

75+ Health Assessments: a Randomised Controlled Trial

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Abstract

Preventive care for the elderly originated with a study in Great Britain in 1964 that reported a large number of unmet health needs in the elderly and advocated early intervention.

Subsequent randomised controlled trials (RCT) used a broad assessment of health including bio-medical, functional, psychological and social /environmental components but inconsistently demonstrated improved outcome for the elderly. 'Health checks' were introduced for all patients in British general practice in 1990. European and American models of care evolved similarly and justify a multidisciplinary team assessment, thorough training of assessment staff and medical supervision of recommendations. Two literature reviews published in 2000 have not reported sound evidence in favour of health assessments. Medicare funding of health assessments for the Australians aged 75 years and over was introduced in November 1999.

A protocol for conducting 75+ Health Assessment (75+ HA) was developed and a pilot study was conducted in Yarrawonga in 1995 to initiate Australian research of this model of care. A RCT in the Adelaide Western Division of General Practice tested this model of care. The intervention group (n=50) had two 75+ HA one year apart. The control group (n=50) was left to usual care and had a 75+ HA one year later. Demographic data and the Short Form-36 were used to ensure both groups were comparable.

Primary outcome measures did not demonstrate statistically significant reduction in problems nor mortality in the intervention (75+ HA) group compared to the control group. Significant improvements in secondary outcome measures in the intervention group were in self-rated health, depression score and decreased numbers reporting falls.

75+ HAs have been widely taken up by Australian general practitioners. It is no longer possible to conduct a RCT due to the inability to find a legitimate control group.

Recommendations arising from this literature review and RCT include; evaluation studies of 75+ HA, concentration on a functional model of health and that nurses or allied health professionals should conduct the assessment in the elderly person's home. A consistent framework for analysis of 75+ HA is proposed.

The elderly can be conceived to occupy one of 3 cohorts defined by their function state: No impairment of Activities of Daily Living (ADL), Impairment of Instrumental ADL only or Impairment of Basic ADL. The elderly without ADL impairment have not been demonstrated to benefit from 75+ HA and should be left to access the acute care stream of health services. The most disabled elderly with Basic ADL impairment have not consistently been shown to benefit from 75+ HA probably because they need a more intense level of community care. They should have Care Plans renewed regularly, as tested in the Australian Coordinated Care Trials. The cohort with Instrumental ADL impairment only seems most likely to benefit from annual 75+ HA.

An evaluation of screening the elderly for Instrumental and Basic ADL impairment and providing appropriate services for each cohort is recommended.

Disclaimer

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Dr Jonathan Newbury

Date

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