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Client self-assessment in community aged care:

A comparative study involving older Australians and their case managers.

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Aims of the Study:

Needs assessment in community aged care can take opaque forms that lack transparency and generate unreliable outcomes. The report outlines the results of a study focusing on the efficacy and inter-rater reliability of a self-assessment questionnaire. Self-assessment within this study formed part of a comprehensive co-assessment process that screened participants providing a starting point to indicate their social care needs.

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INTRODUCTION

A transparent and accurate needs assessment to determine appropriate levels of support services is crucial in consumer-directed aged care. If older people are to exercise greater control over their care services, needs assessment has to be transparent and based on clear criteria that produce replicable outcomes. Moreover, the process must involve the views of older people as client engagement in establishing and maintaining well-directed and mutually agreed services is central to both successful client outcomes as well as the increased likelihood of client satisfaction (Issakidis and Teesson, 1999). The perennial question for aged care providers and policy makers is how client involvement is best achieved. After two decades of person-centred care that had only very limited impact on the professional culture of case managers and, ultimately, client involvement (Challis et al., 2008), self-assessment offers itself as a potential policy solution. Self-assessment is a process in which persons assess their own needs, if required with the assistance of care professionals. To date, there is limited evidence regarding the role, efficacy, and effectiveness of self-assessment within a community aged care context. This report presents the findings of a study that investigated the inter-rater reliability of a self-assessment questionnaire and its acceptability to users. The questionnaire was developed by In Control UK, and was adapted to the Australian context. The Self-Assessment Questionnaire was evaluated as part of a larger research project that developed a three-tiered, personalised Consumer-Directed Care (CDC) model for older Australians.

The present study compared case manager assessment and client self-assessment, using the same scoring criteria. The aim of the study was to:

1) To introduce a set of comprehensive and coherent criteria for the assessment of client needs framed in such a way that they could be used independently by clients;
2) To test the inter-rater reliability of such a self-assessment questionnaire to test for positive response bias; and
3) To obtain client feedback regarding satisfaction with and utility of the assessment process.

Context, Scope, and Role of Self-Assessment

In Australia, assessment of community aged care needs typically occurs in two stages:

1. A government-contracted assessment team staffed by allied health professionals, nurses, and social workers determines older people’s eligibility for Commonwealth Aged Care Packages. Care packages are held and administered by community aged care providers and
pay for their operational and administrative expenses. If approved, applicants are offered eligibility to a low or high needs community aged care package and placed on a waiting list. They are then contacted by a service provider who formally offers them a package.

2. If the person accepts this offer, a more detailed needs assessment process takes place. UK-focused research has shown that clients are often unaware of the fact that they are being assessed (Cornes and Clough, 2004, Challis et al., 2007). An agency's case managers determine the need of a client. This in conjunction with the overall budget set by the agency determines how much of a package is passed on to a client to pay for direct services, how much is to be retained for overheads, and how much is to be placed in a pool of funds to cover other clients' needs that exceed package levels.

Research suggests that this kind of assessment process leads to an amalgam of client needs and operational imperatives where the needs-led quality of the assessment is often compromised and where outcomes are often influenced by operational decisions and availability of services (Ellis, 1993, Caldock, 1994, Hardy et al., 1999, Richards, 2000). Moreover, the evidence suggests that the reliability of process is further undermined by the differing conceptions of need held by case managers (Ellis, 1993, Caldock, 1994, Hardy et al., 1999, Richards, 2000). Unsurprisingly, anecdotal evidence suggests that this second stage of the needs assessment process can have unpredictable outcomes.

In this study the self-assessment process replaced the second stage of the assessment process. Its role was both instrumental and didactic. The aim was to introduce a simple, coherent, and transparent system to that could be used as a rough measure of a client’s needs that could then be refined in conversation with the client. Another important aim was to alert clients to the fact that they were being assessed and inform them about the content of the assessment and what its consequences are. The score derived from this self-assessment process formed part of a more complex co-assessment process in which case managers were encouraged to complete the same tool to assess and to compare their scores with those produced by their clients. If the two scores diverged significantly, they then formed the basis of a discussion between client and case manager focusing on contextual factors affecting the client’s needs not captured by the assessment. The process was to be repeated whenever a client’s support needs would change significantly. This report features the outcomes of this co-assessment process.
Review of the Literature

Self-assessment has become a common feature in a wide range of health and human services aged care settings mainly to assess eligibility or determine support needs (Griffiths et al., 2005). However, the employment of self-assessment methodologies within a community aged care context is a recent phenomenon. Griffiths at al. (2005) conducted a major review of the literature focusing on self-assessment within an aged care context. The authors highlighted major gaps in the evidence base on self-assessment. They concluded that self-assessment should not be seen as a replacement of a professional assessment but rather as an addition to generating a more holistic perspective. However, their study did not yield any examples of needs self-assessment within a community aged care context.

In the UK, where client self-assessment has become part of a larger personalisation agenda (Xie et al., 2012), self-assessment has been piloted and evaluated in 11 English authorities (Abendstern et al., 2011, Challis et al., 2009, Challis et al., 2008). Evidence derived from this major evaluation suggests that users had no preference when it comes to case manager-led assessment or self-assessment. As long as they were conducted face-to-face, users were extremely satisfied with either option (Challis et al., 2009, Challis et al., 2008). However, users of online self-assessment found the experience less satisfying than either face-to-face option (for a contrasting view, see Purdie, 2003). Moreover, people from an Asian background, people with cognitive issues, and those who rated their health ‘less than very good’ found self-assessment more difficult than other users (Challis et al., 2009, Challis et al., 2008). People with ‘low mood’ and males found the process less satisfactory but not more difficult (Challis et al., 2009, Challis et al., 2008). In terms of its application, the evaluation team found that self-assessment requires appropriate targeting and a consensus within service provider organisations what the process should achieve, how it is to be used, and how it is to be integrated into the existing service context (Abendstern et al., 2011). The overall conclusion of the evaluation team mirrors that of Griffiths et al. suggesting that self-assessment adds a client perspective and ‘appears to have greatest utility when it complements existing processes, rather than to substitute them (Challis et al., 2008). The authors further suggest that self-assessment benefits from the presence of a mediator or facilitator and/or a staff member to translate the ‘assessment into an appropriate response’ (Challis et al., 2008).

The social care management literature does not provide any evidence whether self-assessment reproduces the Positive Response Bias (PRB) often evidenced in the research literature (Applebaum et al., 2000, Bauld et al., 2000) focusing on service satisfaction evaluations involving older people.
While service satisfaction surveys tend to generate very positive responses in terms of satisfaction across all age groups, older people tend to depict themselves as more satisfied than younger people (Challis et al., 2009). Challis et al. (Challis et al., 2009) summarised the research investigating the source of positive response bias among older people. Reasons provided in this literature include fear of services being removed or downgraded, reluctance to criticise care professionals, fear to be seen as a ‘trouble maker’, lack of information about what to expect from services, and a perceived power imbalance between themselves and care providers (see, also Atwal and Caldwell, 2005, Bauld et al., 2000). Challis et al. argue that for these reasons negative response patterns carry extraordinary weight and that even generally positive responses may disguise dissatisfaction (Challis et al., 2009).

Within the field of psychology, a number of researchers have focused on a very similar phenomenon the ‘Social Desirability’ (SD) effect. In particular, researchers were interested in the effect of ‘social desirability’ on the outcomes of self-assessment focusing on a number of domains involving older people. In this literature, the SD effect refers to the tendency to leave an exaggerated positive impression to either avoid criticism, or to satisfy a need for social approval (Johnson & Fendrich, 2002, as cited in Faustane and Penna, 2012). On self-assessed measures of subjective well-being, including emotional competencies and cognitive efficiency, older adults were more likely than younger adults, to have a socially desirable responding style, which is seen to contribute to the preservation of self-esteem and positive self-image (Faustane and Penna, 2012). Furthermore, it is suggested that preservation of self-esteem through reporting a higher perceived level of satisfaction and well-being, may be beneficial to the older adult by improving self-belief that things aren’t as bad as they may appear. In other words, where older adults are more positive in their personal estimate of their performance on some tasks, their optimistic attitude may help to preserve their actual performance in daily life activities (Faustane and Penna, 2012). Conversely, if the older adult is more negative about their level of functioning, this may be reflected in their poorer actual performance. In the event that the client is unaware of, or unwilling to acknowledge functional losses, they may be placing themselves at risk of harm (Suchy et al., 2011). Such errors in responding may be due to cognitive decline, lack of insight or functional physical decline (Suchy et al., 2011).

Again, this would suggest that the presence of an expert case manager assessment in the assessment process may help to minimise the influence of such factors upon performance scores. What remains unclear from the current literature is whether, in the case of older adults, ‘social desirability’ effects recorded for well-being measures also influence the self-rating of Activities of
Daily Living (ADLs). The psychological literature reviewed for this report focuses mainly upon measures of psychological well-being, such as depression, life satisfaction and the like.

**Method**

In order to assess whether positive response bias, social desirability, or other factors interfere with accurate assessment of older people’s needs by means of a self-assessment process, we employed a mixed methods evaluation comparing the self-assessment scores of older people with an ‘expert’ assessment conducted by community aged care case managers. The case managers had an in depth knowledge of the needs of these clients as they had been assisting them over a period of at least six months prior to the commencement of the study.

**Participants**

The sample of participants (n=48) comprised older people over the age of 65 (31.4% male and 68.6% female) with complex care needs involved with two community aged care providers in Melbourne’s Eastern Region. Their mean age was 79.8 years (SD=8.96). Around two thirds (66%) of the participants were born in Australia and a minority (13.4%) spoke a language other than English at home. Around two thirds (67.2%) were from a lower socio-economic background and received a means-tested aged care pension and 7.3% of participants received a disability support pension. A significant minority (26.8%) was eligible for a high care Commonwealth aged care package, whereas the majority (73.2%) of participants received low care support. Around 41% of the participants lived alone and around half (52%) of the participants lived with a partner of family. Around 8% had a confirmed diagnosis of dementia.

**Procedure**

Participants were recruited between July and October 2010. Over the following months, participants completed the Self-Assessment Questionnaire to assess their perceived level of need for 7 domains (Category 1: meeting Personal Care Needs; meeting Nutritional Needs; Practical Aspects of Daily Living; and Risk. Category 2: Physical & Mental Health & Well-being; Relationships & Social Inclusion; Choice & Control) by associating their condition with given statements (e.g. ‘I need help with doing some things around the home’) that carried a score. Community Case Managers of these older people completed the same questionnaire assessing their client’s needs. The weighted outcomes were transformed into scores on linear 4 or 5 point scales. The scores were aggregated and compared.
Participants’ satisfaction with the self-assessment process was captured using a semi-structured interview conducted as part of an evaluation of the larger project. Interviews took place between October and December 2011.

Data Analysis
Quantitative data was analysed using SPSS. Demographic information was compiled using the usual descriptive statistics. To explore the relationship between the two samples we calculated the Pearson product-moment correlation coefficient (r).

Qualitative data was analysed using NVIVO. An inductive and deductive thematic analysis was used to identify key themes.

The study was approved by Deakin University’s Human Ethics Committee.

Results
Results revealed a strong positive correlation between client self-assessment scores and Case Manager assessment scores in each of 6 out of 7 domains (see Table 1), suggesting high inter-rater reliability. Unsurprisingly, given the strong correlation, T-test analysis did not yield a significant difference between the client and case manager results.

Table 1: Comparison of Client and Case Manager Responses

<table>
<thead>
<tr>
<th>N = 48</th>
<th>Q1**</th>
<th>Q2**</th>
<th>Q3**</th>
<th>Q4*</th>
<th>Q5*</th>
<th>Q6*</th>
<th>Q7**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client Mean &amp; SD</td>
<td>3.12 (1.60)</td>
<td>2.60 (1.20)</td>
<td>3.83 (1.21)</td>
<td>2.90 (1.10)</td>
<td>2.50 (1.11)</td>
<td>2.08 (1.31)</td>
<td>2.83 (1.22)</td>
</tr>
<tr>
<td>CM Mean &amp; SD</td>
<td>3.23 (1.56)</td>
<td>2.69 (1.17)</td>
<td>3.90 (1.15)</td>
<td>3.04 (.85)</td>
<td>2.53 (1.07)</td>
<td>2.06 (1.29)</td>
<td>2.90 (1.34)</td>
</tr>
<tr>
<td>Pearson’s r</td>
<td>0.96</td>
<td>0.92</td>
<td>0.90</td>
<td>0.74</td>
<td>0.94</td>
<td>0.96</td>
<td>0.85</td>
</tr>
</tbody>
</table>

* 4 point scale, ** 5 point scale

Satisfaction with Self-Assessment:
Participants were interviewed as part of a larger evaluation. They were asked to comment on their experience of using the Self-Assessment Questionnaire. Slightly less than half the participants (n=20) found the self-assessment process to be positive and helpful. The process assisted clients with “becoming aware of what was available in terms of services and equipment” (SA020), raising issues they may not have thought about when asked about their own needs, and helped to clarify their expectations of what the service agency needed to know in order to deliver targeted services.
self-assessment process also gave the agency a clearer picture of the client’s needs and what “the client can and cannot do” (SA020). The process was described as “straight forward” (SA033) and “quite easy to do” (SA007).

Slightly less than half the participants were either unable to recall the process or were unsure whether the process was helpful.

Finally, seven participants regarded the self-assessment as a negative experience. They regarded the process as “confusing” (SA002, SA014) due to the “terminology” used (SA014) or because “it did not cover” items such as medical issues (SA002). Several participants required the assistance of the case manager to complete the self-assessment form and two participants would have required a translated version of the form in order to complete it.

**Discussion**
Within an aged care context in which parts of the needs assessment process are ill defined or lack transparency, use of a self-assessment questionnaire may render the process more comprehensive and predictable. The strong correlation between client and case manager assessment scores suggests a good inter-rater reliability of this particular self-assessment questionnaire. The high correlation of the scores between groups also suggests that the questionnaire was, if at all, minimally affected by positive response bias or SD effect. It would appear that clients have an understanding of their own strengths and limitations that is similar to that of their case managers. This can be regarded as testimony to a good working relationship between case managers and clients. Indeed, case managers were actively involved in assisting approximately one third of the participants to complete the questionnaire. Due to this fact, we would expect around one third of the client/case manager dyads to produce strongly correlated scores. However, the remainder of the scores were also strongly correlated. Given the strong interpersonal relationship between clients and case managers, this raises the question whether case managers were far more frequently involved in assisting clients than officially stated. A closer analysis of the scores reveals that around half (24) of the case managers and clients scores differed in the way they assessed the client’s needs. However, clients and case managers rarely disagreed by more than 1 rank.

It is possible that the very comprehensive construction of the questionnaire giving participants choices between clearly distinguishable conditions may have helped to reduce PRB or SD effects. Research into comparative ratings of need of clients with a mental illness and their case managers
revealed higher levels of agreement in domains for which there is a defined service response (Issakidis and Teesson, 1999). Several of the domains addressed by the self-assessment tool used in this study, such as personal care, home assistance, nutrition, and safety could be met with a defined service response. The other domains (health and wellbeing, relationships, and autonomy) required a more complex and less standardised service response. Further research is required to determine whether comprehensive, statement-based or service response-focused questionnaires reduce PRB or SD effects.

One item assessing health and wellbeing, whilst still positively correlated ($r = .74$), was visibly less so than other items. This would suggest that the strong relationship between case managers and clients invited independence of response. Many clients rated themselves as requiring less support from others on health and wellbeing, whereas case managers believed their client required more support. While this clearly suggests that clients had a more positive view of their health and wellbeing than their case managers, this may not necessarily suggest the presence of a positive response bias or social desirability effect. Rather, the finding lends support to a growing body of research suggesting that for a number of reasons older people tend to rate their own health and wellbeing higher than younger people (Faustane and Penna, 2012).

Although the self-assessment tool used in our study was comprehensive to a point where all except for two participants were able to complete the document, seven participants found the document confusing or difficult to come to terms with. Particularly people with cognitive issues, those facing significant challenges regarding their health, or those who were uncomfortable with the English language required extensive case management support. This echoes the findings of Challis et al. (Challis et al., 2009, Challis et al., 2008). Interestingly, bi-lingual case managers were unable to translate the self-assessment questions, suggesting that questionnaires have to be made available in the required languages.

Although the self-assessment form used in this study did not provide a detailed clinical assessment, it served well as a screening tool able to provide a rough indication of the support needs of a person. It also encouraged a discussion between case managers and clients regarding the assessment of needs and its consequences and, thus, played an important didactic role. Indeed, in about half of the sample of participants, the self-assessment process raised awareness of the assessment process, its criteria, and available service options, or helped to clarify client needs. Hence, if couched in a context of a more complex, holistic co-assessment process, self-assessment has the potential to
produce a more reliable, transparent, and holistic outcome (see, also Challis et al., 2009, Challis et al., 2008). However, rather than seeing self-assessment as an appendix to expert assessment (Challis et al., 2009, Challis et al., 2008), we would like to highlight the benefits of a more collaborative approach as outlined in this report. Particularly older people who wanted to better understand the aged care system and the basis on which resources were allocated to them regarded as valuable the dialectic process using client and case manager scores as a point of departure for an ongoing discussion about needs.

**Conclusion**

Within an aged care context in which the assessment of client needs is complex and lacks transparency a self-assessment process particularly when employed as part of a complex co-assessment process may produce more reliable and comprehensive outcomes.
References


