

# Ongoing Needs Identification In Queensland Community Care: Why Use the Tier 1 Screening and Referral Tools - Evidence and Explanations

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## 1 Introduction

The Ongoing Needs Identification (ONI) suite of tools has been developed from projects in a range of jurisdictions, trials and pilots from 2000-2004. This manual is for the Queensland ONI Tier 1 screening tools but shares the same design logic and structure as its predecessors. It is a supplementary manual to *Ongoing Needs Identification in Queensland Community Care: How to use the Tier 1 Assessment and Referral Tools* (the 'How Manual'). The How Manual provides a detailed explanation on how to use each item and also includes a copy of the ONI Tools. The How Manual is designed for practical use in assisting screeners complete the tool. This 'Why Manual' necessarily covers some of the same material. But it adds to the How Manual by providing information on how the ONI tools were developed, why particular domains and items were selected and summarises the evidence-base on which the ONI was developed. It also has an extensive reference list. It is designed primarily for ONI trainers and for those wanting a more detailed explanation of why the ONI tools are being introduced or why particular items are included.

The work that has led to this explanatory material is based on previous research projects carried out by the Centre for Health Service Development at the University of Wollongong. These were:

- Development of assessment tools for use in the Illawarra Coordinated Care Trial (1997-2000)<sup>1</sup>
- Development of a national measure of function for HACC (2001-2002)<sup>2</sup>
- Development of Initial Needs Identification (INI) Tools for use in Primary Care Partnerships in Victoria (2001-2002)<sup>3, 4, 5, 6</sup>
- Refinement of the Victorian INI tools for use in South Australia in its ERA project (2003)<sup>7,8</sup>
- Development of Ongoing Needs Identification (ONI) Tools for use in the Mid North Coast Aboriginal Coordinated Care Trial (2002-2003)<sup>9</sup>
- Refinement of the ONI Tools for use in the NSW DADHC Comprehensive Assessment System Pilots (2003)<sup>10, 11</sup>
- Testing of the HACC functional tools with school leavers with disabilities as part of the NSW DADHC ATLAS Reform Strategy<sup>12</sup>
- Development of a service priority rating tool for NSW Home Care<sup>13</sup>, and
- Further refinement of the ONI Tools as part of the Queensland Health HACC Reform Strategy<sup>14, 15, 16</sup>.

### 1.1 Why screen?

There is growing evidence to suggest that current practices of need identification will be improved by the adoption of more standardised data items and formal processes for measuring function and other consumer characteristics. This evidence is based on research that has a long history in geriatric medicine and rehabilitation, and the domains of functional dependency and the best ways of measuring them are well understood in the literature.<sup>17</sup> More recent evidence suggests that valid and reliable serial functional assessments promote early intervention and proactive care planning, and in addition, they can indicate an individual's rate of decline and prognosis.<sup>18</sup>

There is substantial diversity in the health status and needs of consumers receiving support from services in community care programs. While some consumers would benefit from a comprehensive assessment, for others this would be an unnecessary burden and intrusion. Consequently, a two-stage (or multi-stage) problem identification and assessment system is required to ensure comprehensive assessments are performed only on consumers who are likely to benefit from them.<sup>19</sup>

The starting point in developing the ONI was the creation of a tool for screening for functional abilities that contains prompts to consider further assessments for the four domains of domestic, self-care (or basic activities of daily living), cognitive and behavioural function. Other ONI profiles contain recommendations for referral, further assessments and estimates of a number of risks, based on evidence that the data items are useful.

The Action Plan in the Core ONI is the starting point for referral or the development of care plans and service coordination. The forms can be used in the record so that the ONI contains an ongoing measure of an individual's decline or improvement in function, sensitive enough to identify changing needs over time, which will ultimately reflect in the consumer's priority rating. The ONI Priority Rating is one of the ways that the information collected can then be combined to assist decision making in response to the consumer's needs. Other ways that the standardised screening items are used are for prompts for referral, the informing of care plans and service coordination plans, and a report on the activities of various programs.

## **1.2 How we decided on the ONI tools and items**

As a first step, the literature was reviewed to ascertain which areas or domains of consumer health and well being should be assessed, concentrating on community and primary care assessment<sup>20</sup>. Having ascertained the relevant domains, the instruments in common usage in different States and Territories and elsewhere were identified, and the literature to support their use was reviewed.

A number of books on measuring health, notably McDowell and Newell (1986) and Wilken et al (1992) were used as the guide for the approach taken<sup>21, 22</sup>. The period since the review was originally carried out in 2001 has seen rapid progress in the field, but little evidence to suggest the conclusions drawn and the decisions taken on the domains and items should be questioned. The more recent literature reviewed emerges from the growth of evidence-based practice, and this remains the tradition within which the ONI tools were developed. In particular, there has been recent (2004) work on research and outcomes measures in health and human services<sup>23</sup> and a very useful glossary of evidence-based public health<sup>24</sup>.

The review was restricted to short scales or questions that may be regarded as screening instruments for initial and ongoing needs identification. Longer instruments, which may be regarded more as comprehensive assessment or diagnostic tools, were excluded from the review. These are suited to the specialist or comprehensive assessment phase, and are therefore outside the direct scope of the ONI, based on the two tier model.

The literature review identified the most valid and reliable ways to capture the dimensions of relevance to initial and ongoing needs identification. The review was used to examine why an item may be preferred and then the item was mapped against the array of existing screening and assessment forms. The literature was also used to identify items and instruments for any dimensions not currently included in existing data sets. For example, one of the tasks was to capture information on 'opportunities for health promotion'. No such set of items is captured in either the Home and Community Care (HACC) or by the Enhanced Primary Care (EPC) data items, so the literature is useful to identify an appropriate method of getting this information.

The items in the ONI do not form a minimum data set (MDS) in the sense that not all items need to be completed on all consumers. This does not rule out the ability of the ONI to meet the requirements of some MDS's, for example the HACC MDS.

The task of identifying a common set of initial and ongoing needs identification data items for a relatively broad set of applications across different types of providers is a complex technical task, but not an inherently difficult one if the scope is limited to tools that are valid and reliable.

### 1.3 Areas for screening

Broadening the approach from screening for function to include function within the relevant domains of need in the primary care sector as a whole was the logical next step in the sequence of studies that led up to the development of the ONI. The research behind this step was first carried out to support implementation for Victoria and involved a review of both the literature and current practice in this aspect of primary care<sup>25</sup>. Key points from this wider review are emphasised in the sections below.

Most of the tools reviewed related to screening people living in the community and they had a broader focus that included primary care services as well as function. Only a small number of examples are described here to illustrate the evidence and the thinking behind the ONI tools.

A paper by Fleming et al (1995) describes measures of physical and psychosocial function to detect problems and enhance the care of elderly persons from a review of pertinent articles and current standard textbooks of geriatric medicine<sup>26</sup>. Key areas for review include activities of daily living, mobility, cognitive function, vision, hearing, continence and nutrition. Screening for depression and alcoholism is also recommended and evaluation of the well being of the primary caregiver may be necessary for some elderly people.

The assessment of the personal functional status of older persons in the OARS Multi-dimensional Functional Assessment Questionnaire (OMFAQ) includes basic demographic data, social resources, economic resources, mental health, physical health, and activities of daily living. The second section of the instrument measures utilisation and perceived need for twenty-four non-overlapping services<sup>27</sup>.

In her review of published randomised controlled trials of health assessments for older people, Byles (2000) noted the components most commonly included in health assessments<sup>28</sup>. 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.

Maly et al (1997) evaluated the clinical performance of simple screening instruments in selecting older people for outpatient comprehensive geriatric assessment<sup>29</sup>. Screening measures for depression, urinary incontinence, falls and functional impairment were used, because these conditions have a prevalence in community based samples of 15 to 30%, are potentially treatable and are often overlooked by the medical profession.

One important article by Philp (1997) provided an example of a consensus based approach; a group of European experts in health and social care met a consensus conference sponsored by the WHO. The conference had the aim of agreeing on a standardised medical and social assessment<sup>30</sup>.

Another article referred to the development of a tool to meet new legislative requirements in the UK. The legislation introduced a compulsory annual health check for people aged over 75 by their GP<sup>31</sup>. Similar areas are covered in the Australian general practice assessments<sup>32</sup>.

The domains seen as important in these articles are outlined in the table below: They can be seen to cover the list of items relevant to the screening of people for dependency and/or obtaining information relevant to the delivery of care.

**Table 1: Common medical and social domains for screening**

European Union Consensus Conference (Philp 1997)	Legislative requirements for UK GPs (Donald 1997)	Australian GP assessments (RACGP 2000)
Perceived health and well-being, Individual needs, goals and satisfaction with care, Confusion, behaviour and depression Vision, reading, hearing and chewing Instrumental and personal activities of daily living, Housing finance and carer	Sensory function Mobility Mental condition Physical condition Continence Social environment Use of medicines.	<i>Must consider:</i> ADLs, physical function, falls within last 3 months, BP pulse rate and rhythm, continence, medication review, mood, cognition social function, support required, carer status, vaccinations.  <i>Should consider:</i> Multi-system review, fitness to drive, hearing and vision, oral health, diet and nutrition, foot care, sleep, risk factors, alcohol, smoking, home safety

These similar sets of domains highlight an important issue relevant to the role of screening tools. The included domains can be seen to extend beyond measures of functional status (activities of daily living (ADLs), mobility and instrumental ADLs). The limitation of only including measures of function in a screen is the apparent difficulty in linking these domains to a particular screening goal or to the screening instrument's role, which is usually broader than function alone.

The American Health Maintenance Organisation Workgroup on Care Management gave a preliminary list of items for inclusion in a screen where an important design consideration was whether or not there were effective interventions for the people being screened and identified as high risk<sup>33</sup>. This is an important consideration in ongoing needs identification because we are seeking to prompt further action at the assessment or referral level, and if no further action is likely to follow, we may be collecting information only for its own sake.

The items that were most relevant to practical interventions were again, only partially related to functional status and included:

- physical inactivity;
- depression;
- falls history;
- urinary incontinence;
- medications (poly-pharmacy);
- under-nutrition

Another reason that useful domains extend beyond measures of function is that there are important additional factors that are associated with functional decline. A systematic literature review by Stuck et al. (1999) reviewed 78 longitudinal studies published between 1985 and 1997 that reported statistical associations between risk-factors and subsequent functional decline in the elderly living in the community<sup>34</sup>. Although the usefulness of the review is limited because it did not consider which risk factors are potentially modifiable, it provided evidence linking functional status decline to a range of factors and domains. The strongest evidence for an increased risk was found for:

- disease burden (number of co-morbidities);
- increased or decreased body mass index;
- low level of physical activity;
- reduced observed lower extremity function;
- cognitive impairment;
- no alcohol consumption (compared to moderate consumption which is protective)
- low frequency of social contacts;
- poor self perceived health;
- smoking;
- poor self-reported vision;
- depression;

There was weaker evidence linking functional decline to high medication use and a history of multiple falls. But the authors noted that the lack of evidence for some other domains was not an indication of no association, as several domains had not been investigated adequately in the literature, notably nutritional status, social support and the physical environment.

#### **1.4 Screening linked to further assessment**

A large proportion of the literature on assessment within the community deals with the assessment of older persons, and there is substantial literature on the efficacy of geriatric assessment programs, in for example the review undertaken by Byles (2000). This was background research to the introduction of the Commonwealth's Enhanced Primary Care Program with its associated Medical Benefit Schedule assessment, case conferencing and care planning items<sup>35</sup>. There is a clear preference for multi-dimensional assessment, incorporating functional, social, disease, and environmental measures<sup>36</sup>.

There is an apparent bias in the assessment literature towards aged care, but this bias should be discounted somewhat given that a considerable number of consumers within community health and community care are older people. As a result, this literature is quite relevant and extensive. However, concerns will remain in the broader community care sector (including services for children and people with disabilities) because of the seemingly medical and aged care focus of many commonly used tools.

The Commonwealth's national framework for community care, based on Budget measures in 2004/2005, includes a tiered model, an intake assessment system and comprehensive assessment for complex needs using the nine Functional Profile items as the core component.<sup>37</sup>

In the tiered system the purpose of the ONI is to trigger one or more assessments or referrals. Ideally it should also have the ability to select out those people who do not need assessment. This corresponds with the technical approach used in developing most screening tests, where the indicators of interest are the screening test's sensitivity and specificity. The aim in designing the ONI was for it to be sensitive enough to identify those people who need help and specific enough to identify those people who do not require assistance. **Sensitivity** is the ability of a screening test to identify those that have particular characteristics and traits whilst **specificity** is the ability of a screening test to identify those who do not have these characteristics and traits thereby identifying those who would not benefit from intervention<sup>38</sup>.

These are two of a number of key concepts that have been used to guide the technical approach in designing the ONI. They help to resolve decisions like determining the preferred cut-off points in a priority rating system and working out what are the best triggers for further action. Further action includes plans informed by more investigation, in this case is usually further assessment, carried out at Tier 2. For more discussion of these technical issues see McDowell and Newell (1996) and Streiner and Norman (2003), and (Streiner 2004)<sup>39</sup>.

#### **1.5 A quick explanation and overview: What is the ONI screening tool?**

The ONI screening tool is designed to prompt timely and appropriate service delivery, referral and/or further assessment based on the issues and needs that are identified for each person. This tool is not just an eligibility screen and it is designed to be used in a range of primary health care programs and settings. The aim of screening is to differentiate between people who:

- Have no problems and need no services;
- Have minor problems (i.e., low need), need some services (eg, meals, home maintenance), but do not need a full comprehensive assessment;
- Have medium to high needs and require a full assessment.

This tool has been designed so that it can be undertaken via telephone or face to face interview. It also lends itself to being used more broadly, and as such can be used by a range of service providers to help them identify the needs of a range of population target groups. The ONI is designed for use in community services such as home support and nursing care, and can also be useful for discharge planners, GPs, aged care assessment and community health services.

## 1.6 The design of the ONI

### 1.6.1 Core ONI

The first 4 pages cover the core information that should be collected on all consumers to register them as a consumer. There is a summary of what information has been gathered, a summary of the functional profile, a check for the consumer's permission to proceed, a list of current services and an action plan that sets out the action to be taken. The Core ONI Profile on Page 3 of 4 also contains boxes for registering Alerts and noting the ONI Priority Rating category. The core ONI forms the basis of the consumer referral record and is used when referring a consumer to a service/agency, with consent.

### 1.6.2 Optional profiles and the ONI Priority Rating Tool

There are six optional profiles and a Priority Rating Tool that assigns a relative priority rating to each consumer. The *Functional Profile (Activities of Daily Living)*, *Carer Profile* and *Psychosocial Profile* are used to determine the priority rating for a consumer, along with any other problems identified. Two profiles (*Health Conditions* and *Health Behaviours*) cover domains that can be investigated at the discretion of the contact worker and depending on the nature of the consumer's problem. These also give information that helps complete the *Decision Tree Flow Chart* or *Matrix* option that can be used to determine a priority rating. The way you use the optional 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.

### 1.6.3 When to use the ONI

#### In Queensland, HACC service providers use this tool:

- When a potential consumer contacts a service provider to request a new service.
- When a carer, friend, or other person (eg another service provider) contacts a service provider to request a new service for a potential consumer.
- When an existing consumer contacts a service provider to change any current service or to request a new service.
- When a carer, friend, or other person (eg, another service provider) contacts a service provider to change a current service or request a new service for an existing consumer.
- On review.

The frequency of screening will depend on each agency's procedures and/or consumer situation.

There are multiple uses for the data items and they can be combined in different ways to prompt further action. For example the information collected by the suite of profiles contained in the ONI can be used to establish a consumer's priority rating category, and to describe situations where alerts may need to be raised.

The information can also be used to establish a care plan and is a sound basis to inform a multi-agency service coordination plan. The tools are designed for ongoing use. The ONI suite of tools described here is the latest in a series of versions and consists of standard items carried on from earlier versions and a number of useful refinements. These tools are summarised in the table below:

Name of Tool	Explanation and contents	When to use
Core ONI	Forms the basis of the consumer registration and referral record and includes: Consumer contact information; Consumer service entry data set; Why the consumer is seeking services; and Action plan.	Mandatory if you want to register a consumer or make a referral.
Functional Profile Activities of Daily Living (FP)	A Tier 1 functional screening tool; Identifies equipment &/or aids that the consumer may use; and Triggers Tier 2 functional assessments.	Mandatory for HACC services program reporting
Living Arrangements (LAP)	Identifies consumer's living arrangements, legal and financial management status.	Mandatory for HACC services if the HACC MDS Supplementary Items form is not completed
Carer Profile (CP)	Identifies carer arrangements, carer issues and the sustainability of carer arrangements.	Mandatory for HACC services if the HACC MDS Supplementary Items form is not completed
Health Conditions Profile (HC)	Identifies issues about the consumer's health and physical wellbeing that may trigger appropriate referral.	Optional profile – use depending on consumer request and needs.
Psychosocial Profile (PP)	Identifies issues about the consumer's social, emotional and mental health that may trigger and appropriate referral.	Optional profile
Health Behaviours Profile (HB)	Identifies consumer's lifestyle behaviours that may trigger issues for further investigation and appropriate referral.	Optional profile may help in formulating an action plan.
HACC MDS Supplementary Items (HS)	Identifies HACC MDS items if LAP & CP not completed.	Mandatory for HACC services if the LAP &/or CP are not completed
ONI Priority Rating Tool (OPR)	Includes options for establishing a consumer's priority rating based on the information gathered in the ONI Tools.	Optional tool at end combines need and risk items.

The ONI may result in the consumer being referred for a more in-depth assessment if required. However, it can also result in an action plan without the need for a more detailed assessment.

The prompts and combinations of items in the ONI screening tools allows service providers to decide whether a Tier 2 assessment is required, thereby conserving and better targeting resources. The aim is to prompt appropriate referral to other service providers and help in the identification of consumers with urgent needs. It is a decision support tool.

#### 1.6.4 Paper or electronic?

In designing the ONI and choosing the items and their format, the issue of compliance with various minimum data sets, and their correspondence with the National Health Data Dictionary (from Version 10 to Version 12) was taken into account. This is comparability is important because that is one factor in ensuring the items will work efficiently in an electronic environment. There are still significant issues arising from the non-comparability of data items, and those issues are within the responsibility and work program of the Australian Institute of Health and Welfare, which is the organisation supporting the national-level organisation of this type of information.<sup>40</sup>

In their present form the ONI tools are compatible with a paper and fax-based information system, and are also suitable to be adapted to an electronic information-sharing environment. This Manual is written on the assumption that the ONI is being completed on paper forms rather than electronically. This is because at the time of writing this Manual, most agencies are still not able to use the information in an electronic format. However, when the necessary support services and software are in place (and this is likely to vary by local area), the information can be handled electronically and the tools will be simpler to use.

### **1.6.5 Standardised items, multiple uses**

The ONI in its paper-based form is designed from the point of view of a system of providers receiving and sending summarised screening information between agencies. It also supports a general approach to planning and coordinating care and multiple service provision, as well as rating a consumer's priority for receiving a service. There are many other functions that the ONI shares with comparable systems, particularly in residential aged care<sup>41</sup>:

- Assessing and determining eligibility for services
- Contributing to care planning and management by clinicians
- Establishing a structure for allocating resources within an agency or organisation
- Providing a basis for provider reimbursement
- Developing a sound basis for quality indicators
- Assisting in determining who uses which services
- Matching services and settings for persons with various conditions
- Tracking frailty in individuals and specific populations over time
- Rationalising services and systems
- Contributing to the projection of need and attendant costs.

## 2. The Core ONI

The Core ONI contains 4 pages that include:

- Contact Information
- Service Entry Data Set
- Why the consumer is seeking services
- Action Plan

The contact details and other Core ONI items are designed for collection early in the process. Most of the individual items are designed to be compliant with the National Health Data Dictionary Version 12 (NHDD v12)<sup>42</sup>, and other national minimum data sets based on those data element definitions, where such definitions exist and where the item is useful for ongoing needs identification. However collecting the sum total of all relevant minimum data sets does not make for a workable system, and is not a sensible place to start if the aim is to design a “clinical” application, rather than a compliance-based and program-specific reporting system.

There are many overlaps, redundancies and data inconsistencies between the minimum data sets required for community care and health programs. And most important, the ONI is designed specifically *not* to collect all items on all consumers.

The function of the ONI is to provide a suite of tools to capture a wide view of an individual’s needs and risks, and to use the information as a decision-support tool in the service system. It is an ongoing record and also covers a range of programs and goals of care, from population health and primary care, through early detection for vulnerable groups and treatment and rehabilitation, to maintenance at home and palliative care.

The information collected is for the purpose of being shared and used by all service providers involved, and the Action Plan is meant to summarise the next steps, agreed to by the consumer, to address their needs.

This core data is the main data that will be shared between services. Core information infrequently changes, hence completion of this minimises the number of times this has to be collected and this should help rapport with the consumer. This design element in the ONI is similar to the Client Information and Referral Record (CIARR) which has been promoted for use in the Home and Community Care Program.<sup>43</sup>

### 2.1 Contact Information

The contact details are designed for collection at the point of first contact with the consumer or when a referral to a service is made. This information then allows for contact to be made between other service providers and the consumer.

The data items in the Contact Details sheet (Core ONI page 1 of 4) are shown in the following table. How they conform to the requirements of a number of minimum data sets and the NHDD v12 compliance is noted in the tables.

The data items in this section of the ONI were originally used in the Victorian INI and have been refined following field trials with independent evaluations in Victoria, South Australia, New South Wales and Queensland. Testing has been in terms of acceptability and burden, and to assess the training needs for implementation purposes.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	Medical records standards
CONSUMER DETAILS		
Title	Alphanumeric	Reviews of current practice and NHDD v12
Surname or Family Name	Alphanumeric	
Given Names	Alphanumeric	
Preferred Names	Alphanumeric	
Sex	Alphanumeric	
Date of Birth	Numeric	
Usual Address (for correspondence, home visits)	Alphanumeric	
Contact Address (if different from usual address)	Alphanumeric	
Contact Phone (tick preferred, leave message)	Numeric	
Work Phone, Mobile, Fax, E-mail	Numeric	
Comments	Box	
Who the agency can contact if necessary (case manager, next of kin, carer, guardian emergency contact)		
Person 1, contact details, relationship to consumer	Alphanumeric	
Person 2, contact details, relationship to consumer	Alphanumeric	
GP name and contact details	Alphanumeric	
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

To encourage consistency and in conformity with national and jurisdiction-specific requirements, the consumer details are made up of items as defined by the HACC Data Dictionary. The assumption is that these items would be transferable across settings and systems and be easily captured electronically. These items correspond with the requirements of minimum data collection for local area information systems.<sup>44</sup>

## 2.2 Service Entry Data Set

The use of standard codes helps data entry and means that the information can be used later for reporting. The data items selected come from a variety of different minimum data sets, not all of which are comparable.<sup>45</sup>

The data items in the Service Entry Data Set (core ONI page 2 of 4) are shown in the following table. They are sourced primarily from various minimum data sets. The data items in this section were originally used in the Victorian INI and have been refined following field trials in Victoria, South Australia, New South Wales and Queensland.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	
Source of Referral	Numeric	Items compliant with or mappable to
Consumer consent for referral (tick box)	Y/N	

ITEM	Data type	Source
Source of referral contact details (if not GP)	Box	NHDD v12
Country of birth	Numeric	
Indigenous status	Numeric	Items compliant with or mappable to NHDD v12
Main language spoken at home	Numeric	
Interpreter required	Numeric	
Preferred language (if not spoken English)	Alphanumeric	
Government Pensioner/Benefit Status	Numeric	
Government Pensioner/Benefit Card Number	Numeric	
Medicare Number	Numeric	
Health Care Card Number	Numeric	
DVA Card Status	Numeric	
DVA Number	Numeric	
Insurance Status	Numeric	
Health Insurer Name and Card Number	Alphanumeric	
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

This information has been designed to conform to the requirements for EPC items and the Department of Veterans Affairs (DVA), as well as HACC. No single set of data requirements or item formats is completely compatible with any other, so this format and content is seen as a workable compromise solution.

### 2.2.1 Indigenous Status

The consumer should be informed during the interview that the answer given or refusal to answer will not affect the consumer's access to services. The response to this question may prompt considerations of cultural sensitivity and requires an awareness of the range of services to which the consumer may have access. Visit [www.health.gov.au/oatsih](http://www.health.gov.au/oatsih) for more information. Although many in the Australian Indigenous population reside in rural or remote areas<sup>46</sup>, many do not, and cultural sensitivity should be a consideration for service providers in all settings.

### 2.2.2 Main Language Spoken at Home

This data element is important in identifying those people most likely to suffer disadvantage in terms of their ability to access services due to language and/or cultural difficulties. In conjunction with Indigenous status, Proficiency in spoken English and Country of birth, this data element forms the minimum core set of cultural and language indicators recommended by the Australian Bureau of Statistics (ABS).

Data on main language spoken at home are regarded as an indicator of 'active' ethnicity and also as useful for the study of inter-generational language retention. The availability of such data may help providers of health and community services to effectively target the geographic areas or population groups that need those services. It may be used for the investigation and development of language services such as interpreter/translation.<sup>47</sup>

If an electronic information system is in use, all responses can be coded to the Australian Standard Classification of Languages (for the ASCL see the Australian Bureau of Statistics<sup>48</sup>). But note this is not included on the paper-based version of the form.

### 2.2.3 Interpreter Required

Note that this is the consumer's self-assessed need for an interpreter, and may include a sign language interpreter.

### 2.2.4 Preferred Language

Do not assume that the main language spoken at home is the consumer's preferred language. For example, a young person in a non-English-speaking household may have English as their own preference. This item may also have relevance for younger people with a disability in terms of noting the use of augmentative communicative systems or hearing devices that may be relevant to record here.

### 2.2.5 Australian DVA Card Status

There are pensions and allowances to compensate and support veterans for injuries or conditions caused or aggravated by war service or certain defence service on behalf of Australia, as well as for eligible widows and widowers. The entitlements of veterans and their spouses are considerably greater than the general population and this should be considered in the context of referral to private service providers. If DVA entitlements and programs can be accessed directly by the consumer then referral to a wider set of service options can be considered. Phone 13 32 54 or visit [www.dva.gov.au](http://www.dva.gov.au) for more information.

### 2.2.6 Insurance Status

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.

## 2.3 Why the consumer is seeking services

This page is to record presenting problem/s and issues of relevance for the consumer. Most information on this page will be able to be completed at the end of the initial interview or contact process. The data items in this section of the ONI were originally developed for use in the Victorian INI and have been refined following field trials in Victoria, South Australia, New South Wales and Queensland.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	Medical records standards
Alerts box for risk, urgency etc	Alphanumeric	Victorian PCP tools and SA INI
Consumer's priority category	Alphanumeric	NSW Home Care, Qld Health
<b>WHY THE CONSUMER IS SEEKING SERVICES</b>		
Description of problem or issue	Alphanumeric	Victorian PCP tools and SA INI Reviews of current practice
Action required	Numeric	
Other issues	Alphanumeric	
Action required	Numeric	
Current services	Alphanumeric	

ITEM	Data type	Source
Name, agency, signature, date and contact number	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

### 2.3.1 Alert Box - Using the ONI to record risks and urgency

*The Alert box should be completed only after completing any relevant supplementary profiles.*

The Alert box can be used to make a note of risks and any matters of urgency that have arisen from using the ONI profiles. The Alert box is designed to record information that a new health professional seeing the consumer should be alerted to. It should capture information on potential risks to the consumer as well as potential risks to the health professional.

The information captured in the Alert box can be quite diverse. It can include information which is non-controversial (eg, consumer allergies; consumer has large dog known to bite visitors) but also information which may be highly sensitive (eg, domestic violence, consumer is physically aggressive, query child sexual assault etc). Use of the Alert box requires professional judgement, and should only be completed if there is a reason to do so.

Each agency will need to develop their own protocol to define whether or not the information in the Alert box or more detail is provided to other agencies and, if so, under what circumstances. It is generally accepted that consumer consent for information to be recorded in the Alert box is not required. Nor is consumer consent required to provide Alert information to another health professional or agency. Alerts that are classified as 'confirmed' should be specifically considered in developing a Care Plan for the consumer.

### 2.3.2 Consumer's priority rating

A consumer's service priority rating cannot be determined until the end of the ONI process. The information from items on a number of profiles is required to determine the consumer's ONI Priority Rating. An explanation of the model used is included in section 10.3 below.

The research behind the approach to determining a priority rating has involved selecting the most useful items by analysing large data sets to determine the best indicators of need and risk.<sup>49</sup>

### 2.3.3 Current services

Use this box to record details of services (both formal and/or informal) used by the consumer in the last three months or on a recurring basis. Because the sustainability of the carer arrangements is important in determining a priority rating, a full picture of the support network is helpful. If the relationship between carer and care recipient is weak, then a higher priority rating is likely to be given, as the care recipient will become vulnerable, should at any point the carer leave.

There are many non-standard lists of items for inclusion from existing forms. The list of service types under HACC forms one point of reference and there are many other examples. The key point is that it should be a list that makes sense for local referral purposes.

## 2.4 Action Plan

A person's eligibility for HACC, disability or other services is determined in this section. An opportunity to summarise the Functional Profile is also available to assist information transfer. The data items in this section of the ONI were originally developed for use in the Victorian INI and have been refined following field trials in Victoria, South Australia, New South Wales and Queensland.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	Medical records standards
HACC eligibility	Numeric Y/N	Qld Health
Reason for HACC consumer status	Numeric	HACC MDS
Disability Eligibility	Alphanumeric	Qld Health
Other eligibility	Alphanumeric	
Functional profile completed and attached	Tick box Y/N	
Functional profile summary scores and total	9 scores and total	
<b>ACTION PLAN</b>		
Agency/health professional	Alphanumeric	Victorian PCP tools and SA INI  Reviews of current practice and Qld Health consultations and field testing
Purpose of referral	Alphanumeric	
Consumer consent to proceed	Numeric	
Referral method	Numeric Y/N	
Transport method	Numeric	
Feedback required	Numeric	
Date	Alphanumeric	
Review date	Alphanumeric	
Referrals, disclosures and consents confirmed	Tick box Y/N	Medical record standard format
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

Completion of the Action Plan for a consumer should be based on services currently in place and issues/needs identified in the mandatory and additional profiles. This section therefore cannot be completed until all other relevant profiles are completed. Local agencies will also have their own versions of care plans and service-specific plans for taking this summarised screening information to the logical next stage of providing some planned assistance to the consumer.

Eligibility is based on the guidelines for the different programs including the HACC Program<sup>50</sup>, disability programs, DVA<sup>51</sup> and respite. Remember that special programs and eligibility criteria change from time to time.

The key points that a worker needs to be concerned about in recording consent are that it must be:

- **Informed**, that is the consumer understands what is being consented to and for what purpose: the worker must ensure that the consumer has been provided with adequate explanation of the need for the proposed disclosure of information;
- **Freely given**, that is, the consumer must be made aware that they have the right to refuse consent;
- **Specific**, that is consent must relate to the agencies specified in the Action Plan and to the uses and disclosures referred;
- **Current**, that is the consent must remain current and be reviewed on a regular basis. In practice this means that where a subsequent referral is being proposed then an updated consent form must be completed. In addition, a consumer can revoke their consent at any time.

### 3. Functional Profile (Activities of Daily Living)

A measure of functional dependency identifies key areas in which a person requires assistance with daily living and quantifies the extent to which the person has to rely on someone else to help them. The focus is on normal activities of living in the person's own home and in the community. In some cases, functional measures may also need to capture factors in the external environment such as accessibility to transport and the layout of the home.

The profile uses the tool developed for the Commonwealth's HACC Dependency Data Items Project, and is also referred to as the Functional Screen. A detailed review of the screen and its performance analysed in terms of sensitivity and specificity, is available elsewhere<sup>52</sup>. In pilot testing the screen was found to be acceptable to staff in terms of time and the burden on consumers. It required minimal training to administer and was suitable for self-report or the use of a proxy informant.

A separate manual called *Functional Screening and Assessment: How and Why*, covers the background concepts and what items might prompt further assessment in the functional domains of self-care and domestic assistance and behaviour and cognition. That manual contains more detailed references and forms for the recommended assessment tools. These are available on the Centre for Health Service Development website: [www.uow.edu.au/commerce/chsd](http://www.uow.edu.au/commerce/chsd).

The items and their source or evidence-base is shown in the following table:

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	Medical records standards
Functional screen	Scale scores	Eagar et al 2002
Housework	Scale score	Items based on the Duke University OARS/MFAQ modified for Australian primary care
Walking out and about	Scale score	
Shopping	Scale score	
Medicines	Scale score	
Money	Scale score	
Walking	Scale score	
Bathing	Scale score	
Cognition (asked of third party)	Scale score	
Behaviour (asked of third party)	Scale score	
Aids and equipment currently used	Tick boxes	
Comment box	Alphanumeric	
Screeener's name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

### **3.1 What is the Functional Profile?**

The Tier 1 Functional Profile is a short telephone or face-to-face administered questionnaire. It consists of nine carefully selected questions, which indicate client domestic, self-care, behaviour and cognitive functioning. The Tier 1 Functional Profile is evidence-based. The research literature demonstrates a hierarchical relationship between domestic and self-care tasks, with domestic tasks generally being lost before self-care tasks and this finding was confirmed in the national HACC field trial (Eagar et al 2001).<sup>53</sup> The literature also indicates that inability to carry out some domestic tasks may be an indicator of cognitive impairment.<sup>54</sup>

The Tier 1 Functional Profile 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 client who is independent in these tasks does not usually require a more detailed assessment of domestic or self-care tasks. Mobility and bathing are self-care tasks that are generally lost later than domestic abilities but earlier than self-tasks such as feeding or toilet use. A client who is independent in mobility and bathing does not generally require more detailed assessment of self-care tasks.

The first 3 items (housework, travel and shopping) are early loss Instrumental Activities Daily Living (IADL) items<sup>55</sup>. The next two IADL items (medication and money management) represent complex tasks and may act as markers of cognitive impairment.<sup>56</sup> The final task (bathing) is an early loss activity of daily living (ADL or self-care) task.

The structure of the scale is based on research that indicates that ADL and IADL activities form a hierarchical order, such that some activities are generally lost before others<sup>57</sup>. Consequently, if a consumer is screened on functions lost early and no dependency is identified, then further detailed assessment of function is likely to be unnecessary. The wording of the individual items is based on the Duke University OARS/MFAQ.<sup>58</sup>

### **3.2 Thresholds for Tier 2 Assessments**

The recommended thresholds to trigger Tier 2 functional assessments are included on the form. Additional work has been done by CHSD to determine the best mix of scores that prompt particular assessments, but this does not yet have sufficient agreement to warrant changing the current decision rules. It also makes sense to keep one approach and then change it later on the basis of sound evidence (ie looking at the relationships inside a large data set) and a measure of agreement at national level.

There are several policy issues relating to the question of determining the rate at which consumers might be referred for Tier 2 assessments. Thresholds may differ for particular agencies or service types depending on their policy about the preferred proportion of their clients that they can realistically send through to further assessment. The recommended self-care assessment (modified Barthel scale), domestic assessment (modified Lawton's scale), and the behavioural assessment (modified Residential Classification Scale sub-items for behaviour) are commonly used and appear to have few problems, but the question about the best Tier 2 cognitive screening tool is where most disagreement exists.

### **3.3 The Tier 2 Tools**

The aim of the Tier 2 Functional Assessment Tools is to measure the same four domains picked up by the Functional Profile, but using different and more detailed instruments. In the HACC assessment model, you only need to undertake a Tier 2 assessment of those domains suggested by the Screen.

Remember that this is solely a functional assessment and that is usually part of a more comprehensive assessment. HACC agencies will routinely need and use other important information. While some States and Territories have not moved towards introducing more standardised approaches to comprehensive assessment, some States are moving quite rapidly in this direction. The ONI is designed to allow functional assessment to be incorporated into a more comprehensive assessment model.

The four Tier 2 Functional Assessment measures recommended from the national HACC functional dependency study were chosen on the basis of considerations from reviewing the literature and after reviewing current Australian practice.<sup>59</sup> The actual tools to capture the data items have been designed and modified for use in community settings.

**Self-care** is measured by a version of the Barthel Index (the 20 point Collins scoring)<sup>60</sup>. The dimension is sometimes called motor function and it captures the characteristics of personal care and mobility, and was originally designed to reflect the level of nursing care required. It is most commonly used with chronic patients, long term hospital patients with conditions affecting their mobility, and is used to test patients before and after treatment. It is in common use in community settings. The structure of all questions is the same. Like the HACC Functional Profile and the other Functional Assessments, the higher the score, the more independent the person is.

**Domestic function** is sometimes called Instrumental Activities of Daily Living – how a person gets around and what they can do in their domestic environment. The original Lawton's IADL Scale<sup>61</sup> has eight areas of function covering telephone, shopping, food, housekeeping, laundry, transport, medications and finances. These have been modified for use in the HACC sector. The modifications for the HACC program take more account of technical aids and transportation options, and some cultural factors. The structure of all questions is the same.

In the disability sector as well as in aged care and respite care, the client's **behaviour** (especially any challenging behaviour) is important in determining levels of service provision and has occupational health and safety implications. The behaviour tool adopted as the national standard is a community modification from the Australian Residential Classification Scale<sup>62</sup>, which is in common use by many Aged Care Assessment Teams. It covers wandering/intrusiveness, verbally disruptive or noisy, physically aggressive, emotional dependence and danger to self or others. The scale asks for scores for how often the behaviour has occurred: extensively, intermittently or occasionally.

The scale described for the **cognitive** domain is the community version of the Folstein Mini-Mental State Examination (the MMSE "30 point scale").<sup>63</sup> This instrument is reported to have good reliability and validity when used with community clients and is in widespread use. It is a brief instrument that can be performed by a non-clinician. However, some training is necessary. While the scale can be administered by a non-clinician: the administration of this test should be undertaken by someone trained in its use; staff who are not trained in its use but who suspect a client of cognitive impairment (eg, due to poor performance on many domestic tasks or IADLs) should refer the client to a trained assessor for evaluation.

The MMSE should only be completed if the assessor is trained in its use (see above). The MMSE comprises a series of questions that give indicators of how oriented a person is in space and time and how well they perform simple tasks like counting, naming, spelling and writing. Remember to record the client ID and date. This instrument is scored based on the total (out of 30) because it makes sense to experienced clinicians when it is added up.

There is some recent evidence that the RUDAS (Rowland Universal Dementia Assessment Scale) may be a more reliable tool, and the first detailed study of the development and useful properties of the RUDAS has just been published.<sup>64</sup> The design of the RUDAS is sensitive to aspects of culture, language and educational status. The RUDAS can be administered by a non-clinician who has the appropriate training.

## 4. The Living Arrangements Profile

The data items in the Living Arrangements Profile (LAP p.1 of 1) are shown in the following table.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	Medical records standards
Living Arrangements	Numeric & box	HACC MDS NCSDD (000527)
Comments on living arrangements	Alphanumeric	Vic and SA INI, Qld ONI
Accommodation	Numeric & box	HACC MDS
Comments on accommodation	Alphanumeric	Vic and SA INI, Qld ONI
Employment Status	Numeric & box	Rehabilitation MDS Mappable (000317)[retired added]
Comments on employment	Alphanumeric	Vic and SA INI, Qld ONI
Financial and Legal Profile		Review of current practice
Mental Health Act status and decision-making responsibility	Numeric & circle	Mental Health (NHDD V12 000092)
Financial decisions	Numeric & circle	Guardianship and Administration legislation
Cost of living decisions	Tick box	MDS-HC (Trade-offs)
Comments on legal and financial issues	Alphanumeric	Vic and SA INI, Qld ONI
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

### 4.1 Living arrangements

The first two items (living arrangements and accommodation) on this profile are mandatory items for HACC consumers in Queensland. If this profile is not completed, complete the HACC MDS Supplementary Items page to satisfy MDS reporting arrangements. The HACC MDS v. 1 has a suitable question to find out what living arrangements the person has, eg. - whether they live alone, with family or with others. This will need to be taken into account in formulating an action plan and, if necessary, developing a service coordination plan.

The employment item comes from the National Minimum Data Set for Medical Rehabilitation<sup>65</sup>. It is selected because the wording is geared to the health implications of employment, eg it separates a person who is retired for reasons of their age from a person who has retired for reasons of a disability.

### 4.2 Decision-making

There are a number of questions that derive from existing commonly used forms and cover the common categories of legal orders seen by community care agencies, as well as common categories related to personal and financial decision-making. These are likely to also prompt the collection of further information where that bears upon issues of consent and disclosure. For

example the *Mental Health Act status*, which might be an involuntary treatment order in hospital or an involuntary order for community treatment.

Decision-making ability relates to numerous areas in an individual's life, not just financial decisions. Taking the cue from relevant legislation, which varies only marginally between jurisdictions, decision-making capability refers to the person (their self care and health behaviours will be most relevant) and to financial decision-making. Consent to medical and dental treatment, access to accommodation, health care and services are the most common functions given to substitute decision-makers.

A Power of Attorney (POA) gives another person the ability to act on your behalf in financial and legal matters, and an Enduring Power of Attorney (EPA) gives that power to another when you become incapable of making your own decisions. It is also possible to appoint someone as an Enduring Guardian, and to formalise an Advance Directive that states your wishes should you become incapable. Under guardianship legislation a close friend or relative can give consent to medical and dental treatments as a 'person responsible', and in other cases where a person with a disability is incapable of making their own decisions, a Guardian may be appointed.

Guardians are relatively rarely appointed in practice because a large range of informal arrangements are possible, and it is only when disputes (most often between family members) make decision-making impossible that formal guardianship comes into play.

Financial administration or financial management orders give control of a person's finances to another person where there is no satisfactory informal arrangement or Power of Attorney in place. It is useful to know these arrangements, as they will influence a care plan.

Decision-making capacity cannot be easily quantified. The intention of including this item in the ONI is that it can contribute to the overall picture and act as a prompt for further investigation. For example a person may have a disability and be incapable of making decisions in some areas but have informal or formal arrangements in place to help them. They may be a lower priority than someone with fewer problems but no supports in place, because their 'functional burden' on others is comparatively less.

It should be remembered that at tier 1, a screening process or assessment cannot be used to determine the level of a client's decision-making ability. Rather, this is something that a tier 2 Cognitive Assessment would be able to determine. However, any legal and/or financial decision-making issues should be noted and detailed in the relevant 'Comments' section.

### **4.3 Cost of living decisions**

It is sometimes useful to inquire as to whether there are any trade-offs the person makes because of financial difficulties. This question can generate important information to allow you to assess both risk and urgency. It has been selected from the MDS-HC<sup>66</sup>, where it has the colloquial American label of "Trade-offs". The validity and reliability of this item for Australian populations is unknown, however it did appear to have content validity when used in the Illawarra Carers Survey (conducted in 2002). The MDS Assessment and Identification system (MDS-HC) is a multi-nationally evaluated assessment system for use in community care programs that grew out of national legislation for nursing home reporting in the USA.

## 5. The Carer Profile

The refinement of the Carer items has been based on a number of surveys and studies where items were adapted to local requirements, while keeping a standardised approach. This resulted in many useful refinements of individual items, particularly about carers, but also in health conditions and psychosocial problems.

The data items in the Carer profile are shown in the following table.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	Medical records standards
Need for a carer	Numeric	Modified from Maddock (1998)
Carer profile		HACC MDS
Availability	Numeric	NHDD V12 (000022)
Residency status	Numeric	
Relationship	Numeric	
Carer Support		Modified from the Illawarra Carer Survey
Someone to help	Numeric & tick box	
Carer payment	Numeric & tick box	
Carer support information	Numeric & tick box	
Carer training	Numeric & tick box	
Current threats to carer arrangements		Modified from the Illawarra Carer Survey
Current threats	Numeric	
Sustainability of arrangements	Numeric	
Comments on emergency arrangements	Box	
Carer issues		
Consideration of further exploration of issues	Tick boxes	
Other comments	Box	
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

The basic dimension to be described is whether the consumer needs a carer and, if so, whether they have a carer who is both willing and capable of undertaking tasks that would otherwise be undertaken by health and community care providers. Certain rare circumstances must be considered, such as, the carer may be a child or adolescent looking after their parent. The carer does not necessarily have to be a relative, they may be a close friend or neighbour.

The Carer Profile first identifies if the primary consumer has a need for a carer, and then goes on to collect three items on availability, residency and the relationship of the carer to the care recipient. There are also items in this section that identify supports available for the carer, current threats to carer arrangements and whether the carer arrangements are sustainable.

The three items - carer availability, carer residency status, and relationship of carer to care recipient on this profile come from the HACC MDS and are mandatory items for HACC consumers. The carer availability item was recently changed to align with the National Community Services Data Dictionary. The original HACC MDS items do not capture whether the consumer actually needs a carer, and no validated measures of the need for a carer or carer availability could be identified in the literature. For the purposes of determining a consumer's functional burden and/or priority rating category it is not sufficient to simply ask whether the person lives alone.

### **5.1 Need for a Carer**

This question seeks to identify if a consumer needs a carer. If a carer or other person were unable to assist a consumer, you must determine if the consumer could manage independently. This item originally comes from a study of carers in South Australia<sup>67</sup> and this source is also used in the forms developed for the Western Australian HACC assessment strategy.<sup>68</sup>

Knowledge of whether or not a carer is needed will be of relevance when allocating a priority rating for consumers using the ONI Priority Rating Tools. This priority will increase if the consumer has a high demand for a carer ie, it is impossible for the consumer to perform daily tasks such as bathing and food preparation by themselves, and no carer is currently available to assist them with these duties.

Details of formal paid care and the service provided need to be recorded in the comments box of the Carer Profile and any sustainability issues noted. Current services including those of paid or volunteer services also need to be recorded in the Core ONI page 3 'Current services' section.

Note that Version 1 of the HACC MDS does not have an item corresponding to "Need for a carer" (see below).

### **5.2 Carer arrangements and resources**

If a consumer is mainly (or only) a carer, they will be eligible for HACC assistance because they look after someone who is HACC eligible because they are frail or have a disability. The assistance provided to this carer is to help them cope with their caring role.

By definition then, they are not paid a wage or salary to help, **but** they may receive a carer benefit. Information on benefit payments can be found electronically at the Centrelink (phone 13 27 17) or visit the website [www.centrelink.gov.au](http://www.centrelink.gov.au). Support for carers varies from time to time and Carer Resource Centres are designed to help and can be phoned on 1800 242 636. The Government also supports respite care services across Australia – phone 1800 059 059.

To be eligible for a benefit or to take on other responsibilities like substitute decision-making for others (eg, to take on a position of "person responsible" under the relevant guardianship legislation), the person must have a continuing relationship with the care recipient. This does not have to be only 'next of kin', and recent changes have been made to eligibility and entitlements such that co-residency is no longer a determining factor to be considered when deciding whether a person is considered to be a carer.

Knowledge of carer residency status can assist with identifying if arrangements can be sustained. Ask "does your carer live with you" or "do you live with the person you care for?" Where a consumer has several carers, ask about the carer who does most of the caring and if the two carers live apart. A consumer may stay over at the carer's home, or the carer may stay over at the consumer's home, but the carer is not co-resident. In this situation record they have a non-resident carer. The Commonwealth Carelink centre can advise and assist with access to home support services. Phone 1800 052 222 or visit [www.commcarelink.health.gov.au](http://www.commcarelink.health.gov.au) for more information

For further information about Aged Care Assessment Teams (ACAT) contact the central phone link number 1800 052 222, or contact your local Community Health Service.

The Carer Profile is a way of summarising important carer issues, whether the arrangements are workable short and long term, and if required, to guide the referral of the carer for an assessment of their own, and to prompt service provision, respite arrangements, training and support.

### **5.3 Carer items and compliance with data reporting requirements**

The secondary purpose of collecting data for reporting requirements and planning can also be met by these items for some programs. This reporting function is not practical at this stage for all relevant programs because the administrative arrangements for the range of services using the ONI are different and cannot be adequately met by any one program alone. The multiple program reporting requirements are too wide to be covered in total in one set of forms and still remain practical to use. This is because of the non-comparability of the different programs' requirements, and because not all the ONI items are expected to be collected on all consumers.

In order to simplify the reporting function, compliance with the HACC MDS is facilitated in Queensland by the use of the HACC MDS Supplementary Items, which are also on the Carer Profile. Within the HACC Program a number of differences between the ONI items and the reporting requirements can be noted.

The current HACC MDS does not have an item corresponding to 'Need for a carer'. In the ONI Carer Profile we are interested in whether the person has someone they identify as their carer, independently of whether they need a carer or not. So, there are 5 possible options in recording whether a person has a carer. Record (1) Has a Carer (2) Has no Carer (3) Not Applicable – no Carer required (98) Not Applicable – paid Carer (99) Not Applicable – the consumer is the Carer.

Note that when there is no carer, the additional code "(98) Not Applicable – paid Carer" has been added to the three HACC MDS questions that relate to carers for the purpose of identifying whether a consumer has one or more paid or formally arranged carers in place.

As code (98) is not a HACC MDS code, it cannot be reported in an agency's HACC MDS (Version 1) data reports. Agencies in Queensland have been advised to record the carer arrangements using the new codes (98 or 99) when completing the Carer Profile so that accurate information can be used to develop a care/service plan, and can also be shared with other services on referral (with consumer consent).

In the HACC MDS Version 1, paid or formally arranged volunteer support is recorded as "Has no carer", and this not useful in understanding whether the person's functional needs are being met.

If a person has a paid carer, for example because they receive domiciliary services (and this is substituting for a family carer), we rate them on the availability item code "(98) Not Applicable – paid Carer". For the purposes of the ONI priority rating we should also assess the sustainability of that arrangement. It could be that there is no carer, other arrangements in place are working well, and as result, there is limited unmet need.

Agencies may chose not update their electronic client management systems until such time as Version 2 HACC MDS has been implemented, so any error messages that result from reporting the new Carer Profile carer item codes to the National Data Repository will be ignored in the interim.

## 6. The Health Conditions Profile

This profile was developed out of the literature review and includes self-rated health, bodily pain, interference with normal activities, vision, hearing, teeth, speech, swallowing, falls, feet, vaccinations, driving, continence, height, weight and blood pressure pulse. Additionally, it includes a summary of self-reported health conditions and confirmed medical diagnoses, current medicines and assistance and referral options.

An important design element is that it meets the requirements for Enhanced Primary Care (EPC) payments for general practitioners.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	
Overall health		Compliant or mappable to NHDD V.12.
Self reported health status	Scale tick box	SF-36 used in national health surveys and EPC compatible
Bodily pain	Scale tick box	
Interference with normal activities (past 4 weeks)	Scale tick box	SF36, EPC and DVA-673
Vision		1999 NSW Older People's Health Survey
Reading	Scale tick box	
Distance	Scale tick box	
Hearing	Scale tick box	
Oral health problems	Tick box	Queensland Health consultations and review of current practice
Comments	Box	
Speech/swallowing	Tick box	
Comments	Box	
Falls (inside/outside past 6 months)	Alphanumeric	NSW Health
Number of falls	Alphanumeric	DVA D677
Feet	Tick box	EPC assessment items and review of current practice
Comments	Box	
Vaccinations	Tick box	
Vaccinations – date	Alphanumeric	
Does drive	Tick box	
Fit to drive	Tick box	
Comment	Box	
Continence		
Leaking urine	Tick box	
Reason	Tick box	
Faecal incontinence	Tick box	
Comment	Box	
Height	Numeric	
Weight	Numeric	

ITEM	Data type	Source
BMI	Numeric	
Blood pressure/pulse	Numeric	
Health conditions	Alphanumeric	Review of current practice
Medical diagnoses	Alphanumeric	EPC assessment item
Current medications	Alphanumeric	
Cooperation with treatment – takes own medicine	Numeric	Rosen at al 1989
Cooperation with treatment – willingness to take own medicine	Numeric	Included in national mental health outcome measures suite
Cooperation with treatment – cooperate with health professionals	Numeric	
Use of Webster pack or similar	Numeric Y/N	Review of current practice
Comments	Alphanumeric	
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

### 6.1 Overall health and bodily pain items

These questions were derived from the SF-36, an epidemiological survey, which has been linked to several national health surveys, hence making the ONI information comparable at a national level. These questions are in current use in the DVA D677 and the D673. Self-reported health status aligns well with objective measures of health. It has been found to be a good predictor of subsequent illness and premature death.<sup>69</sup>

#### Interference with normal activities

This item comes from the form DVA-673. No studies have been conducted to indicate whether it is valid and reliable, however it is included to conform to DVA requirements. The actual items used are recommended because of their common usage, rather than because of evidence of how they perform in any given population.<sup>70</sup>

#### Vision, hearing and falls

These questions have been selected from the NSW Health (1999) Older Peoples Health Survey.<sup>71</sup> The falls item has been selected from the DVA D677 form on the basis of its common usage and because falls in the elderly are one focus of injury prevention, which is one of the seven national health priority areas.<sup>72</sup>

#### Feet

This is an EPC assessment item.

#### Vaccinations

The National Health and Medical Research council (NHMRC) recommends the Australian Standard Vaccination Schedule (ASVS)<sup>73</sup>. This is an EPC assessment item.

### 6.2 Driving

This is an EPC assessment item. If a person has a mental or physical incapacity that is likely to adversely affect their ability to drive safely, or if they are 75 years or older, they may require a medical certificate from a general practitioner as evidence that they are fit to drive<sup>74</sup>. For car drivers, annual medical reviews are required from 80 years of age and annual driving tests from 85

years of age. This is to ensure that older drivers are medically fit and are able to drive competently and safely. Annual medical and driving tests begin for motorcyclists at the age of 70<sup>75</sup>.

Some medical conditions that may affect driving ability include: epilepsy, diabetes, heart disease, stroke, arthritis and other joint problems, loss or partial loss of a limb, eye or hearing disorders, lung disease, sleep disorders, Alzheimers' disease and other cognitive problems, depression and other mental problems, injuries and disabilities. If a person notifies the relevant State or Territory Transport or Road and Traffic Authority of a medical condition under the age of 70 years, an annual medical review may be required.

Note that at the screening level the ONI is not asking the screener to determine whether or not the consumer is fit to drive. This decision should be made by a general practitioner, once they have tested to see if the consumer is medically fit to drive. Fitness to drive can be an important element of independence for the consumer and has to be weighed against public safety concerns. Other health disciplines that may be required for assistance or assessments relating to driving include Occupational Therapy, Physiotherapy, or Optometry.

### **Continance**

This is an EPC assessment item. If the consumer reports any episodes of incontinence and/or the use of containment aids, this suggests that a referral for a focused continence assessment is required, or a reassessment where an initial assessment has already been undertaken. Consider review by GP or specialist continence adviser should changes/concerns in bowel opening regularity be evident<sup>76</sup>.

### **Height and weight**

The completion of this item is optional except where this form is used as part of an EPC assessment. BMI is a commonly used measure to determine someone's height to weight ratio. It is important to detect weight issues in consumers, especially those who are overweight, as obesity can lead to several other severe medical conditions such as heart disease, diabetes (type 2) and high blood pressure.

### **Blood pressure / pulse**

The completion of this item is optional except where this form is used as part of an EPC assessment.

## **6.3 Health conditions as reported by consumer or carer**

This section is not meant to be diagnostic, as these are self-reported problems from the consumer, and should not be translated into a diagnosis for the purposes of this item.

## **6.4 Medical diagnoses**

There are different medico-legal implications depending on who completes the profile, so non-medical staff should be clear about not recording their own versions of medical diagnoses. If it is completed by other disciplines, a medical diagnosis should only be recorded if there is written evidence that a medical practitioner has confirmed the diagnosis. If not, record the condition under 'Health Conditions' (see above) and complete it based on what the consumer tells you.

## **6.5 Current medicines**

The medication section relates to all medicines, including over the counter, bush medicine, nutritional supplements and alternative treatments. It can be used to check if the consumer knows why their medication is being taken or if any problems exist. Note that in some cases consumers may be taking another person's medicines or they may be sharing medications with a partner or spouse.

If appropriate to the conversation you are having, or if there is some suggestion that circumstances such as this might apply, explore whether any problems exist from issues such as

sharing of medicines. If it is identified that the consumer is unclear about what his/her medication is for, consider referral to a General Practitioner or a Pharmacist. Note that asking this question may identify useful information about cognitive function and ability to manage medications and may be useful for the Action Plan.

## **6.6 Cooperation with treatment**

There are 3 questions about cooperation with treatment, 2 of which relate to medicines. These questions are modified from the Life Skills Profile<sup>77</sup>. This profile is part of the suite of national mental health outcome measures under the National Mental Health Plan.

## **6.7 Medications**

'Webster Pack or similar' asks whether the person uses pre-packaged medicines. If the person's compliance with medicine would be improved by having it in a pre-packaged form, or by using a dosette box that they either fill themselves or have a carer fill for them, then this should prompt the provider to make the necessary arrangements.

A Home Medicines Review (HMR) provides an avenue for a consumer's pharmacist and GP to review medication management needs at home. Medicare Item 900, covering GPs' involvement in HMR, is available for HMR services provided by a medical practitioner (including a general practitioner, but not including a specialist or consultant physician). The consumer's usual medical practitioner or practice should generally provide HMR services. To coordinate the pharmacy component of HMR a pharmacy must be registered to supply pharmaceutical benefits under Section 90 of the National Health Act 1953 and be an Approved HMR Service Provider through the Health Insurance Commission (HIC). Applications can be made on an official application form available from the HIC or from the HIC website on:

[http://www.hic.gov.au/providers/incentives\\_allowances/pharmacy\\_agreement/about\\_hmr.htm](http://www.hic.gov.au/providers/incentives_allowances/pharmacy_agreement/about_hmr.htm)

HMR also involves the services of accredited pharmacists, i.e. pharmacists with current accreditation to conduct medication reviews from an approved body (eg the Australian Association of Consultant Pharmacy).

Examples of risk factors known to predispose people to medication related adverse events are:<sup>78</sup>

- currently taking 5 or more regular medications;
- taking more than 12 doses of medication per day;
- significant changes made to medication treatment regimen in the last 3 months;
- medication with a narrow therapeutic index or medications requiring therapeutic monitoring;
- symptoms suggestive of an adverse drug reaction;
- sub-optimal response to treatment with medicines;
- suspected non-compliance or inability to manage medication related therapeutic devices;
- patient's having difficulty managing their own medicines because of literacy or language difficulties, dexterity problems or impaired sight, confusion or dementia or other cognitive difficulties;
- patients attending a number of different doctors, both general practitioners and specialists;
- recent discharge from a facility or hospital with multiple changes in therapy (last 4 weeks).

### Comments box

Use this box to note any health risks and problems that might need further investigation eg, a chronic or degenerative disease, diabetes, cardiovascular disease, lung function, falls and so on can be noted in the box for comments.

Note that some conditions may be episodic in nature, recurring or degenerative and the impact of this on function could be commented upon here. In variable disability and illness, consider rating the person at their worst in the last three months, and checking progress at a subsequent screen or re-assessment within the next 90 days if possible.

## 7. The Psychosocial Profile

This is an optional profile that can be used to screen for psychosocial issues related to emotional and mental well being, personal and social support, family and personal relationships and relationships with service providers. It provides a means of capturing some common risk factors associated with emotional and/or mental health problems (such as lack of social supports).

Mental health is one of the seven national health priority areas<sup>79</sup> and a key focus of national planning has been the development of better links to the primary care sector<sup>80</sup>. This profile, therefore, identifies opportunities for screeners to consider and discuss referral options that may address the consumer's psychosocial issues, where they are identified.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	
Mental health and wellbeing (the K-10 scale)	Scale scores	Andrews et al (2001)
Total scale score as indicator for referrals	Total score	Part of national MH suite of tools
Sleeping trouble	Tick box	EPC assessment item
Details of sleeping trouble	Comment box	
Personal and social support	Scale tick box	Dartmouth COOP Charts
Support risks and opportunities	Comment box	
Family and personal relationships	Comment box	Rosen et al. 1989
Relationships with service providers	Numeric Y/N/DK	Mid North Coast ATSI CCT
Relationships with service providers	Comment box	
Name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

### 7.1 Mental health and well being (K10)

The K10 screen (the Kessler Psychological Distress Scale) can be used for the early identification of individuals who may have, or are at risk of developing, common psychological problems such as anxiety and depression. It aims to measure the level of current anxiety and depressive symptoms a consumer may have experienced in the four weeks prior to interview<sup>81</sup>. The K10 is commonly used in epidemiological studies, has been used worldwide and is recognised for having reliability and validity for use in the general population<sup>82</sup>. One benefit of the K10 is that it can be self-administered or administered by the screener. It is also part of the recommended suite of mental health outcome measures promoted under the National Mental Health Strategy<sup>83</sup>, so that means it has the potential to be part of a common language of communication between mental health and primary care providers.

Making sure the consumer has a choice on how to complete the K10 is important. Self-administration would not be acceptable for consumers who are illiterate or consumers who display some form of learning difficulties, which could limit their ability to correctly complete the K10. It is important that the consumer thoroughly understands the questions being asked and the relevance of these questions to their screening.

## **7.2 Sleeping difficulty**

This question is an EPC item and offers another opportunity to identify emotional issues and worries. Consider a GP referral or a referral to a stress management program if sleeping is a problem. A local area authority will have a list of appropriate services.

## **7.3 Personal and social support**

This question comes from the Dartmouth COOP Charts, and is known to be a reliable predictor of the need for social support.<sup>84</sup> The level of support is also a useful indicator of both risk and urgency. Social isolation may lead to depression, so it is important to pick up on any cues of loneliness. It is also important to assess the social support of the carer, should the consumer have one. Carers often find themselves socially isolated due to their caring roles taking up a majority of their time and energy.

‘During the past 4 weeks...was someone available to help you if you needed and wanted help?’

Then if clarification is needed ask, ‘For example if you felt very nervous lonely or blue ... etc’

Use this question if you feel that it is appropriate to the consumer’s presenting problems. The person’s social support situation may need to be taken into account in formulating an action plan and, if necessary, developing a care plan. The answer to this item can be used in the OPR Tool to help determine a priority category.

## **7.4 Family and personal relationships**

This area contains two questions with coded answers about friendships and personal problems with others modified from the Life Skills Profile (Rosen et al. 1989).<sup>85</sup>

You may also enquire about the person’s current personal and family relationships – whether they are experiencing any particular difficulties and record the response in the comment box. If 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, record any issues that may require action in the comment box. The answer to this item can be used in the OPR Tool to help determine a priority category.

## **7.5 Relationships with service providers**

This question seeks to identify whether the consumer mistrusts health and community service providers because of what they see as bad experiences with providers and government agencies in the past. This item was originally designed for the Mid North Coast (NSW) Coordinated Care Trial which has a focus on Aboriginal and Torres Strait Islander (ATSI) peoples. It was developed because ATSI representatives felt that a consumer’s perception of their relationship with previous service providers has a significant impact on relationships with current and future service providers. Its intention there was to capture situations where people may have had bad experiences as a result of policies and practices from being part of the Stolen Generation.

However, it has more general relevance, and we expect it can prompt areas of further investigation that might suggest strategies to improve access to a range of services. This might include legal services (policy, custody disputes in court, divorce), health services (hospitals, doctors), schools, community services (health, welfare) or social security (pensions, benefits or other entitlements). On the other hand the consumer may have experienced a positive outcome with a service and place a lot of their trust in future services and service providers.

Document any issues relevant to service providers in the Alert section of the Core ONI, and the answer to this item can also be used in the OPR Tool to help determine a priority rating category.

## 8. Health Behaviours Profile

This is a profile that is used 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 malnutrition items, which ask for a total score that can be used to indicate risk.

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.<sup>86</sup> For this reason, it is important to take every available opportunity to involve health promotion during the ONI interviewing process.

ITEM	Data type	Source
Initial Contact Agency Unique Consumer Identifier	Alphanumeric	
Regular health checks (date)	Y/N	EPC assessment
Screens in last 2 years	Alphanumeric	
Smoking	Scale scores	DVA D677 and EPC
Alcohol	Scale tick box	
Frequency	Scale tick box	
Quantity	Scale tick box	
Malnutrition (total score as risk indicator)	Scale scores	Ferguson et al (1999)
Hydration	Alphanumeric	Queensland Health
Weight (appearance)	Tick box	Review of current practice
Physical activity	Y/N	Bauman (2002)
Physical fitness	Tick box	Dartmouth COOP Charts
Comment box	Alphanumeric	
Screener's name, agency, signature, date and contact number of person completing this page	Alphanumeric	Medical record standard format
Box to indicate that the information on the form has now been updated, date, name and signature.	Alphanumeric	

### 8.1 Regular health checks

This question identifies if health checks are taken and their regularity. Consider referral to a GP if there is a need for a regular screening check-up.

### 8.2 Smoking

This question clarifies if the consumer is a smoker or has any history of smoking. For consumers currently smoking, this question provides an opportunity to discuss desires and options of referral eg, to a Quit smoking program or GP.

### 8.3 Alcohol

This item asks if the number of drinks consumed exceeds recommended standards and enables consideration of the impact of drinking pattern on overall health and well being.

If excess alcohol consumption is an issue, consider referral eg, to an alcohol and drug service, or to the GP. Refer to the 'How Manual' (pg. 40) for measurements of Australian Standard drinks in order to determine if alcohol consumption is an issue.

The sources of these items are the DVA D677 and EPC forms and the evidence for their inclusion is in the Australia Alcohol Guidelines, NHMRC, 2001.<sup>87</sup>

#### **8.4 Malnutrition**

This item contains a screening scale that identifies individuals who are at risk of malnutrition. The malnutrition screening tool consists of 3 questions that identify occurrence of weight loss and/or appetite loss. The sum of the 3 individual scores provides a total score.

The source of these items is a hospital-based tool that was recommended for use in the community care setting in Queensland on the basis of evidence reviewed by an expert panel whose advice was canvassed amongst HACC and hospital based nutritionists.<sup>88</sup>

#### **8.5 Hydration**

There is no clear determination of the risk factors for dehydration and decreased fluid intake, and the literature suggests more studies are required. Guidelines state that the fully dependent elderly are at a higher risk of dehydration, and the semi-dependent resident should also be monitored for adequate fluid intake<sup>89</sup>.

No standard recommended daily intake (RDI) of fluids is available, but it should not be less than 1600ml/24 hours in order to ensure adequate hydration for the average older person.

A fluid intake sheet is the best method of monitoring daily fluid intake. Urine specific gravity may be the simplest, most accurate method to determine patient hydration status. Evidence of dry furrowed tongue and mucous membranes, sunken eyes, confusion and upper body muscle weakness may indicate dehydration.

More research is required to determine the optimum, non-invasive method of maintaining adequate hydration in older people. However, regular presentation of fluids to bed bound older people can maintain adequate hydration status. Due to the observation that medication time can be an important source of fluids, fluids should be encouraged at these times.

There are at least 3 different methods for calculating the RDI of fluids:

Standard 1: 30 ml/kg body weight

Standard 2: 1 ml fluid/Kcal consumed

Standard 3: 100 ml/kg for the first 10kg  
50 ml/kg for next 10 kg  
15 ml/kg for the remainder of weight

Taking a worked example, if you take an average weight of 60 kg and an intake of 2000 kCal (8200 kJ), the fluid intake would be 1800 ml for Standard 1; 2000ml for Standard 2; & 2100 ml for Standard 3. A "cup" is usually 200 to 250 ml fluid. Six to 8 cups per day would then be 1200 to 2000ml per day. The 6 cups would then be less than the 1600ml/24hour minimum as recommended above for a 60 kg person and only appropriate for someone weighing 40 kg (using standard 1). In the absence of more definitive evidence, the recommendation for the screen is:

- 1) Do you drink regular amounts of fluid every day? or Do you have 8 cups (1.5 to 2 litres) of fluid most days? Yes/No
- 2) Have you recently decreased your normal fluid intake? Yes/No

If fluid intake is low or recently decreased, consider referral to GP or health professional.

Note that when identifying a need for an action plan in relation to hydration ensure consideration is given to environmental temperatures and the risk of dehydration eg, extremes of temperature. Additionally, consider any fluid restrictions in place based on medical direction. A fluid is generally defined by dietitians as being any type of beverage, but water is the preferred fluid and it is not recommended that this be replaced by supplementing soft drinks or coffee instead of water.

## **8.6 Weight**

This item asks the interviewer to judge the appearance of the person and record in a tick box if they are underweight, average or overweight.

This item has not been validated but is used on the assumption that it is unrealistic to measure the height and weight of consumers presenting to every agency. It is simply a prompt for the health care worker to consider weight with regard to the promotion of health. However, it should be noted that insight into whether the current weight is appropriate for the individual requires height and weight measurements, and BMI calculations (weight in kg/(height)<sup>2</sup> in m).<sup>90</sup>

There are a number of questions that are selected from the Nutrition Checklist used in the D677 and the EPC Assessment Forms. Because their use as single items is not validated, the checklist as a whole should be used. This then allows total item scores to be used as a trigger for GP referral, as is recommended on the Level 1 Nutrition Screen for Older Persons.<sup>91</sup>

Note that it is important to use your own judgement about whether a person has significant weight problem before prompting further investigation. Whether the weight loss or gain has taken place over a short period of time will be relevant. There may be additional information from other Tier 1 screening profiles.

## **8.7 Physical activity**

Physical activity includes leisure, gardening and yard work, household chores, active transport and occupational physical activity. Take the opportunity to promote exercise with the consumer. It is recommended that one exercises 30 mins everyday, this time label may actually put some people off, as they consider themselves too busy to take 30 minutes out of their day to exercise. Inform consumers that 3 x 10 minute blocks of exercise is also acceptable, and much easier to achieve.

The evidence and source of these items is *Getting Australia Active*.<sup>92</sup>

## **8.8 Physical fitness**

Ensure the responses here are consistent with the responses for the Activities of Daily Living in the Functional Profile and consider the need for referral if the consumer's response can be judged as 'light' or 'very light'. Physical fitness is more about the intensity and type of exercise, whereas physical activity is about the frequency of the exercise.

The source of these items is the Dartmouth COOP Charts<sup>93</sup> and the evidence for their inclusion can be found in *Getting Australia Active*<sup>94</sup>

### **Comment box including other relevant issues**

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 ONI Action Plan summarised on ONI page 2 of 2 and if necessary, to develop a care plan.

Use your own judgement to probe for sensitive issues such as substance abuse (legal or illegal) and safe sex habits.

## 9. The HACC MDS Supplementary Items

This is an additional tool for HACC funded agencies. It allows them to complete the current version of the HACC Minimum Data Set mandatory national reporting requirements in Queensland, should the Living Arrangements and Carer Profiles not be completed.

This profile should be completed on any client who is HACC eligible and is to receive a service but who has not had the Living Arrangements and Carer Profiles (which include some HACC MDS items) completed.

A HACC eligible client is either a care recipient who receives a service because of frailty or a disability, or a carer of a care recipient. A carer is someone who provides regular and sustained care and assistance to another person without payment other than a pension or benefit.

Leave this tool blank if it is not required.

## 10. The ONI Priority Rating Tool (OPR)

### 10.1 What the OPR does

The ONI Priority Rating Tool provides a way of determining an individual consumer's priority for community care, based on their needs, burdens and risks, and is an optional tool for service providers to use if sufficient information is collected. The purpose of priority rating is to allow consumers to be consistently screened for their needs and their risks, with the intention that those with greater needs and risks will get access to services first.

While both need and risk can be objectively measured, it is inevitable that the decision about an individual consumer's priority for services (ie. combining need and risk) will involve some level of value judgement. The judgement takes the form of the agency or program-level policies that set the ranking of the priority categories, and the thresholds for the points at which different services are then offered.

The literature on priority rating suggests that point-count scoring systems seem to be the most appropriate way to determine a consumer's priority. Items selected for their relevance to the interventions are combined in a "clinically sensible" way. They have been developed in New Zealand and applied in a range of specialties in Canada<sup>95</sup>, offer high face validity because they are developed to make clinical sense, and are practical for implementation and use in clinical settings<sup>96</sup>.

The ONI has taken this same approach, arriving at a rating category that is based on combining the scores from selected items in a tick box format, with item selection based on evidence from previous studies (particularly coordinated care and casemix studies<sup>97</sup>) and examining the data from a number of relevant ONI items collected on a routine basis<sup>98</sup>. The combination of scores gives a ranking system that can be used to determine priority for care and access to services.

This ranking can of course change, depending on the consumer's needs at a certain time, especially if the consumer has a degenerative disease. Either their priority rating may be higher, or the level or distribution of resources within an agency may change, allowing for lower priority consumers to be offered a service.

The OPR Tool is designed to be a practical and reliable way to determine a consumer's priority, relative to that of other consumers, on a waiting list. Those with the highest need and urgency should be seen to first. Priority scales add fairness to the system, with access to services being determined by one's needs and potential to benefit. Given it is not possible to provide a full variety of interventions to an entire population from finite resources, so it is necessary to channel those resources most effectively to those with greatest need<sup>99</sup>.

### 10.2 How the OPR is used is a matter of policy

Each agency, service type or practice must decide if the priority rating is a way of improving access to services and resources, or if it is a method of gate-keeping. Gate-keeping can be about cost containment, rather than a planned and rational allocation of health care resources. Entry point screening or triage in a primary care system refers to the consumer seeking generalist help before being referred on to specialist help. Failure of the screener to refer on in a coordinated way may lead to inappropriate care and hence cause further problems with continuity for the patient<sup>100</sup>.

As with any waiting list procedure, there will always be grey areas with implications for some service types and interventions and not others. The ranking used to order the priority ratings should be open to debate. Some agencies or programs may wish to give a 'weighting for waiting'. This is where someone who has been waiting a long time for a service, although it may not be

crucial, will feel they have more right to access than someone who has only been waiting a short time, but has a higher need for the service.

### 10.3 Components of the ONI Priority Rating Tool

#### Technical definitions of the 9 Service Priority Categories in the Queensland model

Service Priority Category	Need	Priority	Evidence in the ONI to assign to this category
1	Low function OR Mid function with significant psychosocial or other problems	No carer able to provide necessary care	Low function - A total score of < 6 or a total for items 6 & 7 of < 2 AND Has no Carer OR Medium function PLUS psychosocial or other problems AND Has no Carer
2	Mid function with no significant psychosocial or other problems	No carer able to provide necessary care	Functional assessment, not low score AND Has no Carer
3	Low function OR Mid function with significant psychosocial or other problems	Carer arrangements exist but are unsustainable without additional resources	Low function - A total score of < 6 or a total for items 6 & 7 of < 2 AND Has a Carer BUT sustainability score <4 OR Medium function PLUS psychosocial or other problems AND Has a Carer BUT sustainability score <4
4	Mid function with no significant psychosocial or other problems	Carer arrangements exist but are unsustainable without additional resources	Functional assessment, not low score AND Has a Carer BUT sustainability score <4
5	Good function but health, psychosocial or other problems	No carer able to provide necessary care	No functional assessment required AND Has no Carer
6	Low function OR Mid function with significant psychosocial or other problems	Carer arrangements suitable and sustainable OR Carer not required	Low function - A total score of < 6 or a total for items 6 & 7 of < 2 AND Has a Carer with sustainability score of 4 or 5 OR Carer not required OR Medium function PLUS psychosocial or other problems AND Has a Carer with sustainability score of 4 or 5 OR Carer not required
7	Good function but health, psychosocial or other problems	Carer arrangements exist but are unsustainable without additional resources	No functional assessment required AND Has a Carer BUT carer sustainability score <4
8	Mid function with no significant psychosocial or other problems	Carer arrangements suitable and sustainable OR Carer not required	Functional assessment, not low score AND Carer not required (availability score of 3 or 4) OR Carer sustainability score 4 or 5
9	Good function but health, psychosocial or other problems	Carer arrangements suitable and sustainable OR Carer not required	No functional assessment required Carer not required (availability score of 3 or 4) OR Carer sustainability score of 4 or 5

## 10.4 Combining the relevant items

The aim of using the ONI Priority Rating Tool, is to make the waiting time to access services as fair as possible, and give those in greater need a higher priority. It can be a valuable means of determining the level of unmet need for community care, by showing the characteristics of those people not getting access to crucial services.

The OPR tool offers a way to combine a lot of summarised screening information in the form of selected standard data items. These items were chosen on the basis of their ability to predict levels of need and to act as useful proxies or indicators for risks and urgency.

### Option 1 Decision Tree Flow Chart

Follow the flow chart, circling each category that applies. An ONI priority rating score will be identified on completion of the steps through the flow diagram.

### Option 2 Decision-Making Matrix

There are two axes. On the far left column, identify the consumer's category in relation to their carers, based on information collected in the Carer Profile. In the top row, identify the consumer's category of function and need. The ONI priority rating is the score in the box where these axes cross.

RISK (all rated in Carer Profile)	NEED			
	Low function Total score on all 9 items is <6 or total for items 6 & 7 is <2	Medium function (not Low or High Function)		High function but health, psychosocial or other problems. High function - no cognitive or behaviour problems, a score of 2 on 3 or more domestic functions (items 1 to 5) and a score of 2 on both items 6 and 7
		with significant psychosocial or other problems (see below)	with no significant psychosocial or other problems (see below)	
<b>Needs a carer but has no carer or carer arrangements have already broken down</b> Reason for Carer Status item – score 1 or 2. Carer Availability item – score 2 OR Carer Sustainability item – score 1	1	1	2	5
<b>Carer arrangements exist but are unsustainable without additional resources (likely to break down in to weeks to months)</b> Reason for Carer Status item – score 1 or 2. Carer Sustainability item – score 2 or 3	3	3	4	7
<b>Carer arrangements suitable and sustainable</b> Carer Sustainability item – score 4 or 5 OR <b>Carer not required</b> Reason for Carer Status item – score 3 or 4	6	6	8	9

## 10.5 Definitions and explanations of terms used in the ONI Priority Rating Tool

**Function:** (Identified in the Functional Profile)

- Low function: the total score on all 9 items is <6 or total for items 6 & 7 is <2
- Medium function: does not meet criteria for Low or High function
- High function: no cognitive or behaviour problems, a score of 2 on 3 or more domestic functions (items 1 to 5) and a score of 2 on both items 6 and 7.

The design of the ONI assumes a central role for measures of function as a good proxy for overall consumer need. The functional hierarchy gives the means of determining low, medium and high levels of function.

**Need for a Carer:** (A consumer attribute that is identified in the Carer Profile)

A consumer will rate as needing a carer, if they have a code of 1: the consumer cannot be left on their own at any time (whether by day or night); or a code of 2: the consumer can only be left on their own for some, but not all of the time (whether by day or night) in item 1 of the Carer Profile.

By using this item to clarify the need for a carer, the priority rating system developed for NSW Home Care was able to produce a more evenly distributed set of priority rating categories.

**Psychosocial problems:** (Identified in Psychosocial Profile)

- K10 score of 30 or more AND/OR
- No personal and social support AND/OR
- Significant family and personal relationships problems (score of 4 on both items).

Any one or a combination of these items can indicate complexity in the problems that have been identified by the consumer.

**Other Problems:**

- Consumer mistrusts health and community service providers (Psychosocial Profile) AND
- Does not cooperate with health services (Health Conditions Profile) OR
- Significant behavioural problems (Functional Profile) OR
- Significant cognitive problems (diagnosis of dementia in Health Conditions Profile or cognitive problems (Functional Profile) OR
- Decision-making problems (Living Arrangements Profile).

If a consumer is assessed as a 2 or 3 for 'Does this person cooperate with health services?', then depending on the scale or scope or significance of the problem, this can translate into 'Other Problems' in the ONI Priority Rating Tool. In order to translate into 'Other Problems' this item must be in addition to the assessor reporting that the 'consumer mistrusts health and community service providers'.

**Carer sustainability:** (Identified in Carer Profile)

- No carer able to provide necessary care or care arrangements broken down
- Carer Availability item – score 2 OR Carer Sustainability item – score 1
- **Carer arrangements exist but are unsustainable without additional resources (likely to break down in weeks to months)**
- Carer Sustainability item – score 2 or 3
- **Carer arrangements suitable and sustainable**
- Carer Sustainability item – score 4 or 5 OR

- **Carer not required** - Need for a Carer – score 3.

These carer items summarise the carer arrangements in terms of their suitability to the consumer's level of need, and the likelihood that they can remain in place without support. If the relevant profile has not been completed, the consumer should be rated as having no needs on that domain.

## 11. Using the tools to investigate need and to develop an Action Plan and/or a Care Plan

How the tools are used depends to some extent on adaptations to the local circumstances into which they are introduced. An entry point, eligibility screening, referral, care planning, service coordination planning, or priority rating function might be the primary focus, depending on the agencies involved.

### *11.1 Using ONI items as prompts for referral and further assessments.*

When all the relevant information has been collected, then the Action Plan (Core ONI Page 4 of 4) and appropriate referrals should be considered. This might not be done at the point of initial contact, but at a later time when sufficient information is available.

To develop an Action Plan, 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.

Other information might be based on their discussion with the consumer, direct observation, information contained in a referral letter, consumer notes or information provided by a third party, such as a friend, relative, carer or referring agency.

On each profile, if a need, issue or concern has been identified, this may trigger:

- referral to the appropriate agency or service provider for assessment; or
- completion of the relevant additional profiles or Tier 2 assessments, depending on the agency's protocols.

The optional profiles contain prompts for further assessment, referral or further action on behalf of the screener. The end section of the Core ONI page 3 provides options to consider specific health and community service domains that may be relevant to the consumer's identified problems or issues.

### *11.2 Using the ONI to record risks and urgency*

Page 3 of the Core ONI section has an Alert box on the top left-hand side. This box may be used to record any concerns identified in relation to danger, loss of social participation or reduction in health status.

Contact details relevant to your agency for further information can also be added here for further information.

Agencies and organisations will have their own related forms and scoring procedures for environmental assessments, workplace risk and incident reporting, and the ONI tools are not meant to replace these.

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'. If you trigger your own agency's alert procedures, consider indicating this in the box.

Note that the description of risks and the urgency of consumer issues can be considered 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. It excludes risks to community care workers. It excludes risks to health professionals (See Group 3). Current and future service providers may need to observe the consumer and take appropriate intervention. Specific situations or triggers that are likely to give rise to the behaviour may need to be addressed in a care plan to minimise the likelihood of occurrence.

Examples might be a consumer who engages in abusive language and verbalised threats directed at family, carers, neighbours or others, or consumer behaviour that causes sufficient noise to distress other people, is threatening and has the potential to harm someone else. Or it might be that the physical care of the consumer is demanding on carer to the point that the health of the carer is at risk in the short-term.

3. Situations in which the consumer represents a possible risk to a health professional or community care worker, whether intentional or unintentional. These might be situations in which the consumer presents an occupational health risk to a health professional, or the consumer may engage in behaviour with the intention of intimidating or harming the health professional. Current and future service providers may need to observe the consumer and take appropriate action. Specific situations or triggers that are likely to give rise to the behaviour may need to be addressed in a care plan to minimise the likelihood of occurrence.
4. Situations in which there is an occupational health risk to a community care worker or health professional for any other reason. The consumer's home or neighbourhood environment may be dangerous and put a visiting health professional at risk. Occupational health action may be required.

### **11.3 Using the Action Plan for referrals**

The Action Plan (Core ONI Page 4 of 4) is used to describe a referral pathway for consumers who need further assessment or for those with complex problems. The purpose is to keep track of how progress is going and whether any variation needs to be 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 profiles or the person's caregivers or GP require feedback
- It is often the case that more than one option for feedback will be recommended.

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.

#### ***11.4 Developing care plans and service coordination plans***

At the point when the ONI has been completed there may be enough information for some agencies to develop a care plan, especially in cases where the consumer's needs are adequately described without referrals for Tier 2 assessments. In those instances a service specific plan of care is the next step.

A service coordination plan is only useful where multiple agencies are involved and after the consumer's needs have been fully assessed. That means referral for Tier 2 assessments should be the next step before a service coordination plan is developed.

Note that in a service coordination plan, several goals of care might be involved, each with their own care plans at the level of different agencies. The format for service coordination planning developed for the Victorian Primary Care Partnerships contains a useful template for consumers with complex needs requiring a range of service types<sup>101</sup>.

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