guideline consistently advocates for *'the sooner, the better'*, and *'the more comprehensive, the better'*. The New Zealand Guideline itself thus offers an algorithm, using the language of screening/proactive/complex needs assessment, along the continuum of care, indicating 'best practice' and evaluating the evidence for costs and benefits at each point on the continuum.

Throughout the evidence-based review of best practice in needs assessment of older people (answering the core questions surrounding assessment – why, when, where, which older people, how, by whom?) it became clear that the best evidence was expressed in large scale systematic studies using a small range of 'languages' of standardised, valid and reliable clinical and social assessment; languages represented in these assessment tools were referred to independent consultants, who performed a more intensive technical review of their validity and reliability.[11] The combined recommendation of these two reports, published in late 2003, was that New Zealand would be best served by implementation of the New Zealand Guideline on Assessment Processes for Older People, through adoption of the interRAI[12] suite of assessment tools, with the MDS-HC of highest priority initially.

Learning the interRAI language – local lessons

InterRAI represents a suite of assessment tools developed, researched and promoted by the interRAI not-for-profit research collaborative, based in North America but now operating in 25 countries. 'Inter' stands for international and RAI refers to Resident Assessment Instrument (as residents in long-term care were the initial population with whom the tool was developed).

The Older Persons Health division of the Canterbury District Health Board has elected to trial the Home Care tool known as the MDS-HC. The MDS-HC is a multidimensional compilation of critical elements, i.e. a minimum data set, in a comprehensive geriatric assessment designed to assess the medical, rehabilitation and support requirements of an older person in order for them to remain at home. One trained assessor enters information into a computerised database to complete the assessment.

The software associated with the database suggests further action for any specific problem triggered, depending on the individual configuration of responses. This information is then available to the care team as a starting point for any further in-depth, single-discipline assessments and plans. While the purpose of the assessment is to improve geriatric assessment practice, the tool has added value features that produce outcome measures, resource utilisation groups, and quality indicators. These features are helpful for individual planning and may be aggregated to assist population health planning.

The two-year interRAI implementation project aims to trial how the interRAI home care assessment fits around current processes in two health settings: primary care and secondary care. The project is part of a national trial where five District Health Boards are testing and developing different ways of using the assessment, in a variety of service settings. CDHB are trialling the tool in the inpatient (AT&R) setting first and then community sites. It is an iterative process that involves developmental testing of the assessment process, the software and associated technology, in order to identify and resolve problems and provide insight into the practice and resource implications of using the tool.

The project has two parts, a practical implementation aspect and a review aspect. The implementation aspect involves assessing incoming patients to an assessment, treatment and rehabilitation (AT&R) ward using the MDS-HC, then within a few months extending this process to community sites. The aim is to have information about the patient available to inform each discipline's assessment, to use the information obtained for care planning and to update and review the MDS-HC over time. The information is thus available for discharge planning, and for ongoing treatments, rehabilitation and support. Positive signals to date include having a concise summary report which notes patient management issues identified for immediate Interdisciplinary Team consideration. Other more detailed reports are available according to need. There are indications that duplication of the questions asked in individual domains, or at repeat assessments, is reducing with a corresponding opportunity for individual disciplines to become more involved in rehabilitation and care planning.

Challenges to date have included technology issues related to the software, which is still being tested through the five DHBs in the initial project, as well as connection and device problems. The project is also identifying adjustments needed to reduce the length of time required to complete the assessment and exploring the nature and type of reports that the system could potentially generate. The overall outcomes of the implementation aspect of the project will include a project report detailing challenges and solutions for wider implementation and use. The report will also detail the learning obtained during the trial such as resources and the technology support systems required for a wider sectoral or national roll out, and will recommend health professional training requirements for ongoing interRAI implementation.

The review aspect of the project involves a descriptive study following a selected cohort of 240 patients (120 first assessed in an inpatient setting and 120 from community contact) who will be reassessed at two, six and/or 12 months. It will report the patient's health outcomes including readmissions, current level of need, service utilisation and current domicile. At a cohort level it will report on the type of patients who were assessed (case mix), show any patterns of problems triggered by the assessment and assign the patients into resource utilisation groups. The review also surveys the patient's experiences of the assessment to provide a qualitative aspect to the research. There is a concurrent University of Otago-funded research project, working with the carers of those being assessed in this pilot project in Older Person's Health, to build a better understanding of the community and informal care contexts of older people and their families.

Implications for primary care

InterRAI offers an international language in older person's health, which starts with comprehensive needs assessment and builds to enhance capacity for systematic population-based service management, which the Canterbury District Health Board is taking active steps to introduce. There will be opportunities for primary care to participate in this learning and developmental process, as local work in improving communication between older people and their health service providers continues.

New Zealand has recently gone through a sequence of policy, structural and practice-based changes, which offer significant challenges for those who care for and about older people. Several of these have made explicit reference to the local knowledge-building which has taken place in Canterbury, particularly through the Elder Care Canterbury Project. The latest step in this process of integrating and improving health services for older people includes local participation in learning and adopting the interRAI language of assessment, as a central part of understanding and meeting the needs of older people in our communities. A genuine research and service development partnership with community organisations, primary, secondary and tertiary services, and older people themselves involves finding ways to communicate effectively through this language, and offers promise as well as challenges.

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