

Primary Care Partnerships: Better Access to Services

Guideline 2: Completing the Summary and Referral Information step of Initial Needs Identification

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2. 1 Overview

2.1.1 About the Summary and Referral form

This is the second of four guidelines in the Initial Needs Identification (INI) tool suite. This second guideline is designed for those completing the Summary and Referral form as part of Initial Needs Identification. The Summary and Referral Information form (SRI pages 1 and 2) is required for all referrals and should be used for intake summary functions. Other practitioners may choose to use this template for initial needs identification and action planning, but are not required to do so.

2.1.2 Overview of the tool templates

This document is part of a set of four guidelines for completing the Initial Needs Identification (INI) tool templates. A complementary consumer consent template and guidelines have also been prepared. This is obviously part of a larger process that staff undertake in Initial Needs Identification, and it may prompt referral and/or further assessment, and lead on to provide information useful to complete a Service Coordination Plan using the template (form 4) described in Guideline 4.

Issues relating to assessment (service specific, specialist and comprehensive) are not included. To describe the scope of the activities covered by these tools, the following table is useful. The distinction between the INI and various types of assessment are summarised in this table. These distinctions essentially relate to the depth and breadth of the information sought from the consumer.

Table 1: A tiered screening and assessment model

Activity	Depth	Scope	Used for referral purposes?	Current status
INI:				
Consumer Information	Shallow	Narrow	Yes	Required
Summary and Referral Information	Shallow	Narrow	Yes	Required for all referrals and should be used for intake summary functions
Supplementary Profiles	Shallow	Broad	Yes, where relevant	Optional, to be used at discretion of the professional, except in the case of HACC referrals where the living arrangements and functional profiles should be used (both to make and receive a referral)
Assessment:				
Service specific*	Deep	Narrow	No	Out of scope
Specialist*	Deep	Narrow	No	Out of scope
Comprehensive*	Deep	Broad	Yes, where relevant	Out of scope
Care Plan*	Deep	Narrow	No	Out of scope
Service Coordination Plan	Deep	Broad	Yes, where relevant	Should be used with consumers with both multiple agency involvement and complex needs

* Indicates activity is not covered by the current suite of Service Coordination Project tools.

There are 4 guidelines in this series:

- Guideline 1: Completing Consumer Information as the first step in Initial Needs Identification
- Guideline 2: Completing the Summary and Referral Information step of Initial Needs Identification
- Guideline 3: Completing the Supplementary Profiles as part of Initial Needs Identification
- Guideline 4: Developing a Service Coordination Plan

This introduction and summary of key points is included in each section to make them mostly self-contained. Consent and information disclosure issues are dealt with separately.

Overview of the tools

The Initial Needs Identification tool templates consist of a core set of **Consumer Information** that contains items designed to collect demographic and social details about individual consumers. The **Summary and Referral Information** form is to record a summary of their problems/issues and outline an initial action plan. There is also a 1 page **Consumer Consent** form. The INI tool template also has 5 **supplementary profiles** that allow further information to be collected on those areas relevant to the consumers' circumstances and presenting problems. Not all profiles will be relevant for every consumer and, in some cases, some specific information within a profile will not be required. In these cases, simply record NA (not applicable) or code 99, depending on the instructions on the top of each page. The final form in the series is a **Service Coordination Plan** form.

Each PCP will need to develop its own protocol (who, what, when, how) for collecting and sharing information using the Initial Needs Identification tool template. It is likely that many of the items in the Contact Details component 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. The content and purpose of the different components are summarised in the following table:

Table 2: Purpose of the INI Forms

COMPONENT	PURPOSE	Pages
CONSUMER INFORMATION		
p.1	Demographic and social details of the consumer, contact person/s and GP, and how the information was obtained	CI p.1 of 2
p.2	Codes to record source of referral, other demographic information and benefits, entitlements and insurance status	CI p.2 of 2
SUMMARY AND REFERRAL INFORMATION		
p.1	Summary of presenting problems and a text box to record other relevant information.	SRI p.1 of 2
p.2	Describes current services used in last three months, and proposed initial action plan. Completed at the end using information from other profiles if appropriate	SRI p.2 of 2
SUPPLEMENTARY PROFILES		
LIVING ARRANGEMENTS	Codes and comments for living arrangements, legal, financial and employment, carer profile	LA 1 of 1
HEALTH CONDITIONS	Overall health, pain, vision hearing and falls, list of conditions and medications.	HC 1 of 1

COMPONENT	PURPOSE	Pages
PSYCHOSOCIAL PROFILE	Covers mental health, well being, social and family supports and disability criteria	PP 1 of 1
FUNCTIONAL PROFILE		
p.1	Functional screen for activities of daily living and self care	FP1 of 2
p.2	Screening questions for cognitive and behavioural problems, with prompts for further assessments	FP2 of 2
HEALTH BEHAVIOURS	Screen for risk factors, nutrition and physical activity, with prompts for further investigation	HB 1 of 1
DEVELOPING A SERVICE COORDINATION PLAN		
p.1	Key worker, review date, participants' list, evidence of assessment of need, case conference /date and information given to consumer.	SCP 1 of 2
p.2	Action plan for each goal including dates, action, review date, who is responsible.	SCP 2 of 2

The tools are designed so that the first 2 pages (the Consumer Information form) cover the core consumer information that should be collected on all consumers. The next form (2 pages) is for a summary of the action to be taken. The core INI thus consists of two forms over 4 pages and includes:

- **Consumer information** which information about the consumer, other agents and their GP and information with codes for categories to cover demographic details, benefits and entitlements, and insurance status. The Notes box at the top on page 2 has space for comments that can be used for information on risk and urgency.
- **Summary and referral information** to record why the consumer is seeking services, describe the problem or issue as identified by the consumer or referring agency, describe other issues as identified by the consumer or in the initial needs identification process, record current services, and record an initial action plan including listing the agency/health professional to receive the referral, the reason, whether consumer consent has been obtained, the referral method, whether feedback is required and the date.

The Summary and Referral form is informed by any relevant detail from the additional profiles that are used for the particular consumer or from the areas usually investigated by a particular agency or clinician. These are either used or left out depending on the consumer's presenting problems or as a result of any issues arising during the initial contact. As a result this page will usually be completed at the end and is used as a basis (in conjunction with subsequent assessments and care plans) for putting together the service coordination plan (if required).

The Summary and Referral form may be used in a duplicate fashion to cover multiple problems with differing levels of confidentiality requirements. It can be used if the information is sensitive and not to be shared, in which case the interviewer can complete a separate copy of page 2 for each issue. For example there may be 2 issues – seeing the dentist and getting referred to a sexual assault service – and it may not be relevant or necessary to share all information for both referrals.

The **supplementary profiles** are completed *only* if they are relevant to the client's presenting problems and needs and after the core information has been collected. The core information is recorded in the Consumer Information and Summary & Referral components. The assumption is that the next stages of referral, assessment or care planning, or service coordination, is a continuation of that process, and that the core consumer information will therefore already be available.

There are 5 supplementary profiles. The five supplementary forms cover profiles of living arrangements, health conditions, psychosocial factors, a functional screen and health behaviours. These are domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem. In some cases, there will be no need to complete any of these supplementary domains. However, for consumers with complex needs, contact workers may choose to use several forms to identify their initial needs.

COMPLETE ONLY THOSE PROFILES THAT ARE RELEVANT FOR THE CONSUMER

The profiles 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. The profiles are designed to be completed based on all sources of information available to the person completing them (observation, information contained in a referral letter, consumer notes or information provided to you by a carer or referring agency). Record NA for any issues that you have either not canvassed or that are inappropriate for the consumer unless otherwise instructed. The design of the set of profiles assumes that children and adolescents will be directly referred for a relevant assessment to be completed.

The profiles are not designed as a diagnostic tool, nor are they considered to be an assessment. They are tools to help determine the consumer's risk, eligibility, priority for service and health promotion opportunities as early in their contact with the service system as possible.

This set of optional domains has been chosen by combining evidence from the literature, a review of the range of forms currently in use, and consultations with the field on different draft versions of data collection tools. They can be used to further investigate the scope of the consumer's needs at the initial contact point.

The Living Arrangements and Functional Profile forms should be completed for all consumers requiring Home and Community Care (HACC) services. These two profiles contain HACC minimum data set (MDS) items and the collection of this information during the INI will mean that the information will not need to be collected at a later time. The remainder of the HACC MDS will be collected at the assessment stage.

The Service Coordination Plan template brings together all the different information that is useful for service coordination for those consumers that require this level of intervention. It covers the contact details of the key worker and other participants, a series of prompts for the collation or collection of evidence of consumer needs, a description of the consumer's problems/issues and associated goals, and the current required approach to consent and information disclosure as part of planning. The Service Coordination Plan is only completed for those consumers with both multiple agency involvement and complex needs.

Design issues common to all tools

Each page of every form has the same space at the top for an agency-assigned consumer identifier to be recorded and a space at the bottom for identifying the person and agency completing the tool template. There is also a box for recording at a later time that the information on the page has been superseded and has been updated. This allows the superseded information to be kept as a historical record in the file.

Information superseded

Each page has a box on the bottom to record if the consumer's situation has changed. If new issues or problems are identified after a page has been completed, the new issues should be recorded in 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 superseded. 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 consumer history and should be stored on the clinical record.

Using the tools

As you complete the templates, 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.

The design of the tool templates assumes that most of the supplementary information will not be relevant for children and adolescents. The core information, however, is likely to be relevant. A separate profile for this group is not included because it is assumed they will be referred directly for a more detailed assessment by an experienced agency or professional.

Background on the development of the tools

The selection of the content of the tool templates has been the result of a separate literature review that examined both international and Australian experience. For example, in developing a consumer assessment instrument for the National Long Term Care Demonstration¹, the factors considered important included physical health, mental health, ability to perform activities of daily living, social support and participation, financial and related resources, physical environment and living arrangements, and services.

In a review of published randomised controlled trials of health assessments for older people, Byles² noted the components most commonly included in health assessments. These included the following: height/weight, blood pressure, vision/hearing, teeth or oral examination, balance and gait testing, medications, activities of daily living, instrumental activities of daily living, functional status, medical problems, nutrition, alcohol, smoking, exercise, depression, cognition, social support, service use and home environment.

Detailed references for each item selected have not been included in the guidelines, however the rationale is contained in a separate literature review and a summary statement on the source of each item is included in the guidelines.

The design of the tools to be used at the entry point to services and initial needs identification involved a number of background assumptions:

- that service structures will vary according to the local setting and agency type;
- that the various intervention strategies will also vary according to local needs;
- nevertheless, that the data collected need to be consistent and conform with a number of technical and ethical requirements. As much as possible, information should be recorded in a way that allows for it to be subsequently computer coded;
- that, during the pilot, the INI should be designed for completion by staff. After the pilot, a consumer-completed version would be developed, with both then being available for use; and
- that each consumer will be assigned a unique record number at the initial contact agency, but this is not a common State-wide identifier.

The tools were developed based on a review of literature and current practice and then pilot testing was undertaken using draft tools in order to improve their usefulness. The tools developed in this process are regarded as Generation 1, with further developments and refinements being expected to occur over time.

¹ An initiative to improve care for functionally impaired adults, particularly the elderly. Consumer assessment and case management used to provide care to meets individual need and control long-term care expenditure.

² 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.

2.2 How to Complete the Summary and Referral Information

The Summary and Referral information is required for all referrals and should be used for intake summary functions. Other practitioners may choose to use this template for initial needs identification and action planning, but are not required to do so.

Why the consumer is seeking services and other relevant consumer issues

The items on this sheet cover a summary of the identified needs and an initial action plan. Most information on this page will be able to be completed at the end of the process.

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. A code set is provided to record the action required.

Any other issues (which may be unrelated to the reason for seeking services) should also be recorded here. These issues may be those identified by the consumer or may be those identified in the process of completing supplementary sections of the INI. This section is thus completed at the end of the INI process.

Other consumer issues

At this point it should be clear whether or not the consumer is likely to enter the service system for a simple service response (eg home maintenance service or food service without further complicating issues) or whether their presenting problem or profile of needs should be investigated further. If this is not the case or if the consumer does not wish to proceed, the action plan should be finalised at this point. Only if there is a need for further questions, the completion of supplementary profiles or recommendations for further assessments, should other consumer issues be explored.

This summary, along with any information from the supplementary sections can later be used to formulate an Initial Action Plan and, if necessary, to develop a consumer service coordination plan.

Notes and comments

The box on page SR1 of 2 can be used to record any notes, including information on current interventions, medications, social issues and other matters that may be relevant.

Current services

The top of page SR2 of 2 has a table to list current services. The prompts for services are listed alphabetically, including self-help, but are not comprehensive. Use the prompts to ask the consumer about the services they have used in the last 3 months. Use this box to record details of services used by the consumer in the last three months. The purpose of listing a set of current services being used (a utilisation profile) is twofold:

- ◆ First, the information will often suggest consumer problems and issues that have not been identified to this point. If so, consider whether other sections in the supplementary INI forms need to be completed.
- ◆ Second, current service utilisation will need to be taken into account in formulating an initial action plan and, if necessary, in developing a service coordination plan with the consumer.

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.

Initial Action Plan

This box summarises the initial action required – a list of referrals including recording whether the person completing the tool template will continue to see the consumer and the purpose of the referral.

A set of codes is used to record whether the consumer consents to the recommended referral and/or to sharing of information.

The method of referral and whether feedback on the referral is required are also coded here. The feedback column is of most relevance when this template is received by another agency and they can determine if the original referring agency, the agency completing the template, or the person's care-givers or GP require feedback.