Pilot Test of the ACAP MDS Draft Version 2.0: Report to ACATs

WELFARE DIVISION
WORKING PAPER NO. 33

Pilot Test of the ACAP MDS Draft Version 2.0: Report to ACATs

Melinda Petrie and Kerrily Jeffery

July 2000

Australian Institute of Health and Welfare
Canberra

A complete list of the Institute's publications is available from the Publications Unit, Australian Institute of Health and Welfare, GPO Box 570, Canberra ACT 2601, or via the Institute's web site at http://www.aihw.gov.au.

Suggested citation
Petrie, M and Jeffery, K. 2000. Pilot Test of the ACAP MDS Draft Version 2.0: Report to ACATs. Canberra: Australian Institute of Health and Welfare (Welfare Division Working Paper no. 33).

Any enquiries about or comments on this publication should be directed to:

Trish Ryan
Australian Institute of Health and Welfare
GPO Box 570
Canberra ACT 2601

Phone: (02) 6244 1054

Contents

List of tables

Acknowledgments

We wish to thank all of the following Aged Care Assessment Teams who participated in the Pilot Test.

New South Wales

Broken Hill
Dubbo
Kiama
Liverpool/Fairfield
Mona Vale
Moruya
Newcastle
Wagga
Waverley

Victoria

Barwon
Peter James
Goulburn Valley
Mildura
Mt Eliza
Wangaratta

Queensland

Maryborough
Prince Charles Hospital
Royal Brisbane Hospital
Toowoomba

South Australia

Port Pirie

Western Australia

Geraldton
Kimberley
Sir Charles Gairdner Hospital

Tasmania

North West
Southern

Australian Capital Territory

Intake and Assessment Unit

Northern Territory

Darwin

1 Purpose

This Report

The purpose of this report is to provide feedback to Aged Care Assessment Teams (ACATs) on the Pilot Test of the ACAP MDS Draft Version 2.0. Twenty-seven ACATs contributed considerable time and effort to the process of developing Version 2.0. The AIHW Project Team and the Aged Care Assessment Program Data Working Group appreciates their contribution and are keen to provide all ACATs with the results of the Pilot Test, to date.

Many ACATs that participated in the Pilot Test expressed interest in knowing the comments and suggestions of others. This report includes detailed summaries of the comments and suggestions of ACATs as well as responses to those suggestions, where possible.

The documentation used during the Pilot Test is also included as Appendices to this report.

The final content of the ACAP MDS Version 2.0 will not be confirmed until the Aged Care Assessment Program Officials meet in November 2000.

The Pilot Test

The purpose of the Pilot Test was:

- to test the practicality, clarity and utility of the draft data elements being considered for inclusion in Version 2.0(ie. are definitions clear, understandable, do they provide comprehensive coding options etc);
- to test the quality of data reported (eg missing values, coding errors);
- to assess the ability of ACATs in different operational contexts to collect and report the data;
- to identify any guidelines for collecting the individual data elements that need to be modified or added to ensure consistent implementation across all ACATs; and
- to test the relevance and utility of each data element to the day-to-day operations and management of ACATs.

The purpose of the Pilot Test was not to derive descriptive statistics but rather to test whether the draft data elements are defined clearly and concisely and in a way that can be consistently interpreted and collected by ACATs operating in different areas and in different ways.

2 Scope of the Pilot Test

2.1 Data elements

The Pilot Test included data elements that were agreed by the ACAP Data Working Group (DWG) (see Appendix A for a membership list) as candidates for inclusion in Version 2.0 of the ACAP MDS. The data elements included had the status of DRAFT, and were screened by the DWG to ensure their relevance to key policy issues, performance measurement and planning.

2.2 Aged Care Assessment Teams

The DWG agreed that every State and Territory be included in the Pilot Test. In addition, the following sampling criterion were used in selecting participating ACATs:

- metropolitan/non-metropolitan;
- large/small; and
- integrated/stand alone.

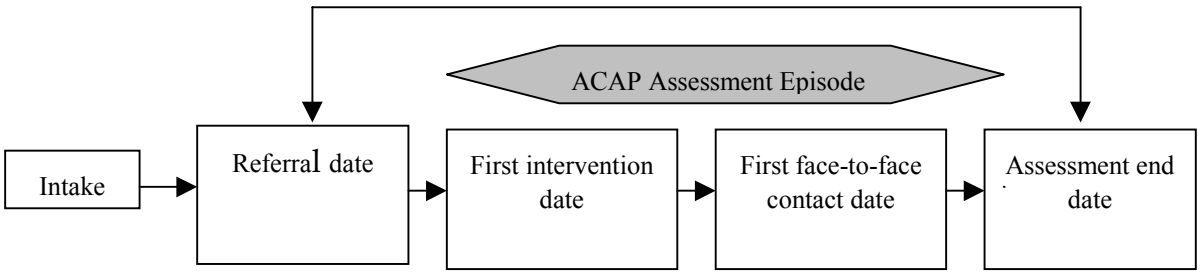
Participation in the Pilot Test was voluntary. A total of 27 ACATs nationally were included, with a reasonable range of ACATs meeting the above criteria spread across States and Territories, but not within States and Territories. A list of the ACATs who participated in the Pilot Test is included under Acknowledgements.

Participating ACATs individually determined the number of team members to be involved in the Pilot Test and included a range of disciplines where possible.

2.3 Assessments

A maximum of 25 completed client assessments was requested for reporting by each ACAT. Some ACATs negotiated a lesser number on the basis of their team size, composition and client load. A few ACATs returned more than the required 25 assessments. The client assessments included were initial assessment or reassessments that began and ended during the pilot collection period. Of all the records submitted for the Pilot Test, teams were asked to provide approximately two thirds for people who were assessed in community settings and one third who were assessed in institutional settings. A total of 678 assessments were reported during the Pilot Test.

The data elements included in the Draft ACAP MDS Version 2.0 relate to the assessment process from receipt of referral to the point of completion of a care plan or ending of the assessment for other reasons (eg the person dies or withdraws).



2.4 Clients

The sample of ACATs who participated in the Pilot Test included some operating in geographic areas with high numbers of people from culturally and linguistically diverse groups and some remote ACATs servicing areas with a high number of people of Aboriginal or Torres Strait Islander origin. The sample was also designed to capture clients living in metropolitan, regional, rural and remote geographic areas in Australia.

3 Collection methods

The Pilot Test collection period was from Monday 20 March 2000 to Friday 14 April 2000. All data was requested to be sent to the Australian Institute of Health and Welfare (AIHW) by Friday 5 May 2000, including data from any incomplete assessments at the end of the collection period. Feedback forms from participating ACATs were also required by 5 May 2000. There was some delay in receiving all Pilot Test data and Feedback forms. However, all returns by ACATs were received within 2 weeks of the original closing date.

The collection of the Pilot Test was paper-based (refer Appendix B for a copy of the form used and accompanying Guidelines). Given the limited size and scope of the Pilot Test, development of supporting software to facilitate electronic data capture and reporting would have introduced an unnecessary level of complexity to the Pilot Test. Use of electronic capture and transmission methods may have even distracted from the primary purpose of the pilot which was related to the content, meaning and appropriateness of the information proposed for collection rather than the collection and reporting mechanism.

However, the issues surrounding data capture/transmission and current/planned system developments in ACATs were canvassed as part of the Pilot Test. Relevant questions were included on the ACAP MDS V2.0. Feedback form and related issues were also canvassed during the on-site visits to selected ACATs at the end of the pilot collection period (see Section 9 for further details).

4 Support

The AIHW provided telephone-based support (1800 Helpline) to all participating ACATs throughout the pilot testing period. Six teams reported using the Helpline on

their feedback forms and rated the usefulness of the information provided as high (average 87%).

5 Confidentiality of data

The confidentiality of data reported for the Pilot Test was protected under the provisions of the Australian Institute of Health and Welfare Act 1987. In addition, the AIHW Ethics Committee approved the ACAP MDS Version 2.0 Pilot Test proposal on 15 February 2000.

6 Pre Pilot Test briefing sessions

The AIHW conducted ACAP MDS V2.0 Pilot Test briefing sessions before the pilot collection period for all participating ACATs. These briefing sessions were either via face-to-face meetings or videoconferences.

These briefing sessions were invaluable for the AIHW Project Team and gave participating ACATs the opportunity to provide feedback and comments on the suggested format of the Pilot Test, including the Pilot Test form, questions and code lists, as well as providing information to the Project Team on the organisational context and usual practice of individual ACATs, for example, when an assessment is considered to be complete.

Over the page is a summary of the suggestions and comments that were provided by ACATs during these briefing sessions.

Table 1: Pre-Pilot Test briefing session comments and suggestions

Question/data element		Comments/suggestions
1	Client ID	Use the AGS Sequential Record Number (SRN) where applicable.
2	Letters of name	Check consistency with Centrelink name standard
		Include guidelines for cultural differences with respect to transposing names.
3	Date of birth	Include guidelines for estimating DOB.
4	Sex	Specify biological in guidelines.
5	Suburb/town/locality name	Need option to write 'no usual'.
6	Postcode	Include '0000' coding option for 'no usual'.
7	Indigenous status	
8	Country of birth	
9	Main language spoken at home	Does not include a comprehensive listing of Indigenous languages.
10	Proficiency in spoken English	Include an 'unable to determine' coding option.
		Difficult to determine for people with dementia and strokes.
11	DVA card status	
12	Accommodation setting	Include 'where lived for past 6 months' in guide for use.
		Include the word 'usual' in the title.
		Combine with 'Recommended long term care setting' question.
13	Living arrangements	Problems with coding people in residential care to 'living alone' category.
14	Carer availability	Include an 'unable to determine' coding option
		Include an instruction to go to the next question if no carer or unable to determine.
		Include additional information to help determine whether the amount of assistance provided by someone means that they are a carer: "If the care or assistance provided was withdrawn from the recipient, would the recipient's care be compromised as a result? If the answer is yes, the person should be coded as having a carer".
15	Carer residency status	Include an instruction to 'tick one box only'.
		Make the guide for use clearer.
		Most significant carer can be difficult to identify in Indigenous communities.
16	Relationship of carer to care recipient	Include an instruction to 'tick one box only'.
		Make the guide for use clearer.
17	Referral date	Move to the front page of form.
18	Urgency category	Change the name to 'Priority category'.
		More information needed in the guide for use.
		Good that this is about client need.
		Consideration of using a numeric coding option (ie. 1, 2, 3) instead, with no time attached.
		Move to the front page of the form.
19	First intervention date	Positive response to the inclusion of this date.
		Clarify the guide for use—clinical information gathering that results in the creation of a clinical record. Clearly distinguish from making an appointment.
20	First face-to-face contact date	Need to allow for no face-to-face contact for particular circumstances.
21	First face-to-face contact setting	

Question/data element		Comments/suggestions
22	Health condition	Will change time series data in Queensland.
		4 options may not be enough.
		Include '0000' option for no health condition.
		Remove the ICD-10 codes from the code list.
		Good shift to focus on the impact on functional abilities.
		Some concern over whether the health condition has been diagnosed. If the health condition is recorded on the MDS but is not a clinically diagnosed condition, this could be interpreted as "diagnosed" and will remain on the client's files as such.
23	Sustainability of caring role	More information in guide for use to specify the choice of the most significant reason from the ACATs perspective.
		Move to be with other carer questions on form.
24	Types of personal assistance/Source of assistance	Good to distinguish between received prior to and needed after assessment.
		VIC and TAS requested an extra set of tick boxes for "Recommended" assistance be added to all the types of assistance/support data elements. "Recommended" should take into account an agreement by the client, and whether the service is available. Definitions to be supplied by Victoria. To be piloted in VIC and TAS only.
25	Types of professional assistance	Need to qualify in last 12 months.
		Need to add '/adviser' to Specialist clinic and an 'other, please specify' option.
		Will include Case management by ACAT & Case review/monitoring by ACAT.
		Will include an 'Other, please specify' option at end of list.
		Not a comprehensive list.
26	Program support	Need to qualify in last 12 months.
		Change 'Other' option to 'None of the above'.
27	Carer support	Need to qualify in last 12 months.
28	Aids and equipment	Need to qualify in last month.
29	Assessment end date	
30	Reason for ending assessment	Inconsistent with practice in some ACATs.
31	Recommended long term care setting	Combine with Accommodation setting.
General comments		Code lists—1 copy of each code list per team member.
		Streamlining of data collection would be a good outcome of MDS review, eg. Replacement of '2624' form (Aged Care Application and Approval form, from herein referred to as the '2624') (with the exception of the approvals page) with the MDS.
		AIHW to visit WA DWG representative and WA teams after the pilot, in order to facilitate more WA involvement in the revision of the ACAP MDS V2.0.
		WA teams will eventually have electronic software that will automatically generate the letters of name data elements. It was agreed to pilot this on the form to familiarise teams with the statistical linkage concept.
		Some ACAT team members in rural Victoria are allocated a number of assessments at one time from the local hospital. Problems may arise with allocating the correct referral date, as the date the referral was received at the hospital will be different to the date that the ACAT received the referral.

7 Summary of validation checks for Pilot Test data

The 27 ACATs participating in the Draft ACAP MDS V2.0 Pilot Test returned a total of 678 completed Pilot Test Forms. The largest number returned by a team was 36, and the smallest number was 16. The average number of forms returned per team was 25, which was the amount originally requested from each of the teams for the Pilot Test (this number was subject to negotiation). The data was entered into a password protected database at the AIHW, where it was subsequently cleaned, a random sample cross-checked and a series of validation checks were run in order to check the overall quality of the data. Separate validation reports on each team's data were given to the 9 ACATs visited post pilot.

The main purpose of the validation checks was to verify that no major anomalies were occurring and to get an indication of the quality of the data. The checks reported on the sequencing of dates (Referral date, First intervention date, First face to face contact date and Assessment end date), the invalid recording of any data elements in conjunction with other related data elements, the number of missing fields for each data element, and the number of data elements that were recorded as Unknown/unable to determine.

Validation checks were only one way of checking the quality of the data. Many areas of misinterpretation or confusion cannot be picked up with this process. This was found to be the case during the post pilot on-site visits. At times, cross-checking of client files with Pilot Test returns from Teams with very low errors rates revealed considerable discrepancies between information recorded on client files and that reported on the Pilot Test form. In addition, at times there were discrepancies between what was recorded on the 2624 (Aged Care Application and Approval form, from herein referred to as the '2624'), ACAP MDS V1.0 and the Pilot Test return.

7.1 Sequencing of dates

Overall, a total of 22 completed Pilot Test forms reported what appeared to be an invalid sequencing of dates (3.2% of the total forms). This meant that one or more of the following occurred: Referral date came after First intervention date, First face to face contact date or Assessment end date; First intervention date came after First face to face contact date or Assessment end date; or First face to face contact date came after Assessment end date. In 30% of cases, First intervention date was recorded as being different to First face to face contact date.

Table 2: Number and type of invalid date sequences

Type	No. (N	% of total (N=35)
Referral date after First intervention date	13	37
First face to face contact date after Assessment end date	9	25
Referral date after Assessment end date	5	15
First intervention date after Assessment end date	5	14
Referral date after First face to face contact date (*where First face to face contact date is different to First intervention date*)	2	6
First intervention date after First face to face contact date	1	3
	*35	100%

* Total is more than 22 as some forms had more than one date sequencing problem.

The relatively high number of Referral dates following First intervention dates may be in part explained by the fact that some teams have clients that require ongoing case coordination. It may be that for these clients, an intervention occurred before the client was registered as a new referral requiring an assessment. (This was the case for one of the teams visited post pilot that serviced rural and remote areas). The recording of Referral date after an intervention date is spread over a wide range of teams (9 in total), and sometimes a time period of a month elapsed between the first intervention and referral. Some of these records may also be simply errors in recording. For all the other dates with invalid sequencing, it is most likely that these are recording errors, as there is no likely explanation for why an Assessment end date would precede any other date in the assessment process.

Table 3: Missing dates

Type of date	No.	% of total (N=678)
Assessment end date	24	3.5%
First intervention date	7	1.0%
First face to face contact date	5	0.7%
Referral date	3	0.4%

Assessment end date had the highest number of missing fields (24), which may be in part due to the fact that 17 of these either did not have a **Reason for ending assessment**, or were recorded as incomplete assessments. (5% of all assessments were recorded as incomplete). This suggests that there may not have been a clear end to the assessment process, (ie: it was interrupted or the client withdrew), and the assessor had difficulty deciding upon an appropriate date to record. It could also reflect difficulties with the approach in Draft Version 2.0 that requires assessments to be recorded as ended in circumstances where some ACATs would usually treat the assessment as still "open" or "suspended". It may also be in part a form design issue, as the Assessment end date is located at the bottom of page 8 of the Pilot Test form, and does not clearly stand out.

First intervention date has the second highest number of missing fields (7). Two of these were coupled with a missing **First face to face contact date**, although both were

completed assessments and were not recorded as "no face to fact contact" which could be a recording error. The other 5 missing intervention dates were incomplete assessments without any First face to face contact date or recommended long term care setting, which implies that intervention did not occur as the client was not able to be assessed. This may indicate a need to specify in the guidelines that assessments which have no form of intervention or contact with the ACAT should not be recorded in the MDS, although a very low number (0.3%) were reported for the Pilot Test.

7.2 Other invalid data elements

For Pilot Test forms completed by Victorian and Tasmanian ACATs, 106 **types of assistance** were ticked as recommended but not needed, across 85 different client assessments. These included 30 types of personal assistance, 31 types of professional assistance, 21 types of program support, 21 types of carer support and 24 types of aids and equipment. This presents a problem for interpreting this data clearly. Coding an assistance type as 'recommended', for the purposes of the Victorian/Tasmanian Pilot means that the assistance is agreed to by the client and the ACAT, and is available. Therefore, it is unlikely that this type of assistance is not also needed by the client. More than likely the high number of assistance types recorded as recommended but not needed represents an assumption by the ACAT that a recommendation assumes a need as well, although this isn't clearly reflected in the data. If the distinction between "need" and "recommended" is retained, then guidelines for coding 'needed' and 'recommended' types of assistance will need further clarification. .

All 678 **postcodes** entered into the Pilot Test database were checked against the Australia Post postcode book (September 1999 version) to make sure they were correct for the Suburb/town/locality name reported. Both these data elements were included in the MDS as an alternative to recording **Area of residence** (statistical local area). The total number of incorrect postcodes was 21 (3% of the total).

For **Letters of name**, 18 Pilot Test forms (1.3% of total) reported invalid answers, where not enough letters or numerals were provided. See Section 9 for more information on the accuracy of Letters of name reporting.

For **Carer availability**, 11 clients (2.3% of the total 478 clients with carers) were coded as having a carer, but had no information recorded for **Carer residency status**, **Relationship of carer to care recipient** or **Sustainability of the caring role**. Each of these were completed assessments. On the other hand, 39 clients (5.8% of total) were coded as having no carer, yet 4 of these had responses for Carer residency status, Relationship of carer to care recipient and, Sustainability of the caring role and the remaining 35 had a wide range of carer support services coded. Eight clients (1.2% of total) were coded as having a co-resident carer, and were coded as living alone, which represents an invalid coding. Only 2 clients were coded as having more than one carer for Carer relationship.

Three clients were incorrectly coded with non-existent **Health condition** codes. ACATs were asked to code up to 4 health conditions for each client. 16% of clients

were coded with 1 condition only, 26% were coded with 2 conditions, 27% were coded with 3 conditions and 31% were coded as having 4 conditions.

Six clients were coded with more than one **Recommended long term care setting**.

7.3 Other blank/missing fields

Table 4: Data elements with missing fields, by number and percentage of fields missing.

Name of Data element	No. missing	% of total N= 678
Client ID	95	14.0
DVA card status	71	10.5
Accommodation setting – usual	63	9.3
Reason for ending assessment	21	3.1
Suburb/town/locality name	12	1.8
Recommended long term care setting	11	1.6
Carer availability	9	1.3
Health condition	9	1.3
Priority category, Indigenous status, Country of birth, Main language spoken at home, Proficiency in spoken English, Postcode and Living arrangements		Less than 1%

Client ID had the highest proportion of missing fields (14% of total). This may have been a form design issue (it was reported in a post pilot visit that a box should have been provided on the form instead of a line to record the Client ID number). **DVA card status** had 10.5% of total fields missing. It was reported in post pilot visits that this question caused confusion because assessors often assumed it was not to be coded at all for those clients that were not DVA. **Accommodation setting– usual** had 9.3% of total fields missing, which was most likely a form design issue, as it was located at the end of the form together with **Recommended long term care setting**, and was often missed out for assessments that were incomplete. (Approximately half of those missing were also recorded as incomplete assessments). 3.1% of the total fields for **Reason for ending assessment** were missing, although most of these had assessment end dates reported. **Suburb/town/locality name** had 12 missing fields (1.8% of total) which were all completed assessments. **Recommended long term care setting** had 11 missing fields (1.6% of total) for completed assessments. **Carer availability** and **Health condition** had 9 missing fields (1.3% of total).

7.4 Not known/Unable to determine responses

Use of Not known or Unable to determine coding options in questions on the Pilot Test form that included these coding categories is described in the table below. Although the sample size is small there was a very low use of these coding options.

Table 5: Use of 'not known/unable to determine' categories

Data element	No.'not known/ unable to determine'	% of total N = 678
Sustainability of the caring role	21	3.0%
Country of birth	9	1.3%
Indigenous status	4	0.6%
Carer availability	4	0.6%
Recommended long term care setting	3	1.3%
Living arrangements	3	1.3%
Carer relationship	2	0.3%
Health condition	2	0.3%
Accommodation setting – usual	2	0.3%

Sustainability of the caring role represented the highest proportion of not known/unable to determine fields (although still only 3.0%), which may serve as a true reflection of the ACATs knowledge about the client and their carer. On the other hand, it may also reflect a degree of hesitancy in coding this data element, which requires a professional judgement on the part of the ACAT (as reported on some Feedback Forms).

Country of birth was the second highest proportion of "unable to determine" responses, although 1.3% of the total is a low figure. The rest of the fields with "unable to determine" responses had proportions under 1%.

7.5 Summary

Overall, the total percentage of invalid coding errors reported for the Pilot Test (as a percentage of the total amount possible) was a very low 2.0%, which indicates that roughly 98% of the data reported in the Pilot Test was logical with few obvious errors. Likewise, the percentage of missing fields was 1.9%, which shows that roughly 98% of the data fields were completed. The percentage of possible unknown/unable to determine codes was 0.8%. However, the results of the validation checks only provide a cursory report on the logicality and completeness of the data. The actual meaning and content of the data is another issue which was explored in more depth during post-pilot site visits (see Section 10).

8 Scenarios

8.1 Summary

All of the ACAT team members participating in the Pilot Test were asked to complete the ACAP MDS V2.0 Pilot Test collection form for 3 hypothetical scenarios, in order to test the consistency of interpretation and reporting of information based on a given situation and set of circumstances. A copy of these scenarios can be found in Appendix D. A total of 123 assessment forms were entered into the database, including those completed by the AIHW Project Team (62 related to Scenario 1, 55 related to Scenario 2 and 56 related to Scenario 3). The scenarios helped to identify areas in the Draft ACAP MDS V2.0 where variability in interpretation existed. The main purpose of including the scenarios in the Pilot Test process was to examine the extent of variability in interpretation between ACATs rather than to test for "right" or "wrong" answers.

Some of the key points are listed below, followed by a table summarising all the results for each scenario.

8.2 Key points

- 40 ACATs interpreted Scenario 1 as being one single assessment (for MDS purposes), which included an episode of rehabilitation. 10 ACATs (plus the AIHW) interpreted Scenario 1 as being made up of 2 separate assessments. The first assessment involved face to face contact in an acute care setting with a reason for ending due to 'client's functional status unstable, rehabilitation care required before assessment'. The second MDS assessment record was recorded post rehabilitation, with an 'assessment complete, care plan developed' reason for ending assessment. For those who completed a single assessment record, the variation in coding for almost all the questions is markedly higher than for those who divided it into 2 separate assessments.
- In an attempt to standardise reporting of assessments nationally, the Draft ACAP MDS Version 2.0 required that clients who withdrew, were transferred, or who required a period of acute care or rehabilitation before an assessment of their long term care needs could be made, should have their assessments recorded as ended. The ACAT should record an end to that assessment (**Assessment end date**) and tick the box indicating the relevant reason (**Reason for ending assessment**). When the client has completed the period of acute/medical care or rehabilitation and is ready for an ACAT assessment, a new referral date should be recorded. The fact that the majority of ACATs completing the forms for Scenario 1 interpreted it as one assessment indicates that a lot more training about this may be required before full implementation, if this approach to ending assessments is retained in Version 2.0. In addition, the fact that there was less variation in coding for ACATs who divided Scenario 1 into 2 separate assessments suggests that the

data is cleaner and has fewer interpretations when assessments are recorded in this way.

- Data elements with more than 3 different answers coded, that occurred in at least 2 scenarios, were **First intervention date, Carer sustainability, Health condition** (taking into account the specified order) and **Assessment end date**. This indicates that these particular data elements were more open to differing interpretations than the others.
- **Proficiency in spoken English:** In Scenario 1, this was coded as 'not well' on 5 separate Pilot Test forms, although the client's main language was English and this question was therefore not relevant. However, the client had suffered a stroke and had speech difficulties, which may explain why this was question was interpreted and coded as such.
- **Living arrangements**: In Scenario 1, Joseph O'Donnell was recorded on 8 Pilot Test forms as 'lives with others', although he lives in his own room in a hostel, which according to the guidelines should be coded as 'living alone'.
- **Carer availability**: In Scenario 1, Joseph O'Donnell was recorded on 12 Pilot Test forms as having a carer, which did not fit the definition of a carer in the guidelines.
- **Assistance data elements** (Personal/Professional/Carer support/Aids and equipment): There was a very high number of different combinations reported as prior, needed and recommended for each Pilot Test form (too many to report here!). Instead, the frequency of each type of assistance reported is shown in the table below. Many of the ACATs ticked assistance types that weren't mentioned in the scenarios, possibly because they would have recommended this in any real situation presenting with similar characteristics. The highest number of variations in coding existed within the Professional assistance data elements.
- **Recommended personal assistance (VIC/TAS)**: In Scenario 3, although the client did not agree to a referral for self care or meals, and transport was not available, these types of assistance were recorded as both needed and recommended in 4 Victorian/Tasmanian Pilot Test forms.

Table 6: Summary of data reported for Scenarios 1, 2 and 3.

(Codes reported by the AIHW are in bold).

Scenario 1 was interpreted by 40 ACATs as including one single assessment. The results are shown in Column 1. 10 ACATs (plus the AIHW) interpreted Scenario 1 as being made up of 2 separate assessments, for which the results of assessment 1 are in column 2, and the results for assessment 2 are in column 3.

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						**Scenario 2 (Jo Williams)**		**Scenario 3 (Maria Bracco)**	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
Referral date	15/01/00	38	**15/01/2000**	11	**18/2/2000**	11	**17/01/2000**	53	**06/03/2000**	55
	05/01/00	1					17/02/2000	2		
	15/02/00	1					Missing	1		
Priority category	Within 48 hours	26	**Within 48 hours**	6	Between 3 & 14 days	10	**Between 3 & 14 days**	42	**Within 48 hours**	44
	Between 3 – 14 days	14	Between 3 & 14 days	5	**Within 48 hours**	1	More than 14 days	14	Between 3 & 14 days	6
									Blank/missing	5
Letters fam name	DOA	36	**DOA**	11	**DOA**	11	**ILI**	53	**RAC**	49
	DON	3					ILL	1	BRC	1
	DOH	1					WLI	2	IAC	1
									PIT	2
									RAO	1
									RCO	1
Letters of first name	OS	39	**OS**	10	**OS**	11	**O2**	47	**AR**	55
	JS	1	UI	1			O	8	NG	1
							OO	1		
Date of birth	3/01/1918	39	**30/01/1918**	11	**30/01/1918**	11	**05/02/1920**	55	**03/12/1923**	55
	3/1/1915	1					05/02/1929	1		
Sex	Male	40	**Male**	11	**Male**	11	**Female**	56	**Female**	55

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						**Scenario 2 (Jo Williams)**		**Scenario 3 (Maria Bracco)**	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
Suburb/town/ locality name	Randwick	40	**Randwick**	11	**Randwick**	11	**Bendigo**	55	**Norman Park**	54
							Blank	1	Brisbane	1
Postcode	2031	31	**2031**	6	**2031**	7	**3550**	38	**4170**	35
	2806	1	2170	1	2170	1	Missing	14	Missing	19
	Missing	8	Missing	4	Missing	3	3806	1	4000	1
First int. date	15/01/2000	24	15/01/2000	10	**21/2/2000**	8	**21/01/2000**	40	**06/03/2000**	50
	16/01/2000	15	**16/01/2000**	1	18/2/2000	3	17/01/2000	2	6/1/2000	1
	16/02/2000	1			Missing	1	18/01/2000	11	7/3/2000	1
							17/2/2000	1	12/3/2000	1
							21/2/2000	2	14/3/2000	1
									Missing	1
First FTF date	16/01/2000	38	**16/01/2000**	11	**21/2/2000**	10	**21/1/2000**	51	**12/3/2000**	52
	16/02/2000	2			21/3/2000	1	21/2/2000	4	14/3/2000	3
							Missing	1		
First face to face contact setting	Hospital (acute care)	39	**Hospital (acute care)**	11	**Other inpatient setting**	10	**Other**	53	**Other**	54
	Other inpatient setting	1			Hospital (acute care)	1	Blank	2	Multi purpose service	1
							Other inpatient setting	1		
Indigenous status	Neither Aboriginal or Torres Strait Islander	40	**Neither Aboriginal or Torres Strait Islander**	11	**Neither Aboriginal or Torres Strait Islander**	11	**Neither Aboriginal or Torres Strait Islander**	54	**Neither Aboriginal or Torres Strait Islander**	55
							Aboriginal	1		
							Not known	1		
Country of birth	1101	38	**1101**	11	**1101**	11	**1101**	55	**3104 (Italy)**	55
	Not stated	1					Missing	1		

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						**Scenario 2 (Jo Williams)**		**Scenario 3 (Maria Bracco)**	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
	Missing	1								
Main language spoken at home	2 (English)	37	**2 (English)**	11	**2 (English)**	11	**2 (English)**	54	**13 (Italian)**	55
	Not stated	3					Not stated/inad. Descr.	2		
Proficiency in spoken English	Not relevant (client speaks English)	33	**Not relevant (client speaks English)**	5	**Not relevant (client speaks English)**	8	**Not relevant (client speaks English)**	47	**Not well**	53
	Not well	3	Very well	4	Very well	1	Very well	5	Blank/missing	2
	Very well	3	Well	1	Well	1	Well	4		
	Well	1	Not well	1	Not well	1				
DVA card status	No card	32	**No card**	11	**No card**	11	**No card**	50	**No card**	45
	Missing	8					Missing	6	Missing/blank	10
Living arrangements	Lives alone	34	**Lives alone**	9	**Lives alone**	9	**Lives with family**	55	**Lives with family**	54
	Lives with others	4	Lives with others	2	Lives with others	2	Lives alone	1	Lives with others	1
	Unable to determine	2								
Carer availability	Has no carer	24	**Has no carer**	10	**Has no carer**	10	**Has a carer**	56	**Has a carer**	55
	Has a carer	12	Has a carer	1	Unable to determine	1				
	Missing	4								
Carer residency status	Not relevant (no carer)	28	**Not relevant (no carer)**	10	**Not relevant (no carer)**	11	**Co-resident**	56	**Co-resident**	55
	Non co-resident	12	Missing	1						
Carer relationship	Not relevant (no carer)	28	**Not relevant (no carer)**	10	**Not relevant (no carer)**	11	**Husband/male partner**	55	**Daughter**	55
	Son	10	Missing	1			Wife/female partner	1		
	Personal employee	1								
	Unable to determine	1								

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						**Scenario 2 (Jo Williams)**		**Scenario 3 (Maria Bracco)**	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
Carer sustainability	Not relevant (no carer)	27	**Not relevant (no carer)**	10	**Not relevant (no carer)**	11	**Sustainable**	41	**Unsustainable – Carer unwilling to continue**	40
	Sustainable	9	Missing	1			Unsustainable – deterioration in carer's health and wellbeing	6	Unsustainable – carer and or recipient at risk	7
	Unsust./deter. in recipient's health	3					Unsustainable – carer and/or care recipient at risk	4	Unsustainable – deterioration in care recipient's health cond.	3
	Unable to determine	1					Unsustainable – deterioration in care recipient's health cond.	3	Unsustainable – change in carer's circumstances	2
							Unable to determine	1	Unable to determine	2
							Blank	1	Unsustainable – deterioration in carers health and wellbeing	1
Health condition	Diabetes/ Hyptertension/ Stroke	21	Diabetes/Hypertension/Stroke	9	Diabetes/Hypertension/Stroke	6	Hypotension/Parkinson's /Depression	3	Dementia/Depression/Arthritis/Stress or urinary incontinence	21
	Diabetes/ Hyptertension/ Stroke Stress/urinary inc.	8	Diabetes/Hypertension/Stroke/Stress & urinary incont.	1	Diabetes/Hypertension/Stroke/Restricted physical activity	3	Parkinson's/Hypotension	18	Dementia/Depression/Arthritis	20
	Diabetes/ Stroke	3	**Diabetes/Paralysis/Hypertension/stroke**	1	Diabetes/Hypertension/Stroke/Stress & urinary incont	1	Parkinson's disease	9	Dementia/Arthritis	3
	Diabetes/ Heart disease/ Stroke	2			**Diabetes/Paralysis/Hypertension/Stroke**	1	Parkinson's disease/Hypotension	6	Dementia/Arthritis/Stress or urinary incontinence	2
	Diabetes/ Stroke/ Stress/urinary inc.	1					Depression or Mood affective disorders/ Parkinson's disease	5	Alzheimers's disease/Arthritis	2

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						Scenario 2 (Jo Williams)		Scenario 3 (Maria Bracco)	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
	Diabetes/ Speech impediment/ Hypertension/ Stroke	1					Hypotension/Depression /Parkinson's disease	5	Dementia/Arthritis/Stress or urinary incontinence	1
	Diabetes/ Other nervous system diseases/ Hypertension	1					Parkinson's disease/Hypotension/ Depression	4	Arthritis/Stress or urinary incontinence	1
	Diabetes/stroke/limited use of arms & fingers/ limited use of arms & legs	1					Hypotension/Parkinson's disease	1	Dementia/Arthritis	1
	Diabetes/heart disease/stroke/stress/urinary incont.	1					Limited use of feet or legs/Parkinson's disease/Hypotension	1	Depression/Alzheimer's disease/Arthritis/Stress or urinary incontinence	1
	Blank	1					Depression/Restricted in physical activity/Parkinson's disease/Hypotension	1	Dementia/Depression	1
							Restricted in physical activity/Depression/Parkinson's disease/ Hypotension	1	Arthritis/Dementia/	1
							Parkinson's disease/ Depression/Hypotension	1	**Depression/Arthritis/Dementia/Stress or urinary incontinence**	1
							Blank/missing	1		
Personal assistance prior (formal)	Blank	29	**Blank**	10	**Blank**	10	Health care	1	**Blank**	55
	Self care	6	Domestic assistance	1	Self care	1	**Meals**	46		
	Mobility	5	Health care	1	Mobility	1	Transport	2		
	Communication	5	Home maintenance	1	Domestic assistance	1	**Social/comm partic**	42		
	Health care	5	Meals	1	Meals	1				

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						Scenario 2 (Jo Williams)		Scenario 3 (Maria Bracco)	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
	Domestic assist.	3	Social/comm part	1	Home maintenance	1				
	Meals	8	Transport	1	Transport	1				
	Social/comm. Part.	1			Social/comm part	1				
Personal assistance prior (informal)	Blank	38	**Blank**	11	**Blank**	11	Self care	48	**Self care**	55
	Social/comm. Part.	1					**Mobility**	53	**Mobility**	7
	Transport	1					Communication	1	Communication	23
							Health care	16	Health care	12
							Domestic assistance	42	**Domestic assistance**	49
							Meals	24	**Meals**	46
							Home maintenance	24	Home maintenance	16
							Transport	21	**Transport**	43
							Social & Comm part	16	**Social & comm part**	45
Personal assistance needed	Blank	30	**Blank**	10	**Blank**	9	**Self care**	53	**Self care**	48
	Self care	10	Self care	1	Self care	2	Mobility	21	Mobility	4
	Mobility	9	Mobility	1	Mobility	2	Health care	3	Communication	3
	Communication	2	Health care	1	Communication	1	**Domestic assistance**	49	Health care	7
	Health care	9	Domestic assistance	1	Health care	1	**Meals**	51	**Domestic assistance**	9
	Domestic asssist.	3	Meals	1	Domestic assistance	2	Home maintenance	10	**Meals**	44
	Meals	5	Home maintenance	1	Home maintenance	1	Transport	6	Home maintenance	2
	Transport	4	Transport	1	Meals	1	**Social/comm part**	48	**Transport**	29
			Social/community part.	1					Social & Comm part	

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						Scenario 2 (Jo Williams)		Scenario 3 (Maria Bracco)	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
Personal assistance recommended (VIC/TAS)	Blank	15	**Blank**	3	**Blank**	1	**Self care**	22	Self care	3
	Self care	5			Self care	1	Mobility	8	Health care	1
	Mobility	5			Mobililty	1	**Domestic assistance**	23	Domestic assistance	3
	Communication	1			Domestic assistance	1	**Meals**	23	Meals	3
	Health care	5					Home maintenance	2	Transport	1
	Domestic assist.	1					Transport	3	Social & comm part	4
	Meals	2					**Social/comm partic**	21	**Blank**	18
	Transport	2								
	Social/comm. part	2								
Professional assistance prior	Geritrician	2	Geriatrician	1	Geriatrician	4	**Other medical spec**.	53	**Blank**	52
	Other med. Spec.	13	Other med spec.	8	**Other med specialist**	4			Continence	1
	Continence	2	Other (diabetes)	1	Continence	4			Other counselling	1
	Mobility	2	Continence	1	Mobility	4			Case review by ACAT	1
	Falls	1	Mobility	1	Falls	1				
	Other	1	**Rehabilitation care**	1	Other (phyisotherapy)	2				
	Rehabilitation	8			Other (diabetes)	2				
	Other counselling	1			**Rehabilitation**	6				
	ACAT Case review	2								
	Blank	23								

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						Scenario 2 (Jo Williams)		Scenario 3 (Maria Bracco)	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
Professional assistance needed	Geriatrician	14	Geriatrician	4	Geriatrician	3	Geriatrician	2	Geriatrician	2
	Other med. Spec.	6	Other med spec	1	Other medical specialist	3	Psychogeriatrician	1	Pyshogeriatrician	6
	Continence	23	Continence	1	Continence	4	**Other medical spec**	52	Continence	17
	Mobility	29	Mobility	1	Mobility	8	Continence	2	Dementia counselling	20
	Falls	3	Other (diabetes)	4	Falls	1	Mobility	23	Other counselling	28
	Other (diabetes)	3	Other (speech pathology)	3	**Other (phyisotherapy)**	5	Falls	22	Case mgt by ACAT	3
	Other (physio/OT)	7	Rehabilitation	10	Other (diabetes)	1	Other (OT)	9	Case review by ACAT	20
	Other (speech therapy	5	Other counselling	4	Rehabilitation	2	Rehabilitation care	2	**Blank**	12
	Rehab	37	Case review by ACAT	2	Other counselling	1	Dementia counselling	1		
	Other counselling	11			Case review by ACAT	1	**Other counselling**	46		
	Case rev. by ACAT	21					Case mgt by ACAT	4		
							Case review by ACAT	18		
							Other (CCP case mgr)	1		
Professional assistance recommended (VIC/TAS)	Geriatrician	1	Rehabilitation	2	**Other (Physiotherapy)**	2	**Other medical spec**	24	Psychogeriatrician	1
	Other med spec.	3			Mobility	1	Continence	1	Continence	4
	Continence	9					Mobility	5	Dementia counselling	6
	Mobility	11					Falls	6	Other counselling	8
	Falls	1					Other (OT)	6	Case mgt by ACAT	1
	Other (Diabetes)	1					Dementia counselling	1	Case review by ACAT	10
	Phsyio/OT	5					**Other counselling**	18	**Blank**	12
	Rehab	19					Case review by ACAT	6		
	Other counselling	3					Other (CCP Case mgr)	1		
	Case rev. by ACAT	11								

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						Scenario 2 (Jo Williams)		Scenario 3 (Maria Bracco)	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
Program support prior	Residential respite None of the above Blank	1 22 17	**None of the above** Blank	6 5	**None of the above** Blank	9 2	**Blank** Residential respite	55 1	**Residential respite** None of the above	48 1
Program support needed	None of the above Residential respite Blank	21 2 17	**None of the above** Blank	6 5	**None of the above** Blank	9 2	**CCP** **Residential respite** None of the above	54 45 1	**Residential respite** CCP None of the above	50 1 2
Program support recommended (VIC/TAS)	None of the above Residential respite	13 1	**None of the above**	3	**None of the above**	3	**CCP** **Residential respite**	23 20	**Residential respite** None of the above	24 1
Carer support prior	Blank	40	**Blank**	11	**Blank**	11	Resp care comm.based Carer respite centre **Carer allowance** Dementia counselling	28 5 51 1	Respite comm based **Blank**	2 53
Carer support needed	Blank Other Other counselling Respite/community	37 1 1 1	Blank Other counselling	10 1	Blank Other counselling	10 1	Resp care comm based Carer respite centre Carer allowance Dementia counselling Other counselling	48 25 45 1 43	Respite comm based Carer respite centre Carer allowance Dementia counselling Other counselling Other	8 30 4 21 31 1
Carer support recommended (VIC/TAS)	Blank Other Other counselling	19 1 1	**Blank**	3	**Blank**	3	**Resp care comm based** Carer respite centre **Carer allowance**	13 2 19 1	Respite comm based Carer respite centre Dementia counselling **Other counselling**	2 8 6 15

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						Scenario 2 (Jo Williams)		Scenario 3 (Maria Bracco)	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
							Dementia counselling	17		
							Other counselling			
Aids/Equip prior	Medical care aids	1	**Blank**	11	**Blank**	9	**Sppt and mobility aids**	37	Self care aids	17
	Spprt/mobility aids	1			Sppt and mobility aids	2			Support/mobility aids	1
	Blank	38			Communication	1			**Blank**	31
Aids/Equip needed	Self care aids	25	**Blank**	8	Self care aids	2	Self care aids	26	Self care aids	19
	Spprt/mobility aids	31	Self care aids	1	**Support and mobility aids**	11	**Sppt and mobility aids**	53	Support/mobility aids	3
	Communicat. Aids	7	Sppt/Mobility aids	3	Communication aids	1	Medical care aids	2	Personal alarm	1
	Aids for reading	2	Communication	1	Medical care aids	1	Car modifications	1	Medical care aids	1
	Medical care aids	3	Car modifications	1	Other	1	**Mod's to dwelling**	52	**Blank**	31
	Personal alarm	1					Other	1		
	Mod's dwelling	1								
	Other	9								
	Blank	7								
Aids/Equip recommended (VIC/TAS)	Self care aids	13	**Blank**	3	**Support and mobility aids**	3	Self care aids	7	Self care aids	9
	Spport/mobility aids	16					**Sppt and mobility aids**	23	Support/mobility aids	1
	Communicat. Aids	4					Car modifications	1	Personal alarm	1
	Aids for reading	1					**Mod's to dwelling**	24	**Blank**	13
	Medical care aids	1								
	Mod's to dwelling	1								
	Other	1								
Assessment end	23/02/2000	34	**16/01/2000**	7	**23/2/2000**	9	**24/01/2000**	45	**14/3/2000**	49

	Scenario 1 Joseph (aka Guiseppe) O'Donnell						**Scenario 2 (Jo Williams)**		**Scenario 3 (Maria Bracco)**	
Data elements	**Scenario 1 (single asst) Total = 40 asst's (20 VIC/TAS)**		**Assessment 1 Total = 11 asst's (2 VIC/TAS)**		**Assessment 2 Total = 11 asst's (2 VIC/TAS)**		**Total = 56 asst's (23 VIC/TAS)**		**Total = 55 asst's (24 VIC/TAS)**	
	Answers	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**	**Answers**	**Freq**
date										
	25/02/2000	3	18/01/2000	2	25/2/2000	1	24/2/2000	4	12/3/2000	4
	21/02/2000	1	16/02/2000	1	21/2/2000	1	21/1/2000	3	Blank/missing	1
	18/01/200	1	23/02/2000	1			29/1/2000	1	14/2/2000	1
	21/3/2000	1					21/2/2000	2		
							Blank/missing	1		
Reason for ending assessment	Complete – care plan developed	40	**Incomplete/ funct. status unstable, rehab. req. before asst.**	9	**Complete – care plan developed**	11	**Complete – care plan developed**	55	**Complete – care plan developed**	54
			Incomplete /medical cond unstable, req. acute care or medical attention before asst.	1			Missing	1	Missing	1
			Missing	1						

9 Summary of Feedback Forms

The AIHW developed a Feedback Form for completion by each ACAT team member (or a combined form from each ACAT) participating in the Pilot Test. A copy of this form can be found in Appendix C.

A total of 50 Feedback Forms were received from the 27 participating ACATs. The following tables summarise comments made on these forms.

Table 7 summarises comments on the information and support provided for the Pilot Test (eg. briefing sessions, form, guidelines, Helpline)

Table 8 summarises comments on individual data elements and includes Project Team responses where appropriate.

Table 9 summarises ACATs views on which data elements should be included in Version 2.0 with Project Team responses where appropriate.

Table 10 summarises ACATs views on which data elements should **not** be included in Version 2.0 with Project team responses where appropriate.

Table 11 summarises ACAT views on which data elements would be useful for ACAT service delivery and local management purposes. Every data element pilot tested except for **Letters of name** and **Assessment end date** was identified as useful by at least one ACAT.

The Section concludes with a listing of ACAT responses to questions about:

- the likely impact of Draft V 2.0 on ACAT processes and systems
- ACATs' ability to manage any necessary changes within current resources

Finally, a list of some of the general comments made by ACATs is also provided.

Table 7 : Comments relating to information and communication provided

Briefing sessions	
Average (rating) N=50	**Comments**
70%	Useful, clear, informative, very enjoyable. Too drawn out and video conferencing equipment malfunctioned. Interesting opportunity to experience tele-video hook up. Good chance to go over the form etc. and to brainstorm. Appreciated that comments were taken into account. Difficult to follow at times. Beneficial to network with other teams. Excellent method of clarifying pilot and going through form. Session did not cover all that presenters had intended. Appeared to become more of a debate than briefing. Allows a lot of discussion and recognises differing viewpoints. Wasn't fully enough informed to capitalise on briefing - could only send manager, needed others to attend as well. No briefing sessions were offered except to Team Leader who gave minimal feedback Only leader attended feedback, referred us to guidelines as straight forward. Interesting to see how other teams interpreted some questions. Little additional information. Request for comments/opinions but too late for input into the instrument.
Form	
Average (rating) N=50	**Comments**
76%	Slow to complete because a new form, but not difficult to use. Very clear and comprehensive. Some team members found it confusing and daunting to complete. Difficult for reassessing residential care reassessment. Generally useful but a number of anomalies were identified. Some questions were difficult to answer and need clarifying. Clear and concise. Plenty of explanation, some items missed. There appeared to be several gaps in the information boxes provided - not always clear. Useful reference when completing form.
Guidelines	
Average (rating) N=50	**Comments**
79%	Very clear, excellent. Some areas needed clarification. When we consulted the guidelines for the more difficult ones - didn't help. Extremely useful/helpful Clear and concise. Helpful as we worked through project initially and during assessment period. Useful Long to read Time consuming to refer to a separate document.

Table 8 : Comments relating to data elements with Project Team responses where appropriate

Question/data element	Comments	Response
1 Referral date	No definition of 'comprehensive' assessment provided. I took it to mean any assessment.	A definition of a data element concept 'Comprehensive assessment' will be provided.
	The date the intake person may take the referral as noted in the file may not be the date the referral was actually received initially - may be difficult to obtain.	This question is designed to capture the date that the referral was first received by the ACAT.
2 Priority category	The referrer's urgency did not necessarily reflect our urgency.	This is the intention of this question. The allocation of a priority category is based on the information available to the ACAT at referral and should reflect factors related to client need rather than the priority with which the referrer would like the ACAT to respond.
	But urgency category does not necessarily reflect our response rate, eg. a non-urgent case may still be seen within 5 days.	Which is fine, but it can be used in conjunction with Referral date and First face-to-face contact date (or First intervention date) as a measure of the appropriateness of the length of time that a client waited for an assessment of their care needs by the ACAT.
	Discussed what category with team members at intake.	
	Some difficulty trying to prioritise clients who may be 'urgent' but need to wait for the monthly visit of the geriatrician, or for a team visit to country areas; or may not be 'urgent' but family members only available for a short time and need to assess in their presence, but not related to safety perse.	If this data element is included in the MDS Version 2.0, instructions will need to be incorporated within new program guidelines. The Data Working Group will consider these factors when developing performance indicators for the ACAP.
		We would expect that someone needing urgent attention would usually receive some form of intervention by the ACAT prior to seeing a geriatrician.
	As an outreach worker I only pick up referrals weekly. Have not operated with a category or priority in the past due to geographical area covered.	A lot of ACATs have advised that they have routine case allocation/intake meetings whereby the priority category of referrals is allocated. If priority is allocated post assessment you lose the advantage of demonstrating that some clients were unable to be seen because of resource or location issues. For eg. if a client was allocated the priority 'Within 48 hrs' but the ACAT was unable to see the person for a week because of workload and the fact that the person lived 150km away, then you are able to demonstrate a need for increased resources.
	Implication is that priority would be coded prior to assessment, ie. forms would be completed throughout the assessment. I don't think this is a realistic expectation – priority category will be completed post assessment, ie. retrospectively.	
	Because of the distance we cover, very rare need responses >48hrs.	
	Sometimes due to workload ACAT isn't able to respond within the	

Question/data element	Comments	Response
	timeframe that client need would indicate. We manage this as best we can, eg. arranging interim services – or giving emergency respite information.	This 'interim' work can be reported under First intervention date.
3 Client ID	Unclear, some staff used hospital medical record number and others were unsure. Sequential record number used.	There is no intention to standardise the Client ID. As with MDS Version 1.0 each client record submitted should have a client ID that is unique within the ACAT, at least.
4 Letters of name	Unusual to collect. Time consuming and has a big margin for error. Why can't we put in the whole name and have the database pull out the letters required? Need to clarify which name/spelling as ATSI clients often have different variation. Used Centrelink spelling where possible. But I wonder about its usefulness when a number has already been assigned.	This is an important issue that will be recommended to the Data Working Group for systems development to support the implementation of the MDS Version 2.0. As with the HACC program use of the Centrelink card as a standard in these cases will be recommended. Letters of name will be used for statistical record linkage across programs, ACATs and States. Client ID is not nationally unique. Statistical record linkage does not require 100% accuracy in matching records.
5 Date of birth	ATSI clients often have varying records – used Centrelink records where possible.	
6 Sex	Would 'gender' be a more appropriate title than 'sex'.	Sex is used to denote the biological distinction between male and female, whereas gender is generally used as a sociological term to describe a socially constructed male or female identity. Sex has been used here as it is the national standard and refers to the biological distinction only.
7 Suburb/town/locality name	Easier coding system than current system. It also identifies rural areas.	
8 Postcode	Easier coding system than current system. Preferred this to writing in SLA.	
9 First intervention date	Some difficulty in knowing when a phone call could be first intervention. The amount of information given to client/referrer to constitute an 'intervention' may be subject to individual interpretation –question the accuracy and validity of this item. There is still some uncertainty as to when assessment actually starts if you are taking a referral over the phone as a duty officer, then continue on as the case manager. Date was written down when information was collected from relatives or	The definition and guidelines for this question need to be tightened. The intention was to try to capture more information about the enormous amount of work that ACATs often do before face-to-face contact is made with the person. It can be used to record the date on which an interim care plan is developed before a full assessment is completed (eg. emergency respite admission).

Question/data element	Comments	Response
	medical records however the client had not yet been seen. Usually interpreted as same date as duty officer intervention (eg. Organising respite, phone contacts re more details, urgency etc.) As professional ACAT staff members are now deployed as Intake officers/Duty officers, this can vary depending on the amount of service given at intake. Often quite a lot of ACAT time is involved in making an appointment - so this is very arbitrary. 'Significant information' that you would normally collect at time of assessment, eg. Extra information from team, family member, be considered here, even if not 'plan' developed and no 'action' at this time, other than eg. Plan for assessment visit.	
10 First face-to-face contact date	Is it necessary to have both First intervention and First face-to-face contact dates?	This is yet to be decided by the Data Working Group. It relates to decisions about performance indicators for the ACAP.
11 First face-to-face contact setting	Difficult and strange not to have home as an option. I wondered why community residences are all lumped together under 'other' and why this question is asked. If it is important to look at contact environment from a community service perspective specifying the detail is essential for our arranging appropriate services. Highlights sickness/disability model, not focussing on 'staying at home'.	The Data Working Group will consider changing 'Other' to 'Community based setting'. As "home" for some clients is residential care, we need a way of differentiating these settings without using "home" as a label. Main purpose is to differentiate institutional from community based setting. The data elements Accommodation setting and Recommended long term care setting provide more detailed information on where the client lives or is recommended to live.
12 Indigenous status	We have to rely on the accuracy of what the clients says. In terms of statistics where does self report and identity stop. A person may identify as a) Aboriginal by association and not be so by descent b) or be by ascent via, grand or great grandparent. How far back in generations may it be recognised?	The Australian Bureau of Statistics developed this standard and recommend that it be self reported (see comment below for Proficiency in spoken English). An Aboriginal or Torres Strait Islander person is defined by a decision of the High Court of Australia. This definition states that 'An Aboriginal or Torres Strait Islander is a person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander and is accepted as such by the community in which he or she lives'. While this definition has 3 components (descent, self-identification and community acceptance) it is recognised that it is not possible to collect the 3 components of the definition in a single question. The Australian Bureau of Statistics recommends that the focus of a single question should be the first component of the definition—

Question/data element	Comments	Response
		descent.
13 Country of birth	Code list not very user friendly. Should you have 'United Kingdom' on the list rather than 'England'. It may be difficult when boundaries of countries have since changed. Must go by immigration documents if possible.	The code list is a national standard developed by the Australian Bureau of Statistics which does not give us any scope to change the list. England, Ireland, Scotland and Wales are all identified separately as areas within the United Kingdom. The Australian Bureau of Statistics standard coding guidelines will be checked fro cross-referencing of countries where names have changed.
14 Main language spoken at home	At times, client identified that two languages were spoken at home and were unable to identify the 'main' language. Best to have ATSI languages grouped unless going to list all possible dialects which would be unrealistic. Codling lists not practical. Need for code to be obtained electronically.	The Australian Bureau of Statistics standard coding guidelines will be checked This will be recommended to DWG – consistent with HACC MDS. Will be recommended to the Data Working Group for systems development to support the implementation of the MDS Version 2.0.
15 Proficiency in spoken English	New question to start to remember to use. What is the purpose of this question? Subjective question and relative to the regions. Self-reporting is unreliable and subjective, particularly for dementia clients. Clients perception of proficiency can vary greatly to assessor's perception, query the value of this question. Potentially insulting and intrusive on the assessment process to use this question. This question would usually be answered by family or interpreter if client has difficulty.	Is included as it is 1 of 3 core data elements recommended by the Australian Bureau of Statistics as the national standard for identifying potential disadvantage related to cultural and linguistic diversity. The appropriateness of including this data element in the MDS Version 2.0 will be discussed by the Data Working Group and consideration given to recommending a change in the national standard. A lot of the questions within the MDS potentially rely on information provided by the client, self-reported, for example Date of birth, Indigenous status, Country of birth, Main language spoken at home, Carer availability, Personal assistance received prior to assessment, Types of professional assistance received prior to assessment etc. Clarification of the scope of the MDS – ie which clients and which assessments are included in the MDS may assist. That's OK

Question/data element	Comments	Response
	Our current data collection doesn't specify whether it is the client's self perception, or service providers perception of Proficiency in English. This (usefully) requires us to ask client/carer re: their perception.	
16 DVA card status	Is this question referring to the DVA card status of all clients (including Centrelink clients) or only DVA clients. Assumed it is the latter. Difficulty with spouses where husband had Gold card and spouse only received small benefit from DVA. 'Unable to determine' option required. Surprised that other pension types not included for data collection, eg. Carers benefit, Disability benefit.	This question applied to all clients. The 'no card' option can include DVA clients who do not hold either a gold or white card issued by DVA, as well as persons who are neither veterans or war widows ie. Centrelink clients and self-funded retirees. Recommended changes to this item to be considered by the Data Working Group are to change the name to DVA status and change coding options to 'No DVA entitlement' and 'DVA benefit–but no card'. Will be included. The Data Working Group has identified no national reporting need for this information, however this does not preclude ACATs from collecting this information if reqjuired.
17 Living arrangements	No provision for stating client is temporarily in an altered situation ie. staying with carer. People's living arrangements are sometimes in a state of instability with carer stress, death, inability to return home after hospitalization etc. There is not category for living with spouse to differentiate between spouse and family which is very important. I accept your explanation of concepts and parameters for questions but what about our needs as assessors in trying to provide quality care knowing the more specific environment can help pinpoint clients who need extra support. Change of definition of living alone is inaccurate – change please to differentiate between living alone at home and in community setting in residential care. Don't think the question does indicate the level of informal support the client can access.	The focus in Version 2.0 of the MDS is on the person's usual (ie. the place where the person has lived or intends to live for a period of six months or more) living arrangements (also applies to Suburb/town/locality name, Postcode, Accommodation setting) The Carer data elements (especially Relationship of carer to care recipient) give more detail. This is certainly important for ACATs to know, but has not been identified by the Data Working Group as required for reporting at the national level. ACATs are not precluded from collecting more detailed information The Data Working Group will consider whether this item is required to be collected for permanent residents of aged care services or multi-purpose services. The Carer data elements supplement this item and give more info on informal support.
18 Carer availability	Difficult when in an aged care facility as not 'unable to determine'. Would it not also be relevant to carers in aged care facilities?	This question is about the identification of 'informal' carers. If the person is in an aged care facility they can still have 'informal'

Question/data element	Comments	Response
		carers which are coded as such for this item, eg. a daughter who visits on a regular basis and does their mother's washing and provides emotional support. The care provided by the aged care facility is considered implicit.
	'Formal' carers, eg. residential care should be included as this relates to the low to high assessments ACATs provide for aged care facilities.	A low to high assessment can be identified within the Accommodation setting and Recommended long term care setting items.
	Subjective, criteria need to be tightened.	
	Difficult to determine in the case of a temporary carer.	The definition of a carer states that it is someone who has been identified as providing regular and sustained care and assistance to the person.
	Question would be better put by asking 'Has the client a carer?, Is the carer paid or unpaid? Are they part of a formal/informal service?'	The Data Working Group have expressed an interest in identifying the assistance provided by unpaid/informal carers only at this stage. However, the data elements Personal assistance received and Source of assistance indicate the presence of formal carers.
	This appears to refer to 'informal' carers such as spouse/partners, but is not very clear.	
	How frequently must a regular visitor/helper be involved, eg. is once a month sufficient?	The definition excludes formal carers, '…excluding paid or volunteer carers organised by formal services'.
	The comment re 'if this care was withdrawn would the recipient's care be compromised' is a very relevant comment.	The Guide for use states that 'If in doubt about whether the level and type of assistance provided by another person is sufficient to identify them as a carer, if the removal of that assistance would significantly compromise the care available to the person to their detriment, record the person as having a carer'. However, there may be a need for more specific guidelines to assist ACATs identify carers.
	Difficult at times, eg. Regular contact by family member living a distance away, if not there would not change physical care, but would emotional.	
	This can be a cloudy issue. Sometimes a carer will answer one way in front of the client and an opposite way privately to the ACAT.	
19 Carer residency status	Unclear whether clients in aged care facilities should be seen as having a resident carer. Should you specify 'informal' and 'formal' carers?	See comment under 'Carer availability'.
	Is granny flat co-resident or not?	No – if granny flat is a separate dwelling Yes – if granny flat is part of same dwelling
20 Relationship of carer to care recipient	Too many categories but left out sister which we find is one of higher use.	These coding options are consistent with the HACC program and are mappable to the national standard. The coding option 'Other female relative' would cover sister, but ACATs can collect further detail if required for their own purposes.
	Understandable, but obviously refers to 'informal' carers. Should 'formal' carers in residential facilities also be included as an item?	It is assumed that all people in residential facilities have formal carers.

Question/data element	Comments	Response
	Often a family living with an elderly person provide equal amounts of care.	
21 Sustainability of caring role	Carers often reluctant to advise of their inability to continue in the caring role.	This is intended to be a judgement made by the ACAT of a carer's capacity to sustain caring after consultation with the carer and care recipient. Where the ACAT has insufficient information to make this judgement then they should code 'Unable to determine'.
	Very wordy.	
	Very subjective question, judgemental. No timeframe for sustainability – short or long term..	The sustainability of the caring role has an impact on determining the care recipient's care plan, so the intention of this question was long term. This will be clarified in the Guide for use.
	Clients or carers may sometimes be unwilling accept assistance or services. ACATs may view this as 'unsustainable'. Needed another category for 'Unsustainable – care recipient unwilling to have carer continue'. Reasons are often complex and involve overlapping categories. The identification of only one category is too simplistic. Need more 'sustainable' options like the 'unsustainable' options. Sustainable - this would be better divided into 2 categories ie. With and without - 'With' makes a difference to whether or not the carer can continue.	The Data Working Group will consider these issues when deciding whether this data item will be included in the MDS Versions 2.0.
22 Health condition	Coding is vague for certain conditions; list is too generalist; difficult to use.	An alphabetic listing will be developed, as well as a listing of 20 of the most common diagnoses.
	Not all ACAT staff are doctors. Therefore these conditions should be in broad general categories eg. Stroke, dementia. Current format will lend to inaccurate data.	
	Much easier to use.	
	Do you include previous diagnoses eg. depression?	Yes if this still has a significant impact on the client's functional abilities and their long term care needs.
	How do you record 3 digit codes? eg. 503-, -503 or 0503?	With a zero before the 3 digit code, ie. 0503. This will be clarified in the Guide for use.
	Discipline subjectivity.	
	This question is seen as positive improvement. The health condition which has the greatest impact on client is relevant.	
	No space for written diagnosis which allows for cross checking and for	This is an important issue that will be recommended to the Data

Question/data element	Comments	Response
	future reference when codes change. Would be easier to write client's condition on form and the database allocate code electronically.	Working Group for systems development to support the implementation of the MDS Version 2.0.
	Identifying the health condition which has greatest impact on function is at times subjective, especially where several severe diseases exist.	It is acknowledged that this relies on the professional judgement of the ACAT, but was an attempt by the Data Working Group to move away from a diagnostic based code list (ie. principal diagnosis).
	Need to be able to report more than 4 conditions.	The reporting of four conditions is considered by the Data Working Group (at present) as the maximum requirement for national reporting purposes, this does not mean that individual ACATs cannot collect on more than four conditions. However, consideration will be given to increasing the numb r ACATs can report in the MDS.
	Stroke should be CVA; Cardiovascular rather than circulatory diseases as heading; diabetes not specified as IDDM or NIDDM; some anomalies eg. Heart disease and Other heart disease.	The code list will be reworked to incorporate as many of the conditions identified as being required as possible and to eliminate the anomalies identified during the Pilot Test – while retaining consistency with the ICD-10-AM. The revised code list will be considered by the Data Working Group.
	Differentiating between 501 (dementia excluding Alzheimers) and 605 (Alzheimers) not always possible. Clients often diagnosed as probable Alzheimers.	
	The aetiology of deafness, blindness and sometimes type of dementia is often unknown to us.	
	Some of the disease definitions are hard to understand eg. 'brain disease/disorder-acquired' is 606 and there is also head injury/acquired brain damage 1701. Stroke is in 'circulatory system', could also be in nervous system.	
	CVA clients can have difficulty using hands/feet etc. Do you fill out both 910, 1801, 1802, 1803, 1804, 1805, 1806, 1899?	
	Much better and more comprehensive list than current diagnosis codes used. A more sensitive guide.	The application and focus of the code list in conjunction with the data items Types of personal assistance and Aids and equipment is an issue for consideration by the Data Working Group.
23 Types of personal assistance received prior to assessment and needed after assessment Source of assistance	Do not have any trouble with this section, quite clear. New area to differentiate but important.	
	Important to record informal services needed after assessment also. No provision for a change from formal prior to assessment to informal after assessment eg. using agency care but now being provided by family or friends.	An additional item to enable the recording of informal services need after assessment will be considered by the Data Working Group for inclusion.
	When recording 'Needed after assessment' do you include things that	Yes, as long as they will continue to be provided.

Question/data element	Comments	Response
	have already been provided formally in the past.	
	Does it also need to be documented where (a) client/carer refusal and (b) service not available.	Victoria and Tasmania Pilot Tested an extra item that recorded whether a service was agreed to by the client and available (Recommended). The Data Working Group will consider the inclusion of Recommended or separating the information into 'agreed' and 'available'.
	Needed' is hypothectical and will not provide consistent data. What the client is agreeable to following any advice and negotiation with the health professional, is the relevant issue. Resources needed can be determined from population and aged-based data.	
	Unclear how to indicate formal needs if permanent placement is needed.	It was intended that this question would be completed for those clients going into residential aged care services in the same way as for those clients remaining in the community. Further detail will be added to the Guide for use to clarify.
	'Driving' – does this refer to the client driving themselves or being driven?	This refers to the client needing help with driving, ie. being driven.
	Do you tick formal box if person is on a waiting list for a service (eg Home care)?	Yes
	Informal – how often? Criteria not stated, could have been yearly.	The Guide for use stated 'record those types of assistance that the client has received in the month prior to assessment'.
	For clients in residential care this category does not show functional profile nor functional change.	The MDS is not designed to cover all information needed by ACATs or service providers. The detail considered necessary to properly record an individual's functional status is likely to vary between individuals and between ACATs. The MDS only needs to draw from that information a core set of items that are needed for national analysis – rather than care management.
	If client refuses formal assistance even though it is recommended by ACAT - should formal box still be ticked?	
	What we recommend is not often what is available. There can be months of delay eg. before CCP available so other services may be referred to fill gaps.	Yes. Personal assistance needed is designed to capture the needs of the client only according to the ACAT's professional opinion, regardless of whether the client agrees to the assistance or whether or not it is available.
	How are supportive residential services classified?	
	? Self care should be 'personal care'.	
	I found this question messy and difficult to complete - hard to read the guidelines 'Formal support' eg. CCP may require some financial contribution.	Self care is used to allow consistency with the Australian Bureau of Statistics Disability, Ageing and Carers Survey for population based comparisons.
	Distinction between formal and informal care a difficulty with private agencies - a growth industry with the lack of subsidised community services. Such agency support can be thought of as 'formal' which does	

Question/data element	Comments	Response
	not fit the definition. Although formal vs informal is clearly defined, there still could be some confusion especially when private carers are utilised.	Assistance from private organisations should be coded as 'formal' assistance, as per the guidelines. The guidelines included on the form stated that assistance provided by private agencies is also counted as 'formal'. There is the capacity under the item 'Relationship of carer to care recipient' to code 'Personal employee (not organised by formal services)' which are classified as informal. Whereas assistance provided by private agencies is stated to counted as formal.
23d Types of personal assistance recommended (Vic & Tas only)	Difficulty with what is needed and what is recommended. Does this mean what is available or what is needed? Recommended may not necessarily indicate that the service is available eg. service is available but frozen now. HACC services to outlying areas not easy to access. Some inconsistency within Guide for use – 'result in referral to the relevant agency' and later statement 'is recommended to be ongoing'. Good idea to differentiate between 'needed' and 'accepted and available'. I have a lot of difficulty knowing whether to mention services to clients that I know aren't available or likely to accept (from previous referrals) and thus what to put in this item if I have mentioned but not really recommended. Recommended - instead of 'recommended' it should be 'accepted' if agreed to by client.	'Needed after assessment' – Needed by the client whether or not they are available. 'Recommended after assessment' – takes account of both availability and client preference and represents a consensus between the client and the ACAT. Whether a service is available or not (taking into account waiting lists) is an issue for consideration by the Data Working Group. If the concept of availability is retained (either within "recommended" or as a separate item), the Project Team recommends that "available" be defined as related to the individual's needs at the time of assessment. That is, if a client needs a service now and there is a 6 month waiting list then it is not available to the client. This was intended to capture both recommendations for new services required as well as those that will remain, ie. fi the client is in receipt of services already that are appropriate to their needs, and will therefore be ongoing. The Guide for use and Context will be clarified. The issues surrounding the inclusion of both 'needed' and 'recommended' in the MDS Version 2.0 will be considered by the Data Working Group.
24 Types of professional assistance	Nothing to show need for socialisation and mental stimulation for those who are isolated. This does not clearly reflect the services referred to by ACAS. These categories are too limiting and do not include all the possible clinics etc involved. Does a falls assessment equate to an O.T. assessment? Does a mobility assessment equate to an P.T. assessment?	Coding options included were specific areas of interest identified by the Data Working Group and were not intended to capture all the professional assistance recommended by ACATs. Issues surrounding the inclusion of this item for the MDS Version 2.0 and the suitability of the coding options will be considered by the Data Working Group.

Question/data element	Comments	Response
	Frequently recommend allied health, so it is not adequately recognised in 'other'.	
	Rehabilitation, palliative care etc - need to indicate if inpatient or in community.	
	More detail required on what is meant by rehabilitation care, as this can be misinterpreted where there are no specific rehab units in country areas, but may have allied health staff providing rehab.	
	Unable to determine category required.	This will be included.
	Some clients need none of these items post visit eg. straight forward future planning cases and renewals with no complications.	'None of the above' coding option will be included.
	Unsure sometimes ascertaining level of involvement to indicate whether case managing or monitoring, it sometimes waivers between both. Unsure whether Case management is the correct terminology, Case coordination may be a better reflection. Definitions need more discussion and clarity.	These definitions will be tightened up and considered by the Data Working Group.
	?Case management - do ACATs do case management?	Yes, some say they do.
	There is no time frame.	On the form it stipulated to 'Tick types of assistance if received in the last 12 months prior to assessment'.
	Information regarding whether the services 'needed after assessment' are actually available would be useful and help to identify gaps.	The issues surrounding the inclusion of both 'needed' and 'recommended' (including availability) in the MDS Version 2.0 will be considered by the Data Working Group.
	Does not reflect actual counselling and assistance given by ACAS themselves.	This is assumed to be part of the multidimensional approach of ACATs in their evaluation of the care needs of a person, ie. a comprehensive assessment.
	Are they to be included if used as part of ACAS assessment?	No – as it stands now.
	No opportunity to record professional assistance provided during the assessment, eg. if client was reviewed by a geriatrician.	The DWG has previously rejected an item that records the various disciplines contributing to an assessment. However, this will be raised again.
	This question does not take account of professional assistance provided as part of the assessment/episode of care, eg. hospital based ACAT can access rehab, palliative care, continence, mobility assessment, geriatrician, psychogeriatrician and other medical specialist as part of the assessment and will therefore have less recommendations for these services after the assessment.	This is one of the trickiest areas of the MDS. The Draft MDS V2.0 is trying to distinguish between an episode of care that is primarily directed towards assessment as opposed to other purposes eg rehabilitation, palliation, acute care. The contribution of various disciplines to an assessment could be captured by another data element but there may still be a need to distinguish between an assessment episode that includes eg

Question/data element	Comments	Response
		a mobility assessment, an OT assessment, a Physio assessment and episodes of care that are directed at treatment eg a rehab episode, a palliative care episode etc. These issues will be considered by DWG
	Often unable to obtain this information from client or family, particularly when dementia involved; and sometimes difficult to collect over the 12 month period.	Perhaps an "unable to determine" code fro Types of professional assistance received prior would help.
	Is it appropriate to give the client dementia specific support/counselling rather than the carer?	Yes – especially in early stages. There is the ability to code dementia specific support/counselling for the carer also under the question Carer support
	Needed and recommended also had the potential for some confusion, although was reasonably straight forward when thought about.	
	Might be useful to put in 'interim care' which is often needed.	Not sure what "interim care" covers. If residential respite this can be recorded under Program support. if it refers to a range of home based support services this can be covered under Types of personal assistance needed. If these types of needs are recorded in conjunction with a Recommended long term care setting of residential care then we could assume these supports represent 'interim care'.
	Specialist clinic/adviser not clear and overlap - all available at a community rehab centre/outpatients. Services should be CDAMS, Falls clinic, Movt. Disorders clinic other.	The inclusion of specialist clinic/adviser was made for those ACATs who do not have access to specialised clinics or units but may have access to individual persons who specialise in these areas..
25 Program support	Respite care – residential may be clearer as residential respite.	Will be considered by Data Working Group.
	Need to include community based respite and day respite centre.	Community based respite should be recorded under Carer support question and day centre respite under Personal assistance 'Social and community participation'.
	Confusing to be instructed to tick that a program was needed when it is not available eg. EACH.	This information allows for limited reporting on potential gaps in services. So if an ACAT thinks a person needs the sort of assistance provided by an EACH package then they can report this – even if it is not available.
	This does not include other community supports eg. HACC, Dementia Home support, Dom Care type services.	These programs are the only ones identified by the Commonwealth for separate reporting in the absence of statistical record linkage.
	Would like to see 'none of above' used consistently.	This will be incorporated.
26a Carer support received prior to	What would 'other' incorporate? Should this be specified?	Other is intended to incorporate any other services that are not

Question/data element	Comments	Response
assessment		identified in the coding options.
	Where does a local 'carer support service' go, under 'assistance from Carer Respite Centre/Carer Resource Centre' or 'Other counselling/support etc.' as it is a different agency?	'Other counselling/support etc'.
	Does 'Respite care-community based' include in-home respite?	Yes
	If receiving assistance via Carer Respite Centres do we assume advocacy and counselling is being done or do we tick both?	Yes – assume this is being done as these Respite Centres are meant to identify carers' needs and facilitate appropriate supports – including counselling and advocacy.
	Time consuming.	
26b Carer support needed after assessment	No where to identify if carer requires an ACAT assessment.	To be considered for inclusion by the Data Working Group.
	Needed guidelines to determine if to record if client refused.	The Data Working Group will be considering the inclusion of another category for 'recommended' which will take into account availability and client preference and represent a consensus between the client and ACAT – or – alternatively, separately recording client agreement and availability of services.
	Is this what the ACAT thinks is necessary or what the carer identifies?	It is the type of support that the ACAT considers that the carer needs, regardless of whether the carer (or client) agrees to the appropriate provider or whether the support is available.
	No opportunity to give information on what was provided during the assessment.	It is assumed that the multidimensional, comprehensive approach of ACATs in their evaluation of the care needs of a person often includes some counselling of the client and their carer. Some comments and responses under Types of professional assistance are relevant.
27 Aids and equipment	Uncertain why this needs to be collected as it stands. Categories too broad.	This item is consistent with the Australian Bureau of Statistics Disability, Ageing and Carers Survey, which will enable population comparisons. The categories have only been broken down to the level needed for national population comparisons. Some ACATs consider this list to be too detailed – see below.
	No indication of change in functional status, eg. increased mobility support needed. Aids may be used prior to assessment and new range of aids after assessment but this will not reflect any change.	No, but this would add another level of detail and complexity to this question, that is considered unnecessary by the Data Working Group for national reporting purposes, at present.
	Do you need to complete for continuing use of aids and equipment with no change?	Yes
	Do we tick home modifications if waiting for this to happen?	Yes
	Information is too detailed and time consuming to collect.	There are varying views on whether the code list is too broad or

Question/data element	Comments	Response
		too detailed – see above.
	Do reading frames refer to spectacles or book supports?	Reading frames refers to book supports.
	Is this what the ACAT assessor believes is viable or carer identifies?	It is the type of aid or equipment that the ACAT considers that the client requires, regardless of whether the client agrees to a referral or whether it is available.
	Suggest continence aids be added separately	To be considered by the Data Working Group.
	This cannot be identified until after physiotherapy assessment.	Doesn't the physiotherapy assessment form part of the ACAT comprehensive assessment?
	Often unable to obtain this information from client or family, particularly if dementia involved.	'Unable to determine' coding option to be included.
	Couldn't answer even though the question should be answered for all clients.	
	Says 'should be answered for all clients' but some do not need any of these and there is no 'no aids' box.	'None of the above' coding option to be included.
	Availability is also an issue; if not available , information not relevant. Availability would be beneficial for rural areas to identify gaps in services.	To be considered by the Data Working Group.
	Unsure of the items included in guidelines - names used, what else not named might be included?	A more comprehensive list will be included in the final Data dictionary for the MDS Version 2.0.
	Aids for reading should include all aids for vision - reading is only one of the areas.	Australian Bureau of Statistics standard guidelines will be checked.
28 Assessment end date	This can be a grey area and can be dependent on profession of worker and level of involvement.	The Assessment end date is defined as the date that the ACAT completes the care plan (ie. decides on the content of the care plan) for the client or ends the assessment process because of other factors or events that mean that the assessment cannot proceed.
	Is this the date the care plan is decided or when the approval is completed and delegated?	This should be the date the care plan is decided, as not all ACAT assessments end with an approval.
29 Reason for ending assessment	ACAS are not funded for case management.	Some ACATs have advised they do provide case management in the short term.
	A category needs to be included that relates to the outcome of the care plan.	Not all ACATs follow-up care plan implementation and therefore this is difficult to standardise. To some extent statistical record linkage may help by identifying those ACAT clients who go on to become HACC client, or CCP recipients or residents of residential care facilities

Question/data element	Comments	Response
	If client dies before being seen, do we leave blanks in all the questions?	This will be dependent on what the Data Working Group decides with respect to which client assessments should be reported for the MDS Version 2.0, eg. those clients who have a First intervention date or those with an Assessment end date. At present we will be recommending that only comprehensive client assessment that have progressed to the point of First intervention date should be reported in the MDS.
30 Accommodation setting/ Recommended long term care setting	'Long term' needs definition. ACATs sometimes support an existing situation with a fall back plan ie. outcomes and recommendations not always clear.	Recommended long term care plan is one of the most important data elements in the Draft MDS V2. It is intended to record the ACAT's view, incorporating the client's and/or carer's preferences, of the setting most appropriate to the person's long term care needs. So if the recommended long term care setting is at home (private residence) but there is some doubt that this will be sustainable, an ACAT may approve the client for residential respite or low level residential care on a 2624. Many 2624s have multiple approvals and we assume that this is often because the ACAT wants to cover all the possibilities without having to reassess the person if the preferred plan does not succeed. This issue needs to be considered by the Data Working Group.
	Need to include CCP in usual and recommended.	This information is recorded under the Program support item.
	Inappropriate to have categories for short term crisis and public place/temporary shelter.	Some people do stay for long periods of time within short term crisis and public place/temporary shelters, eg. homeless people. They may not stay in the same place but move from one shelter or refuge to another – all of which are the same type of setting, although different actual places.
	Is Abbeyfield type accommodation considered 'Supported Community Accommodation' or something else?	It should be coded to 'Supported Community Accommodation'.
	Does not include living with family not paying rent.	The latest version of the National Community Services Data Dictionary includes a new standard for Tenure type which separately identifies "rent free". This will be considered by the DWG for the ACAP MDS.
	It talks about accommodation setting but the tick box is for 'level of care'. With high care required in a low care facility we were not sure how to tick the boxes.	If the person needs residential care with a high level of care then this should be coded. It is assumed that with the Structural Reform of Aged Care, it is possible that a facility previously limited to providing low level care (hostels) may be able to provide high level care.

Question/data element	Comments	Response
	Can be intrusive and irrelevant to the purpose of the ACAT assessment eg. As to ownership /rental status of accommodation. As cited earlier we need a category for respite plus home care to indicate to statistic collectors and planners just how many people cope because there's no long term residential care available or they choose to remain at home to relatives help caring. In other items, ACAT judgement of client need (even if they don't agree with recommendations) is what's sought. In this one, instructions are contradictory ie: is it based on ACAT recommendations or what the negotiated care plan came up with.	Respite can be recorded under Carer support (in-home respite), Program support (residential respite) and Personal assistance (day centre respite). Other types of home care will be captured under the Personal assistance item (formal needed after assessment) and/or the Program support item (CCPs). This item is supposed to take into account service availability and the preferences of the client and their carer, and may not therefore be what the ACAT considers optimal.

The following table identifies the data elements that were considered by ACATs to be required in the ACAP MDS Version 2.0.

Table 9 : Data elements that should be included in the ACAP MDS Version 2.0

Data elements	Comments	Response
Personal assistance received prior to assessment	Client satisfaction with formal services would be useful.	This is out of the scope for the MDS Version 2.0, but could be the subject of an ad-hoc survey. It is relevant to performance indicators related to quality of service but is notoriously difficult to collect reliably from frail older people.
Continence	Although mentioned in Professional assistance, in a lot of cases there is no continence adviser available or it is not necessary and yet continence is a major reason for entering Nursing Homes and is probably needed.	In addition to the Professional assistance item, the Health condition code list allows for the recording of incontinence (1403, 1602) and the Aids and equipment item allows for the recording of self-care aids for the management of incontinence. It has been suggested that continence aids be separated out.
Continence, mobility, orientation	These functional items reflect dependency levels in some way, although at present quite crudely. These items could be further developed to better reflect the dependency of clients.	The Data Working Group agreed to test the data item Types of personal assistance which can be used to identify severe or profound core activity restriction. This information can be used to compare with the Australian Bureau of Statistics Disability, Ageing and Carers Survey for population based comparisons.
Inter-team referral	It would be advantageous to gauge the numbers of inter-team referrals and to whom they are going, eg. if every second inter-team referral goes to the social worker, we may need more of them. Secondary referrals within the team should be recorded to reflect the cost, time and complexity of assessments.	This is assumed to be part of the multidimensional approach of ACATs in their evaluation of the care needs of a person. Although there is no national reporting requirement for this information, it does not however preclude ACATs from collecting this information.
Referring agent	To identify education requirements as there may be gaps in some agents.	Not seen as required for national reporting purposes by the Data Working Group, at present. However, if this refers to the need for training or qualifications of ACATs to be improved in some way then this may be appropriate for a specific survey rather than via the MDS..
Pension status Source of income	Essential for ACAS practice. For equipment criteria need to know if on Aged pension, self-funded or DVA. Why not use format from the 2624 form re 'What is your source of income? Govt pension or benefit? DVA or Centrelink/Self funded retiree.	The Data Working Group has identified no national reporting need for this information, however this does not preclude ACATs from collecting this information if required. Since the Pilot Test the Federal Budget has introduced a new DVA initiative where all home care needs of veterans with a gold or white card will be met by DVA. This adds some importance to the DVA information, in particular.
New client referrals	Required for statistics on new clients compared to those clients who are seen by ACATs episodically.	

Data elements	Comments	Response
Availability and client wishes for Personal assistance, Professional assistance, Program support, Carer support, Aids and equipment Recommended after assessment	Availability in short-term, long-term or not available. No mentions is made of what the client's wishes are and how they recognise their needs. This information is vital. Would be helpful to differentiate why needs weren't recommended eg. client refused or service availability. It is not highlighting service gaps	This issue is to be considered by the Data Working Group. Project Team will recommend that "availability" be defines in relation to the individual clients at the time of assessment. The DWG agrees that this is an essential part of the comprehensive assessment process. However, they considered that including this information in the MDS would add considerably to the size of the MDS and was more relevant to good practice than national reporting for statistical purposes. Strategies for developing, and monitoring quality of ACAT service will be considered by the DWG. We will be recommending to the DWG that if ACAT recommendations are required in the MDS the issues of client agreement/refusal and service availability be separately identified rather than collapsed in "recommended".
Availability of services in each area	Useful for future service planning and delivery.	Some of this information is currently provided on the narrative reports. Whether this should be standardised and reported say once a year to government will be considered by the DWG
Behavioural information	Dementia information could be more detailed and include more behavioural information.	We will be considering whether the inclusion of more specific information about functional impairments would help to pick up more useful information – particularly for clients with dementia.
Guardianship	Is this recorded under advocacy?	We think so – but will discuss with DWG.
Inpatient assessment service use	Need to identify resources in the community for inpatient assessment over longer period eg. use of GEM beds.	May need to be collected via specific survey.
Accommodation setting	Accommodation setting usual, temporary and recommended to cover short term recommendations while awaiting placement.	Data Working Group interested in long term situations and recommendations only, not temporary measures.
Reason for referral Source of referral	Needed so data can reflect what areas in assessment are not picked up or easily recognised in the community or by GPs. Relevant for future studies and program development	To be considered by DWG. To date, the DWG has identified no national reporting need for this information, however this does not preclude ACATs from collecting this information if required.
Dementia specific residential	Useful to record number of times this would be a preferred option, as it is not currently available in area.	2624 currently allows for this to be recorded for those ACAT clients who go on to have a 2624 approval for residential care.
Elder Abuse	Is covered in Q21 (Sustainability of caring role) - ? To be expanded.	This issue was considered for inclusion by the Data Working Group but was decided against. We are aware of some interest (in NSW) in developing a national standard definition for inclusion in the National Community Services Data Dictionary.
Driving concerns	We are now seeing a number of people with dementia that are still driving - what should we do? We need numbers to lobby a change in	This is out of the scope for the MDS Version 2.0, but could be the subject of an ad-hoc survey. The DWG will be informed of

Data elements	Comments	Response
	guidelines/professional responsibility.	the concern.
Proficiency in spoken English	The suggested question and categories plus emphasis on clients self report would be a useful adjunct to our training notes for new staff eg. when introducing interpreter services.	

The following table identifies the data elements that were considered by ACATs to be not required in the ACAP MDS Version 2.0.

Table 10: Data elements that should not be included in the ACAP MDS Version 2.0

Data elements	Comments	Response
Aids and equipment used prior	Relevant, but too time consuming to provide detailed information. Should concentrate on key aids and equipment only. OTs may be specifically able to answer these questions. Other disciplines not always aware of all the options on how to assess appropriately for these options - particularly such items as calipers - pacemakers - structural changes.	
Proficiency in spoken English	What is the value and purpose of this question?	Is included as it is 1 of 3 core data elements recommended by the Australian Bureau of Statistics as the national standard for identifying potential disadvantage related to cultural and linguistic diversity. The appropriateness of including this data element in the MDS Version 2.0 will be discussed by the Data Working Group and consideration given to recommending a change in the national standard.
Priority category	Difficulties for ACATs with large country regions to cover. We would contact the referrers by phone, but may not be able to visit within the given urgent timeframes. If a geriatrician (or mental health service) visit is required these are only monthly visiting services in this regions.	If this data element is included in the MDS Version 2.0, instructions will need to be incorporated within new program guidelines. The Data Working Group will consider these factors when developing performance indicators for the ACAP. We would expect that someone needing urgent attention would usually receive some form of intervention by the ACAT prior to seeing a geriatrician.
Carer residency status	Can this be amalgamated with Carer availability?	For definitional purposes no, but could be done so for data collection purposes eg. forms design.
Client ID/ Letters of name	Do we need this and the letters of the name as well.	Yes for the purposes of statistical record linkage across programs.

	There is already a number	
DVA Status	Query as to why this is needed.	This item is still to be considered for inclusion by the Data Working Group. Recent initiatives announced in the Federal Budget may add importance to this item.
First intervention date	Additional; no justification; compliance will vary (ie. consistency of data). Suggest an intensive pilot trial before incorporating such an item.	The definition and guidelines for this question need to be tightened. The intention was to try to capture more information about the enormous amount of work that ACATs often do before face-to-face contact is made with the person. It can be used to record the date on which an interim care plan is developed before a full assessment is completed (eg. emergency respite admission). The Data Working Group is still to consider whether this item will be included in the MDS Version 2.0.
Living arrangements	? Combine with accommodation setting.	Accommodation setting may become too complex – it already contains information about tenure. Living arrangements may only need to be reported for people in some accommodation settings.
Professional assistance	By definition ACAS assessments are multidisciplinary and comprehensive. The responses would be ambiguous and contribute little to the outcome information with regard to medical specialists.	This issue will be considered by the Data Working Group.
Proficiency in spoken English	This question should be deleted or replaced with one regarding need for interpreter which is more useful clerically.	Is included as it is 1 of 3 core data elements recommended by the Australian Bureau of Statistics as the national standard for identifying potential disadvantage related to cultural and linguistic diversity. The appropriateness of including this data element in the MDS Version 2.0 will be discussed by the Data Working Group and consideration given to recommending a change in the national standard. If the item was to be included it does not preclude ACATs from collecting information with respect to need for interpreters.
Suburb/town/locality name	Will just postcode do?	Both are needed for cross-checking purposes and because postcodes (particularly in remote areas) may cover very large geographic areas that cover several towns/localities.

Table 11: Data elements identified as useful for ACAT service delivery and local management.

Data Element	Freq*	Data Element	Freq*
Carer availability	11	Country of birth	6
Personal assistance needed	11	Date of birth	6
First face to face contact date	10	Professional assistance received	6
Professional assistance needed	10	Program support recommended	6
Indigenous status	9	Recommended long term care setting	6
Referral date	9	First face to face contact setting	5
Accommodation setting	8	Carer support needed	4
Sustainability of caring role	8	Proficiency in spoken English	4
Main language spoken at home	8	Reason for ending assessment	4
Aids and equipment needed	7	Relationship of carer to care recipient	4
Aids and equipment used prior	7	Source of assistance received	4
First intervention date	7	Suburb/town/locality ame	4
Health condition	7	Carer residency status	3
Living arrangements	7	Carer support received	3
Personal assistance received	7	Carer support recommended	3
Personal assistance recommended	7	DVA card status	3
Priority category	7	Postcode	3
Program support needed	7	Professional assistance recommended	3
Program support received	7	Sex	3
Aids and equipment recommended	6		

* Frequency shows the number of Feedback forms where this data element was indicated as useful. N=50.

The impact on ACAT processes and systems if the ACAP MDS Draft Version 2.0 were to be implemented

Following is an outline of some of the key issues that were identified by ACATs as potential problems:

- recording interrupted assessments as ended;
- providing more information on specialist medical intervention, carers and aids and equipment;
- time consuming;
- team education and staff training;
- more complex care planning;
- allocation of the Priority category would require professional intake duty officer to allocate;
- recording referral date, first intervention date and first face-to-face contact date;
- modifications to forms;
- new and/or upgrades of computer software and hardware required; and

- would require more administrative support.

Could ACATs manage any necessary changes within current resources?'

Out of the 28 responses to this question 12 ACATs said 'yes', 14 ACATs said 'no', 1 ACAT 'probably' and 1 was 'unsure'.

Summary of additional comments provided by participating ACATs reflecting their experience of the Pilot Test.

- most of the data elements are already included as part of our general assessment procedure;
- found the Pilot Test manageable and quite straightforward;
- feedback form time consuming and repetitive;
- took longer to complete forms, but this would decrease with familiarity;
- clear and concise;
- using Version 2.0 has helped to highlight necessity for accurate and thorough assessment and planning;
- time directed to Pilot Test has been taken away from client time, extending waiting times for assessment and service focus;
- consultation and inclusion in Pilot Test greatly assists country teams and the experience has been used as a Quality Improvement exercise and to improve consistency with the team;
- regular funded upgrades of software is vital, and ability to troubleshoot with consultants;
- far too much information being collected;
- explanation boxes on the form very useful;
- overall impression and application of the data collected to the ACAS role, the assessors commented that questions 24, 25, 26, 27, 28 items recommended reflected the consensus between the clients and ACAS and helps the assessment form to become more client focused rather than data collection;
- Some of the demographic information collected would be of benefit to the ACAS. However the data outcome information may pre-empt some of the assessment outcomes, but not all possible features of an ACAS assessment included, this may therefore give a skewed picture of the process and outcome of an assessment;
- We all felt that the pilot was done extremely well and allowed plenty of trials;
- Although we see the benefits of more data and using some of these questions to explore more options for our clients, we feel that if these are incorporated into the form 2624, most of this information would be of no value to residential care facilities. Many of these facilities already say this form is of little assistance to them in planning admissions;

- as each of our assessors only completed 2-3 survey forms each, it was difficult to assess possible problems with such a small sample.
- I feel that the pilot MDS form is comprehensive and covers all areas of assessment that should be electronically recorded;
- Quite a comprehensive tool, which was well complemented by the guidelines provided;
- Could attempts be made to attain the database information collected directly/or more closely from the 2624 approval form. This would improve accuracy of information collected, and also efficiency of time spent doing database (ie. avoid duplication of filling in approval form, and then having to convert/duplicate onto a separate database);
- It has taken a lot of time, but if you can reduce the amount of time spent on database entry, it will be worth it;
- I liked the emphasis on the carer's role and help received to support carers and clients.
- It was a very busy period for us, which meant fairly rushed form completion. Nonetheless, generally I found forms clear and easy to complete. It seemed as though more useful data was being gathered about our clients needs, than the currently used MDS.

10 Post Pilot Test on-site visits

Following the Pilot Test collection, the AIHW Project Team visited nine participating ACATs to cross-check a sample of pilot client assessment records with the ACAT's own records/systems (see Appendix E for a list of ACATs visited). This process was particularly targeted at identifying any problems with reporting the Letters of name data element. However, it also provided an opportunity to examine the primary source of reported data and uncover any problems the ACATs had, or anticipate having, in meeting the future reporting requirements for the ACAP MDS collection.

While visiting the WA teams, the AIHW also took the opportunity to meet with approximately 6 Aged Care Assessment Teams (both metro and rural), the WA DWG member and the Evaluation Unit representative, to discuss the development of MDS Version 2.0. A large number of ACATs attended the meeting, and were eager to learn more about the development of version 2.0 and to share their views on the proposed content. The meeting was very valuable and informative from the AIHW's perspective, as it enabled the Project Team to get a better understanding of the issues involved for the WA teams.

Below is a summary of the issues identified during these visits.

Table 12: Summary of comments on data elements from post pilot on-site visits

Name	Comments
Referral date	Referrals are often received before clients are medically stable. ACATs reason for not seeing client is because they are not yet stable for assessment, but the hospital refers them because they will eventually need an ACAT assessment. A measure of ACAT response time using this referral date is not appropriate.
Priority category	Coding Priority as a reflection of client need is a good approach.
Client ID	
Letters of name	Aboriginal people often use more than one surname. Need to standardise with Centrelink name (recorded on the card). Concerns over confidentiality – will have to be passed by hospital ethics committee.
Date of birth	Aboriginal people often have an estimated DOB recorded as 1 July for any given year, according to Centrelink standard. ACAP MDS currently estimates using 1 January of any given year. Need to standardise with Centrelink?
Sex	
Suburb/town/locality name	Homeland or country is a term often used by Aboriginal people.
Postcode	
First intervention date	More clarification needed on what constitutes clinical intervention ie. not just the opening of a clinical record. Include not applicable option to capture those clients that withdraw before they reach this stage. Work over the phone is difficult with NESB clients.

	Intervention is written up in the progress notes on the client record not on the referral sheet. Intervention—in-depth gathering of information. Intervention – understood to mean an actual intervention and not a clinical record. NT has Aboriginal health workers in remote regions who will often visit a person in need of assessment, and then send in a referral to the ACAT. In these cases the First Intervention date will come before the Referral date. This data element is much appreciated by ACATs servicing rural/remote areas. They will often perform a Blaylock risk assessment over the telephone for clients in remote areas, and may put HACC services in place if they are not able to get out to see the person straight away. This data element allows the ACAT to record that some intervention has taken place before face to face contact.
First face-to-face contact date	Include not applicable option to capture those clients that withdraw before they reach this stage. In the ACT clients are recorded as a withdrawal if no face-to-face contact (MDS V1.0). It is considered an assessment of the situation as opposed to the assessment of a person.
First face-to-face contact setting	Need to include Crisis Respite Centre in the 'Other' category. Some assessments can be done in shopping centres ie. in cases of elder abuse. Home should be a separate category. "Other" should be called "Community setting".
Indigenous status	
Country of birth	Code list time consuming to look up. Would be better if the coding was left up to the data entry person.
Main language spoken at home	Code list time consuming to look up. Would be better if the coding was left up to the data entry person. Code list is very comprehensive and covered all the possible dialects.
Proficiency in spoken English	The ACATs opinion of the client's proficiency in English may often differ to the client's view. Problems with self-reporting component. Can be awkward and embarrassing to ask.
DVA card status	This was confusing – are those with "no card" meant to be DVA people without cards, or people that are not DVA at all?
Living arrangements	What is the purpose of this information? Does not make sense for people in residential facilities or those people living in granny flats in the backyard of a family members house.
Carer availability	What level of care is considered significant. Could be a wide ranging interpretation of a carer. In remote Aboriginal communities it can be difficult to identify the primary carer, as there are often many carers that alternate in the caring role.
Carer residency status	
Relationship of carer to care recipient	Difficult to determine one only.
Sustainability of caring role	Difficulty arises in situations where the carer is willing, but the care recipient does not think that the carer should continue in their caring role.

	Ethical problems with it being the ACATs judgement. Codes 36 are the reasons why the caring role is Unsustainable carer unwilling to continue and should be a subset of this code. Alternatively code 2 could be removed.
Health condition	Further detail for some categories required eg. Certain infectious & parasitic diseases. Why is Alzheimer's a separate code? May need to be in alphabetical order also. More detail required in 1800 codes; functional focus is applicable. The 1800 codes are functional codes and the rest are pathological. The following conditions need separate codes: - Delirium - Short term memory loss - Cataracts - Poor vision - Non-specific falls - functional decline - Gait disorder - Frequent falls - Elder abuse ?? - Alcoholism - Urinary tract infection (code 199 not specific enough) - Fractures (by type & maybe internal fixation) - Rheumatoid arthritis - Spinal injuries - Renal failure (end stage) - Chronic Obstructive Airways Disease - Deconditioning (muscle wasting from lack of use) Concerns about non-clinical staff coding health conditions. Health condition is important for ACATs that do not have medical staff to make diagnoses, especially in remote areas where a geriatrician may only visit twice a year. ICIDH coding may be more useful than ICD10 coding for the purposes of the ACAP MDS. More work needs to be done on this. Need specific expertise to code mental illnesses. Long standing mental illness reveals more than a recent condition.
Personal assistance received prior to assessment	
Source of assistance received prior to assessment	
Personal assistance from formal agencies needed after assessment	Need to include informal assistance needed also. Most formal services will fail without informal backup.
Personal assistance from formal agencies recommended after assessment	
Professional assistance received prior to assessment	The list may to be too specific and is too long. May be better as Acute, Geriatric, Allied health, Outpatient review, Rehab, Palliative care. Combines two areas, ie. medical/clinical and counselling/case management. Case management—goal oriented, intervention specific, coordination. Unable to determine category needed.

	These types of assistance are largely not available in the Kimberley region.
Professional assistance needed after assessment	Unable to determine category needed. Need to separate acute geriatric care from outpatient geriatric review.
Professional assistance recommended after assessment	Unable to determine category needed.
Program support received prior to assessment	
Program support needed after assessment	
Program support recommended after assessment	
Carer support received prior to assessment	May need a 'Not known' option.
Carer support needed after assessment	May need a 'Not known' option. Some carers need an ACAT assessment themselves, need to have another category to code this.
Carer support recommended after assessment	May need a 'Not known' option.
Aids & equipment used prior to assessment	Too detailed to collect for all assessments. The information is recorded when it is mentioned or where it is relevant; therefore it is unreliable as well as being difficult to obtain. Aids for reading and Car modifications could be removed as this information is not collected routinely.
Aids & equipment needed after assessment	
Aids & equipment recommended after assessment	
Assessment end date	Use the date the care plan is approved.
Reason for ending assessment	In the ACT clients are recorded as a withdrawal if not face-to-face contact (MDS V1.0). Concern about extra paper work being generated. Eg. previously a person referred for rehab would have that episode of care included as part of the overall assessment. Version 2.0 requires two distinct MDS records – one for the rehab episode and one for the following assessment of long term care needs.
Accommodation setting—usual	Accommodation setting should be separate to recommended long term care setting at the beginning of the form, as it should be linked to the rest of the information that follows. Need to separate out whether home is being owned/purchased by client or by their family. This information is needed by residential care facilities, and if MDS replaces the 2624 then this will be required. Need to link this question to Living arrangements, Suburb/town/locality name and Postcode.
Recommended long term care setting	Is there a need for an urgency category to be attached to recommendations for residential care? Need to specify that there should only be one long term care setting coded here.

General comments from on-site visits - ACATs

- Data collection for inpatients should be streamlined. The collection of the data in Version 2.0 is inappropriate and would be unreliable. Two types of inpatients, those under care and those that are consults. Care planning for inpatients and community based clients is very different. ACAT role in hospitals is very different (rapid response).

- The definition for recommended types of assistance is problematic as a client may agree to a service but it may not be available, and vice versa. Need separate codes to indicate whether the service is available, and whether the person agrees to the service.
- Availability should be coded according to the client's needs at the time of assessment. For example, if a person needs Home Help to help maintain them in the community, but the service is not available for another 6 months, it should be coded as unavailable. Alternatively, if a person doesn't need Home Help straight away, but will need it in 6 months time when their carer goes away, it could be coded as available according to their needs.
- Availability should also take into account the person's ability to pay for the service. If the cost of a service is too high (which may be due to shortages and charges at cost price) then this is an important factor in determining availability.
- VIC/TAS - Differing interpretations of what 'Recommended' means. Some would code a service as recommended only if a service is agreed to by the client, whereas others may code it as recommended regardless of whether the client agrees.
- Informed consent – problems with literacy/understanding amongst Aboriginal people in remote areas, who often don't understand what an ACAT assessment for residential respite or residential care means. A special kit containing pictures and stories that are culturally appropriate can help to explain this more clearly.
- Carers: The National Respite for Carers and Family and Children's Service's programs have different requirements than the ACAP MDS regarding carer data. This places a significant collector burden on the ACAT.
- Waiting times: It is useful to capture this in the MDS, as it makes clear the differences between how rural/remote and metropolitan ACATs work.
- ACAP MDS inclusions – need for clarification as to what kind of assessments/clinical work should be included in the ACAP MDS, and what shouldn't. Need to clarify the definition of a comprehensive assessment, as distinct from other types of care or treatment. (DEED program – WA).
- Services received as part of the assessment (eg. geriatric assessment) won't be captured under prior or needed. Would like option to code the professions involved in the assessment.
- 2624 – need for a "plain English" consent. Also needs a note on the form that specifies its confidentiality to protect the privacy of clients.

General comments from on-site visits—Project Team

When looking at client records it was sometimes difficult to cross-check details recorded for the Pilot Test due to inconsistencies on the client record, especially the recording of dates. Inconsistencies existed between information recorded for MDS Version 1.0, the 2624 and on the progress notes within client records.

Letters of name/Date of birth: The project team cross-checked the letters of name and date of birth Pilot Test data with the names/dates of birth recorded on client files. The error rate differed considerably from team to team. The error rates (percentage wise) for each of the teams follow: 0%, 0%, 6%, 12%, 16%, 29%, 45%, 53%. The average error rate was 20%.

There was a perception amongst some of the teams (reported in the Feedback forms and during Post pilot visits) that the Pilot Test form for Draft Version 2.0 was intended for use as an assessment instrument. This was not the intention of ACAP MDS V2, which is a minium data set to be used for national reporting purposes only. The form (together with Guidelines) used in the Pilot Test were only intended for use during the Pilot Test.

11 Proposed changes

Following are a summary of recommended changes to Version 2.0 of the ACAP MDS that are proposed as a result of feedback from the Pilot Test. These changes are subject to the agreement of the Aged Care Assessment Program Data Working Group.

Table 13: Summary of proposed changes to data definitions in the ACAP MDS Version 2.0

Name	Comments
Referral date	Some clarification of the guide for use to ensure the correct date is captured.
Priority category	No major change to data definition but the development of more detailed guidelines on how this process should work will be recommended to the Data Working Group.
Client ID	No change.
Letters of name	Accurate reporting of Letters of name will need considerable support and training. Wherever possible system generated letters should be used. Use of the Centrelink card as the standard will be recommended when people use different names or spelling of names (eg. some Aboriginal clients).
Date of birth`	No change.
Sex	No change.
Suburb/town/locality name	No change.
Postcode	No change.
First intervention date	Further clarification needed in guide for use to assist in recording what constitutes clinical intervention.
First face-to-face contact date	No change.
First face-to-face contact setting	Change code ‘other’ to ‘community setting’.
Indigenous status	No change.
Country of birth	Wherever possible codes should be system generated.
Main language spoken at home	Wherever possible codes should be system generated.
Proficiency in spoken English	If this data item remains in Version 2.0, additional information under guide for use will be needed.
DVA card status	Name change to DVA status; coding option ‘no card’ changed to ‘No DVA entitlement’ and additional coding option ‘DVA benefit–but no card’.
Living arrangements	Recommended that this data element not be recorded for those clients who are permanent residents of residential aged care services or multi-purpose services.
Carer availability	Minor change to guide for use to clarify which people should be identified as carers.
Carer residency status	No change.
Relationship of carer to care recipient	No change.
Sustainability of caring role	No change but additional support for implementation will be recommended.

Health condition	Conditions highlighted by pilot ACATs have been incorporated where possible. An alphabetical listing and an additional code list of the top 20 health conditions has been developed.
Personal assistance received prior to assessment	Feedback from the Pilot Test and possible alternatives that would simplify reporting will be considered by the Data Working Group.
Source of assistance received prior to assessment	
Personal assistance from formal agencies needed after assessment	
Personal assistance from formal agencies recommended after assessment	
Professional assistance received prior to assessment	
Professional assistance needed after assessment	
Professional assistance recommended after assessment	
Program support received prior to assessment	
Program support needed after assessment	
Program support recommended after assessment	
Carer support received prior to assessment	
Carer support needed after assessment	
Carer support recommended after assessment	
Aids & equipment used prior to assessment	
Aids & equipment needed after assessment	
Aids & equipment recommended after assessment	
Assessment end date	No change.
Reason for ending assessment	No major change to definition, but implications for ACAT practice will be considered by the Data Working Group.
Accommodation setting—usual	No major change.
Recommended long term care setting	More information in the guide for use to clarify that this is a recommendation that the client agrees with and to reinforce the coding of one option only.

Appendix A- ACAP Data Working Group membership

Penny Anderson
Department of Human Services
Victoria

Judy Barnes
Territory Health Services
Northern Territory

Kathy Beacham
Queensland Health
Queensland

Chris Benson
NSW Evaluation Unit, Westmead Hospital
New South Wales

Jan Child
Department of Human Services
Victoria

Damien Conley
Territory Health Services
Northern Territory

Julie Gardner
SA Health Commission
South Australia

Alison Kidd
ACT Dept. of Health & Community Care
Canberra

Justin Mcdermott
Department of Human Services
Victoria

Rebecca Meckleburg
Territory Health Services
Northern Territory

Maureen Pigott
North West Aged Care Assessment Team
Ulverstone, Tasmania

Kathy Stack
Health Department of Western Australia
Western Australia

Scott Stafford
NSW Health Department
New South Wales

Joanne Young (replaced by Darlene Hennessy)
NSW Health Department
New South Wales

Appendix B–Pilot Test form and Guidelines

Appendix C–Feedback form

Appendix D–Scenarios

Scenario one

An urgent referral was received by the ACAT from the acute regional hospital on 15 January 2000, from the discharge planner for Joseph O'Donahue (who likes to be called Guiseppe) who is 82 years old. He was born on 3 January 1918 in Sydney, Australia, and is not an indigenous Australian. He has lived in the Pleasant View Hostel for the Aged in Randwick, Sydney, since his wife passed away 4 years ago, and receives an aged pension. He took some time to settle into his new home but now likes the place and is anxious at the thought that he might have to move. Guiseppe has a son that also lives in Sydney. His relationship with his son is very important to him, but his son is only able to visit and take his father out about once a month.

The ACAT telephones the hospital on the same day and finds out the following information: Guiseppe has Insulin Dependent Diabetes and is on medication for high blood pressure. Last week Guiseppe was admitted to hospital after collapsing before dinner at the hostel. He has been diagnosed as having suffered a CVA (Cerebral Vascular Accident). After five days of acute care Guiseppe still has some paralysis down his left side and is having difficulty with his speech. He is unable to get himself to the toilet or in or out of bed without assistance. He also needs his food cut up for him and some assistance with feeding. The hospital considers that there is no more to be done for him in his current situation and have requested an assessment to have him re-located.

The ACAT team member visits Guiseppe in the ward on 16 January 2000 and recommends that Guiseppe receive some inpatient rehabilitation before they can determine his long term care needs. A bed is located within a rehabilitation unit and Guiseppe is transferred two days later, on the 18 January 2000.

After four weeks the rehabilitation unit contacts the ACAT on the 18th February to let them know Guiseppe has completed his rehabilitation, and will soon be discharged. The ACAT arrives on the 21st February 2000 to assess Guiseppe at the rehabilitation unit. Guiseppe still has some paralysis down his left side, and needs assistance with transfers and mobility. He requires full assistance with personal activities of daily living such as showering, is urinary incontinent and can no longer administer his daily injection of insulin.

In the ACAT's view, Guisseppe needs high level residential care, which he can receive at the Pleasant View hostel. He also needs ongoing physiotherapy and a motorised wheelchair. The ACAT discusses Guiseppe's needs with Guiseppe and his son, and they both agree with these recommendations. The ACAT refers Guiseppe to the local hospital for both physiotherapy and to investigate the option of a motorised wheelchair. The ACAT completes a 2624 that approves Guiseppe for a higher level of care on 23 February 2000. Guiseppe moves back into Pleasant View hostel, on 25 February.

Scenario two

The ACAT received a referral from a GP, Dr Helen Thomson, on 17th January 2000, requesting a non-urgent assessment of her patient, Mrs Jo Williams. Dr Thomson reported that Mrs Williams has Parkinson's disease, and that she is concerned about Jo's husband's ongoing ability to continue caring for his wife. The ACAT contacted Mrs Williams on 18th January and scheduled an appointment with her and Mr Williams at their home on 21 January.

Mrs Jo Williams of Bendigo, Victoria lives with her husband Tom in their family home. Tom attends to all his wife's domestic and personal care needs, and runs the household. He receives a carer's allowance (formerly DNCB) for his caring role, and Jo receives an aged pension. Jo is 80 years old, was born on 5 February 1920 in rural Victoria, and is not an indigenous Australian. Tom is 78. Jo and Tom have children living interstate whom they see usually at Christmas time.

Jo's health has declined in the last 6 months due to progression of her Parkinson's disease. She is quite depressed and is having a lot of difficulty coming to terms with her illness. She requires Tom's assistance and a walking frame to move around the house, and is largely confined indoors. Jo also requires assistance getting in and out of bed and chairs. She has low blood pressure and often feels dizzy, and has fallen twice in the past 6 months. Her Parkinson's is managed to a large extent by medication prescribed by her neurologist whom she sees every six months. Recently when attempting to help Jo out of her chair, Tom injured his back, and Dr Thomson is concerned that Tom cannot continue to safely lift and support Jo while she showers, toilets and moves about the house. Jo and Tom both receive meals on wheels five times a week, and Jo receives centre-based respite care one day a month so that Tom can play bowls at the local bowling club.

After completing a comprehensive assessment of Jo's care needs, the ACAT believes that Jo can stay at home with extra assistance and support. In the ACAT's view, she needs regular assistance with house-cleaning and showering once a week, continued meals on wheels, centre-based day care once a week and home based respite care twice a week. However, after making some phone calls the ACAT discovers that there is no service availability for home-based respite care in the area. Instead, the ACAT suggests that Jo use residential respite care once a month if needed, to give Tom a more extended break from his caring role. Jo and Tom are open to this idea, although both would prefer in-home rather than residential respite care. The ACAT also considers that Jo needs a wheelchair and some bathroom and home modifications to assist her with mobility around the house.

The ACAT discusses all the options with Jo and Tom, and they agree on a care plan that gives approval for a Community Care Package. As part of the community care package, the ACAT recommends that Jo receive regular assistance with showering, house-cleaning once a week, meals on wheels, and that centre-based day care is increased to once a week. The ACAT also recommends that Jo and Tom use residential respite care once a month if needed. Jo and Tom both agree to look into getting her a wheelchair from the local hospital, and the ACAT organises home modifications including a hand rail and shower chair in the shower, hand rails in the toilet, and a ramp in place of steps leading up to the front door of the house.

After the ACAT's discussion with Jo's neurologist, Jo went back for another consultation and the dosage of Jo's medication was changed to reduce likelihood of further falls, and an earlier review appointment was organised with the neurologist. The ACAT also discussed with both Jo and Tom the advantages of support and counselling through local support groups, and gave Tom the contacts for thee local carers support service to receive advice and support relating to his caring role. Jo was given information about relevant groups for Parkinson's sufferers. The 2624 form was completed and signed by the ACAT delegate on 24th January 2000

Scenario three

The ACAT receives a phone call on 6 March 2000 from Mrs Angela Spittari, who has been caring for her mother, Mrs Maria Bracco. Maria moved in to the home owned by her daughter Angela 6 months ago, who works full time and lives with her husband Dominic and 3 school-aged children in Norman Park, Brisbane. Angela decided at the time that her mother's health problems and increasing loneliness (her husband passed away five years before) meant that it would be worthwhile having her mother live with her.

Maria was born on 3 December 1923 in Italy, where she lived until she was 31. Her family tend to speak mostly Italian at home, as Maria finds it difficult to speak English well. Maria has chronic arthritis and mild dementia and a past history of depression. She has some nocturnal urinary incontinence, and needs assistance with all domestic activities of daily living and some personal activities such as changing pads and showering. Mrs Bracco receives no formal support services but had residential respite care at Standsville Aged Care Residential Facility some ten months ago where she received low level care. Angela transports her mother to Church on Sundays, and choir practice on Thursday nights.

Recently Maria has become more and more difficult to relate to and Angela describes that she 'blows up' at members of the family over small matters. She has a room in the family home and has become increasingly intolerant of the noise that the children make around the house, and does not get along with Angela's husband. She has said that she is not happy living with them and wishes she had not made the decision to sell up and leave her home. Angela has reached a point where she is quite exhausted from working full-time, trying to meet her mother's needs and caring for three school aged children. She is no longer willing or able to cope with her mother's occasional ill temper and the demands of her caring role.

Angela explains to the Intake worker that she has reached a crisis point and is requesting an immediate break from her caring role. The ACAT immediately organises emergency respite care for Mrs Bracco, at Standsville Aged Care Residential Facility the next day. Mrs Bracco remains in respite care for five days and on the sixth day (12 March 2000) returns home for the ACAT assessment.

The ACAT undertakes a comprehensive assessment of Maria's care needs. During the assessment a lot of time is spent counselling the family. After much discussion it is agreed by all that the best option for Maria is to move into residential care permanently, where she can get the help she needs and where Angela can visit her

often. The ACAT informs both Maria and Angela about the residential care facilities in their area and also provides information about the aged care facility for people of Italian heritage in Brisbane. The ACAT fills out the 2624 recommending low level care on 14 March.

For the interim period, the ACAT recommended that Maria return to Standsville and complete her period of respite and that Angela contact the Carer Support Service for support and counselling. In the event that Maria returned home from respite prior to moving to a permanent bed, the ACAT suggested that to best meet the needs of Maria and her family, she should receive meals on wheels and personal care assistance with showering. However, Maria did not agree to this type of assistance, instead preferring (with Angela's consent) that Angela continue to provide this assistance informally if needed in the interim period. In addition, although Maria needs transport to and from choir practice and church, the service is not available in her local area. Angela agrees to continue assisting with this, if there is an interim period before Maria enters residential care.

Appendix E–List of ACATs visited post pilot

New South Wales

Liverpool/Fairfield
Waverley
Wagga Wagga

Victoria

Mt Eliza

Western Australia

Kimberley

Sir Charles Gairdner Hospital

* Approximately 6 other WA teams attended a meeting with the AIHW in Perth.

Tasmania

Southern Aged Care Assessment Team.

Australian Capital Territory

Intake and Assessment Unit

Northern Territory

Darwin