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Functional decline in community-dwelling older people and the Medicare 75+ Health Assessment

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Background

This is the Final Report prepared for an Australian Primary Health Care Research Institute (APHCRI) 2014 funded project: *Functional decline in community-dwelling older people and the Medicare 75+ Health Assessment*. The overall aim of this research was to improve the sensitivity and timing of identification of functional decline (FD) in community-dwelling older people, focusing on primary care settings, so that older people's entry onto the trajectory of FD could be prevented or slowed sufficiently early, to be effective in supporting them to live independently for as long as they desired in the community home of their choice. This Final Report brings together salient methods and findings of Project Stages 1, 2 and 3 (provided for reference in Appendices 1-3). The final Report makes recommendations for policy and practice in relation to the 75+ Health Assessment (HA) and the context in which it is most effectively delivered. Appendix 4 provides a publication to date, from Stage 1 of this project (Beaton et al 2014).

Prior to commencement, the Research Team, in consultation and with the approval of APHCRI, changed the original research proposal.

ORIGINAL PROJECT PROPOSAL

The project hypothesis was that current detection of FD is too late, as it mostly occurs in hospitals after a health crisis, when the older person is unwell and out of their familiar environment. This leads to a real potential for error both in assessment/ measurement of FD, and provision of appropriate services. We proposed a project with three stages:

- > Stage 1: Literature review of early markers of FD
- > Stage 2: Focus groups with older people, their families, neighbors, and with primary healthcare providers, to identify their perspectives of important markers of early FD
- > Stage 3: Longitudinal study of a cohort of older people to assess the sensitivity of these markers.

REASON FOR CHANGE

Subsequent to submitting the original full proposal, there were significant changes in the politics and practicalities of screening programs for older people in primary care settings, and uncertainties regarding primary care funding. The team had also published two papers from their recently completed ARC-funded research into FD, which brought their work to the notice of researchers, GPs and policy-makers keen to incorporate a more sensitive assessment of FD into the current Medicare-funded 75+ HA.

MODIFIED PLAN

This looked to explore the nexus between the current 75+ HA measures and newer measures of early FD, and ways in which the uptake and effectiveness of the 75+ HA Medicare item could be improved in general practice. Project changes were approved to focus more on current implementation issues, as follows:

- > Stage 1: As previous, but with the focus sharpened by using the current 75+ HA Medicare item elements as the framework for a realist synthesis review (Pawson 2005)
- > Stage 2: Broadened to encompass two streams ie in addition to older people, their families and carers, increase the number, and emphasis on, discussions with GPs, practice nurses and more broadly to examine the use and perceived effectiveness of, and barriers to, 75+ HA in primary care
- > Stage 3: Modified to follow-up a smaller number of older people who had undergone a 75+ health assessment, with the more specific aims of identifying how the assessment has assisted older people to manage at home; what services they consider or access as a result of the assessment; and their perspectives on the health issues identified in the assessment and on the assessment itself.

75+ HEALTH ASSESSMENT (75+ HA)

The Australian 75+ HA was constructed in the early 2000s with the aim of identifying issues and/or undiagnosed disease impacting on an older person's health, and which may be amenable to interventions. This assessment is also intended to identify risk factors in an older person to focus ongoing management, and to anticipate factors that could influence an older person's physical, psychological and social functioning (FD). The 75+ HA can be conducted in a person's home or a GP's consulting room. This assessment is not intended for people already on a care plan for a chronic disease, or who were in a hospital or day-hospital facility.

There are four health assessment items in the Medicare Benefits Schedule (i.e. government funded health assessments): 701 (brief), 703 (standard), 705 (long) and 707 (prolonged). A GP, or a practice nurse or allied health provider (usually physiotherapists or occupational therapists) working with a GP, can undertake a health assessment for a person aged 75 years and older. They may select any one of these items depending on the length of consultation. This is largely determined based on the complexity of presentation. No other healthcare providers are involved in the assessment (eg dentist, optometrist, or other allied health professionals such as a dietician, psychologist).

Methods

STAGE 1

Stage 1 comprised a comprehensive systematic review of published literature on early FD, and a comprehensive grey literature review and synthesis of international primary care assessments for older community-dwelling people.

Review 1: Systematic review of published literature

In the first review, data was extracted on the measurement tool and the context in which it was administered. The tools were then grouped into constructs, and then again into broader domains. These were positioned in a hypothesised time-sequence of decline.

Aim: This review aimed to identify a comprehensive pool of relevant articles identifying features, measures and/or manifestations of early FD or frailty in a community setting. FD and frailty are used interchangeably in the research literature, thus both terms were needed.

Search strategy: A comprehensive, systematic and iterative process was applied to a comprehensive list of library databases to collate research relating to measures of early FD or frailty. The databases searched comprised Medline, Embase, AMED, AgeLine, CINAHL, PsychInfo, Psychology and Behavioural Sciences Collection, Cochrane Library, Wiley Online Library, PubMed, Sociological abstracts. Hand-searching (pearling) of the included studies was conducted to identify any relevant evidence not found in the search, and personal libraries of the lead author and colleagues were also searched for additional relevant literature. The search terms consisted of MeSH terms and keywords and were derived from concepts related to ageing, testing or screening, functioning, frailty and community. Appropriate Boolean operators, truncation symbols and wildcards were applied for each database searched. The search was restricted to papers published from 2000 to October 2013.

Inclusion criteria: Any peer-reviewed journal article, primary research or expert opinion article, which describes measures of early FD or frailty in a primary health care setting, on community dwelling independent elders aged ≥ 65 years. Literature could include descriptive, precision or validation studies. Relevant systematic reviews and literature reviews were pearled for references that fit the search criteria.

Exclusion criteria: These were applied to ensure that the search focused only on early FD, community settings and primary care:

1. Subject group/population referred to were considered beyond 'early FD':

- > not living independently (ie. own home, independent living units, retirement village, or details pertaining to a subgroup of independence unable to be analysed separately)
 - > already identified as fallers, being dependent on care or needing home nursing
 - > measures taken in acute, rehabilitation, palliative or surgical settings rather than primary care/community
2. The research should not be published in languages other than English
 3. Subjects not ≥ 65 years (or where details pertaining to a subgroup of ≥ 65 years were unable to be analysed separately)
 4. Purpose or findings of study not relevant to the research question:
 - > measures relating to FD not taken
 - > disease-specific outcome measures
 - > mortality the only outcome
 5. Study published prior to 2000, literature or systematic review, or from a non-peer reviewed journal.
 6. Unable to obtain full text article.

Data validation: Potentially-relevant articles were imported into EndNote reference manager software and duplicates were removed. An initial validation set of title and abstract selection was conducted on 21 consecutive search results by two researchers. Initial titles and abstracts were then independently screened for adherence to the inclusion/exclusion criteria by the same two researchers, who then came together to discuss any differences in agreement. This process was repeated once full texts of potentially relevant articles were retrieved. Disagreements at this point were arbitrated by a third researcher who had final discretion in inclusion.

Hierarchy of evidence: The included literature was sorted into the relevant Australian National Health and Medical Research Council hierarchy of Evidence.

Critical appraisal: Included literature was not critically appraised as study quality was not congruent with the aims of the review

Data management: Data from the included studies was extracted by two researchers into a purpose-built MSExcel file. Extracted data included author and date details, country. Information on study aims, design, location and population were extracted in addition to definitions of early FD or frailty, and the tools used. Psychometric properties of tools were recorded, based on report of validation in each article.

Data extraction: Information from the 147 relevant articles was extracted in the manner described in the search strategy. A great many constructs of FD were discussed in the

included literature, however, only those that were proposed as significant predictors of an increased risk of developing frailty or downstream FD, or of measuring frailty or early FD, were identified for further investigation. An initial count of over 300 measures or tools for detecting early FD or frailty in primary healthcare settings (not including those measures which had been translated and validated into other languages and/or cultures) resulted in 195 which were psychometrically tested.

Constructs: In order to make sense of the large number of measurement tools, and to gain clarity on the indicators of early FD and/or frailty, relevant measures were organised initially into constructs using an iterative qualitative research approach as advocated by Rice and Ezzy (1999). These constructs reflected the main purpose (or intent) of each measure, rather than the measure itself. Each construct was then written on a sticky note, and a visual map was created, on to which the constructs could be categorised into FD domains by two researchers. The constructs were broadly categorised into domains. These domains were validated against the World Health Organization International Classification of Function, Disability and Health (ICF) in consultation with colleagues from occupational therapy, nursing, physiotherapy and epidemiology backgrounds and a consumer representative.

Review 2: Review of the grey literature

In the second review, the elements of the Medicare 75+ HA items and international geriatric assessment items were collated.

Aim: This review aimed to describe the core elements and features of primary care geriatric assessment in older people internationally.

Search strategy: The following databases were searched: Google, Google Scholar, Scirus, Grey Literature Report, and Grey Matters. The search terms included a combination of:

- > Concept 1: assessment, evaluation, examination
- > Concept 2: function, functional decline, frailty
- > Concept 3: older, geriatric, aged

Inclusion criteria: Grey literature (e.g. technical reports, government reports, theses, commercial documentation) or websites which described functional assessment of older people aged 65 and above, or reported any measure of FD or frailty, were considered in the review. The search focused on assessments conducted in countries other than Australia to allow comparison between assessment practices in Australia and other countries.

Exclusion criteria: The search was limited to articles published in the English language.

Data validation: The articles and websites identified by the search strategy were independently assessed by two reviewers. The reviewers examined the articles and

websites against the selection criteria and any disagreements regarding inclusion and exclusion were resolved by discussion.

Data extraction: Data extraction was undertaken using a purpose-built data extraction tool. The data extraction tool was piloted by two reviewers on three included articles/websites to ensure that all relevant information was captured and that both reviewers were interpreting the form in the same way. Following this process, the included articles/websites were divided between the two reviewers. Data domains extracted from included articles/websites comprised the following: author or source, country where the assessment was undertaken, assessment tool, assessment process/procedure, domains of assessment, characteristics of the population to which the assessment is administered, and personnel involved in the assessment.

These findings were then compared with the findings of the first review. This synthesis was used as a framework to identify recurring constructs in geriatric assessments, and to set the scene on what primary care assessment initiatives are happening internationally for community-dwelling older people.

STAGES 2 AND 3 – ETHICS AND PARTNERSHIPS

Ethics: University of South Australia Human Research Ethics Committee approval was provided in January 2014 (No. 0000031475) for Project Stages 2 and 3.

Partnerships: To assist us to efficiently complete Stages 2 and 3 of this research, a formal partnership was established with Adelaide Unicare, a university-linked corporate group which manages six general medical practices in South Australia (two in the Adelaide Central Business District, three in Adelaide's northern suburbs and one in rural South Australia). This partnership was facilitated because the missions of iCAHE and Unicare aligned. Unicare's mission is to support undergraduate and postgraduate training of medical, nursing and allied health students, and research undertaken by General Practitioners (GPs). Thus our research need to access healthcare providers and patients was recognised as legitimate practice activity by Unicare, and entry into these practices was supported.

iCAHE had an already well-established partnership with the Health Consumers Alliance of South Australia (HCA) and had worked previously with COTA South Australia, both of whom agreed to advertise the opportunity to be a Stage 2 study participant.

STAGE 2

Consumers

Reference sample: People aged 65+ years living independently in the community

Sample recruitment: The first sample consisted of subjects recruited purposively through Unicare Practice Managers and HCA staff who asked people aged 65+ to join the study if they believed they had a 'story to tell' about ageing in place. Potential subjects were provided with an information sheet and consent form. Researchers telephoned people who had agreed to be contacted, answered any questions, arranged an interview time and finalised consent. Twenty-three participants were in this group. Ten of these 23 participants also agreed to be interviewed a second time by a different interviewer, who was also a health practitioner, to explore in more detail their relationship with their GP.

A second purposive sample was recruited via invitations extended to members of COTA (Council on the Ageing) in South Australia. Nineteen people responded and were interviewed.

Interviews: Interviews / focus groups for all participants were conducted in people's homes, in GP surgeries or other agreed location, such as a local coffee shop. A male volunteer aged 65+ attended the first round of in-home interviews for safety/risk management.

Semi structured questions addressed older people's perspectives of their own, and others', ageing-in-place and declining function. The interview questions were pilot tested with five people and no changes were required prior to data collection. The interviews commenced with an explanation of the purposes of the study and questions allowed participants to describe and expand on issues that they considered important. Participants were given the option of individual face-to-face or telephone interviews or small focus group. Of the 42 people interviewed, 17 chose individual telephone interviews; eight individual face-to-face interviews; nine face-to-face in a couple/with a family member; and the remaining eight via focus group. Of the 10 interviewees who agreed to a second interview to explore further their relationship with their GP, two were interviewed individually, four as couples and four in a focus group. All interviews were audio-recorded and transcribed verbatim.

Saturation and validation: We used the approach of Guest et al (2006) to determine when we had reached data saturation. The descriptive analytical approach was informed by the work by Sandelowski (2000). Sandelowski argues that qualitative descriptive studies need to focus on recognising patterns and repeating sections within descriptive data. All interview transcripts were carefully studied to inductively identify patterns of meaning and any contradictions and inconsistencies within the transcripts. The second round of interviews with the 19 COTA volunteers confirmed that our recruitment model had not biased our findings; no new information was raised.

Data analysis: Themes regarding important aspects of ageing-in-place were identified from the categories, along with illustrative quotations. The themes were then reconsidered, within the context of the interview transcripts, to identify what they represented in terms of characteristics of people who were successfully ageing-in-place. Participants were sent a follow-up letter summarising the findings of the thematic data analysis and inviting further comment: no changes were requested by study participants.

Healthcare providers

Reference sample: GPs and practice nurses from the six Unicare practices. Other interested practice staff were not excluded from focus groups.

Sample recruitment: A preliminary visit was made to each of the six Unicare practices to explain the research project, and an invitation extended to participate in interviews or focus groups, whichever was most convenient. Information sheets and consent forms were provided to each Practice Manager during the initial visit.

Data collection: Face-to-face meetings with groups of healthcare providers, or individual face-to-face or telephone interviews with individuals, were conducted. A flexible interviewing approach was taken in which general questions about delivery of the 75+ HA ie how individuals were identified by healthcare providers for the 75+ HA; how they were recruited; who undertook the assessment; what was assessed; what was learnt from the assessment; and how findings were actioned. Interviewees were encouraged to speak freely about their experiences and perspectives of delivering this assessment. All meetings were taped and later transcribed.

Data analysis: Thematic analysis of the transcribed interviews, using the approach outlined above for consumer interviews, enabled documentation and comparison of shared and differing views between the practitioners and practices.

STAGE 3

Consumers

Reference sample: People who had recently undergone a 75+ HA

Sample recruitment: Unicare GPs and Practice Managers in four practices invited consumers who had recently undergone a 75+ HA. The two city-based practices did not recruit because of the very low number of 75+ patients. Twenty consumers were recruited sequentially from the four practices. One person moved away from the area and withdrew from the study.

Interviews: This sample provided 71 interviews. A semi-structured interview approach allowed exploration of consumer perspectives on the 75+ HA, and how it influenced their thinking about ageing in place.

Data analysis: Thematic analysis, conducted as described for Stage 2, identified six key themes in terms of consumer perspectives on the 75+ HA. These themes were mapped against the findings of Stage and 2 and found to be consistent. Thematic analysis also identified three consumer groups or characteristics relevant to consumers' relationship with their GP, which were also found to be consistent with Stage 2 findings.

CONSUMER PARTICIPATION IN THIS STUDY

This is one of the few studies in Australia which reports on patient-perspectives on ageing in place, in the context of primary care. Our data was collected from participants generated from one group of general practices in South Australia, and may not be representative of other general practices and primary care services (for example Aboriginal Community Controlled Health Services and Migrant Health Services), their patients and communities. Our findings therefore need to be tested in a broader sample. However we conducted a large number of sequential interviews with people who had recently had a 75+ HA, and we believe that this provides the first robust information on consumers' views of the place and value of the assessment in the context of their lives. It also provides a model for expanding consumer and health practitioner engagement in a review of how best to utilise the 75+ HA within the context of health and community services, to maximise consumers' capacity to live independently, safely and well in the community home of their choice.

Results

This study provides important findings in relation to:

- > 75+ HA alignment with research and grey literature
- > Consumers' approaches to, and perspectives on, FD and ageing in place
- > Health practitioners' management and views of the 75+ HA
- > Consumers' experience and perspectives of the 75+ HA in relation to ageing in place.

75+ HA ALIGNMENT WITH RESEARCH AND GREY LITERATURE

In summary, the two systematic reviews identified that:

- > Early FD can manifest as many things and in many ways, and no one 'size fits all'
- > There is no standard approach either in the published or grey literature on items for geriatric assessment, or how they should be delivered
- > The 75+ HA provides a structured way of identifying health issues and conditions that are potentially preventable or amenable to health interventions in order to improve health and/or quality of life
- > While the 75+ HA reflects all the major domains and subdomains reported in the first literature review, it does not assess all the important constructs
- > Conduct of the 75+ HA in primary care may miss opportunities to comprehensively measure early FD, as it manifests differently in different people, and at different rates.

Search 1 (systematic literature review) results

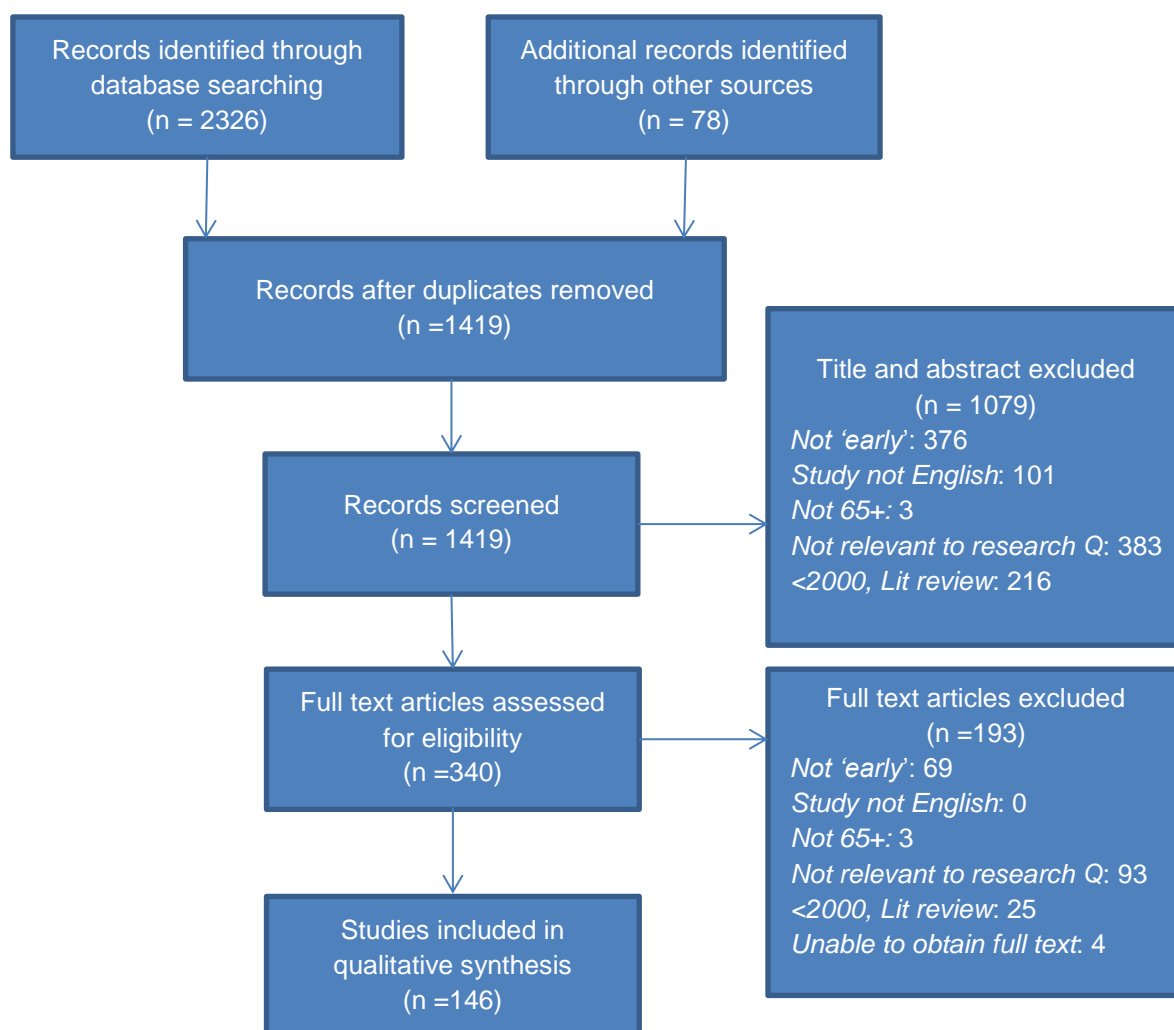


Figure 1. CONSORT diagram of the systematic search results

107 constructs were identified and clustered into six broad domains, three of which were presented in three sub-domains (see Figure 2 for domain clusters). Frailty, in the Medical Status Domain, was the most frequently measured construct (59). However, Participation and Performance Capacity were the most frequently measured domains over all (see Appendix 2). In Participation, ADLs (58) and IADLs (39), were the most frequently measured. In Performance capacity, gait speed (25), cognitive functioning (23), mobility (19), depression (16), multidimensional physical abilities (16), balance (13), grip strength (13) and rising from a chair (12) were all found frequently in the literature. Constructs within the Medical status domain; co/multi-morbidities (17) and nutritional status (10), were found in the literature as measures of early FD or frailty. In the Demographic domain, age (15) followed by gender (10) and level of education (10), were the most frequently measured constructs.

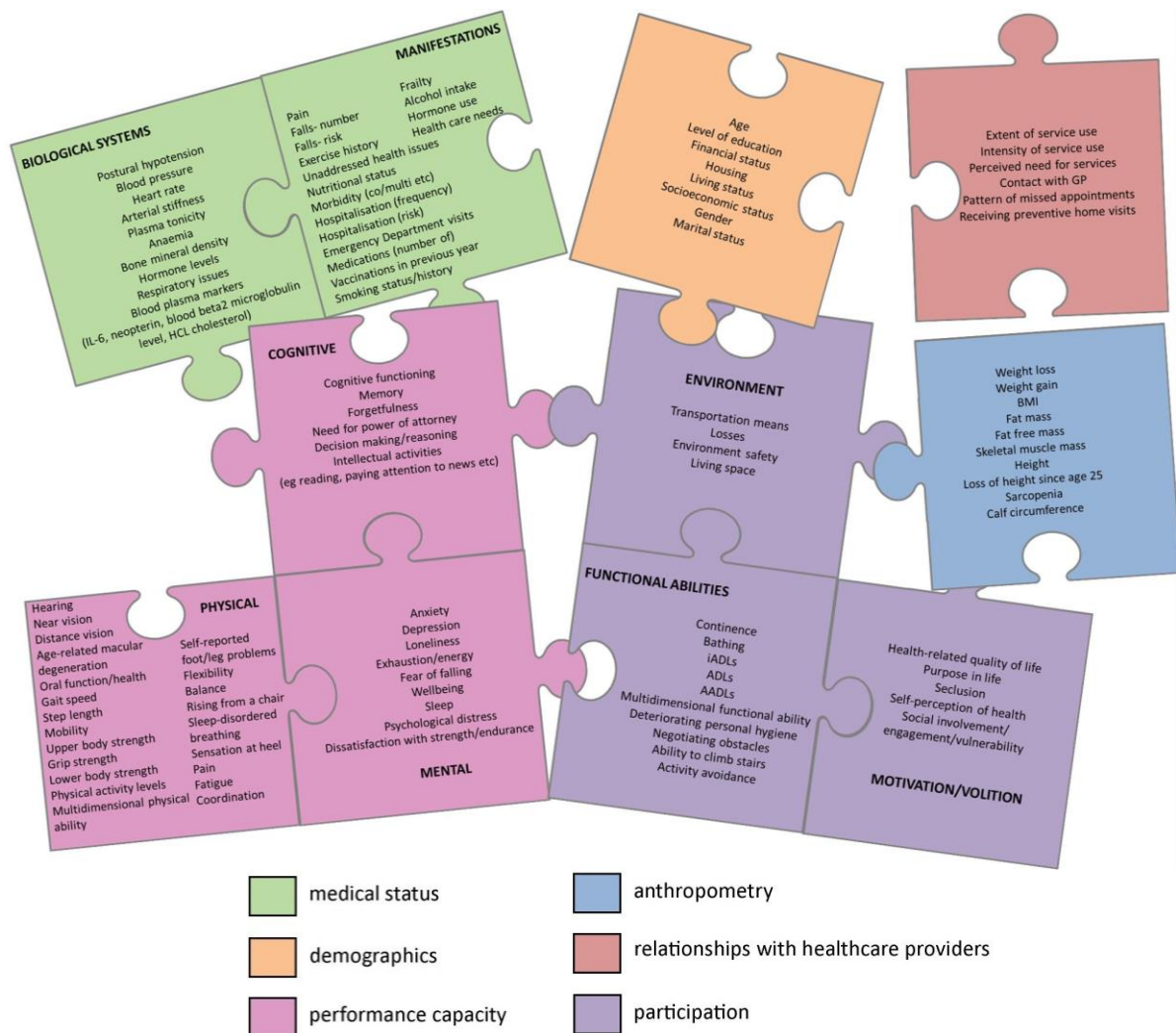


Figure 2. Constructs found in systematic search, clustered into domains and sub domains.

Time sequence

Domains were organised into a proposed time sequence which believe reflects the potential for within-person systems measures to progress to external manifestations of FD in terms of person interaction with their environment and/or community, and manifestations of decline reflected as health service usage (See Figure 3).

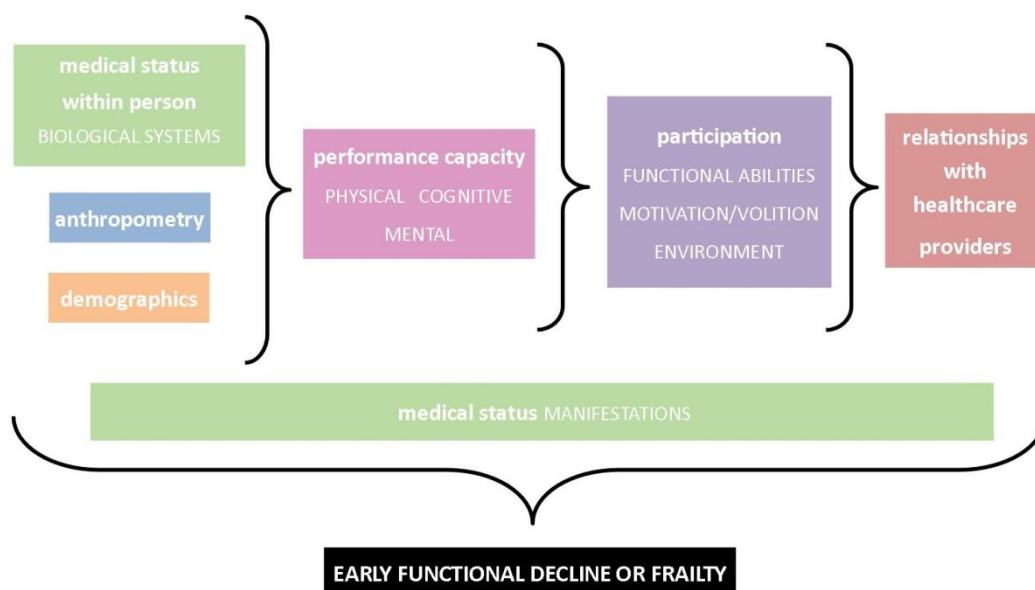


Figure 3. Proposed time sequence organisation of domains

Search 2 (grey literature review) results

The reviewers found information about primary care geriatric assessment practices in the United Kingdom, Canada, Austria, United States of America and Asian countries such as Philippines, Singapore, Hong Kong, India and Israel. They found consistency across these countries in terms of the different domains included in the assessment process and the personnel (i.e. assessment team) who administer the assessment. The assessment team typically involves a physician who specialises in the care of older people (i.e. geriatrician), nurses, physiotherapists, occupational therapists, social workers and other relevant allied health practitioners. Regardless of country, the geriatric assessment is commonly administered to older people who experience health issues and are likely to deteriorate in function.

Table 1 outlines the items in the 75+ HA mapped against the constructs and domains identified in the review of published literature: while the 75+ HA reflects all the major domains and subdomains reported in the literature, it does not assess all the constructs reported for each subdomain. Table 1 also shows different constructs and domains examined by each of the countries and mapped against those identified in Part 1.

Across countries, medical status, performance capacity and participation are consistently assessed, whereas assessment of demographics, anthropometry and service use are uncommon.

Table 1. Items in the '75 plus' health assessment mapped against the constructs and domains identified

Country	Medical status		Performance capacity			Participation			Demographics	Anthropometry	Relationships with healthcare providers
	Biological systems	Manifestation	Physical	Mental	Cognition	Environment	Functional abilities	Motivation/volition			
Australia (75 plus health assessment)	Blood pressure Pulse rate and rhythm Skin and Feet Reproductive and sexual health	Immunisation status Diet and Nutrition Medications	Vision Hearing Mobility/Activity Risk for falls	Mental Status Psychological Assessment	Cognition Memory Thinking Planning Mood	Home Safety	Continence Fitness for Driving Personal mobility/ADL	Social history Social support Legal issues Personal wellbeing	Patient demographics	Height Weight Blood Pressure BMI	Medical support (allied/ pharmacist/ alternative/ others) Community Services
UK		Co-morbid & disease severity Medications Nutritional status	Balance Activity/exercise status Gait	Anxiety	Cognition Mood Fear	Eligibility for being offered care resources Home resources Transport facilities Technology Local resources	Basic & Instrumental ADLs	Informal support Social network			
Canada		Falls Medication management Adverse events	Balance and gait		Cognition		ADLs/self-care Urinary incontinence				
Austria		Nutrition Drug handling	Mobility Balance Vitality	Depression	Cognition		ADL Incontinence	Social situation			

Philippines		Nutrition	Gait and balance	Mental status			ADLs				
Singapore		Falls	Balance Pain		Cognition and memory disorder		Continence				
India		Nutrition	Physical	Psychological		Social resources, familial and economic resources					
Hong Kong			Physical health	Mental function	Cognitive and psychiatric symptoms	Social resources Environmental resources Economic resources	Basic and instrumental ADLs				
USA		Falls risk Nutrition	Gait Mobility Oral health Pain Sensory perception	Depression	Dementia and delirium		ADLs Urinary Incontinence			Weight loss	
Israel		Medications	Gait and mobility Vision Hearing		Memory		Functional status – daily routine and basic needs Bowel and bladder habits	Social needs			

STAGE 2 – CONSUMERS

Consumers' approaches to, and perspectives on, FD and ageing in place: Thematic analysis was conducted of the transcribed interviews with the 42 Stage 2 participants, including second interviews with 10 participants to explore in more detail their relationship with their doctor. This analysis identified older people's characteristics in their approach to ageing; key elements of ageing which older people believe need to be supported to enable them to prevent or better manage FD; and groups of patients or patient views about their relationship with their GP.

Consumer characteristics in approaching ageing: These were identified as resilience, independence and adaptability.

Key elements to address in managing FD: These were summarised, in consultation with participants, in the acronym HIPFACTS:

- > **H** Health: support for self-management, health professionals as needed
- > **I** Information services: timely, accessible, online, face to face, one-stop
- > **P** Practical support: targeted, timely, self-directed, affordable
- > **F** Finance: subsidies for those in need
- > **A** Activity: physical and mental
- > **C** Company: community, family and pets
- > **T** Transport: affordable, reliable, accessible
- > **S** Safety: personal, house and environmental safety and security.

Health was only one of the areas prioritised in describing FD and related support needs. Participants were in agreement that it is not the role of their doctor – or general practice more broadly – to address non-health community support, needs. What they want is information about, and access to, flexible, affordable community support services to enable them to self-manage their planning for ageing in place.

Patient groups or views about their relationship with their GP: Analysis of the 10 second interviews identified 'Keeping active – keeping connected' as the overriding organising construct and themes within this construct included the importance of their GP and how this health professional is positioned in their lives, and how older age brings about different reasons to visit a GP. Stage 2 and 3 interviews identified three patient groups when looking at relationships with GPs: consumers who see themselves variously as not needing to see their doctor often; not wanting to 'bother' their doctor with 'small worries'; and needing to see the doctor regularly to manage their health.

STAGE 2 - HEALTH PRACTITIONERS

Health practitioners' management and views of the 75+ HA: Health care teams (GPs, nurses and allied health) from all six Unicare partner practices provided rich information on how they viewed the 75+ HA.

Summary views: Health care teams provided the following summary views:

- > Practitioners in general practice believe the 75+ HA provides a valuable opportunity to 'touch base' re general health and to make contact with older people and to discuss issues that would otherwise not come to the attention of practice staff
- > Recruitment, conduct and follow-up to a 75+ HA varies within and between general practices
- > Scheduling an 'older person's assessment' earlier in a person's life if required, could support some people to be more proactive in making plans for ageing in place
- > Ensuring the 75+ HA is conducted in the home setting could provide a more accurate picture of the person's capacity and support needs
- > Engagement of other health practitioners in assessment and follow-up could be useful.

There were shared and differing views between the practices and practitioners.

Shared views: Overall, healthcare providers agreed:

- > The assessment provides a valuable opportunity to 'touch base' re general health and to make contact with older people who would otherwise not come to the attention of practice staff
- > It is often difficult to identify older people attending a general practice who do not have a chronic disease, and who might benefit from the assessment
- > Recruitment is not standardised – but is systematised in some practices
- > Assessment and follow-up is not standardised nor systematised
- > Timing could be reconsidered, for example at pre/retirement and earlier than 75 years

- > Items in the assessment do not by themselves provide a comprehensive standard overview of the older person in context i.e. how they operate within family, home and wider community
- > Other healthcare providers could potentially provide and/or contribute to the assessment: GP trainees, medical, nursing or allied health students
- > There can be a mismatch between the intent of assessment items, what was recorded in the assessment, and the everyday concerns of the older people.

Views that differed between practitioners and practices: There were differences in relation to:

- > Identifying people for the 75+ HA, for example opportunistic or via an audit process
- > Recruitment, for example ad hoc or actively marketed
- > Location, for example in the surgery or in the home
- > Who does the assessment, for example GP or nurse with GP oversight
- > The need/priority to gather additional information
- > The need/priority to explore patient concerns
- > Assessment items: considered medically adequate - or inadequate without life context information
- > Repeat assessments: routinely promoted or ad hoc (and with varying patient uptake)
- > Philosophical model: medical or psychosocial, with varying views about consumer centred care.

STAGE 3 – CONSUMERS

Consumers' experience and perspectives of the 75+ HA in relation to ageing in place

Summary messages from stage 3 interviews: These included:

- > Decline is slow and changes and its impact is slow to be detected
- > Consumers are not clear about the purpose of the 75+ HA and so are restricted in choosing and using the assessment as part of their consumer-directed planning for ageing in place
- > The lack of follow-up to the 75+ HA means people see little change as a result
- > Where the nurse conducted the 75+ HA in the home, people often had no recollection of the findings being discussed with them by their doctor
- > Ageing in place issues that fall outside of the health assessment agenda, such as social concerns, environmental issues and future needs, are generally not identified or addressed in the 75+ HA

- > Many consumers regard as valuable the opportunity provided by the 75+ HA to spend time with their GP or practice nurse to discuss their health more holistically. Because this contact was not focused on an acute health event, or a routine visit for prescriptions or health monitoring, consumers saw it as an opportunity to cover a number of bases in their lives, so that they could retain control of their circumstances, and their ageing journey: the 75+ HA is well positioned to become a more valued and valuable primary health initiative, central to supporting older people's ongoing independence in their community.

Stage 3 interview themes in relation to the 75+ HA: These themes were consistent with Stage 1 and 2 findings:

- > Engagement in the 75+ HA is influenced by perception of need (ie whether older people see themselves as needing to see their doctor often; not wanting to 'bother' their doctor with 'small worries'; or as needing to see the doctor regularly to manage their health)
- > Participation in the 75+ HA is influenced by general practice flagging the need
- > Timing and place of 75+ HA influenced participation and information gathered
- > Structure of the 75+ HA identified gaps in assessment and follow-up support needs
- > Lack of follow-up on the 75+ HA created disconnect between the assessment and integration of support services needed
- > Disempowering older people by lack of ownership of, or participation in, choice of services affects support accessed for living independently and safely in the community.

Discussion

SUMMARY COMMENT

The Final Report is supported by the three project Progress Reports, which address:

- > Stage 1: Literature review (published and grey literature) of early markers of FD using the current 75+ HA Medicare item elements as the framework for a realist synthesis review
- > Stage 2: Focus groups with older people healthcare providers to identify markers of early FD and examine use, perceived effectiveness of and barriers to 75+ HA
- > Stage 3: follow-up of a group of people to explore their experience and perspectives on the 75+ HA.

We believe this work has identified ways in which the 75+ HA could be more effectively used to better enable people to live safely, independently and well in the community home of their choice, for as long as they choose. It has also identified the resilience, adaptability and independence of older people and ways in which they consider the community could provide more flexible, timely and affordable support to avoid the need for expensive - and often less relevant - health care services. This report makes recommendations about the ways in which the 75+ HA could be enhanced and support older people as they plan for ageing in place ie ageing while living independently in community accommodation of choice.

REPORT RECOMMENDATIONS

1. Retain the 75+ Health Assessment (HA) and:

- > Routinely offer the 75+ HA at least every two years to every person aged 75+
- > Include more, and more sensitive data items that particularly explore the risks and potential management of the home environment, social circumstances, community functioning and decision-making and caring responsibilities
- > Identify people's concerns and enablers regarding successful ageing in place, and follow these up after the 75+ HA with agreed actions

2. Inform general practice about:

- > Evidence-based use of the 75+ HA, as identified in the literature, including priority constructs to be assessed and tools to use for each construct
- > Person-centred care approaches to conducting the 75+ HA including:
 - > *Recruitment.* ensure people understand the preventative and proactive intent of the assessment and encourage their participation as a vehicle to identify early indicators of FD

- > *Preparation:* ensure people know the nature and purpose of the 75+ HA so they can prepare questions and invite a support person/carer to attend
- > *Timing:* ensure people understand the intent of repeating the 75+ HA
- > *Time:* allow time in the assessment to identify people's concerns
- > *Location:* conduct the 75+ HA in the home environment wherever possible
- > *Confidentiality:* ensure assessment outcomes are not shared with others, including family members and other health and community services, without the person's explicit permission
- > *Follow-up:* if a nurse conducts the assessment, make it clear when and how this will be followed up with the doctor. Give the person a copy of the 75+ HA Report. Refer /recommend people to relevant health and community services
- > *Consumer centred care:* utilise older people's resilience, adaptability and independence to address emerging issues so they can achieve their personal goals for ageing in place
- > *Recognise* that to support people to age in place successfully requires health providers and older people to work together.

3. Inform consumers about how to use the 75+ HA to plan for ageing in place.

Ensure this information addresses the timing and location of the 75+ HA; how people can prepare for it including the option to bring someone with them; whether there might be any follow-up; and the commitment to confidentiality.

4. Enable consumers to access timely local community support service information to enable them to self-direct planning for ageing in place

Planning for ageing in place requires multiple communication methods with a plan for follow-up by both consumers and health care providers. An accessible, relevant, current source of local support service information, including eligibility criteria and cost, is key to It is critical if people are to retain control of their circumstances and future planning.

5. Prioritise further research and development to:

- > Develop and disseminate a revised, evidence-based 75+ HA tool with online links to validated assessment tools.
- > Develop and disseminate a consumer tool to assist consumers to plan for, and get the most out of, their 75+ HA
- > Replicate this model of consumer co-research with other populations to validate the HIPFACTS elements identified by consumers
- > Replicate this research to further explore how best to utilise the 75+ HA within the context of health and community services, to maximise consumers' capacity to live independently, safely and well in the community home of their choice.

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