Government
of South Australia

Initial Needs Identification in South Australian Primary Care: How and Why

InitialNeedsIdentificationHowAndWhyInitialNeedsIdentificationHowAnd
WhyInitialNeedsIdentificationHowAndWhyInitialNeedsIdentificationHow
AndWhyInitialNeedsIdentificationHowAndWhyInitialNeedsIdentification
HowAndWhyInitialNeedsIdentificationHowAndWhyInitialNeedsIdentifica
tionHowAndWhyInitialNeedsIdentificationHowAndWhyInitialNeedsIdenti
ficationHowAndWhyInitialNeedsIdentificationHowAndWhyInitialNeedsId
entificationHowAndWhyInitialNeedsIdentificationHowAndWhyInitialNee
dsIdentificationHowAndWhyInitialNeedsIdentificationHowAndWhyInitial
NeedsIdentificationHowAndWhyInitialNeedsIdentificationHowAndWhyIn
itialNeedsIdentificationHowAndWhyInitialNeedsIdentificationHowAndW
hyInitialNeedsIdentificationHowAndWhyInitialNeedsIdentificationHowA
ndWhyInitialNeedsIdentificationHowAndWhyInitialNeedsIdentificationH
owAndWhyInitialNeedsIdentificationHowAndWhyInitialNeedsIdentificati

August 2002

Preface

This manual was funded by the ERA project and written by the Centre for Health Service Development at the University of Wollongong. It is designed as a practical guide to assist practitioners participating in the ERA project and, more broadly, practitioners in South Australia to undertake Initial needs identification and to develop an initial action plan.

The implementation of the tools outlined in this manual is being trialed in South Australia through the following agencies:

- ERA
- Metropolitan Domicilary Care
- Support link
- South East Single Entry Pilot
- Single Scoop Project

The assistance and contribution of Meredith Appleyard and Janette Gay are acknowledged, as is the feedback and contributions of the members of the ERA working party.

Suggested citation

Owen A and Eagar K (2002) ***Initial Needs Identification in South Australian Primary Care: How and Why***. Centre for Health Service Development, University of Wollongong.

How to use this manual

Welcome to this primer on the hows and whys of Initial needs identification and screening in primary care.

Contents

1 Introduction and background

The ERA (Equity, Responsiveness and Access) Project is a 2-year, HACC funded pilot project, developed from recommendations made by the Review of Country Domiciliary Care Services December 2000, and in line with other South Australian Department of Human Service (DHS) policy and planning frameworks. ERA is a joint initiative of the DHS and the Wakefield, Mid North and Gawler Regions. The scope of ERA was determined by key developments at State and National level, literature reviews, and through consultation with regional, State and national stakeholders and by considering what is achievable within the timeframe and resources.

The Review and the consultations highlighted the need for a common entry point for clients and streamlined screening and assessment processes, with screening a discrete and efficient process that eliminates unnecessary assessment and provides more appropriate service responses. The regional consultations strongly recommended this as a good starting point to achieve the desired outcomes. The ERA Pilot in the Wakefield, Mid North and Gawler areas of country South Australia will involve establishing the new entry and screening arrangements, based on the INI process, in five community screening points. Intranet connections will enable the INI being used in some locations on a secure data base and a service directory on line. In time, with an expansion to the DHS IT rural infrastructure, the INI data will be linked to the DHS information management system. Lessons from the ERA pilot will inform the proposed roll out across rural and remote South Australia and other statewide developments.

This document provides guidelines on how to use the screening and assessment tools that are being implemented as part of the ERA model (see Figure 1 on page 2). These tools draw heavily on those initially developed for use in Primary Care Partnerships on Victoria[1] but have been modified to better reflect South Australian needs. These guidelines discuss how to complete the Initial Needs Identification (INI) tools, how to undertake an Initial Needs Identification that may prompt referral and/or further assessment and how to complete a Summary and Action Plan. Issues relating to assessment (specialist and comprehensive) and care planning are not included.

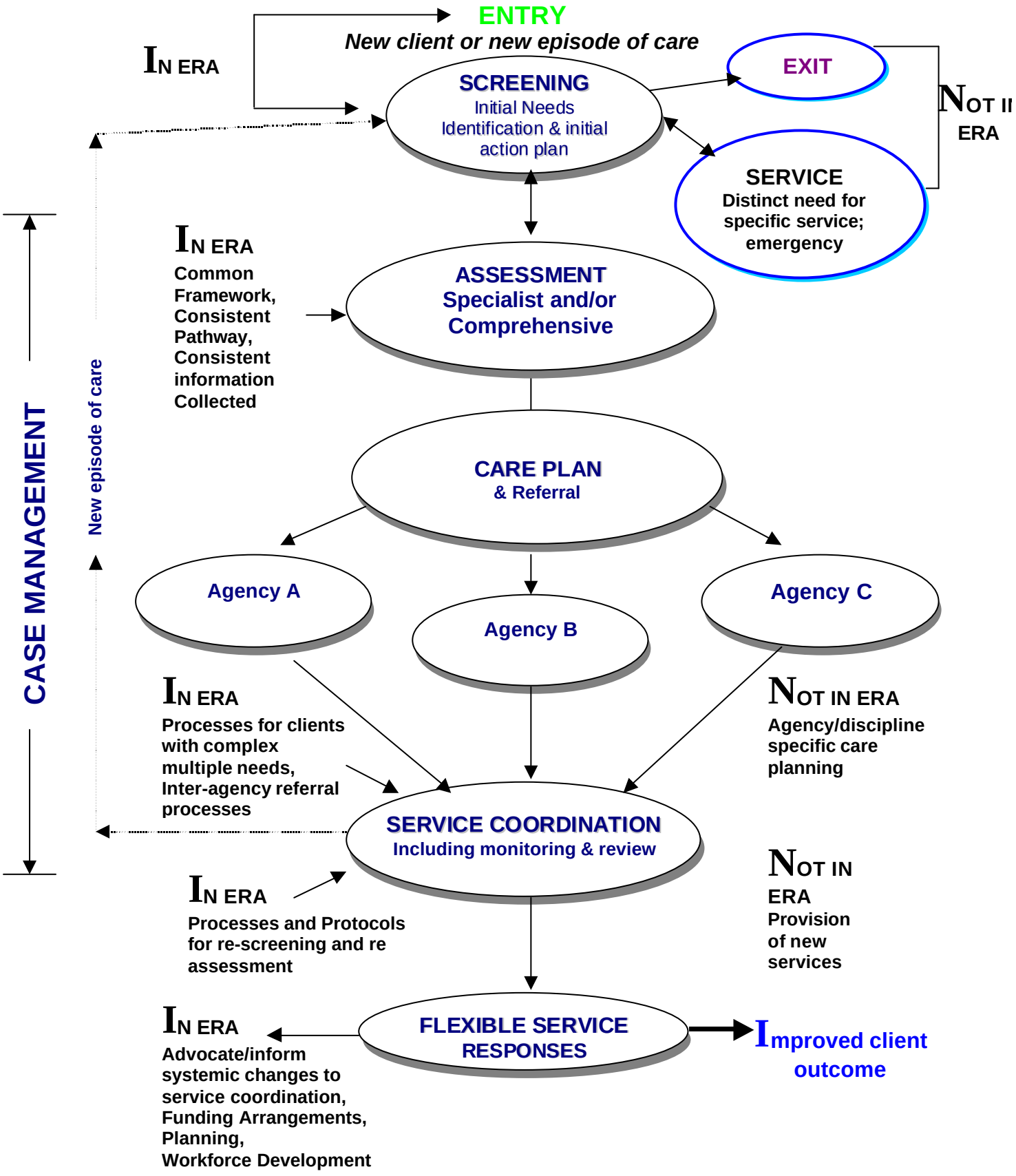
The guidelines are divided into 13 sections:

1. Introduction and background
2. Overview of the Initial needs identification tools and how to use them
3. How to complete the contact details
4. How to complete the service entry data set
5. How to complete the INI summary and action plan
6. How to complete the supplementary living arrangements profile
7. How to complete the supplementary health conditions profile
8. How to complete the supplementary psychosocial profile
9. How to complete the supplementary functional profile
10. How to complete the supplementary health behaviours profile
11. How to use the tools to investigate need and to develop a consumer care plan
12. Frequently asked questions
13. Selected bibliography for screening in primary care

[1] Details of the Victorian model can be found at: http://hnb.dhs.vic.gov.au/acmh/phkb.nsf

Figure 1

ERA PATHWAY



The ERA model recognises that a multi-dimensional assessment is often essential in determining appropriate care for people with complex care needs. However, such an assessment is time consuming and is unnecessary for a large number of consumers.

The first tier screen (INI) built into the ERA model allows service professionals to decide whether a more detailed or comprehensive assessment is required, thereby conserving and better targeting resources. It facilitates appropriate referral to other service providers and helps in the identification of consumers with urgent needs. In the ERA model, an INI may result in the consumer being referred for a more in depth assessment (if required). But it can also result in the development of an action plan without the need for assessment.

This model makes a distinction between the depth and scope of different activities, and it is the depth that defines the difference between screening and assessment. The ideas are summarised in Figure 2.

Figure 2: The ERA tiered screening and assessment model

Activity	Depth	Scope	Used for referral purposes?	Covered in these guidelines?
Initial Needs Identification (INI)				
Consumer Information	Shallow	Narrow	Yes	Yes
Summary and Referral Information	Shallow	Narrow	Yes	Yes
Supplementary (optional) Profiles	Shallow	Broad	Yes, where relevant	Yes
Assessment:				
Specialist	Deep	Narrow	No	No
Comprehensive	Deep	Broad	Yes, where relevant	No
Care Plan	Deep	Narrow	No	No
Service Coordination Plan	Deep	Broad	Yes, where relevant	No

2 Overview of the Initial Needs Identification tools and how to use them

These guidelines are written on the assumption that the INI is being completed (at least initially) on paper forms rather than electronically. However, the information is equally relevant to an electronic environment.

The Initial Needs Identification tools contain items that are designed to collect demographic and social details about individual consumers, plus there are items in the supplementary profiles to allow further information to be collected on those areas relevant to the consumers' circumstances and presenting problems. Not all items will be relevant for every consumer and, in some cases, the information will not be required. In these cases, simply follow the instructions at the top of the form.

While ERA has developed its own model, other agencies outside ERA will need to develop their own protocol (how, who, when) for using the Initial Needs Identification tools. It is likely that many of the items on the **Contact Details** sheet will be collected during the initial contact with the consumer or the person referring the consumer. Some items, however, may not be collected until the first time a consumer is seen by a clinician. In some cases, the information may not be collected until later in the process.

The tools are designed so that the first 4 pages cover the core information that should be collected on all consumers and a summary of the action to be taken. The remaining five profiles are to cover domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem.

The first two sections (called ICI pages 1 to 2 and INI pages 1 to 2 on the paper version) cover:

- contact details (of the consumer, other agents or agencies and their GP);
- a service entry data set with codes for categories to cover demographic details, benefits and entitlements, and insurance status;
- a summary and initial action plan – to be completed at the end and with prompts for investigating other domains using the relevant supplementary profiles.

The set of additional domains covered by the supplementary profiles have been chosen by combining evidence from the literature review[2], a review of the range of tools currently in use, consultations with the field on different draft versions of data collection tools, and the analysis of data from field tests[3,4,5.] They can be used to further investigate the scope of the consumer's needs at the initial contact point. The domains and their associated profiles cover living arrangements, health conditions, psychosocial profile, functional profile, and health behaviours.

The INI Summary and Action Plan brings together all the different information that is useful for planning care for those consumers that require more complex interventions. It covers a description of the consumer's problems/issues, and whether the consumer has given permission to proceed, and a list of current services used in the last three months. The second page contains

[2] Owen A, Poulos R and Eagar K (2001) *Using the evidence to develop best practice models for identifying initial primary and community care needs*. Centre for Health Service Development, University of Wollongong

[3] Eagar K, Owen A, Green J, Cromwell D, Poulos R, Gordon R, Quinsey K, Adamson L and Fildes D (2001) *A National Measure of Functional Dependency for Home and Community Care Services in Australia: Stage 2 report of the HACC dependency data items project.* Centre for Health Service Development, University of Wollongong

[4] Swerissen H, Macmillan J and Weeks A (2002) *PCP Initial Needs Identification & Care Planning Tools Template Development Evaluation Report*. Australian Institute for Primary Care, La Trobe University Melbourne.

[5] Appleyard M (2002) ERA Project: Report on the trial of the Initial Needs Identification Tool Template.

a series of prompts for the collation or collection of evidence of consumer need(s), an initial action plan and a box for comments on risk or urgency.

Each page has the same space for an identifier at the top to allow the information to be shared and the bottom of each page has a space for identifying the person and agency completing the form. Signing and dating every form is an accreditation requirement by most standards agencies. There is also a box for identifying if the information has been updated. This allows the superseded information to be kept as a historical record in the file.

The design of the tools assumes that they can be used for any consumer. However, for children and adolescents most of the supplementary information will not be relevant. A separate tool for this group is not included because it is assumed they will be referred directly for an assessment by an experienced agency or professional.

The content of the different tools is summarised below:

TOOL	CONTENT	Pages
Each form has an agency identifier and an "Office Use Only" section to record how the information was obtained and whether this page has been updated. When a new form is created the old information becomes part of the consumer's record.		
CONTACT DETAILS	Demographic and social details of the consumer, contact person/s, GP details and comment box.	ICI p.1 of 2
SERVICE ENTRY DATA SET	Codes to record source of referral, other demographic information and benefits, entitlements and insurance status.	ICI p.2 of 2
INI SUMMARY AND ACTION PLAN, p 1	Summary of presenting problems and consumer permission to proceed, current services used in last three months.	INI p.1 of 2
INI SUMMARY AND ACTION PLAN, p 2	Describes consumer issues and prompts for supplementary profiles. Initial action plan with codes for referral(s) and further investigation(s). Prompts for risks or urgency factors and alerts. Completed at the end using info from other tools	INI p.1 of 2
LIVING ARRANGEMENTS	Codes and comments for living arrangements, employment, financial and legal profile, carer profile and comment boxes.	LAP p.1 of 1
HEALTH CONDITIONS	Overall health, pain, vision hearing and falls, list of conditions and medications. Prompt for polypharmacy and comment box.	HC p.1 of 1
PSYCHOSOCIAL PROFILE	Covers mental health, and well being (K10 scale), personal and social support, family and personal relationships and disability criteria. Comment box.	PP p.1 of 1
FUNCTIONAL PROFILE, p 1	Functional screening questions for activities of daily living and self-care.	FP p.1 of 2
FUNCTIONAL PROFILE, p 2	Questions for cognitive and behavioural problems, with prompts for further functional assessments and aids and equipment currently used. Comment box.	FP p.2 of 2
HEALTH BEHAVIOURS	Asks about regular checks, screen for risk factors, nutrition and physical activity, with prompts for further investigation	HB p.1 of 1

The **INI Summary and Action Plan** (the third and fourth pages of the core information tool) are informed by any relevant detail from the supplementary profiles. As a result this page will usually be completed at the end and is used as a basis for putting together the action plan.

The use of the supplementary profiles depends on the particular consumer's presenting problems or the areas usually investigated by a particular agency or clinician, or as a result of any issues arising during the initial contact. The supplementary tools are completed after the core information has been collected. The core information is recorded on the **Contact Details, Service Entry Data Set, INI Summary and Action Plan**. The assumption is that the next steps of referral and/or care planning are a continuation of that process, and that the core consumer information will be available to share if the consumer consents to proceed.

There are **5 Supplementary Profiles**. Complete only those profiles that are relevant for the consumer. The tools are not a structured interview. Do not ask consumers about issues in the order that they are listed if they are inappropriate in the context. Rather, use the tools to guide a conversation with the consumer. The tools are designed to be completed based on all sources of information available to the person completing them (observation, answers to questions, information contained in a referral letter, client notes or information provided to you by a carer or referring agency).

There are instructions on each page about how to note any issues that you have not canvassed or that are inappropriate for the consumer. Most accreditation agencies have standards that do not allow for items on a form to be left blank. Accordingly, the general instruction is to record 99 or NA, depending on the case. The design of the set of tools assumes that children and adolescents will be directly referred for a relevant assessment to be completed and so it is expected that supplementary profiles will only rarely be completed with children and adolescents.

The profiles are not designed as a diagnostic tool, nor are they considered to be an assessment (while they are wide in scope, they are shallow in depth). They are tools to help determine the consumer's risks, eligibility, priority for service and health promotion opportunities. The profiles standardise the way this information is collected as early in the consumer's contact with the service system as possible.

As you complete the profiles, consider whether the consumer requires particular types of assessments and/or urgent services that cannot wait for a formal assessment process to be complete. Consumers should be informed about the range of service options that are available to meet their needs. This is not limited to the services provided by your own agency. Consider the wider range of services supports and resources such as for-profit services, information services, financial entitlements or other alternative services.

Pages 1 and 2 of the INI (**Summary and Action Plan**) may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used this way if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of INI page 1 of 2 for each issue. For example there may be 2 issues – seeing the dentist and getting referred to a sexual assault service – and it would be inappropriate to share all information for both referrals.

The Alert Box on INI page 2 of 2 has space for comments that can be used for recording information on risk and urgency, and for prompting the use of your current procedures for notification of **Alerts** if appropriate. An alert sheet (with guidelines) is separately available for agencies without an existing system.

Consider risk and urgency of consumer issues under four main headings:

1. Situations in which the consumer is at risk for any reason.
2. Situations in which the consumer presents a physical or emotional risk to other people, including family, friends and neighbours. This excludes risks to health professionals, which should be separately identified.

3. Situations in which the consumer represents a risk to a health professional, either intentional or unintentional and whether or not this is the consequence of the consumer's presenting problems.
4. Situations in which there is an occupational health risk to a health professional for any other reason.

For the Record - Information Updated

Each page on the paper version of the INI has a box on the bottom to record if new information has been added. If new issues or problems are identified after a page has been completed, the new issues should be recorded on a new page. The new page is used to record any changes or additions, not to repeat issues recorded on the previous INI. Indicate on the existing INI that the information on the page has now been updated. This will indicate to other health professionals that a new page has been created. Do not change the original record as the original record forms part of the client history and should be stored on the client record.

The INI – a bit of a misnomer

In some ways, the term Initial Needs Identification (INI) is a bit of a misnomer because it can imply that all of the information will be collected at the point of referral or first contact. This is not the case.

The INI begins at referral or first contact rather than ends there.

Identifying a person's needs, and their opportunities for health promotion, is an ongoing process that begins at referral. But needs and opportunities change over time (hence the 'information updated' section discussed above) and will be identified at different times.

The INI is a live process that involves all of the contacts a person has with the service system and that continues beyond initial contact.

It makes sense to capture as much information as possible as early as possible. And, with the client's consent, it makes sense to share that information between all of the providers involved in the person's care. Consumers do not want to tell their story multiple times and providers do not have the time or the resources to capture information that is already on record elsewhere.

So, while the tool is called the INI (to reinforce the idea that needs identification initially begins at referral), it can be thought of an ONI (Ongoing Needs Identification) tool or an ongoing process to better identify, and hopefully meet, client needs.

3 How to complete the Contact Details

The contact details are designed for collection at the point of first contact with the consumer or when a referral is made. This first page of information can be completed by a staff member or by the consumer. When the INI is in widespread use, this first page would be completed by the referral agency and either faxed or electronically transferred to the agency receiving the referral. The referral agency would also fax or transfer all other sections of the INI.

The logical order for completion is to work down each column. The data items in the Contact Details sheet (ICI p.1 of 2) are shown in the following table.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
CONSUMER DETAILS		
Title	Alphanumeric	Circle one
Surname or Family Name	Alphanumeric	No
Given Names	Alphanumeric	No
Preferred Names	Alphanumeric	No
Date of birth	Date	No
Sex	Alphanumeric	Circle one
Usual Address (for correspondence, home visits)	Alphanumeric	No
Postal Address (if different from usual address)	Alphanumeric	No
Contact Phone (tick preferred)	Numeric	No
Work Phone, Mobile, Fax	Numeric	No
Email address	Alphanumeric	No
Comments	Box	No
WHO THE AGENCY CAN CONTACT IF NECESSARY		
Case manager, next of kin, carer, guardian emergency contact	Alphanumeric	No
Person(s), contacts, relationship to consumer	Alphanumeric	No
GP CONTACT DETAILS		
GP name and contact details	Alphanumeric	No
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

The remainder of this section provides a description of each item in the Contact Details sheet (ICI p.1 of 2).

Initial Contact Agency Client Identifier

An identification number issued by the initial contact agency for use in identifying a consumer. Any interchange of client identifier numbers must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated guidelines.

Title

The title the person commonly uses.

Family Name

The consumer's family name or surname.

Given Names

The consumer's given name(s) or name by which they are commonly known.

Preferred Name/s

The name commonly used by the person. This can also be used to record any other names or aliases that the consumer commonly uses or by which they are commonly known.

Date of Birth

Record the consumer's date of birth as accurately as possible in dd/mm/yyyy format. Where the exact date of birth is not known, a close approximation should be recorded.

Sex

The sex of the consumer. Where this is not apparent, record the sex as identified by the consumer.

Usual Address

The address where the consumer usually lives, which is usually (but not always) the consumer's contact address for contact and case management purposes. Usual address is made up of the following elements:

- Street number and street name;
- Suburb/town/city;
- Postcode.

State is not required as it can be derived from the postcode. If the person currently lives in a country other than Australia, record this under suburb/town.

If the person is homeless, the usual address should be used to record any way to contact the consumer. This may be nil or might be a particular venue where contact can be made. Some consumers may not wish to have a contact address disclosed. Remember that, if the person is homeless, you should do all you can to develop an initial action plan on the spot. Maintaining contact with a homeless person is difficult, as is organising services for them. Take the opportunity while you have it.

If the usual address is different from the contact address, record the contact address in the comments box,

Postal Address

Record if different from Usual Address. Collect same elements as Usual Address. Otherwise, leave blank.

Contact Phone Number/s (tick preferred)

The consumer's contact telephone number to be captured for contact and case management purposes. Record work numbers if different from usual telephone. Otherwise, leave blank. The consumer's fax, mobile or email address (if one is available) for contact and case management purposes.

Who the agency can contact if necessary

Record the contact person/s and their relationship to the consumer. This might be the case manager, next of kin, carer, guardian, friend, or an emergency contact.

General Practitioner

The name and contact details of the consumer's usual General Practitioner. If none, leave blank. If the consumer sees more than one GP, record the one identified by the consumer as their usual or preferred. If they see a GP in more than one place, record the most common place.

Comment box

Note any relevant directions or contact issues, including contact address if different from usual address. Use this box also to record any particular requirements eg, 'Mrs Brown does not answer phone. Contact daughter only'.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

4 How to complete the Service Entry Data Set

The contact details are designed for collection at the point of first contact with the consumer or when a referral is made. This page of information should be completed by a staff member, rather than by the consumer. When the INI is in widespread use, this page would be completed by the referral agency and either faxed or electronically transferred to the agency receiving the referral, along with all other relevant sections of the INI.

The logical order for completion is to work down each column. The data items in the Service Entry Data Set (ICI p.2 of 2) are shown in the following table. The data items include a number of items that have attached code sets that can be part of an electronic information system.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Source of Referral	Numeric	Yes
Consumer consent for referral (circle)	Y/N	Yes
Source of referral contact details (if relevant)	Box	No
Country of birth	Numeric	Yes
Indigenous status	Numeric	Yes
Main language spoken at home	Numeric	Yes
Interpreter required	Numeric	Yes
Preferred language (if not spoken English)	Alphanumeric	No
Government Pensioner/Benefit Status	Numeric	Yes
Government Pensioner/Benefit Card Number	Numeric	No
Medicare Number	Numeric	No
Health Care Card Number	Numeric	No
DVA Card Status	Numeric	Yes
DVA Number	Numeric	No
Insurance Status	Numeric	Yes
Health Insurer Name and Card Number	Alphanumeric	No
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

The remainder of this section provides a description of each item in the Service Entry Data Set.

Initial Contact Agency Client Identifier

An identification number issued by the initial contact agency for use in identifying a consumer. Any interchange of client identifier numbers must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated guidelines.

Source of Referral

Record the person or organisation that referred the consumer to the agency using the codeset.

Consent for referral

Confirm that, if not self-referred, the consumer has given consent for the referral. Any interchange of consumer identifier numbers must be performed in accordance with South Australian and Commonwealth Privacy Legislation and associated guidelines.

Source of Referral Contact Details

If you will need to provide feedback to the referral agency, or might need to follow up to seek further information, record relevant contact details here.

Country of Birth

The country that the consumer identifies as being the one in which they were born. The codes are for (1) Australia and (2) Other. There is an 'Other, specify' write-in category for responses other than Australia. For data entry into electronic information systems (but not on this form) all responses can be coded to the Standard Australian Classification of Countries (SACC) (ABS 1269.0).

Indigenous Status

A consumer may be recorded as being not Aboriginal but not Torres Strait Islander, Torres Strait Islander but not Aboriginal, both Aboriginal and Torres Strait Islander, or neither Aboriginal nor Torres Strait Islander origin.
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.
Code '9' for where the answer is 'not stated'.

The consumer should be informed during data capture that the answer given or refusal to answer will not affect the consumer's access to services.

Main Language Spoken at Home

This is the main language spoken by the consumer to communicate with family and friends. The item has codes for (1) English and (2) Other and an 'Other - specify' write-in category for responses other than English. For data entry into electronic information systems (but not on this form) all responses can be coded to the Australian Standard Classification of Languages (ASCL) (ABS 1997).

Interpreter Required

This is the consumer's self-assessed need for an interpreter. This may include a sign language interpreter. Record (1) Interpreter not needed or (2) Interpreter needed.

Preferred Language

Record the consumer's preferred language if the 'interpreter needed' option was chosen in response to the 'Interpreter Required' item. For example, if the person uses sign language, and requires a deaf interpreter, record this as their preferred language.

Do not assume that the main language spoken at home is the consumers preferred language. For example, a young person in a non-English-speaking household may have English as their own preference.

Use this box to also record any special communication devices or requirements. For example, the consumer might prefer an interpreter of a particular sex or religion.

Government Pensioner/Benefit Status

Record whether the consumer receives a pension or other benefit from the Commonwealth government by selecting the code for the pension or benefit type. Record any relevant card number in the box. Likewise, record Medicare and (if relevant) Health Care Card numbers in the boxes.

DVA Card Status

Record the consumer's Department of Veterans' Affairs (DVA) Card Status by using the codeset. Record any relevant card number in the box.

Insurance Status

Record the current insurance status of the consumer including the level of private health insurance (if any) and/or whether the consumer is eligible for services paid by a third party payer such as motor vehicle accident insurance, Workers Compensation or Ambulance Fund. The primary purpose of this item is to allow a health professional to

know whether the consumer can access privately funded services such as private dental and allied health services. Where relevant, record the appropriate card number in the box provided.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

5 How to complete the INI Summary and Action Plan

The items on **INI p.1 of 2** cover a summary of the identified needs and current services. Most information on this page will be able to be completed at the end of the process. When the INI is in widespread use, this page would be completed by the referral agency and either faxed or electronically transferred to the agency receiving the referral, along with all other relevant sections of the INI.

Use this page to record presenting problem/s and issues of relevance for the consumer. The top heading asks for one or more short statements of why the consumer is seeking services then the box is used to note the action required. A code set is provided to record the action required.

Any other issues (which may be unrelated to the reason for seeking services) that arise in your conversation with the consumer should also be recorded here. This other information might be based on discussion with the consumer, observing the consumer, information contained in a referral letter, client notes or information provided by a third party, such as a friend, relative, carer or referring agency. This will include any issues arising from the supplementary profiles. Codes are used for the action required and all other information is alphanumeric.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
WHY THE CONSUMER IS SEEKING SERVICES		
Description of problem or issue	Alphanumeric	No
Action required	Numeric	Yes
Other issues	Alphanumeric	No
Action required	Numeric	Yes
Consumer permission to proceed	Yes/No	Yes
Current services	Alphanumeric	No
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Note that, while this is the first section of the INI summary and action plan, it may not be completed until you have completed the next steps in the INI process. The INI is designed in this way because it makes best sense to professionals receiving any subsequent referrals.

Initial Contact Agency Client Identifier

An identification number issued by the initial contact agency for use in identifying a client. Any interchange of client identifier numbers must be performed in accordance with relevant State and Commonwealth Privacy Legislation and associated guidelines.

Why the consumer is seeking services

The first set of boxes are for a description of the problem or issue as identified by the consumer or the referring agency, and the second set is other issues identified by the consumer or through the needs identification process. To elicit this information, the sorts of questions the interviewer can ask might be: 'Can I ask you about some other issues that often impact on peoples health?' or 'Are there any other issues you'd like to discuss or concerns you have?'

Action required

Codes are used for ten types of possible action associated with the problems or issues. They fall into 3 categories:

Services are required that do not need, or cannot wait, an assessment

Code (1) Service provision – see Initial Action Plan

An assessment is required

Code (2) Specialist assessment (eg, mental health assessment)
(3) Comprehensive assessment (eg, aged care assessment)

No further action is planned

The purpose of this item is, in part, to capture unmet demand. This item also captures situations where the issue is addressed at first contact. There may be two or more reasons for no further action. If so, enter both codes. For example, a consumer may refer elsewhere because the requested service was not available. In this case, enter 5 and 9.

Code:
(4) Nil: Consumer ineligible for service.
(5) Nil: Referred elsewhere.
(6) Nil: Advise/information provided. No further action required.
(7) Nil: Consumer declines further referral or service.
(8) Nil: Consumer issue resolved. No further action required.
(9) Nil: Requested service not available.
(10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location).

Consumer permission to proceed

This is about overall consumer consent at this point. It is seeking the consumer's permission to move beyond the presenting problem. Having started the summary and action plan, use this section to check consumer permission to proceed and, if so, to lead into considering what other tools need to be completed. Only if there is a need for further questions, the completion of supplementary forms or recommendations for further assessments, should other consumer issues be explored.

Current services

The prompts for services are listed alphabetically, including self-help. Use this box to record details of services used by the consumer in the last three months. The purpose of listing services used is twofold. First, the information will often suggest consumer problems and issues that have not been identified to this point. If so, consider whether any supplementary profiles need to be completed. This additional probing will need to be age–appropriate. Second, current service utilisation will need to be taken into account in formulating an initial action plan and, if necessary, in developing a care plan.

Ask the consumer whether they have used any **other services** in the last 3 months. If the consumer reports that they have used other services, ascertain what they are and whether the consumer is still in contact with the service.

Page 2 (INI p.2 of 2) prompts for additional screening profiles to be used and summarises the initial action required.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
OTHER CONSUMER ISSUES		
Consideration of further exploration of issues	Tick boxes	Yes
INITIAL ACTION PLAN		
Agency/health professional	Alphanumeric	No
Purpose of referral	Alphanumeric	No
Consumer consent to proceed	Numeric	Yes
Referral method	Numeric Y/N	Yes
Transport method	Numeric	Yes
Feedback required	Numeric	Yes
Date	Alphanumeric	No
Comment box for risk, urgency etc	Alphanumeric	No
OFFICE USE ONLY		

ITEM	Data type	Codeset
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Only after completing the relevant supplementary profiles should you finalise page 2 of the INI.

Other consumer issues

The relevance of other consumer issues can begin to be noted at this point and the tick boxes may prompt one or more supplementary profiles to be completed. Take into account the consumer's presenting problems and issues as well as all other information available to you. This other information might be your judgement based on interviewing or observing the consumer, information contained in a referral letter, client notes or information provided by a third party, such as a friend, relative, carer or referring agency. If there is any suggestion that the issue is relevant for the consumer, complete any relevant domains in the supplementary profiles. Consider:

- Living Arrangements, including issues about informed consent if the consumer's decision-making capacity is in doubt. If carer issues are significant, consider whether completing a separate INI on the carer might be useful (ie registering them as a client in their own right).
- Health Conditions.
- Psychosocial issues, including mental health and well being and disability.
- Functional dependency, including the domestic, self care, cognition and behaviour domains of function.
- Health Behaviours, risk factors and opportunities for health promotion.

Initial Action Plan

The Initial Action Plan can describe a referral pathway for consumers who need further assessment or those with complex problems and help keep track of how progress is going and whether any variation needs to be made to the initial plan of care. The columns capture more detail on what information the consumer has consented to share, and has codes for how the referral is being made, what transport is to be used, and what feedback is required.

This section of the INI draws together all of the other key information collected in the INI process and uses it to outline an initial action plan. It should be completed only after completing any relevant supplementary profiles. This plan has 7 components:

Agency/health professional: Complete in legible text. If you will be continuing to see the consumer, include yourself in the list of agencies/professionals for referral

For: Record purpose of referral in legible text.

If there is some reason for urgency, write 'urgent' in this column (eg, urgent assessment) and, if appropriate, use the Alert box to draw attention to the reason for the urgent response (eg, carer admitted to hospital today).

Consumer Consent: Record:

(1) Yes, consumer consents to referral and to sharing of information as specified on consumer consent form

(2) Yes, consumer consents to referral but not to sharing of information

(3) No, consumer has not consented to this referral.

Referral method: Record:

(1) This form faxed to agency

(2) Letter (copy on file)

(3) Electronic

(4) Verbal request – face to face or phone call

(5) Other (includes referral to self).

Transport Method: Use this column to record how the consumer and the service will actually get together. Record:

(1) Staff travel – service is delivered in home (eg, domestic assistance)

(2) Staff travel - client too unwell to travel

(3) Staff travel – client has no transport

(4) Client travel – own car

(5) Client travel – family/friends

(6) Client travel – public transport or taxi

(7) Client travel – walk

(8) Community transport

(9) Ambulance

(10) Hitchhike

(11) None (eg, telephone service to be provided).

Feedback required: Record:

(1) to initial referral agency

(2) to GP

(3) to agency completing INI

(4) to carer/guardian

(5) other (if other, record details in comment box)

Note that, if feedback is required, contact details will be required on page 2 of the ICI.

Date: Record date referral actually made. If no referral actually made, leave blank

Both pages 1 and 2 of the INI (**Summary and Action Plan**) may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used this way if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of INI page 1 of 2 for each issue. For example there may be 2 issues – seeing the dentist and getting referred to a sexual assault service – and it would be inappropriate to share all information for both referrals.

Alert Box - Using the INI to record risks and urgency

Page 2 of the Summary and Action Plan has an Alert box that can be used to make a note of risks and questions of urgency. Summarise any issues here according to how you judge the possibility of danger, loss of social participation or reduction in health status. Consider whether to trigger your own agencies alert procedures and whether this should be indicated in the box.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

6 How to complete the supplementary Living Arrangements profile

Use this profile if you have any reason to believe that there are issues in relation to the person's housing and living arrangements, their employment status and any relevant financial or legal issues, including decision-making capacity. Carer issues are also captured in this profile.

The data items in the Living Arrangements profile are amenable to electronic recording and reporting for associated minimum data sets. The data items in the Living Arrangements profile (LAP p.1 of 1) are shown in the following table.

ITEM	Data type	Codeset
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Living Arrangements	Numeric & box	Yes
Accommodation	Numeric & box	Yes
Employment Status	Numeric & box	Yes
Financial and Legal Profile		
Legal orders and decision-making responsibility	Numeric & circle	Yes
Financial decisions and cost of living decisions	Numeric & circle	Yes
Carer Profile		
Availability	Numeric	Yes
Residency status	Numeric	Yes
Relationship	Numeric	Yes
Current threats	Numeric	Yes
Sustainability of arrangements	Numeric	Yes
Comments	Box	No
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Living arrangements

Find out what living arrangements the person has – whether they live alone, with family or with others – by asking questions like ''Who lives in the house with you?' The person's living arrangements need to be taken into account in formulating an initial action plan and, if necessary, developing a care plan. They will often flag risks and urgency. Make any comments or summary notes on living arrangements and family situation in the box provided. Note there is a separate carer profile in this profile.

Evidence / source – HACC MDS

Accommodation

Codes are provided to record the consumer's accommodation type. There are 16 different possibilities listed and these are compatible with the codes in the HACC MDS. Record any relevant comments on accommodation difficulties or issues in the comment box.

Evidence / source – HACC MDS

Employment status

Ask about the person's current employment status and occupation, record status using the codes and record any relevant comments or notes. Note that the financial and legal profile on this form includes a question about cost of living decisions that is relevant to financial hardship arising from unemployment.

Evidence / source – modified from the NMDS for Medical Rehabilitation

Financial and legal profile

Legal issues might include any relevant court orders or mental health or guardianship orders, depending on the person's circumstances and presenting problems. Under **decision-making responsibility** consider whether the person is capable of making their own decisions.

If, in your opinion, the answer to the question about decision-making capacity is 'not sure' or 'no', consider the need for assistance, the need for a cognitive assessment and the implications for consent.

Financial issues might include whether a person is capable of making their own decisions about financial matters or whether there is some financial risk in their immediate circumstances. The person's financial situation may need to be taken into account in assessing risks and urgency and in formulating an initial action plan and, if necessary, developing a care plan.

Evidence / source – based on review of current practice in Victoria

Cost of living decisions. It is useful to inquire as to whether there are any trade-offs the person makes because of financial difficulties, by asking: 'Because of limited income, during the last month have you made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, home care?' If yes, discuss issues with the consumer and consider the need for counselling (eg financial, gambling) and need for material support. This question can generate important information to allow you to assess both risk and urgency.

Evidence / source – This question has been selected from the MDS-HC, an instrument developed in the USA for a minimum data set for home care. The validity and reliability of this item for Australian populations is unknown, however it would appear to have content validity.

Carer Profile

The Carer Profile has codes for recording availability, residency, the relationship of the carer to the care recipient, current threats to carer arrangements and whether the carer arrangements are sustainable.

Current threats to carer arrangements are described by a series of six self-explanatory codes and the item asks the screener to tick all that apply:

(1) Carer – emotional stress and strain (if so, consider completing a Psychosocial Profile on the carer)

(2) Carer – acute physical exhaustion/illness (if so, consider completing the Health Conditions and Psychosocial Profiles on the carer)

(3) Carer – slow physical health deterioration (if so, consider completing the Health Conditions and Psychosocial Profiles on the carer)

(4) Carer – factors unrelated to care situation (eg, carer moving away or taking on a new job)

(5) Consumer – increasing needs (including physical health deterioration)

(6) Consumer – other factors

These codes can be used as prompts to guide your conversation with the carer or referral agency. Based on your conversation, determine whether current carer arrangements are sustainable **without additional services or support** and record one of the following 5 codes:

(1) No, have already broken down (the situation is an immediate crisis)

(2) Yes, but only weeks (without additional services or support the arrangements will break down within a matter of weeks)

(3) Yes, months (without additional services or support the arrangements will break down within a year)

(4) Yes, years (without additional services or support the arrangements could eventually break down, but not likely within the next year or two)

(5) Don't know (in which case, consider the need for referral and assessment).

As with other items on the form, simply record a code of 99 if carer issues are not relevant.

Evidence / source – HACC MDS with additional items modified from the Illawarra Carer Survey

If there are significant carer issues, complete a separate INI on the carer, and/or make the appropriate referral to a carer support agency or information service.

The Carer Availability option has a code (4) Not Applicable – the consumer is the Carer. This option is selected when a separate INI is completed on the carer.

Comments

Consider all the issues such as the need for material assistance and decision-making and use the box at the bottom of this section for any relevant comments and to summarise the required action.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

7 How to complete the supplementary Health Conditions profile

This profile is for health issues including self-rated health, bodily pain, interference with normal activities, vision, hearing and falls. These items are based on self-report by the consumer, and as such should not be considered to be diagnoses. A column in the list of health conditions allows for the screener to identify where a consumer's report of a health condition has been confirmed by a medical practitioner. This should be ticked to indicate that a medical diagnosis has been made.

If there are problems reported, consideration should be given to medical referral and further inquiries about activities of daily living and screening for further assessment by completing the Functional Profile. The data items in the Health Conditions profile (HC p.1 of 1) are shown in the following table.

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Overall health	Scale tick box	Yes
Bodily pain	Scale tick box	Yes
Interference with normal activities (past 4 wks)	Scale tick box	Yes
Vision		
Reading	Scale tick box	Yes
Distance	Scale tick box	Yes
Hearing	Scale tick box	Yes
Falls (inside/outside past 6 months)	Alphanumeric	No (list)
Health conditions / GP confirmed?	Alphanumeric	No (list)
Current medications – prompt for poly-pharmacy	Alphanumeric	No (list)
Comments	Alphanumeric	No (list)
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Overall health

This question is selected from the SF-36. This question has been widely used and is in current use in the DVA D677 and the D673. Self reported health agrees well with objective measures of health. It has been found to be a good predictor of subsequent illness and premature death.

In asking the consumer about their overall health inquire about how they are going and whether they have experienced any recent changes in their health. If the consumer reports that they have had significant changes, ascertain whether the consumer is already under the care of a medical practitioner and whether they have told their medical practitioner about the changes.

If the consumer reports poor health, consider completing the Functional Profile and the Psychosocial Profile.

Evidence / source – SF-36

Bodily pain

Consider whether the consumer may be experiencing bodily pain. If so, ask questions such as 'How much bodily pain have you had during the past 4 weeks?' If the consumer reports that they have had significant bodily pain, ascertain whether the consumer is already under the care of a medical practitioner and whether they have told their medical practitioner about their pain. If not, refer the consumer back to their GP. Consider whether pain is impacting on their ability to manage activities of daily living (see Functional Profile) or on their personal or social relationships (see Psychosocial Profile). If so, complete the relevant profile.

Evidence / source – SF-36

Interference with normal activities

Use the question 'How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?' to score the consumer (or have them score themself) on the scale. Score from 'not at all to quite a bit' and identify and record any issues that may require action. If problems are identified, complete the Functional Profile to screen for assessment on activities of daily living.

Evidence / source – DVA-673

Vision, hearing and falls

Tick the box to indicate the description that best matches the consumers situation. If the question is irrelevant or the information is not known, record NA. If problems are identified, complete the Functional Profile.

Evidence / source – these questions have been selected from the 1999 Older Peoples Health Survey and the falls item has been selected from the DVA D677 form on the basis of its common usage

Health conditions

In considering health conditions, check whether the consumer may have had any relevant problems in the past that might be related to their present problem. This may include overall health, hospital stays, medical interventions or other conditions or disabilities. If the consumer has any allergies or other medical conditions that should be known by a health professional treating the consumer, record them in this box.

Also inquire about any current conditions the consumer may have that have been long-standing, persistent or recurrent. Use questions such as 'Do you have any health conditions that interfere with your normal activities that are long-standing or recurring?' to identify and record any conditions that may require action. Age appropriate questions may also be useful. For example, for older people consider questions such as 'People in your age group sometimes have problems leaking urine. Does this sometimes happen to you?' If the consumer reports that they have a chronic condition, ascertain whether the consumer is already under the care of a medical practitioner and whether any plan of long term management, coordinated care or self-help is in place.

General practitioners may use this list to record relevant diagnoses and/or to record consumer reported conditions.

Current medications

The medication section relates to all medicines, including over the counter and alternative treatments. Identify the number of medicines the consumer is currently using. Use questions like: "Please tell me the names of your prescription medicines and how often you take them?" "Do you take them the way your doctor wants you to take them? (if no: why not?)" "Is there someone who helps you take the medicines the way your doctor wants you to, or do you handle this your self?" "Please tell me the names of your medicines for which you do not need a prescription (ie over-the-counter)?"

Poly-pharmacy may suggest that a medication review is required. If so, seek the appropriate referral pathway.

The inability to manage your own medicine (the right medicine, in the right dose, at the right times) is an indicator of problems in managing activities of daily living. If problems are identified, complete the Functional Profile. In some cases, it may also indicate cognitive impairment[6]. If there are no physical reasons why the consumer cannot manage their own medicine, consider the need for a cognitive assessment.

Comment box

Use this box to summarise information on health conditions on this form or to capture any new information arising from questions such as 'Can you think of any other issues that interfere with your normal activities (outside and/or inside the home)?

The form does not contain a list of all the possible health risks and problem conditions that might need further investigation. For example chronic or degenerative diseases, faecal and urinary incontinence, diabetes, cardiovascular disease, lung function, falls and so on might be present, and can be noted in the comment box.

[6] Cromwell D, Eagar K and Poulos R (2002) *Screening for cognitive impairment using instrumental activities of daily living in elderly community residents: a cross-sectional study.* Submitted for publication

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres and agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

Note: If the Health Conditions form is being completed by a medical practitioner, it is used to record the doctor's diagnoses etc. If it is completed by other disciplines, they should complete it based on what the consumer tells them. That is, it is consumer-reported. There are different medico-legal implications depending on who fills out the form, so non-medical interviewers should be clear about not recording their own versions of diagnoses, but simply record what the consumer says their problem is.

8 How to complete the supplementary Psychosocial Profile

The psychosocial profile is used to screen for psychosocial issues including emotional and well being, personal and social support, family and personal relationships and eligibility for disability services.

The psychosocial profile is not a diagnostic tool, nor is it a mental illness profile. The focus of this profile is on emotional well being, not mental illness, and on prevention and early identification rather than diagnosis and treatment. It captures some common risk factors associated with mental health problems (such as lack of social supports) and so identifies opportunities for prevention. It also includes a screen (K-10) that can be used for the early identification of individuals who may have, or be at risk of developing, high prevalence psychological problems such as anxiety and depression. It does not screen for low prevalence mental illnesses or disorders such as psychosis. ERA intends that health professionals will most appropriately use this profile.

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Emotional wellbeing (the K-10 scale)	Scale scores	Yes
Total scale score as indicator for referrals	Total score	Yes
Sleeping trouble	Tick box	Yes
Sleeping trouble	Comment box	No
Personal and social support	Scale tick box	Yes
Family and personal relationships	Comment box	No
Disability		
Eligibility	Y/N/DK	Yes
Criteria	Tick box	Yes
Comment box	Alphanumeric	No
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Emotional wellbeing

Use the K10 scale to probe for signs of emotional wellbeing such as depression, anxiety and coping ability. Record the total score. This is a scale of psychological distress developed for use in population surveys.

Rather than being used as a guide to conversation, the K10 is often best undertaken as a series of structured questions, as detailed in the profile. Preface the questions with a comment such as "I'd like to ask you some questions about how you've been coping over the last month. We routinely ask these questions of everyone…('caring for another person', 'who has had a recent illness', 'who is seeking counselling services' or whatever is appropriate in the circumstances). This approach is non-judgemental. It probes these issues without any implication that this specific consumer is not coping. Ask "in the past four weeks about how often did you feel…"

K10 scale		All of the time	Most of the time	Some of the time	A little of the time	None of the time
		5	4	3	2	1
1	tired out for no good reason?					
2	nervous?					
3	so nervous that nothing could calm you down?					
4	hopeless?					

		All of the time	Most of the time	Some of the time	A little of the time	None of the time
5	restless or fidgety?					
6	so restless you could not sit still?					
7	depressed?					
8	that everything was an effort?					
9	so sad that nothing could cheer you up?					
10	worthless?					

This 10 item scale has five response categories and the score is the sum of those responses. The score range is from 10 to 50. People who score 0-15 have one quarter the population risk of meeting criteria for an anxiety or depressive disorder as identified by the Composite International Diagnostic Interview (CIDI), and a remote chance of reporting a suicidal attempt in their lifetime. People who score 16-30 have a one in four chance (three times the population risk) of having a current anxiety or depressive disorder and 1% chance (three times the population risk) of ever having made a suicide attempt. People who score 30-50 have a three out of four chance (ten times the population risk) of meeting criteria for an anxiety or depressive disorder and 6% chance (20 times the population risk) of ever having made a suicide attempt.

The recommended action is to refer for a primary care (GP) mental health assessment if the total score is 16-29 and for a specialist mental health assessment if the score is 30 or more.

Evidence / source – Kessler R, School of Public Health, Harvard University, Boston (unpublished manuscript).
Andrews G and Slade T (2001) Interpreting scores on the Kessler Psychological Distress Scale (K10*). Australian Journal of Public Health* 25, 6: 494-497.

Sleeping difficulty

Use this question as another opportunity to identify emotional issues and worries. If sleep is a problem, explore whether this is a long or short-term issue. Consider a GP referral or a referral to a stress management program if sleeping is a problem.

Evidence / source –EPC assessment item.

Personal and social support

Use this question if you feel that it is appropriate to the consumer's presenting problems: "During the past 4 weeks…Was someone available to help you if you needed and wanted help? For example if you…

- felt very nervous, lonely or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself"

If the consumer has little support consider referral and the possibility of completing a Functional Profile. The person's social support situation may need to be taken into account in formulating an initial action plan and, if necessary, developing a care plan. It is also a known indicator of both risk and urgency.

Evidence / source – Dartmouth COOP Charts. It has a convergent correlation of 0.61 with the Medical Outcome Study for social support (Nelson et al. 1998).

Family and personal relationships

Ask about the person's current personal and family relationships – whether they experiencing any particular difficulties and record the response in the comment box.

Ask the consumer whether they have any other relevant family or personal problems that might be related to their presenting issue or to their mental well being or social relationships. Identify and record any issues that may require action.

Disability

Check if the person is eligible for disability support services and whether an assessment is required. The tick box format for the criteria can be used to summarise the information. If so, consider referral to a specialist disability agency.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

9 How to complete the supplementary Functional Profile

The information collected on the Functional Profile is used to screen for any difficulties the consumer may have in activities of self care and daily living, things that we all need to do as part of our daily lives. The questions refer to how the consumer is managing at present and should be used to formulate an initial action plan and, if necessary, to develop a care plan.

Other information obtained in the process of completing this profile may also be used to recommend referrals for further assessment in the domains of self care, domestic, behavioural and cognitive functioning. Specific trigger points for these referrals have been developed on the basis of research to develop national measures of functional dependency for HACC and aged care programs[7]. They are also explained on page 2 the form.

The items on pages FP p.1 of 2 and FP p.2 of 2 are shown in the following table:

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Functional screen	Scale scores	Yes
Housework	Scale score	Yes
Walking out and about	Scale score	Yes
Shopping	Scale score	Yes
Medicines	Scale score	Yes
Money	Scale score	Yes
Walking	Scale score	Yes
Bathing	Scale score	Yes
Cognition (asked of third party)	Scale score	Yes
Behaviour (asked of third party)	Scale score	Yes
Comment box	Alphanumeric	No
Aids and equipment currently used	Tick boxes	Yes
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Evidence / source – National HACC Functional Dependency Study (Eagar et al. 2001).

Activities of daily living (functional screen)

Using this profile, you can screen for the consumer's needs over the four functional domains measured through scores on 9 questions. The screen does not attempt to capture all aspects of function. Rather, the 9 items in the screen have been selected because they are **good predictors** of how well a person is functioning in other aspects of their life.

Housework, travelling and shopping are *domestic tasks* that are generally lost early. A consumer who is independent in these tasks does not usually require a more detailed assessment of domestic or self-care tasks.

[7] Eagar K, Owen A, Green J, Cromwell D, Poulos R, Gordon R, Quinsey K, Adamson L and Fildes D (2001) A National Measure of Functional Dependency for Home and Community Care Services in Australia: Stage 2 report of the HACC dependency data items project. Centre for Health Service Development, University of Wollongong

Mobility and bathing are *self-care tasks* that are generally lost later than domestic abilities but earlier than self-care tasks such as feeding or toilet use. A consumer who is independent in mobility and bathing does not generally require more detailed assessment of self-care tasks.

The screen includes 2 items (managing your own medicine and managing your money) that not everyone is comfortable in asking or answering. However, their usefulness justifies their inclusion. Their power as screening questions is that they not only act as screens for domestic functioning. They are also reasonable predictors of cognitive and/or behavioural problems[8]. These are very difficult domains to screen for (you can hardly ask the consumer at 1st contact if they have difficult or challenging behaviour or get confused!) but they are important indicators of a person's needs. For this reason, screening often has to be more indirect (and therefore isn't quite as accurate).

But, unless there are other indicators (for example, information supplied by a carer), a consumer who is independent in medication and money management usually does not require more detailed assessment of cognition/behaviour. Other indicators of challenging behaviour and cognitive functioning comprise the last two items in the screen.

The 7 items on page 1 are hierarchical so, if the consumer does not need help in doing housework and getting about, there is no need to ask about mobility and bathing. On page 2 items 8 and 9 are about cognition and behaviour and are asked of third party informants, not the consumers themselves.

Scoring instructions and an explanation of the way to use the scores to trigger the recommended functional assessments, are included on the form itself, as is a space for comments or other issues raised by the Functional Profile.

How to undertake a functional screen

The screen is designed for telephone administration or may be administered face-to-face.

It is suitable for administration to a consumer or to a carer, friend or other person (eg, service provider) who may be contacting the care coordinator or service provider on behalf of a consumer.

Part One of the screen is to be asked of the client, or the carer, friend, or other person. Where a carer, friend or other person is being questioned, the questions refer to the functional abilities of the client.

The interviewer should inform the respondent that a brief screen is to be undertaken.

After reading the introduction, the interviewer should carefully and clearly read each item (one item at a time), along with the options, to the respondent. The questions should be asked exactly as they are written. The questions ask 'Can you…?' rather than 'Do you…? ' since some clients may not, for example, do the housework because their spouse or carer does it for them, yet be quite capable of undertaking it themselves.

We call this difference *'Can Do:Do Do'*. The task is to rate what a person 'can do' rather than what they 'do do'.

There are three main points to emphasise about how to complete the screen:

1. Rate what the person is capable of doing rather than what they do. Take into account the help that is required and the amount of prompting – if someone can do something but has chosen to have someone else do it (like dressing), rate as independent. If help or prompting is involved, rate as 1. If unable to do the task, rate as a 0.

[8] Cromwell D, Eagar K and Poulos R (2002) *Screening for cognitive impairment using instrumental activities of daily living in elderly community residents: a cross-sectional study.* Submitted for publication

2. Where an item is not relevant (eg, client does not use medicine), rate what the person would be capable of doing if the item were relevant to their situation.

3. Make sure the ratings, especially of items regarding standards of cleanliness, are based on the person's own social or cultural context, not your own.

Answers are limited to specific categories but the structure for the 7 questions in part 1 is the same. If the respondent does not answer with an option, or qualifies the option, the options should be repeated and the respondent asked to select the option which best describes the situation.

The interviewer scores each item according to the answer given by the respondent. If a respondent will not, or cannot answer a question, the score box should be marked with a cross (x), to indicate it was not answered. If the answer box is left blank, it will be assumed that the question was not asked.

Part Two of the screen is not suitable for you to ask the client. You complete it based on all information available to you – your judgement based on interviewing or observing the client, information contained in a referral letter, client notes or information provided by a proxy respondent, such as a friend, relative, carer or referring agency.

Further information on the functional screen can be found by going to the CHSD website and downloading the HACC Functional Screening and Assessment Manual[9].

Part One: Questions to ask the client (or the person who represents the client)

Unique client ID

Use your own agency identifier.

Items 1 to 7:

These are self-explanatory. The questions should be read exactly as they appear. The respondent is to select only from the options provided.

Ratings:

2 = without help
1 = with some help
0 = completely unable to do

Notes on ratings

'X' to be used where the client will not or is unable to answer the question.
A code of 9 indicates that the interviewer did not ask the question.
A cognitively impaired person or a person with an intellectually disability who is able to do tasks with verbal prompting should be rated as scoring a 1.

Part Two: Questions for you to complete

Ratings (Items 8 and 9)

0 = yes (presence of reported cognitive or behavioural problem)
2 = no (no evidence of any cognitive or behavioural problem)

Notes

The purpose is simply to rate yes or no, rather than 'why' or 'how much'. 'Why' and 'How much' needs to be determined through a more thorough assessment.

[9] Eagar K and Owen A (2002) *Functional Screening and Assessment: How and Why.* Centre for Health Service Development, University of Wollongong. The CHSD website address is: www.uow.edu.au/commerce/chsd

What to do with the screening information once you've collected it

- Use the guidelines on the form to guide your decision about whether the consumer needs a more comprehensive assessment. They are guidelines only and you should use your own judgement. These guidelines will inevitably be refined over time as screening becomes routine and as expertise develops. Practical issues such as the availability of comprehensive assessment services and the urgency of the person's needs should also guide your decision.
- If the person has low or moderate functional needs and does not need further assessment, use the information to decide whether the consumer needs services and, if so, what it is they need. The functional screening results alone will not be sufficient for this as you will need a range of other information (eg, information about carers and social supports, financial resources). This information is collected in other profiles. Use all of the information you have to develop an initial action plan or care plan.

Aids and equipment currently used

The last section of the functional profile (FP p.2 of 2) has tick boxes for any aids and equipment that the consumer currently uses. The definitions of the codes used in this section are contained in the following table. These codes come from the HACC MDS but they are being used in the INI in a different way. In the INI, the item captures what aids and equipment the person currently has. In the HACC MDS, it captures what the HACC service provided.

Code Label	Code Label Definition
Self-Care Aids	These aids assist the client in their day-to-day routines of cooking/eating and personal hygiene. Examples of such aids are special crockery/cutlery, bath rails/shower rails, buttonhooks, bowel and urinary appliances etc.
Support and Mobility Aids	Aids mentioned here provide the client with ease of mobility as well as supportive mechanisms while at rest. Support aids include callipers, splints, special beds, cushions/pillows etc. while mobility aids include belts, braces, crutches, wheelchairs (manual and motorised) etc.
Communication Aids	These aids help the client with their inter-personal interaction and are inclusive of telephone attachments, writing aids, speaking aids (electrolarynx), intercom etc.
Aids for Reading	These are reading specific aids provided to clients and comprise of items like magnifying/reading glasses, Braille books, reading frames etc.
Medical Care Aids	Aids described in this category serve to provide assistance to clients with specific medical conditions. They include breathing pumps, pacemakers, Ostomy/Stoma appliances etc.
Car Modifications	These aids allow clients access to safe and comfortable transportation, either as the driver or passenger of the vehicle. They are inclusive of accelerator/brake/mirror and other driver related controls as well as other modifications like automatic transmission and room for wheelchair etc.
Other Goods/Equipment	This category of aids includes all items which lie outside the range of the above mentioned codes.

Office Use Only

Record who has completed the form, and the designation or agency. Note that ‘agency’ includes identifiable centres or agencies, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client’s record.

10 How to complete the supplementary Health Behaviours profile

Use this form to record information about the person's lifestyle and to identify any opportunities that may be available to improve their health and well being. The questions are in the form of tick boxes, except for the nutrition screen, which gives a total score that can be used to indicate risk. The items are listed in the table below:

ITEM	Data type	Code set
CLIENT IDENTIFIER		
Initial Contact Agency Unique Client Identifier	Alphanumeric	No
Regular health checks (date)	Y/N	Yes
Smoking	Scale scores	Yes
Alcohol	Scale tick box	Yes
Frequency	Scale tick box	Yes
Quantity	Scale tick box	Yes
Nutrition (total score as risk indicator)	Scale scores	Yes
Weight (appearance)	Tick box	Yes
Physical activity	Y/N	Yes
Physical fitness	Tick box	Yes
Comment box	Alphanumeric	No
OFFICE USE ONLY		
Screener's name, agency, signature, date and contact number	Alphanumeric	No
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	No

Regular health checks

Use your judgement to ask about likely issues: Have you had any health checks recently (eg a mammogram/pap smear or prostate check)? The question on health checks might cover breast screening for women 50 years and older within the recommended time frame (last 2 years) and, for the pap smear question, women of all ages. This should apply to teenagers and not just adults.

Risk factors

The opportunities for health promotion in the community are almost limitless. The results of the Australian Burden of Disease Study[10] offer some guidance as to which risk factors could most profitably be targeted by the INI. These results and other relevant studies are discussed in the associated literature review undertaken to determine the most useful items[11].

Risk factors such as smoking, alcohol consumption, physical inactivity, hypertension, high blood cholesterol, obesity and inadequate fruit and vegetable consumption are responsible for large proportions of the overall burden of disease in Australia. The chief risk factor, responsible for 10% of total burden, is tobacco smoking, followed by physical inactivity (7%), high blood pressure (5%), and obesity (4%). Alcohol harm from hazardous drinking (4%) is offset by the benefits from alcohol in terms of cardiovascular disease, giving a net harm of around 2%. 'Fewer than five servings of fruit and vegetables' causes an estimated 3% of burden, as does high cholesterol. Illicit drugs, occupation and unsafe sex each account for less than 2% of the overall burden of disease[12].

These results indicate that targeting smoking, hazardous drinking, physical inactivity and obesity in consumers may be most worthwhile. The Health Behaviours form therefore prompts for inquiring about and recording these risks and opportunities for intervention, as well as nutrition, weight physical activity and fitness. Items have been selected from the DVA D677 form, and Enhanced Primary Care Assessment Form (Vic).

---

10 Mathers, C. D., Vos, E. T., Stevenson, C. E., and Begg, S. J. (2000). The Australian Burden of Disease Study: measuring the loss of health from disease, injuries and risk factors. *Medical Journal of Australia*, 172, 592-596.

11 Owen A, Poulos R and Eagar K (2001) Using the evidence to develop best practice models for identifying initial primary and community care needs. Centre for Health Service Development, University of Wollongong www.wrhs.sa.gov.au

12 Mathers et al. (2000) ibid

Smoking and drinking

The next questions are about smoking and alcohol use. Consider opportunities for health promotion and the need for a referral if either is an issue.

Evidence / source –DVA D677, and EPC forms.

Nutrition

These questions comprise the Australian Nutrition Screen and are selected from the Nutrition Checklist used in the D677 and the EPC Assessment Tools. Because their use as single items is unvalidated, the whole checklist should be used. This then allows total item scores to be used as a trigger for GP referral if the consumer scores in the 'high risk' range. Note that some items in the checklist have different scoring weights.

Depending on the consumer's presenting problems, ask questions such as: 'Do you have an illness or condition that made you change the kind and/or amount of food you eat?' or work through the checklist.

Evidence / source – the Nutrition Checklist in the D677 and the EPC Assessment Forms.

Weight

This covers the consumer's overall appearance to the interviewer. It might be associated with the nutrition checklist item above - "In the past six months, have you lost or gained more than 5 kilograms without trying?"

This item is unvalidated and is used on the assumption that it is not realistic to measure the height and weight of each consumer. Whether or not the current weight is appropriate for the individual requires height and weight measurements, and BMI calculations (weight in kg/height^2 in m).

Physical activity and fitness

"Physical activity is any bodily movement produced by skeletal muscles that results in energy expenditure"[13]. Important health benefits can be obtained through activity of moderate intensity - such as walking. It is considered appropriate to accumulate this type of energy expenditure through bouts as short as 10 minutes, towards the recommended total of 30 minutes on most days[14].

Physical activity can be gauged by the question: 'Would you accumulate 30 minutes or more of moderate intensity physical activity on most days of the week?'

Fitness is a different but related concept. The specific wording of this question has not been validated, but it appears to have content validity, given the current understandings of how best to capture this aspect of health behaviour. It should be noted that 'physical activity' has been used instead of 'exercise'. Exercise is a "planned, structured and repetitive bodily movement which is done to maintain one or more components of physical fitness" making it a subset of physical activity[15].

'During the past 4 weeks…what was the hardest physical activity you could do for at least 2 minutes?'
If the hardest activity was less than moderate, consider the need for a referral. The following should be used as a guide:

Very heavy - run, fast pace; carry a heavy load upstairs or uphill (25 lbs, 10 kg)
Heavy - jog, slow pace; climb stairs or a hill at moderate pace
Moderate - walk, medium pace; carry a heavy load level ground (25 lbs, 10 kg)
Light - walk, medium pace; carry a light load on level ground (10 lbs, 5 kg)
Very light - walk, slow pace; wash dishes.

Consider both Activities of Daily Living and need for referral if the consumer's response can be judged as 'light' or 'very light'.

13 NSW Health (1996). *Physical activity and health. A special communication from the Chief Health Officer*, State Health Publication.

14 NSW Health, Public Health Division. (2000). *New South Wales Older Peoples Health Survey 1999*, NSW Health Department, Sydney.

Pate R, Pratt, M., Blair, S. , Haskell, W., Macera, C., Bouchard, C., and al, e. (1995). Physical activity and public health: A recommendation form the Centers for Disease Control and Prevention and the American College of Sports Medicine. *Journal of the American Medical Association*, 273(5), 402-407.

15 NSW Health (1996) op cit

Evidence / source – Dartmouth COOP Charts. This question has a convergent correlation with the MOS Scale for Physical Function of 0.59 (Nelson et al. 1998).

Comment box including other issues

Use your own judgement to probe for sensitive issues such as substance abuse (legal or illegal) and safe sex habits. The comment box should be used as a place to summarise the information gained or to record any other relevant issues about health behaviours and risks. These should then inform the issues and initial action plan summarised on INI page 2 of 2 and, if necessary, to develop a care plan.

Office Use Only

Record who has completed the form, and the designation or agency. Note that 'agency' includes identifiable agencies and centres, GP practices and hospitals. Use the last box to sign and date any change to a new form, at which point the superseded form becomes part of the client's record.

11 How to use the tools to investigate need and to develop a consumer care plan

Using the Summary and Action Plan as prompts for referral and further assessments

The second part of the core information (INI pages 1 and 2) provides prompts and ways to seek further information on specific domains that are relevant to the consumer's problems or issues that have arisen in the initial contact. The interviewer is expected to take into account the consumer's presenting problems and issues, the services that the consumer is currently using as well as all other information available to them. This other information might be based on their discussion with the consumer, observing the consumer, information contained in a referral letter, client notes or information provided by a third party, such as a friend, relative, carer or referring agency.

If there is any suggestion that the issue is relevant for the consumer, tick the relevant box and complete the suggested domains in the supplementary tools.

The supplementary tools also contain prompts for further assessment, referral or more action on behalf of the screener.

- The Living Arrangements form raises issues about informed consent if the consumer's decision-making capacity is in doubt. It also suggests that if carer issues are significant, either referral to a carer specific agency or program might be appropriate or completing a set of tools on the carer might be useful (ie registering them as a client in their own right). This profile also includes indicators of both risks and urgency (living arrangements, housing, fragility of carer arrangements and so on).
- The Health Conditions form has prompts for investigating activities of daily living (the Functional Profile), and for medical referral, or medication review. It also has a column to enter where a medical practitioner has confirmed the consumer's condition as a specific diagnosis.
- The Psychosocial Profile has a scoring system for mental health and well being that recommends generalist or specialist mental health referral depending on the score, prompts for investigating activities of daily living and assessment for disability services. The profile screens for risks such as suicide and for high prevalence disorders such as anxiety and depression,
- The Functional Profile has prompts for the assessment of domestic, self care, cognition and behaviour domains of functional dependency. It also has a place to list the aids and equipment a consumer is currently using.
- The Health Behaviours form has prompts for referral for screening, and checks on risk factors such as smoking, drinking, nutrition advice, weight and physical inactivity. If fitness may be an issue, then consideration can be given to investigating activities of daily living (using the Functional Profile). Its importance is in identifying opportunities for early intervention and health promotion.

When all the relevant information has been collected, then the action plan and appropriate referrals should be considered. This might not all be done at the point of initial contact, but at a later time when sufficient information is available.

Using the INI to record risks and urgency

Page 2 of the INI Summary and Action Plan section has a an Alert Box at the bottom that can be used to make a note of any issues of concern, including risks and record any questions of urgency, and the contact details in your agency for further information. This is used to record any

concerns identified in relation to the possibility of danger, loss of social participation or reduction in health status. This is where a brief note can be made as to the circumstances involved, and attention can be drawn to more detail being available. If you trigger your own agencies alert procedures, consider indicating this in the box.

Briefly, the description of risks and the urgency of consumer issues can be considered under four main headings.

- Situations in which the consumer is at risk for any reason.
- Situations in which the consumer presents a physical or emotional risk to other people, including family, friends and neighbours. It excludes risks to health professionals.
- Situations in which the consumer represents a possible risk to a health professional, whether intentional or unintentional.
- Situations in which there is an occupational health risk to a health professional for any other reason.

Even if an alert system is not being used for this particular consumer, it is sometimes useful to consider if any low-level risks of the types described above are worth mentioning in this box.

Examples of this might be something like: 'note that consumer reports poor relationship with second daughter' or 'bathroom is on list for home modification - shower hose and bath board are temporary arrangement'.

Using the Initial Action Plan for referrals

The Initial Action Plan can describe a referral pathway for consumers who need further assessment or those with complex problems and help keep track of how progress is going and whether any variation needs to made to the plan of care. The columns capture more detail on what information the consumer has consented to share, and has codes for how the referral is being made, what transport is to be used, and what feedback is required.

The 'Feedback required' column is intended to prompt the timely sharing of information between important participants in the consumer's care. The feedback column is of most relevance when this form is received by another agency and they can determine if the original referring agency, the agency completing the form, or the person’s care-givers or GP require feedback.

By recording the actual date that the referral is made, the agency making the referral can keep track of waiting times and this may help determine whether additional follow-up action is required.

12 Frequently Asked Questions

Q. I already waste too much time filling out paper work. When all's said and done, isn't this just a bunch of new forms?

If all you do is flick through the paper version of the tool, it's easy to come to your conclusion. But there's more too it than a bunch of extra forms to fill out:

- The INI is designed to replace most of what you collect, not add to it. If all you do is add the INI to your existing processes and systems, it will undoubtably add to your workload. But that isn't the purpose of the INI. If it adds to your workload, you probably need to go back and review what you do now.
- The design of the INI assumes that you, and the agency you work for, are part of a bigger primary care service system that includes GPs, community health and HACC-funded services. It might also include secondary referral services such as hospitals, mental health and so on. The INI is necessarily broad (but shallow) because it assumes that you are part of this bigger system. The idea is simple but of fundamental importance. You screen for all the consumers needs (including those you can't meet but someone else can) and other agencies screen for you.
- The goal is to get to a point where a consumer can enter the primary care sector at any point they choose and just have to tell their story only once. The advantages for consumers are obvious – not only having to tell their story only once but the ability to access the system at any point and the opportunity to receive care from providers who actually know what the system as a whole is doing.

Whether the INI is just another bunch of forms or a better (more efficient and effective) system of screening for needs across agencies and professionals depends on how you use it.

Q. Aren't we taking all this standardisation too far?

Remember that the tools don't determine the structure of who does what in the local division of labour around screening and assessment. All they do is standardise what gets collected, not how it should be done from an organisational viewpoint and what it all means!

The big upside is that consumers don't have to repeat their details at every step, and we should get to a point of having a common entry point across the service system.

There is an obvious next step, once agreement on who does what has been achieved, and common tools are being used. With both standard ways to collect and share information, and by using the right information technology, we will soon have the opportunity to create virtual community care organisations in which various agencies work together as a virtual system.

However, a move towards virtual organisations represents a massive cultural leap and requires the support of both providers and consumers. Virtual organisations are within our grasp, and are not too far removed from local area arrangements where agreements and protocols already exist. However, we have a long way to go from a reality that is more like 'joined up worrying' to get to something more resembling 'joined up working'.

Q. Can the consumer fill in part of the INI? Will it serve as a consumer held record with a copy left in the consumers home, as tools like the CIARR has been?

This is up to individual agencies and areas to decide in the context of their local service coordination models and agreed practices, processes and protocols within the area. The initial contact details can certainly be completed by the consumer. Consumer and community

consultations will need to consider the needs/requirements of consumers to hold their own records and access their records within the context of privacy guidelines and legislation.

Q. What do the total numbers on the various screening tools actually mean? Should I add them all up?

Except where it is stated in the profile (eg, the K10 in the Psychosocial Profile), the various screening scores don't mean much as 'scores', because the scales don't have equal weighting for all the items. So adding them up doesn't help and they weren't designed to really work that way. We don't expect the profiles to provide the answer to life, the universe and everything, nor for the answer to be '42'!

In practice, the scores are used as prompts for referral or further assessment where necessary. The key point is setting the thresholds for these prompts right such that you don't get either too many that get assessed or referred unnecessarily or too many that need something that miss out. We looked at the sensitivity and specificity of the screening tools to determine the best mix of these two attributes.

Q. If I see another Minimum Data Set I'll go numb with boredom! How will the INI tools link to all the other data collecting and reporting?

The goal is that, eventually, a Common Data Set will streamline the common elements across all data collections. A sensible approach is that all of the Departments' data collections will comply with this data set. Most States are considering options for the implementation of this process across all program areas.

Q. What liaison work is being done with the Commonwealth to streamline data collection and reporting?

The Commonwealth is a major stakeholder in the development of national standards for data collections. In particular, the Australian Community Based Health Services Codeset (National Codeset) is auspiced by the National Health Information Management Group (NHIMG). The National Codeset was created to provide a 'comprehensive suite of codesets for use in the Australian Community Based Health environment' and was intended to reflect the activities and support the information management requirements of all types of health services delivered in a community based setting.

In its current form, the National Codeset provides a valuable first step in the development of a national framework for the collection of consistent and reliable data in community based health services. However, in order to be a relevant reference tool, significant work is required to align the National Codeset with other authoritative standards such as the National Health Data Dictionary (NHDD) and the National Community Services Data Dictionary (NCSDD). This work will be ongoing in order to enhance the synergies between the various standards.

Q. What support will be provided for upgrading/altering of IM/IT systems to support implementation of the tool templates in an electronic format?

A number of States have commenced work with some primary care software providers to inform them of these developments. It is expected that account will be made for development activities in the development cycle of the products. While discussions with vendors will continue during the development of the tools, more detailed work on applications support for the electronic tool templates will take place once the tools are being implemented in an agreed form.

Q. What work will be done over the longer term with GPs to encourage their adoption of these tools?

GPs are well placed to adopt the use of the tools. The Enhanced Primary Care (EPC) Medical Benefits Schedule (MBS) items especially concerning health assessments and case conferencing and care planning promote the involvement of GPs in shared assessment and multidisciplinary care planning. Funding and change management initiatives initiated by the Commonwealth through Divisions of General Practice promotes the involvement of GPs in these activities. The profiles have been designed so that they comply with the requirements for EPC claims.

Q. What level of training and competencies will staff implementing the INI require and how will this be addressed?

Staff undertaking initial needs identification should have a broad understanding of the service system and advanced interviewing skills that provide a capacity to maintain and develop rapport throughout intensive inquiry and an ability to retrieve sufficient information through that inquiry.

The work with the range of primary care providers and other key stakeholders such as consumers and peak and professional bodies to facilitate agreement about the required assessment competencies and the best strategy for embedding these competencies among practitioners, is ongoing. This will ensure that in the longer term, consumers can be confident that workers with agreed competencies undertake screening elements.

Competencies development will build on previous work undertaken in the area of workforce development in the health and community care sectors. The training and skills development strategies that build the capacity of workers, organisations and the service system in this area are ongoing.

Q. What about the carers?

The carer needs and functions are taken into account through the carer profile on the Living Arrangements form (LAP 1) and, if carers have identifiable needs of their own, they might be given their own INI including the functional screen (FP 1&2) and the psychosocial screen (PP 1).

Remember the screening level is not about comprehensive assessment and carer needs might have to addressed by an appropriate referral. The function screen (FP 2) has two questions to ask of carers or other proxy respondents - about behaviour and memory problems - things you can't ask the consumer directly. While these questions are not about carer needs directly, they provide an opening to consider the items about the carer role in the carer profile in form LAP1.

Q. Will there be an adapted version of the screening tools that can be used with children?

The screen is not designed for children in particular and most of the items in the profiles haven't been validated for use with children. But the core information will be able to be collected on children and we assume that a referral for more detailed assessment will be an appropriate next step if needs are identified.

Our general impression from the testing and the training done to date is that kids can have their problems scored reliably on these tools as long as people take notice of the scoring instructions and use a bit of common sense.

Q. For some consumers the difficulties of getting through the screening seem too daunting. For example the consumer's disability or physical circumstances made it difficult to answer many of the questions.

Consumers with high levels of disability and no communication, consumers who were confined to bed, consumers who were very young and some consumers with brain injury and psychiatric illness, could clearly not perform any of the tasks and, in many cases, were unable to respond on their own behalf. For some consumers, the use of an interpreter for a consumer with a non-

English speaking background might be found to be very time consuming and inappropriate. The screener should use their own judgement about the best way to get the relevant information, or refer the consumer to the appropriate assessment agency.

Q. Another problem is the question of the reliability of the answers from some consumers with cognitive disabilities.

Some consumers may have poor memory or be suffering from dementia but with a lack of insight into their condition and resistive behaviour towards care. It might be that a consumer has profound deafness that may prevent his or her understanding the questions. The screener should use their own judgement about the best way to get the relevant information, and/or refer the consumer to the appropriate assessment agency.

For consumers with cognitive problems (lack of insight, delusional) all the questions might seem to be inappropriate. Similarly, most items might be inappropriate for a very disabled, bedridden consumer and for a young child with no speech or independent mobility.

For some younger consumers, the questions might highlight the progressive decline in their functional ability, so it could be quite distressing for the consumer to go into all that. Some young, able consumers might also find the questions invasive, offensive, inappropriate or just a joke.

The screener should use their own judgement about the best way to get the relevant information, either by inquiring of a carer or the referring agency, or refer the consumer to the appropriate assessment agency.

Q. What about special needs groups and ATSI populations?

The sample size in the different field tests of the screening tools to date has been insufficient to test the appropriateness for special needs groups such as ATSI consumers and consumers who do not speak English. This issue can only be assessed when the tools are introduced into routine practice, as the sample size achieved in any one-off field test will continue to be insufficient to test the appropriateness of the instruments for low-volume groups.

The main issue is expected to be around the use of the screening tools in remote areas, where the capacity of the local community to respond to need may be the more important dimension to be considering, but along with the level of need identified in individuals.

Q. What about all the missing bits?

There are a number of general areas that are missing in the screening tools or covered by only a general question. Social isolation, the need for prompting and encouragement with personal hygiene and to use continence aids, problems with literacy and interpreting for consumers with poor English skills are all important.

While functional capacity in particular is thought to be of critical importance in driving the need for services, it is not the only measure of need, nor is it the only consumer-related cost driver. Other important consumer-related drivers (or variables) also need to be captured to gain a comprehensive picture of the consumer's needs. Consumer-related variables thought to be of particular importance (among others) are age, medical conditions and diagnoses, carer availability, risk of abuse and care setting. These should all be considered as part of developing a Summary and Action Plan (INI p.1 & 2).

The box at the bottom of the INI p.2 form is for comments on risks and urgency and can be used to note important issues that have to be taken into account.

Q: If I read the questions out in exactly the form they are written, this is too awkward. Is there a satisfactory middle way?

It is not necessary to read out the questions exactly as they are written, but standardisation is important. The screener is encouraged to keep the sense and direction of the questions while using their own judgement in having a conversation with consumers. As the items become more familiar a more colloquial style will be easier, while retaining the sense and meaning of the question.

Questions specifically about the Functional Profile (FP p.1&2)

Q: Mobility items - inside and outside - ie the consumer can mobilise independently in a familiar environment, but has trouble outside. They can do a bit a bit of housework, but not their lawns and gardens, and the back steps need a rail. How does this score?

The form does not capture most of the important environmental information, however a box at the end asks about aids and equipment currently used. Also, a self-care or domestic assessment may be triggered by the various items on the screen. After the screen, then the assessment of the domains of self care (generally inside) and domestic (a mixture of inside/outside and getting around) should be triggered.

In the above example, a self-care assessment may not actually be suggested by the screen, but a follow-up on domestic function might be. We assume that assessment staff will use both tools in the next level of the assessment process after the screen.

On the FP form the need for a rail outside could be picked up under self-care (in Q9 on stairs). Having an internal stair rail in place means independent inside but its absence outside implies the person needs help (score 1). The consumer's score on the self-care items might then trigger (in routine practice, but not on our form because it is beyond the scope of functional dependency screening as defined in this project) an environmental assessment or OT visit to assess hazards.

Q: Getting around and out and about - transport, shopping and mobility are pretty much all getting at the one thing, so why measure them all?

These items were selected because people tend to loose their ability to do them at different times (and in a consistent order). The ability to shop is generally lost first, followed by transport and then indoor mobility. Knowing where a person sits on this continuum is important. Remember the domestic function items are more for 'out and about' and ask for a rating on shopping independently of transportation, which is covered under item 6. Meanwhile, the self-care items are more about getting around in a familiar environment.

The screen is designed to give reliable indicators for both mobility and basic self-care tasks and some pointers to cognition. Remember that Part Two of the screen isn't used directly with the consumer. It specifically asks an informant about the consumer's thinking and behaviour.

Q: Finances and Medication - not necessarily a cognitive link. The screen is designed to use money and medications as pointers to cognitive function, but this may confuse the situation where someone is cognitively capable of handling their money and pills, but physically incapable (because of blindness or arthritis for example). What should be done here?

In this case the screen score on items 4 & 5 would be: 1 = with some help; or 0 = completely unable. As noted on the form, this would not trigger a cognitive assessment unless you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items. It is likely the person might

also score 1 or 0 on mobility or shopping items, which would trigger the self-care and/or domestic assessment.

Q: Disability without incapacity - what about someone who is partially blind with practical aids in place, like informal financial arrangements or a Webster pack?

They should score 2 on items 4 & 5 on the screen = without help, because they have the functional capability, and the screen tool would treat them in the same way as someone with a lesser level of disability who uses glasses and large digit phones and clocks.

Q; What about someone who is legally blind but uses a magnifying glass and is not neglectful? They may be able to use a Webster pack, and that is an obvious preventive intervention to suggest as part of a care plan. How do they score?

This person would score 2 = without help, on the screening item 4. This is because we want to score the consumer's present function, not a future likelihood or a "what if" scenario, nor even a direct service need. Although they are closely linked in routine practice, we are not scoring the person's need for an intervention, only their level of functional dependency (with their current aids and appliances).

It might be that on a re-screening in six months time the score would be 1 = with some help, or it might be that a domestic assessment now would indicate trouble in other areas like getting around or difficulties in the consumer conducting their business unaided when out and about.

Q; My client varies a lot in his functional ability. Some days he can do a task, but the next day he can't. I have another client who can do domestic tasks but the next day she is in such pain that she can't get out of bed. How do I rate them?

In both cases, rate the client at their worst in the last month. If a person cannot do a task without it resulting in significant pain and fatigue such as you describe, rate as a 0 (cannot do).

13 Selected Bibliography for Screening in Primary Care

Introduction

Andrews G and Slade T (2001) Interpreting scores on the Kessler Psychological Distress Scale (K10*). Australian Journal of Public Health* 25, 6: 494-497.

Brody, K. K., Johnson, R. E., and Ried, L. D. (1997). Evaluation of a self-report screening instrument to predict frailty outcomes in aging populations. *Gerontologist*, 37(2), 182-191.

Byles, J. E. (2000). A thorough going over: evidence for health assessment for older persons. *Australian and New Zealand Journal of Public Health*, 24(2), 117-123.

Collin, C., Wade, D., Davies, S., and Horne, V. (1988). The Barthel ADL Index: a reliability study. *International Disability Studies*, 10, 61-3.

Eagar K and Woods K (1999) *Client assessment - the starting point for coordinating care*. Chapter 3 in Department of Health and Aged Care, The Australian Coordinated Care Trials: Methodological issues in trial design and evaluation. ISBN 0642393834

Fleming, K., Evans, J., Weber, D., and Chutka, D. (1995). Practical functional assessment of elderly persons: A primary care approach. *Mayo Clinic Proceedings*, 70(9), 890-910.

Green L. W, and Kreuter M W (1991*) Health Promotion Planning: An educational and environmental approach.* Mayfield Publishing Mountain View, California.

Katz, S., Ford, A., Moskowitz, R., and al, e. (1963). Studies of illness in the aged. The index of ADL: a standardised measure of biological and psychosocial function. *JAMA*, 185, 914-919.

Katz, S. (1983). Assessing self-maintenance: activities of daily living, mobility, and instrumental activities of daily living. *Journal of the American Geriatrics Society*, 3(12), 721-727.

Lawton, M., and Brody, E. (1969). Assessment of Older people: Self-Maintaining and Instrumental Activities of Daily Living. *Gerontologist*, 9, 180.

Mahoney, F., and Barthel, D. (1965). Functional evaluation: the Barthel Index. *Maryland State Medical Journal*, 14, 41-43.

McDowell, I., and Newell, C. (1996). *Measuring Health. A guide to rating scales and questionnaires*, Oxford University Press, New York.

Pfeffer, R. I. (1982). Measurement of functional activities in older adults in the community. *Journal of Gerontology*, 37, 323-329.

Stuck, A. E., Walthert, J. M., Nikolaus, T., Bula, C. J., Hohmann, C., and Beck, J. C. (1999). Risk factors for functional status decline in community-living elderly people: a systematic literature review. *Social Science and Medicine*, 48, 445-469.

Wade, D., and Collin, C. (1988). The Barthel Index: a standard measure of physical disability?"*International Disability Studies*, 10, 64-67.

Design of screening instruments

Barer, D., and Murphy, J. (1993). Scaling the Barthel: a 10 point hierarchical version of the activities of daily living index for use with stroke patients. *Clinical Rehabilitation*, 7(4), 271-217.

Booth M, Owen N, Bauman A, Gore C (1996). Retest Reliability of recall measures of leisure time physical activity in Australian adults. *Int. Jnl Epidemiology*, 25:153-159.

Booth M, Owen N, Bauman A, Gore C (1996). Relationship between a 14-day recall measure of leisure time physical activity and a sub-maximal test of physical work capacity in a population sample of Australian adults. *Research Quarterly in Exercise and Sport*, 67:2:221-227.

Commonwealth Department of Human Services and Health, Aged and Community Care Division. The Efficiency and Effectiveness Review of the Home and Community Care Program, 1995.

Department of Health and Aged Care (1999) *The Australian Coordinated Care Trials: Methodological issues in trial design and evaluation*. ISBN 0642 39383 4 www.health.gov.au/hsdd/cocare/pdf/cctbook2.pdf

Department of Health and Aged Care (2001) *The Australian Coordinated Care Trials: Reflections and Lessons*. ISBN 0642 44754 4

Donald, I. (1997) Development of a modified Winchester Disability Scale - the elderly at risk rating scale. *Journal of Epidemiology and Community Health*, 51, 558-563.

Duke University Center for the Study of Ageing and Human Development. (2000). OARS: The Method and its Uses. Duke University Center for the Study of Ageing and Human Development.

Duke University Center for the Study of Ageing and Human Development (1978). *Multidimensional functional assessment: the OARS methodology. A Manual*., Duke University Center for the study of ageing and Human Development, Durham, North Carolina.

Dunlop, D. D., Hughes, S. L., and Manheim, L. M. (1997). Disability in activities of daily living: patterns of change and a hierarchy of disability. *American Journal of Public Health*, 87(3), 378-383.

Eagar, K., Owen, A., Green, J., Cromwell, D., Poulos, R., Gordon, R., Quinsey, K., Adamson, L., and D, F. (2001). *A National Measure of Functional Dependency for Home and Community Care Services in Australia: Stage 2 Report of the HACC dependency data items project.* Centre for Health Service Development, University of Wollongong., Wollongong.

Fillenbaum, G. (1985). A brief Instrumental Activities of Daily Living. *Journal of the American Geriatrics Society*, 33(10), 698-706.

Fillenbaum, G. (2000). Use of the OARS. Duke University.

Folstein, M. F., Folstein, S. E., and McHugh, P. R. (1975). 'Mini-Mental State': a practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12, 189-198.

Granger, C. V., Hamilton, B. B., and Shewin, F. (1986). *Guide for use of the uniform data set for medical rehabilitation*, Buffalo General Hospital, New York.

HMO workgroup on Care Management. (1996). Identifying high-risk Medicare HMO members: a report from the HMO Workgroup on Care Management. The American Association of Health Plans, Washington DC.

HMO workgroup on Care Management. (2000). Risk screening Medicare members revisited: a report from the HMO Workgroup on Care Management. AAHP Foundation, Washington DC.

Hoeymans, N., Feskens, E. J. M., van den Bos, G. A. M., and Kromhout, D. (1996). Measuring functional status: cross-sectional and longitudinal associations between performance and self-report (Zutphen Elderly Study 1990-1993). *Journal of Clinical Epidemiology*, 49(10), 1103-1110.

Juva, K., Makela, M., Erkinjuntti, T., Sulkava, R., Ylikoski, R., Valvanne, J., and Tilvis, R. (1997). Functional assessment scales in detecting dementia. *Age and Ageing*, 26(5), 393-400.

Maly, R. C., Hirsch, S. H., and Reuben, D. B. (1997). The importance of simple instruments in detecting geriatric conditions and selecting community-dwelling older persons for geriatric assessment. *Age and Ageing*, 26, 223-231.

Mathers, C. D., Vos, E. T., Stevenson, C. E., and Begg, S. J. (2000). The Australian Burden of Disease Study: measuring the loss of health from disease, injuries and risk factors. *Medical Journal of Australia*, 172, 592-596.

McCallum J, Shadbolt, B., and Wang, D. (1994). Self-rated health and survival: a 7-year follow-up study of Australian elderly. *American Journal of Public Health*, 84, 1100-5.

NSW Health (1996). *Physical activity and health. A special Communication from the Chief Health Officer*, State Health Publication.

NSW Health, Public Health Division. (2000). *New South Wales Older Peoples Health Survey 1999*, NSW Health Department, Sydney.

Noundahl, D. M., Cruikshanks, K. J., Wiley, T. E., Tweed, T. S., and Klein, B. E. K. (1997). Accuracy of self-reported hearing loss. *Audiology*, 37, 295-301.

Owen A, Poulos R and Eagar K (2001) *Using the evidence to develop best practice models for identifying initial primary and community care needs.* Centre for Health Service Development, University of Wollongong

Parkerson, G., Gehlbach, S., and Wagner, E. (1981). The Duke-UNC Health Profile: an adult health status instrument for primary care. *Medical Care*, 19, 806-828.

Pate R, Pratt, M., Blair, S., Haskell, W., Macera, C., Bouchard, C., and al, e. (1995). Physical activity and public health: A recommendation from the Centers for Disease Control and Prevention and the American College of Sports Medicine. *Journal of the American Medical Association*, 273(5), 402-407.

Philp, I. (1997). Can a medical and social assessment be combined? *Journal of the Royal Society of Medicine,* 90(Suppl 32), 11-13.

Poulos, R. (1999). An analytic review of community service utilisation among frail and disabled older people, Unpublished thesis, Macquarie University, Sydney.

RACGP (2000). Standards and guidelines for the Enhanced Primary Care MBS items: Health Assessment. Royal Australian College of General Practitioners, Melbourne.

Sahyoun, N. R. (1999). Usefulness of Nutrition Screening of the Elderly. *Nutrition in Clinical Care*, 2(3), 155-163.

Shinar, D., Gross, C., Bronstein, K., et al. (1987). Reliability of Activities of daily living and its use in telephone interview. *Arch Phys Med Rehabil*, 68, 723 - 728.

Spector, W., Katz, S., Murphy, J., and Fulton, J. (1987). The hierarchical relationship between activities of daily living and instrumental activities of daily living. *Journal of Chronic Diseases*, 40(6), 481-489.

Streiner, D.L. and Norman G.R. (1995) *Health Measurement Scales. A practical guide to their development and use*. Second Edition. Oxford University Press. See explanation of sensitivity and specificity on p 99.

Stuck et al. (1999) Risk factors for functional status decline in community-living elderly people: a systematic literature review. *Social Science and Medicine*, 48, 445-469.

Thomas, V. S., Rockwood, K., and McDowell, I. (1998). Multidimensionality in Instrumental and Basic Activities of Daily Living. *Journal of Clinical Epidemiology*, 51(4), 315-321.

Ware, J., and Sherbourne, C. (1992). The MOS 36-item Short Form Health Survey (SF-36) I. Conceptual framework and item selection. *Medical Care*, 30, 473-483.

Ware, J., Snow, K., and Kosinski, M. (1993, 2000). *SF-36 Health Survey: Manual and Interpretation Guide*, Quality Metric Incorporated, Lincoln, Rhode Island.

Wilkin, D., Hallam, L., and Doggett, M.-A. (1992). *Measures of need and outcome in primary care*, Oxford University Press, Oxford

Field testing instruments and the analysis of results

Cromwell, D (2001). Evaluating Dependency Data Items: Making sense of the field testing . Paper prepared for HACC Dependency Data Items Project. Centre for Health Service Development, University of Wollongong (available on request)

Eagar K, Owen A, Perkins D, Adamson L, Quinsey K, Harvey R and Green J (2000) *Client Experiences in the Care Net Trial. Report 5 of the Final Evaluation of the Care Net Illawarra Coordinated Care Trial.* Centre for Health Service Development, University of Wollongong. ISBN 0 86418 635 5

Feinstein, A., Josephy, B., and Wells, C. (1986). Scientific and clinical problems in indexes of functional disability. *Annals of Internal Medicine*, 105, 413-420.

Hanley J, (2001) Validity study of the severity index, a simple measure of urinary incontinence in women. *BMJ* 2001; 322:1096-1097 (5 May).

Harvey R, Eagar K, Perkins D, Owen A, Sansoni J, Adamson L (2000) National Evaluation Framework for the Sharing Health Care Initiative. Centre for Health Service Development, University of Wollongong.

Last, J. M. (1995). *A Dictionary of Epidemiology*, Oxford University Press, New York.

Maly, R. C., Hirsh, S. H., and Reuben, D. B. (1997). The performance of simple instruments in detecting geriatric conditions and selecting community-dwelling older people for geriatric assessment. *Age and Ageing*, 26, 223-231.

McHorney, C. A., and Cohen, A. S. (2000). "Equating health status measures with item response theory." *Medical Care*, 38,9 (suppl II), II-43 - II-59.

Morris, J. N., Fries, B. E., Steel, K., Ikegami, N., Bernabei, R., Carpenter, Iain, Gilgen, R., Hirdes, J., and Topinkova, E. (1997). Comprehensive clinical assessment in community setting: Applicability of the MDS-HC. *Journal of the American Geriatrics Society*, 45, 1017-1024.

Øvretveit J (1998) Evaluating Health Interventions. Chapter 9. Planning and Managing an Evaluation. Open University Press 1998.

Shah, S., Vanclay, F., and Cooper, B. (1989). "Improving the sensitivity of the Barthel Index for stroke rehabilitation." *Journal of Clinical Epidemiology*, 42, 489-497.

Swerissen H, Macmillan J and Weeks A (2002) *PCP Initial Needs Identification & Care Planning Tools Template Development Evaluation Report*. Australian Institute for Primary Care, La Trobe University Melbourne

Discussion of implications and a way forward

Cromwell D, Eagar K and Poulos R (2002) Screening for cognitive impairment using instrumental activities of daily living in elderly community residents: a cross-sectional study. Submitted for publication Journal of Clinical Epidemiology

Eagar K, Garrett P and Lin V (2001) *Health Planning: an Australian perspective*. Allen and Unwin, Sydney.

Eagar K, Green J and Adamson L (2002) *Clinical, functional and social assessment as a predictor of costs and outcomes*. In The Australian Coordinated Care Trials: Recollections of an Evaluation, Commonwealth Department of Health and Aged Care: Canberra. ISBN: 0642503079

Lincoln Geronotology Centre (1988). National Framework for Comprehensive Assessment - Aged and Community Care Service Development and Evaluation Report No. 34, March,1998

Perkins D & Owen A (2000) *Controlled trials of service systems - what can we control and what variation can we measure?* Conference Proceedings, Health Outcomes for the Nation: Best Bets and Best Buys, Australian Health Outcomes Conference, Canberra, August 2000, ISBN 0957776713

Eagar K, Owen A (1999) *Developing a Classification of Community Care and Support Services' Consumers in NSW*. Centre for Health Service Development, University of Wollongong.

Eagar K and Owen A. *An Evolving Approach to Client-Based Classification and Performance Indicators in Community Health and Community Care*. Centre for Health Service Development, University of Wollongong. September 1998.

Gordon, R (2000) *Development of a Minimum Data Set for Multi Purpose Services: Flexible Rural Health Services Program*. Centre for Health Service Development, University of Wollongong.

Graham C, Coombs T, Buckingham B, Eagar K, Trauer T, and Callaly T (2001) *The Victorian Mental Health Outcomes Measurement Strategy: Consumer Perspectives on Future Directions for Outcome Self-Assessment. Report of the Consumer Consultation Project*. Department of Human Services, Victoria.

Hindle D. Classifying the care needs and services received by HACC clients. A Review of the Options. Aged and Community Care Service Development and Evaluation Reports, April 1998, No.33.

Lewin G. and Eagar K (1996) *Community Care Classification - what does it offer? A discussion paper for the Home and Community Care Program.* Commonwealth Department of Health and Family Services, Canberra.

Swerissen H, Macmillan J and Weeks A (2002) *PCP Initial Needs Identification & Care Planning Tools Template Development Evaluation Report*. Australian Institute for Primary Care, La Trobe University Melbourne

Wollongong City Council (2001). Final report of the Integrated Community Transport Coordination Planning Project, May 2001. Discussion Paper 1: Health Related Assisted Transport Classification Framework, April 2001. solsen@wollongong.nsw.gov.au

Paper versions of the INI Tools

ERA Initial Contact Information CONTACT DETAILS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

or affix label here

CONSUMER DETAILS

Title (please circle) Mr Mrs Ms Other _____

Family Name: _____

Given Names: _____

Preferred Name/s: _____

Date of birth *dd/mm/yyyy* _____ / _____ / _____

Sex (please circle) 1. Male 2. Female

CONTACT DETAILS

Usual Address

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Postal Address (if different from usual address)

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Contact phone number/s (tick preferred number)	Can leave message? Y or N
Home	
Work	
Mobile	
Fax	
Email address	

Comments (including contact address for home visits if different from usual address, directions etc or any other contact issues)

WHO THE AGENCY CAN CONTACT IF NECESSARY

(eg, case manager, next of kin, carer, guardian, friend, emergency contact)

Person 1 Name

Contact details

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone: _____

Relationship to client

Person 2 Name

Contact details

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone: _____

Relationship to client

GENERAL PRACTITIONER (IF NO GP, WRITE NA)

Name

Address

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone:

Fax:

Email:

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new ICI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Contact Information CONTACT DETAILS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

or affix label here

CONSUMER DETAILS

Title (please circle) Mr Mrs Ms Other _____

Family Name: _____

Given Names: _____

Preferred Name/s: _____

Date of birth *dd/mm/yyyy* _____ / _____ / _____

Sex (please circle) 1. Male 2. Female

CONTACT DETAILS

Usual Address

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Postal Address (if different from usual address)

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Contact phone number/s (tick preferred number)	Can leave message? Y or N
Home	
Work	
Mobile	
Fax	
Email address	

Comments (including contact address for home visits if different from usual address, directions etc or any other contact issues)

WHO THE AGENCY CAN CONTACT IF NECESSARY

(eg, case manager, next of kin, carer, guardian, friend, emergency contact)

Person 1 Name

Contact details

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone: _____

Relationship to client

Person 2 Name

Contact details

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone: _____

Relationship to client

GENERAL PRACTITIONER (IF NO GP, WRITE NA)

Name

Address

_____(number) _____(street)

_____(suburb/locality) _____(postcode)

Phone:

Fax:

Email:

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new ICI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Contact Information
SERVICE ENTRY DATA SET

If information not applicable or not known, record 99

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

SERVICE ENTRY DATA SET

Source of Referral
Record: (1) Self.
(2) Family, significant other, friend.
(3) GP/medical practitioner – community based.
(4) Specialist aged or disability assess team/service (eg. ACAT).
(5) Comprehensive HACC assessment authority
(6) Community nursing service.
(7) Hospital (public).
(8) Psychiatric/mental health service or facility.
(9) Extended care/rehabilitation facility.
(10) Palliative care facility/hospice.
(11) Government residential aged care facility.
(12) Aboriginal health service.
(13) Carelink centre.
(14) Other community-based government medical/health service.
(15) Other government medical/health service.
(16) Other government community-based services agency.
(17) Hospital (private).
(18) Non government residential aged care facility.
(19) Other non government medical/health service.
(20) Other non government community-based service.
(21) Law enforcement agency.
(22) Other.

If not self-referred, has client given consent for referral? Y N

Source of Referral Contact Details (if relevant)

Country of Birth
Record: (1) Australia. (2) Other.

If other, specify _____

Indigenous Status
Record: (1) Aboriginal but not Torres Strait Islander Origin.
(2) Torres Strait Islander but not Aboriginal Origin.
(3) Both Aboriginal and Torres Strait islander Origin.
(4) Neither Aboriginal nor Torres Strait Islander Origin. (9) Not stated.

Main Language Spoken at Home
Record: (1) English. (2) Other.

If other, specify _____

Interpreter Required
Record: (1) Interpreter not needed. (2) Interpreter needed

Preferred language, (if not spoken English) including sign language, & any required communication devices or special interpreter needs

Government Pensioner/Benefit Status
Record: (1) Aged Pension
(2) Veterans' Affairs Pension (complete details below)
(3) Disability Support Pension
(4) Carer Payment (pension)
(5) Unemployment related benefits
(6) Other gov pension or benefit
(7) No gov pension or benefit

Pension/Benefit Card Number

Medicare Number

Health Care Card Number

DVA Card Status
Record: (1) No DVA Card
(2) Yes – Gold Card
(3) Yes – White Card
(4) Yes - Other DVA Card

DVA Card Number

Insurance Status
Tick all that apply:

(1)	None	
(2)	Private health insurance - basic cover only	
(3)	Private health insurance - including extras cover	
(4)	Private health insurance - extras cover only	
(5)	Motor vehicle accident insurance	
(6)	Workers compensation	
(7)	Other 3rd party	
(8)	Ambulance fund	

Health Insurer Name and Card Number

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new ICI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification
INI SUMMARY & ACTION PLAN

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

WHY THE CONSUMER IS SEEKING SERVICES

Description of problem or issue as identified by the consumer or referring agency		Action required
1		
2		
3		
4		
Description of other issues as identified by the consumer or in the ongoing needs identification process		
1		
2		
3		

ACTION REQUIRED: Code

(1) Service provision – see Initial Action Plan
(2) Specialist assessment
(3) Comprehensive assessment
(4) Nil: Consumer ineligible for service.
(5) Nil: Referred elsewhere.
(6) Nil: Advise/information provided. No further action required.
(7) Nil: Consumer declines further referral or service.
(8) Nil: Consumer issue resolved. No further action required.
(9) Nil: Requested service not available.
(10) Nil: Requested service not accessible (eg, due to long waiting time, inaccessible location).

CONSUMER PERMISSION TO PROCEED

Yes No

If yes, proceed to next section. If no, finalise initial action plan on next page.

CURRENT SERVICES

Record services used in the last three months

Service	Record contact details or other information as appropriate

Consider all health and community services, including (but not limited to) Alternate Therapists, Aged Care, Alcohol and drug, Community health, Counselling, Dental care, Disability, Emergency accommodation, Family planning, Home care, Hospital inpatient, Hospital outpatient, Hospital emergency, Maternal and child health, Medical (GP), Medical (specialist), Men's health, Mental health, Palliative care, Rehabilitation, Residential Aged Care, Respite care, Self help groups, Sexual health, Women's health, Youth services.

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification
INI SUMMARY & ACTION PLAN
If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

OTHER CONSUMER ISSUES

Issue/s	Tick if relevant	Consider completing:
If consumer requires HACC or HACC-like services	☐	Living Arrangements and Functional Profiles (mandatory)
Health – consider overall health, age-related problems, disabilities, use of medicines	☐	Profile of Health Conditions
Psychosocial – consider mental health and emotional well-being, personal and social supports, family and personal relationships	☐	Psychosocial Profile
Functional status and activities of daily living– consider overall health, age-related problems, disabilities	☐	Functional Profile
Health behaviours – consider lifestyle issues and opportunities for prevention and health promotion	☐	Health Behaviours
Determinants of health – consider living arrangements, housing, carer issues, work, financial, legal	☐	Living Arrangements Profile

After completing the relevant supplementary profiles, finalise the Initial Action Plan below.

INITIAL ACTION PLAN

Taking into account the reason/s that the consumer is seeking services and any other issues you and the consumer have subsequently identified, summarise the initial action required.

TO BE REFERRED TO:

Agency/health professional	For	Consumer Consent	Referral Method	Transport Method	Feedback required	Date

Agency/health professional: Complete in legible text. If you will be continuing to see the client, include yourself in the list of agencies/professionals for referral
For: Record purpose of referral in legible text
Consumer Consent: Record (1) Yes, consumer consents to referral and to sharing of information as specified on consumer consent form (2) Yes, consumer consents to referral but not to sharing of information (3) No, consumer has not consented to this referral
Referral method: Record (1) this form faxed to agency (2) letter (copy on file) (3) electronic (4) verbal request – face to face or phone call (5) other (incl. refer to self)
Transport Method: Record (1) Staff travel – service is delivered in home (2) Staff travel - client too unwell to travel (3) Staff travel – client has no transport (4) Client travel – own car (5) Client travel – family/friends (6) Client travel – public transport or taxi (7) Client travel – walk (8) Community transport (9) Ambulance (10) Hitchhike (11) None
Feedback required: Record (1) to initial referral agency (2) to GP (3) to agency completing INI (4) to carer/guardian (4) other
Date: Record date referral actually made. If no referral actually made, leave blank

Alerts (including any relevant comments on risk or urgency).

.

Office Use Only

Screener's Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification LIVING ARRANGEMENTS

If information not applicable or not known, record 99

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

Living arrangements
Record: (1) Lives alone (2) Lives with family (3) Lives with others

Comments on living arrangements, including family arrangements

Accommodation
Record: (1) Private residence – owned/purchasing (2) Private residence – private rental (3) Private residence – public rental (4) Private residence – mobile home (5) Independent living unit within a retirement village (6) Boarding house/private hotel (7) Short term crisis, emergency or transitional accommodation facility (8) Domestic-scale supported living facility (9) Supported accommodation facility (10) Residential aged care facility (11) Psychiatric / mental health community care facility (12) Public place/temporary shelter (13) Private residence rented from Aboriginal Community (14) Temporary shelter within an Aboriginal Community (19) Other (99) Not stated / inadequately described

Comments on accommodation

Employment Status
Record: (1) Employed/self employed (2) Sheltered (3) Child/Student (4) Home duties (5) Unemployed (6) Retired for age (7) Retired for disability (8) Other

Comments on employment

FINANCIAL AND LEGAL PROFILE

Mental Health Act status
Record (1) Voluntary (2) Involuntary (3) CTO (4) N/A

Other legal order (circle one)

Yes No

If yes, specify: _____

Decision-making responsibility
Record: (1) Self (2) Enduring POA (3) Guardian

Is the person capable of making their own decisions? (circle one)

Yes No Not sure

If 'not sure' or 'no', consider the need for assistance, need for cognitive assessment and the implications for consent.

Financial decisions
Record: (1) Self (2) POA (3) Administrator (4) Parent or Guardian

Cost of living decisions
Because of limited income, during the last month have you made any trade-offs among purchasing any of the following: prescribed medications, necessary medical care, adequate food, home care?

Yes No Not sure

If yes, discuss issues with consumer and consider need for counselling (eg, financial, gambling) and need for material support.

CARER PROFILE

Carer Availability
Record (1) Has a Carer (2) Has no Carer (3) Not Applicable – no carer required (4) Not Applicable – the consumer is the Carer

Carer Residency Status
Record (1) Yes – Co-resident Carer (2) No – Non-resident Carer (3) Not Applicable – the Consumer has no Carer

Relationship of Carer to Care Recipient
Record (1) Wife/female partner (2) Husband/male partner (3) Mother (4) Father (5) Daughter (6) Son (7) Daughter-in-law (8) Son-in-law (9) Other relative – female (10) Other relative – male (11) Friend/neighbour – female (12) Friend/neighbour – male

Current threats to carer arrangements
Tick all that apply

(1) Carer – emotional stress & strain		(4) Carer – factors unrelated to care situation	
(2) Carer – acute physical exhaustion/illness		(5) Consumer – increasing needs	
(3) Carer – slow physical health deterioration		(6) Consumer – other factors	

Are carer arrangements sustainable without additional services or support?

Record (1) No, have already broken down (2) Yes, but only weeks (3) Yes, months (4) Yes, years (5) Don't know

Comments on carer issues, including whether emergency arrangements are in place

If there are carer issues, complete a separate INI on the carer.

Comments

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification HEALTH CONDITIONS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

Overall health
In general, would you say your health is?

- Excellent ☐
- Very good ☐
- Good ☐
- Fair ☐
- Poor ☐

Consider Activities of Daily Living

How much bodily pain have you had during the past 4 weeks?

- None ☐
- Very Mild ☐
- Moderate ☐
- Severe ☐
- Very Severe ☐

Consider Activities of Daily Living

How much did your health interfere with your normal activities (outside and/or inside the home) during the past 4 weeks?

- Not at all ☐
- Slightly ☐
- Moderately ☐
- Quite a bit ☐

Consider Activities of Daily Living

Vision

Is your eyesight for reading (with your glasses)?

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Is your long distance eyesight (with your glasses)?

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Hearing
Is your hearing (with your hearing aid)?

- Excellent ☐
- Good ☐
- Fair ☐
- Poor ☐

Falls
Have you had a fall inside/outside the home in the past 6 months?

Yes ☐ No ☐

If yes, record number of falls _____

Consider both Activities of Daily Living and need for referral if the consumer has any problems with vision, hearing or falls.

Health conditions (include all issues eg, allergies, acute medical conditions, disabilities, continence, dental, developmental)

Condition	GP confirmed?	Condition	GP confirmed?
1		5	
2		6	
3		7	
4		8	

Current Medications – include prescriptions, over-the-counter and alternate products

1	5
2	6
3	7
4	8

Note: Polypharmacy may suggest a medication review is desirable

Comments

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification PSYCHOSOCIAL PROFILE

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Client Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

EMOTIONAL WELLBEING

In the past 4 weeks about how often did you feel…

K10 scale		Score
1	tired out for no good reason?	
2	nervous?	
3	so nervous that nothing could calm you down?	
4	hopeless?	
5	restless or fidgety?	
6	so restless you could not sit still?	
7	depressed?	
8	that everything was an effort?	
9	so sad that nothing could cheer you up?	
10	worthless?	

Score:

1	None of the time	4	Most of the time
2	A little of the time	5	All of the time
3	Some of the time		

Total K-10 Score: _____

Recommended action: refer for primary care mental health assessment if total score is 16-29 and for a specialist mental health assessment if score is 30 or more.

Have you had any difficulty sleeping? Y ☐ N ☐

Details:

PERSONAL AND SOCIAL SUPPORT

During the past 4 weeks…Was someone available to help you if you needed and wanted help? For example if you…

- felt very nervous, lonely or blue
- got sick and had to stay in bed
- needed someone to talk to
- needed help with daily chores
- needed help just taking care of yourself

Yes, as much as I wanted ☐

Yes, quite a bit ☐

Yes, some ☐

Yes, a little ☐

No, not at all ☐

Consider referral & Activities of Daily Living

Comment on personal and social support, including opportunities

FAMILY AND PERSONAL RELATIONSHIPS

Comments

DISABILITY

Is the person likely to be eligible for disability services (circle yes only if they clearly meet all of the criteria below)?

Yes No D/K

Eligibility criteria (tick)

Has a disability attributed to an intellectual disability or a sensory, physical or neurological impairment or brain injury	☐
The disability is permanent or likely to be permanent	☐
Substantially reduced capacity in self-care/management or mobility or communication or learning	☐
Need for continuing support	☐

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification FUNCTIONAL PROFILE

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

ACTIVITIES OF DAILY LIVING (FUNCTIONAL SCREEN)

Questions to ask the consumer (or the person who represents the consumer)[1].

I would like to ask you about some of the activities of daily living, things that we all need to do as part of our daily lives. I would like to know if you can do these activities without any help at all, or if you need some help to do them, or if you can't do them at all. The questions refer to how you are managing at the moment.

Item	Question	Score	Record score
1	**Can you do housework…**		
	Without help (can clean floors etc)?	2	
	With some help (can do light housework but need help with heavy housework)?	1	
	Or are you completely unable to do housework?	0	
2	**Can you get to places out of walking distance…**		
	Without help (can drive your own car, or travel alone on buses or taxis)?	2	
	With some help (need someone to help you or go with you when travelling)?	1	
	Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	0	
3	**Can you go out for shopping for groceries or clothes (assuming you have transportation)…**		
	Without help (taking care of all shopping needs yourself)?	2	
	With some help (need someone to go with you on all shopping trips)?	1	
	Or are you completely unable to do any shopping?	0	
4	**Can you take your own medicine…**		
	Without help (in the right doses at the right time)?	2	
	With some help (able to take medication if someone prepares it for you and/or reminds you to take it)?	1	
	Or are you completely unable to take your own medicines?	0	
5	**Can you handle your own money…**		
	Without help (write cheques, pay bills etc)?	2	
	With some help (manage day-to-day buying but need help with managing your chequebook and paying your bills)?	1	
	Or are you completely unable to handle money?	0	
Do not ask the following 2 questions if the client scored 2 on all of the above 5 items (ie, can do all 5 activities without help). Instead, for clients who scored 2 on all of the above items, record a 9 on each of the following 2 items to indicate that you did not ask the question.			
6	**Can you walk…**		
	Without help (except for a cane or similar)?	2	
	With some help from a person or with the use of a walker, or crutches etc	1	
	Or are you completely unable to walk?	0	
7	**Can you take a bath or shower…**		
	Without help?	2	
	With some help (eg, need help getting into or out of the bath)?	1	
	Or are you completely unable to bathe yourself?	0	

NOTES:

- If unanswered, score X.
- Rate what the person is **currently capable** of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 1). In rating an item that is irrelevant (for example, the person has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.
- Item 6 (walking). Clients who are in a wheelchair should be rated as (1) if they are independent including corners etc or (0) if they are not wheelchair independent.

1 Reproduced from the OARS/MFAQ. Copyright: the Center for the Study of Aging and Human Development, Duke University Medical Center, Durham, North Carolina. Used with permission. Questions 1, 6 and 7 have been modified.

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification FUNCTIONAL PROFILE

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

QUESTIONS FOR YOU TO COMPLETE

Complete the following based on all information available to you – your judgement based on interviewing or observing the client, information contained in a referral letter, consumer notes or information provided by a proxy respondent, such as a friend, relative, carer or referring agency.

Note that the consumer should not be directly asked to answer these questions.

Item	Question	Record score
8	Does the person have any memory problems or get confused?	
	No – score 2	
	Yes – score 0	
9	Does the person have behavioural problems for example, aggression, wandering or agitation?	
	No – score 2	
	Yes – score 0	

RECOMMENDED FUNCTIONAL ASSESSMENTS BASED ON THIS FUNCTIONAL SCREEN

Domestic
Look solely at items 1 to 5. Count the number of these items that scored 2 (ie, count the number of activities that the person can do without help). Refer for a domestic functional assessment if the person can do less than 3 activities without assistance – ie, the count is 2 or less (a count of 0, 1 or 2).

Self-care
Refer for a self-care functional assessment if the consumer SCORED LESS THAN 2 on either Item 6 (mobility) or Item 7 (bathing).

Cognition
Refer for a cognitive assessment if:

- the consumer scored LESS THAN 2 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
- the consumer scored 0 on Item 8.

Behaviour
Refer for a behavioural assessment if:

1. the consumer scored LESS THAN 2 on either Item 4 (medicine) or Item 5 (financial management) AND you have determined that the consumer has no physical disabilities or problems with English literacy that may account for the consumer not being independent on these items OR
2. the consumer scored 0 on Item 9.

Comments

AIDS AND EQUIPMENT CURRENTLY USED

Self-Care Aids ☐
Support and Mobility Aids ☐
Communication Aids ☐
Aids for Reading ☐
Medical Care Aids ☐
Car Modifications ☐
Other Goods/Equipment ☐
List:

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____

ERA Initial Needs Identification HEALTH BEHAVIOURS

If question is irrelevant or information not known, write Not Applicable or NA

Record Agency Assigned Consumer Identifier (initial contact agency)

__ __ __ __ __ __ __ __ __ __ __ __

or affix label here

Regular health checks

Yes ☐ No ☐

If yes, record last date or year _____

If yes, record health screens in last 2 years (eg, pap smear, breast, prostate)

Smoking

Never smoked ☐

Has quit smoking ☐

Currently smokes ☐

If quit, record when _____

Consider referral if currently a smoker

Alcohol

How often do you have a drink containing alcohol?

Never ☐ *If never, proceed to next section*

Monthly ☐

Once a week ☐

2-4 times per week ☐

5+ per week ☐

How many standard drinks do you have on a typical day when you are drinking?

_____

How often do you have more than 6 standard drinks on one occasion?

Never ☐

Monthly ☐

Once a week ☐

2-4 times per week ☐

5+ per week ☐

Consider referral if alcohol consumption is an issue

Nutrition

These questions may not apply to all (eg those with particular conditions or lifestyles). If a question has already been answered in a previous section, record a score based on the previous answer. Use the total score to decide whether action is required.

		Score
Do you have an illness or condition that made you change the kind and/or amount of food you eat?	*yes 2 no 0*	
Do you eat at least 3 meals per day?	*yes 0 no 3*	
Do you eat fruit or vegetables most days?	*yes 0 no 2*	
Do you eat dairy products most days?	*yes 0 no 2*	
Do you have 3 or more glasses of beer, wine or spirits almost every day?	*yes 3 no 0*	
Do you have 6-8 cups of fluids most days?	*yes 0 no 1*	
Do you have teeth, mouth or swallowing problems that make it hard to eat?	*yes 4 no 0*	
Do you always have enough money to buy food?	*yes 0 no 3*	
Do you eat alone most of the time?	*yes 2 no 0*	
Do you take 3 or more prescribed or over the counter medicines every day?	*yes 3 no 0*	
Without wanting to, have you lost or gained 5kg in the last 6 months?	*yes 2 no 0*	
Are you always able to shop, cook and/or feed yourself?	*yes 0 no 2*	
Total score		

Total score: 0-3 'good', 4-5 'moderate', 6-29 'high risk'. Note that these totals have only been validated for older people. Use your judgement for other age groups

Weight

Appearance

Underweight ☐

Average ☐

Overweight ☐

Consider referral to specialist / comprehensive service if significantly under or over weight

Physical Activity

Would you accumulate 30 minutes or more of moderate intensity physical activity on most days of the week?

Yes ☐ No ☐

Consider referral if 'no'.

Physical fitness

During the past 4 weeks…what was the hardest physical activity you could do for at least 2 minutes?

Very heavy (for example) run, fast pace; carry a heavy load upstairs or uphill (25 lbs, 10 kg) ☐

Heavy (eg) jog, slow pace; climb stairs or a hill at moderate pace ☐

Moderate (eg) walk, medium pace; carry a heavy load level ground (25 lbs, 10 kg) ☐

Light (eg) walk, medium pace; carry a light load on level ground (10 lbs, 5 kg) ☐

Very light (eg) walk, slow pace; wash dishes ☐

Consider both Activities of Daily Living and need for referral if response is 'light' or 'very light'.

Comments, including other relevant issues (eg, other substance use, safe sex practices, mens health issues) and opportunities for health promotion

Office Use Only Summarise issues & arising action on page 1 & 2 of the INI

Name_____ Designation/Agency_____

Sign_____ Date_____ Contact number_____

If information needs updating, indicate below and record updated information on a new INI

This information has been updated ☐ Date: _____

Name: _____ Sign: _____