Standardization of health assessments for patients aged 75 years and over: 3 years' experience in the Forth Valley Health Board area

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SUMMARY

Background. *The new contract for general practitioners (GPs) was introduced in 1990. This required all GPs to offer their patients aged 75 years of over an annual assessment.*

Aim. *The study aimed to determine if 3 years' experience had resulted in standardization of the way in which health assessments for patients aged 75 years and over are carried out.*

Method. *The study was carried out in 1993. Questionnaires were sent to the principal partners of all 55 general practices in the Forth Valley Health Board (FVHB) area. The main outcome measures were the fulfilment of contractual requirements and standardization of the health assessment process.*

Results. *Completed questionnaires were returned by 49 practices (89%) Eighty per cent (39 practices) had drawn up their own assessment programme in 1990. Responsibility for assessments was most often (41 practices) shared between different members of the primary care team (84%). Although most practices satisfied contractual requirements, there were wide variations in approach, potentially influencing outcome.*

Conclusion. *Despite three years' experience, no standardized approach to the health assessment of patients aged 75 years and over has been developed. Purchasers of health care require information on the needs of their client population, and this should be available in an accessible, standardized form. There is an urgent need for a review of the way in which the 1990 contract has been implemented to standardize health assessments and improve effectiveness in meeting its original aims.*

Keywords: geriatric assessment; protocols; conditions of service; over 75s.

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Introduction

IN 1990, the new contract for general practitioners was introduced.[1] It contained few details on how health assessments for patients aged 75 years and over should be performed. It was recommended that such health assessments should be based on functional rather than medical assessment and include: a home visit at least annually; assessment of social circumstances, mobility, mental state, senses, incontinence and general function; and review of medication. It was anticipated that with experience a standardized approach might be developed on the best way to fulfil the directive.[2]

The population served by the Forth Valley Health Board (FVHB) includes 16 970 people aged 75 years or over. This study aimed to determine if 3 years' experience had resulted in the development of standard practice regarding methods of assessment, who carries out health assessments and action taken as a result of the information obtained. Such standardized assessments would allow conclusions to be made regarding needs assessment across the health board area and provide essential information to the social work department trying to meet the demands of care in the community.

Method

In 1993, the principal partner in all of the 55 general practices in the FVHB area was sent a standardized structured questionnaire regarding their practice's procedures for health assessments for patients aged 75 years and over. The two-page document had a tick box layout. Anonymity was guaranteed for individual practices. All data were stored in a Paradox database.

Results

Questionnaires were returned by 49 out of the 55 practices (89%). Non-responders were followed up by a second letter and telephone call if necessary.

Thirty-nine practices (80%) had drawn up an assessment programme in 1990 to meet contractual requirements. In 33 practices (67%), patients were invited to attend for assessment, but only 19 practices (39%) followed up non-responders. Forty-one practices (84%) carried out formal assessments, whereas eight practices (16%) assessed patients only on an opportunistic basis.

Thirty-six (74%) practices offered assessments to residential and nursing home residents. The number of patients who accepted the offer of a home visit varied greatly from none in five practices (10%) to all in 11 practices (22%).

The primary care team members who carried out the assessments were as follows: health visitor (36 practices, 74%); district nurse (32 practices, 65%); general practitioner (31 practices, 63%); and practice nurse (20 practices, 41%). Responsibility for assessments was most often (41 practices) shared between different members of the primary care team (84%). Only 39% of practices provided staff with any kind of training in the performance

of these health assessments.

Forty-seven practices (96%) said they used a protocol or checklist to carry out assessments. The protocols were designed by a GP from the practice alone in 18 cases (39%), by another agency in 10 cases (22%), jointly by a local general practitioner and drug company in seven cases (15%), by a health visitor associated with the practice in six cases (12%), by a general practitioner outwith the practice in three cases (6%), and by a drug company in three cases (6%).

All practices were asked to submit the protocol used for further analysis and 37 practices did so. There were 25 different protocols in use, varying in length from one side of a page to 12 (median two) sides. The number of protocols that included areas specified in the contract were as follows: next of kin, 13; carer, 15; carer problems, 3; smoking, 10; alcohol consumption, 8; diet, 10; relationships, 20; mobility, 25; mental state, 25; mental score, 11; depression score, 0; senses, 24; continence, 25; general function, 20; medication, 22. Other topics noted frequently are documented. Out of the 25 different protocols submitted, 15 had space to document problems identified, 15 action planned and six follow-up.

Information gained from assessments was routinely available to nursing members of the health care team in 44 practices (90%), but routinely available to social work staff in only five practices (10%).

Discussion

Most practices (41/49, 84%) carried out assessments predominantly on a formal basis, although many doctors consider opportunistic assessment to be the most appropriate form of proactive care.[3] No one method of assessment is said to identify significantly more problems per patient.[4]

Non-responders were not followed up by 14 of the 33 practices (42%) that invited patients to attend by letter. This may represent a high-risk group.[5] Unmet needs may also exist among patients in residential and nursing homes,[6] yet 13/49 practices (26%) did not include them for assessment.

There was a wide variation (0–100) in the percentage of patients accepting home visits, reflecting the way in which individual practices offered the visit. It has been shown that practices carrying out assessments mainly in patients' home find significantly more problems.[4]

Health visitors and district nurses were most often involved in carrying out health assessments. Representatives of these professions have claimed that they are the most appropriate people to do the work.[7,8] It has been shown that, compared with doctors, nurses with extra qualifications identify a higher number of unmet needs.[9] Previous authors have highlighted the need for education.[9,10] Therefore, it is disappointing to note that only 19 out of 49 practices (39%) had ever conducted any formal training programmes.

The format of an assessment form will affect the number of referrals subsequently made.[11] The protocol used may have been a standardizing factor within practices, but there was a wide variation between practices in the protocols used.

Only 22 out of 37 (60%) protocols submitted for assessment had demarcated space to document the needs identified. The Royal College of General Practitioners suggests that the main purpose of initial screening is to identify patients who require further investigation,[1,2] yet only 9/37 protocols (24%) identified space to record follow-up. It is possible that in some instances the assessments are being taken as an end in themselves rather than as a means to an end, as intended.

McEwan & Forster[13] estimated that the average cost of an assessment as outlined in the contract was between £29.12 and £41.15 at 1988 prices; the overall effectiveness and the cost benefits of annual health assessments are a subject of debate, but further research is restricted by the requirements of the current contract. Despite the considerable resources devoted to these health assessments by the practices, the non-standardized approach makes the information gained of little use to other agencies such as community care organizers or directors of public health.

Review and revision of the way in which assessment of the needs of older people has been dictated by the 1990 general practitioners' contract is urgently required.

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