

Entry One: striving for best practice in professional assessment

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Abstract

The aim of this study was to develop a best practice model of professional assessment to ensure efficient and effective delivery of home-based services to frail and disabled elders. In 2000, an innovative model of professional assessment was introduced by one of Australia's largest providers of home-based care in order to reduce multiple assessments and to reduce the utilisation of assessment as a gatekeeping tool for limiting access to services. Data was analysed from a random sample of 1500 clients drawn from a population of 5000 as well as through the use of a survey tool administered to the Organisation's assessment staff and other key stakeholders.

Results revealed that, contrary to popular belief, carer advocacy plays a significant role in the professional assessment process to the point that clients with carers received significantly more services and service time than clients without such support. However, if not monitored, assessment can also be used as a gate-keeping tool as opposed to one that can provide significant benefits to the consumers through comprehensive need articulation. We argue that the "professional" approach does not preclude empowerment and that assessment should not be used as a gate-keeping tool.

Determinants of assessment

A common premise emerges in the examination of the descriptions, definitions and theories surrounding the provision of human services in modern Western society. The general aim of these Organisations, be they public or privately funded, is to meet the needs of a select population (O'Brien & Murray, 1997). These needs can be both related to, but certainly not restricted to one's emotional support, health, finance or accommodation needs. Likewise, the customers or clients that form this target population may be extremely diverse in their age, ethnicity, gender and financial capabilities.

As a direct result of this diversity in needs and clients, human service delivery organisations, particularly in health and aged care, have readily adopted models of assessment. The assessment process, which appears to be a simple method of determining who needs and should get what from whom, is in practice a highly complex process. It is heavily influenced by a suffocating paradigm of ideology of the professional/medical approach as opposed to empowerment/social welfare models of assessment.

However, it is the authors' intention to argue that the perpetuation of this ideological debate that heavily influences assessment protocol and practice in health care, and particularly aged care, is rendered meaningless. Instead, it is an economic rationalist ideology that has emerged over the last fifteen years that in fact drives not only current assessment approaches but also the delivery of human services. Furthermore, the boundaries between the paradigms of the professional approach as opposed to a social welfare approach have been blurred. This has occurred through the increasing utilisation of non-professional staff in human services and with the increased awareness of the importance and the use of client and carer involvement and advocacy within the professional assessment process.

The professional/medical model of assessment entails the utilisation of professionally trained staff to determine the client's needs and required actions to be taken to address these needs. Critics argue that this approach has a number of inherent and major flaws, including that the professional assessment can be unresponsive to clients and insensitive to those from other cultures (Cheers, 1992, p78). It has been argued that within this assessment process, the professional "assumes" a position of power over the client, instructing them to blindly follow their judgements and dismissing the client's input into the process as obtrusive and non-constructive. This, it is argued, can be readily seen within the assessment process through the interaction between professional staff and the client's carer, family or volunteer help. Their support is viewed as simply an adjunct or "free" resource that can be utilised to supplement the service intervention (Austin, 1997; Manderscheid, 1997).

As indicated, this approach to assessment is criticised as being intrinsically inflexible to any input from consumers (clients, carers or members of the informal support networks). This occurs as a direct result of the assessment focus targeting those most in need or "at risk", who in aged care are broadly defined as those living alone and without informal care supports. However, in focusing on this "archetype" of client, the assessment process and service incorrectly assume homogeneity of its client population resulting in little or no provision being made for and input possible from those with such supports.

The professional assessment is also viewed as a prescriptive and impersonal bureaucratic process that fails to be responsive to some clients' needs which may be viewed as either low-priority, non-conforming or unusual (O'Brien & Murray, 1997). It is often stated that within this process clients feel that they are "managed" by the assessor, totally dependent on the professional and that their self-perceived needs are often ignored or viewed as secondary to others that the professional may identify. Finally, critics claim that this assessment approach is extremely expensive, thus reducing the amount of potential resources that could be used for interventions. This expense is viewed as directly correlating to the labour cost of the professional staff assessor (Kelsey 1996; O'Brien & Murray 1997; Gibson 1998).

Proponents of this approach argue that professional assessment takes into consideration and identifies objectively the multi-dimensional needs of the client (social, mental, functional, physical, etc) through standardised and validated methods. It can therefore both efficiently and rapidly implement proven and reliable intervention strategies to meet these needs (Leutz et al, 1992). Furthermore, through the use of non-professional, bilingual staff and a case management philosophy, this approach can positively assess and take into account the various cultural needs of clients, as well as identify and address both stressful and harmful situations to supporting family members or carers.

Proponents argue that the professional approach is not devoid of client and carer participation, and instead seeks their support in identifying and addressing needs, as well as implementing appropriate interventions. This is no more evident than in community home-based aged care, in which the episode of assessment and care occurs within the consumers' home environment and in co-operation with their family or other informal support networks. Finally, proponents argue that costs associated with this approach are negligible or "cost-neutral" in that direct savings are made by the reduction of inappropriate admissions to service and unnecessary repeat-assessments.

In direct contrast to the professional model is the social-welfare/empowerment model of service delivery and assessment. This approach bases itself on the principle that the locus of control of the assessment process and the intervention that follows lies directly with the consumers (O'Brien & Murray, 1997). The assessment process respects the power of decision-making and choice of the client and carer, with the role of the professional staff member and the assessment unit being one that supports these decisions and choices (Hyduk & Moxley, 1998).

The assessment process should also promote and act on the client's self-perceived needs, and strengthen and recognise their rights to choice as well as their refusal of services or interventions (Gibson, 1998). This should occur not only for physically disabled clients, but also for those with intellectual disabilities who are the most at risk of being placed in a powerless position by the professional assessment (Mansell & Ericsson, 1996). Thus, the skill of the assessor is not necessarily professionally or technically based but one of engaging the client and members of their informal networks in a collaborative and problem-solving process (Hyduk & Moxley, 1998).

Another strength of this approach is that it not only allows and promotes for carer/informal support input but also that through this collaborative identification of the client's needs, there occurs an opportunity for the carers' needs to be identified and acted on. Finally, proponents of this approach point to the resource savings made in

this assessment approach in direct comparison to the expensive labour of professional assessment staff, thus allowing resources to be utilised within the intervention phase of addressing the client's needs.

However, critics of the empowerment approach to assessment cite a number of problems and issues of concern. It is argued that ethical dilemmas occur in the client self-determination process when either the client does not recognise and/or prioritise important needs or likewise does not wish to act on them – for example, alcoholism, carer abuse or conflict. Also there are serious problems when dealing with clients with cognitive impairments who it is argued may not be able to make self-determining choices or recognise their own needs, particularly those without informal supports. Those with extremely frail health status or high levels of dependency also provide a dilemma as there is immediately a limit on the degree of self-care and advocacy that can be obtained (Hyduk & Moxley, 1998). Non-professional staff may also lack the ability to identify successfully psychological, medical and functional needs of the client. This can result in no interventions being put in place to address these important issues or the need for multiple re-assessments being required at a later stage. Thus this approach has been accused of simply being a cost-cutting exercise that is “disguised” conveniently under the banner of client rights and advocacy.

Finally, the authors argue that the perpetuation of this traditional assessment and ideology debate has in fact hidden the most dominant determinant of this practice – economic concerns. It is this determinant, despite the ideological approach taken, that has the most influence on the formal service assessment process. Within the assessment episode, fiscal pressures place a limit upon the potential interventions that can be incorporated to meet the needs of the consumer, whether they are chosen by the consumer or by the professional. O'Brien and Murray (1997, pp29-30) say that “... while one is led to believe that disabled people are involved in decision-making processes and that they are being ‘consulted’ in terms of service delivery, this is often not the case especially in an environment of capped budgets and reduced state involvement”. They argue that “... once in the assessment process the disabled ‘client’ generally assumes that in opening all aspects of his or her life to the gaze of the state, needs will be met. However, this can be a misguided assumption because assessment is ultimately a gate-keeping exercise designed equally to exclude and limit access to scarce resources”.

The rise of managerialism and economic discourse has over shadowed the professional/medicalisation paradigm, with “restructuring” and “resource rationalisation” influencing the assessment and formal service delivery process. Clients are at risk of being viewed as objects to be “managed” and /or their needs “served” within budgets (Fulcher 1989 as cited in O'Brien & Murray 1997). Assessment thus becomes a process of targeting limited resources to those perceived as most in need.

In aged care, those seen as most in need are those perceived to be at risk of leaving the community to supported accommodation (nursing home or hostel care) (Howe & Gray, 1998). Therefore, clients who are not perceived to be at risk are in fact at risk of not having their needs met as resources are consumed by the more dependent and chronically ill clients. Thus it risks becoming purely reactionary to crisis situations rather than preventative.

Finally, the current pursuit of improved practice of assessment and the resulting tighter targeting of services is evidence of both the concerns with fiscal constraint and service equity (Gibson 1998). This is regardless of the approach taken, professional or empowerment, of which it should be reflected that the debate between proponents of both approaches has also shifted to espousing which approach has higher or lower labour and resultant service delivery costs.

Assessment model intervention

As a result of this growing trend, the assessment model utilised by Western Domiciliary Care and Rehabilitation Service, one of Australia's largest provider of home-based care, was subsequently redeveloped in 2000.

Historically, two distinct service assessment teams – the Aged Care Assessment Team (ACAT) and the Domiciliary Care Service (DomCare) – had operated within the same service but focused on separate functions. The ACAT service provided assessment of clients' eligibility for nursing home and/or hostel residency while the DomCare assessment team provided assessment for home-based community services only.

After detailed evaluation of these two models (English & Mykyta 1999) it was apparent that the ACAT team assessment was guided by strict Commonwealth Government guidelines. However, the evaluators revealed that the Domiciliary Care assessment team operated on organically developed principles of “best practice” that were overwhelmingly influenced by the economic rationalism perspective currently engulfing human services. This resulted in assessors clearly practising a “gate-keeping” activity over the initial phone referral as determined by the amount of information gathered from the referrer. Therefore, if the referrer provided little information on themselves (if self-referral) or their client’s predicament, it often resulted in that case being deflected due to the awareness of the assessor of the limited service resources available. This practice clearly disadvantages self-referrals and referrals from the informal care network, as opposed to other clinical referrers (local doctor, hospital, etc) because the clinical referrer possesses the technical language and training to overcome such barriers and their own assessment is not frequently questioned.

As a result, both assessment teams in operation were integrated into one team called Entry One. This team was given a clear mandate of undertaking clinical assessments of all referrals, except those requesting information, in order to provide benefits to its clients of this intervention as well as to avoid service deflection due to perceived limited resources.

Methods

The authors examined in detail the service interaction of 1500 clients from a domiciliary aged care service in South Australia that utilises a professional/medical assessment model. This domiciliary service incorporates both non-professional and bilingual staff to serve a metropolitan aged population characterised by low socio-economic status and a high non-English speaking background (NESB) membership. These domiciliary care subjects were obtained using random sampling techniques and a cross-sectional design approach. The study incorporated quantitative data methods and analysis.

A staff survey instrument was also designed and administered to all staff members of the assessment unit (n=15) and other key stakeholders (n=6). This instrument was used in order to obtain feedback from these subjects on not only the structure of the redeveloped assessment unit but also on their perceptions of the strengths and weaknesses of the assessment process within their human services environment.

Results

Consumer service interaction:

The participants’ mean age was 77 years. Approximately 68% of participants were between 63 and 91 years of age. 65.6% of the sample were female and 34.4% were male. This gender breakdown follows closely that which is often described in the gerontological literature with females being the predominant users of formal services due to a variety of factors including their lower mortality rates.

Despite the general perception as also reported within the literature, the majority of clients reported the presence of caregiver support. 74% of subjects reported the presence of a caregiver, and only 26% had no informal support. Furthermore, those with such informal supports received significantly more services (189 to 160 services ($p<0.05$ df1507)) and service time (120 to 98 hours ($p<0.05$ df1506)) than those without such supports. When examined further, those with a live-in carer received even more services (204 to 160 services ($p<0.05$ df1274)) and service time (133 to 98 hours ($p<0.001$ df1273)) than those without. This trend was reversed, however, when comparing those without informal supports and those with a visiting informal support source, 160 to 133 services (not statistically significant, $p>0.05$ df624) and 98 to 73 hours of service time ($p<0.05$ df624).

Despite traditionally low access rates, the study group also contained a significant non-English speaking background cohort (22.2%, N=335). Again, the researchers found that despite the popular perception reported in the gerontological literature, NESB subjects reported significantly higher service utilisation (233 to 166

services ($p < 0.001$ df1507)) and received more service time (148 to 105 hours ($p < 0.001$ df1506)) than those from Anglo-Saxon backgrounds.

Despite a 10% decline in total referrals to service, there was an 8% percent rise in domiciliary care assessments undertaken since the introduction of Entry One.

The researchers also examined the study data for those who were perceived to be at risk of entering into supported accommodation arrangements. These clients were identified by the presence of a Commonwealth Aged Care Assessment Team (ACAT) episode. There was a near 50% split in the sample when examining those who had received an ACAT assessment for being seen as “at risk” of premature entry into supported accommodation arrangements. Those who had received an assessment accounted for 49.5% ($N=747$) of the sample while those who had no assessment contributed the remaining 50.5% ($N=762$). These subjects, in comparison to non-ACAT subjects, received significantly more services (238 to 126 ($p < 0.001$ df1507)), and service time (153 to 76 hours ($p < 0.001$ df1506)). These subjects also revealed higher dependency rates on their Barthel activities of daily living assessment instrument, $p < 0.05$ df1507.

Assessment staff feedback:

The professional staff of the assessment unit provided valuable feedback on their perceptions of the assessment process within their human services field and in particular the strengths and weaknesses of the single assessment model introduced.

Major strengths perceived by staff on the role and value of the assessment process included the ability to identify consumer needs in a holistic way; to provide advice to clients and their caregivers; to advocate on behalf of clients; and to identify client needs in their totality as opposed to identifying needs only in respect to resources available. The reduction in assessment duplication due to the assessors’ ability to undertake both ACAT and Domiciliary Care assessments was identified as a clear advantage of the new unit’s focus.

Despite these many strengths, staff identified that a major weakness of assessment in human services was clearly that limited resources allocated at a service delivery end determined the extent to which clients’ needs could be fully met.

Discussion

The researchers explored the study data in order to ascertain whether or not the assessment process, with regard to the frail and disabled older population, determines resource utilisation. The study clearly revealed that those identified at being “at risk” of institutionalisation, or in other words, whose needs with relation to community independence were viewed as high priority, received significantly higher amounts of services and service time than those whose needs were not given this priority. This supports the earlier raised notion that assessment acts at prioritising scarce resources to those in most need or in a crisis situation. The result is that highly dependent clients consume the majority of aged care service resources. Researchers (Howe & Gray 1998) are now raising some important questions in relation to this imbalance. They claim that some of these highly dependent clients will not be prevented from entering supported accommodation arrangements and therefore they question the value of concentrating such a high amount of valuable and scarce resources into their care. Also, the opportunity cost of the unbalanced provision to high resource clients is the inability to provide smaller amounts of resources to address a greater number of clients and their needs rather than only a few. Not being able to address the lower priority clients may result in these clients presenting in the future as high priority consumers and / or may place greater burden of care upon the informal network to who then must pick up this formal care gap.

The results also cast doubts on the perceived inability of the professional approach to assessment and ensuring service delivery to take into account the informal networks of the client or to view these supports as simply a “free” resource to be exploited. The focus of the approach has not simply been targeted at those without such supports. Instead clients without carers, who have traditionally been perceived as the principal targets of the professional/medical model to the detriment of those with informal care networks, have received significantly less time and services than those with such supports. The authors argue that this reveals that the professional assessment approach does not ignore the informal care sector, particularly the live-in carer who previous studies (Schofield et al 1998; Madden 1994; Braithwaite 1990) have shown to be predominantly spouses. It reveals that

carers are strong advocates of access and service utilisation and therefore have a strong influence even within the professionally orientated assessment process. Also, current professional training and assessment practices have made significant improvements to overcome the previously perceived lack of consumer (referring to both client and carer) involvement into the care relationship.

Furthermore, this approach has been criticised for its historical inability to attract non-English speaking background (NESB) clients as well as to provide fewer services to this client population in comparison to those from the dominant cultural background. However, the research revealed that not only was there a large proportion of NESB clients but that they also received significantly more services and service time than non-NESB clients. The authors acknowledge however that the formal service studied utilised a high number of bilingual staff, which may have influenced this result, as the literature would indicate. What is important here is that the professional/medical approach with the use of such culturally attuned staff can overcome the repeatedly labelled criticism that this approach does not successfully allow access to and take into consideration the needs of those from other cultural backgrounds.

In conclusion, the empowerment and professional assessment argument has been vigorously debated for the last twenty-five years and has certainly contributed to a greater understanding and involvement of consumers in relation to the management of their care by formal providers. However, Australian service providers and policy makers need to accept and acknowledge that a fiscal and economic paradigm is currently the most influential determinant of aged care assessment and service delivery practice. Innovative funding and assessment strategies must be developed to face the future demands created from the rapid population ageing experience, not only within Australia but internationally as well (Hugo 1998; Schofield et al 1998; Gibson 1998; Torres-Gil 1999). The authors have tried to present a balanced critique of the assessment ideology as well as to show that the professional model, contrary to many previous claims, is both capable and is highly influenced by consumer advocates and their informal networks. Finally, the investigators acknowledge that more research needs to be conducted to further examine this topic. Such research could utilise both longitudinal designs, as opposed to cross-sectional, and multi-method approaches that incorporate both quantitative and qualitative methods of data collection.

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