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home and community care
A JOINT COMMONWEALTH AND STATE/TERRITORY PROGRAM PROVIDING FUNDING AND ASSISTANCE FOR AUSTRALIANS IN NEED

Functional Screening and Assessment: How and Why

Prepared by the
Centre for Health Service Development
University of Wollongong
for Queensland Health

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Preface

This manual was developed by the Centre for Health Service Development at the University of Wollongong and funded by Queensland Health. It is designed to assist HACC services undertake a Tier 1 HACC Functional Screen and undertake Tier 2 HACC Functional Assessments.

Like all other States and Territories, Queensland Health supports the decision to adopt the functional tools described in this manual as the national standard.

Queensland Health recognises that different services across Queensland have different systems in place and varying capacity to adopt the new tools at this stage. Implementation will need to occur in different ways and at a different pace in different services, depending on their various starting points.

A Queensland-wide implementation strategy needs to be developed in the context of the Queensland Aged Care Strategy.

The funding of this manual does not pre-empt the development of an implementation strategy. Rather, this manual is a response to requests from the field for information which will allow those services that are already positioned to do so to begin implementation at their own pace.

Suggested citation

Eagar K and Owen A (2002) ***Functional Screening and Assessment: How and Why***. Centre for Health Service Development, University of Wollongong.

How to use this manual

Welcome to this primer on the hows and whys of functional screening and assessment.

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Background information on function and on why it's important for HACC services

In February 2002, National Home and Community Care (HACC) and Aged Care Assessment Program (ACAP) Officials met to consider the results of the national functional dependency project (see page 5) and agreed that the HACC Program would:

- Develop a common glossary to be used regarding assessment in the HACC, aged care and primary care areas;
- Adopt the tiered or graduated approach to assessment outlined in this manual;
- Adopt the four functional domains outlined in this manual; and
- Incorporate the adopted functional items into the next version of the HACC Minimum Data Set (MDS).

It was also restated that the HACC Program should continue to refine its approach towards the separation of assessment from service provision.

These decisions represent an important development and have implications well beyond HACC and ACAT services. Importantly, these were decisions to work to achieve consistency across the whole of the community and primary care sectors.

But the scope of this manual is simply on Tier 1 Functional Screening and Tier 2 Functional Assessment and what it means for HACC services – what they are, why they are important and how to collect and use the information.

Context

Policy and implementation issues surrounding community assessment models have been receiving increasing attention for several years. The initial impetus for reform was the policy review after a decade of the HACC program – the *Home But Not Alone (House of Representatives Standing Committee on Community Affairs)* report in 1994. This was supported by the administrative reform agenda embodied in the national report on *the Efficiency and Effectiveness Review of the Home and Community Care Program* (Commonwealth Department of Human Services and Health, 1995).

Also in 1995, Michael Fine and others reviewed the factors influencing the effectiveness of community care programs, with lessons from the international literature (Fine and Thomson, 1995). One important finding was the consistent reporting of the value of periodic re-assessment, both as a program planning tool and as a clinical tool for capturing data on outcomes and for changing service and care plans as clients' needs change.

Gradually the momentum for change moved from policy to management issues, and to increased attention to management tools. This was especially the case where standard measures of client need were being explored as the building blocks for a client classification system for community care (Lewin and Eagar 1996, Hindle 1998).

Discussion of the structural and system design implications of these micro-level reforms increased with the release of the *National framework for comprehensive assessment of the HACC program* (Charlton et al: March 1998). In NSW, the release in that same year of *Community Care Assessment in NSW: A Framework for the Future – A Discussion Paper* (NSW Ageing and Disability Department, 1998) illustrated some commitment to taking action based on the national approach.

More recently, the development and subsequent adoption of the national measures of functional dependency for the HACC program (the subject of this manual) is designed to promote the use of common approaches and standardised tools. The expectation is that this strategy might lessen, rather than increase the burdens of reporting, and thereby contribute to reducing 'reform fatigue' (Eagar et al, 2001).

At present, 3 sectors (health, HACC, veterans) are undertaking similar reforms (mostly in parallel) but with common themes around standardising approaches to assessment. Of course, creating a degree of commonality across these reforms would be ideal, so that standardisation, but not necessarily complete uniformity, would be a more common feature.

Most of these common reform themes are driven by common goals requiring better measurement tools as a means for reform:

- Integration
- Substitution
- Efficiency
- Outcomes
- Value for money

The purpose of all current reforms, now well and truly on the agenda for 8 years, is not to introduce assessment into the community sector. Community care workers already assess clients all the time. The purpose is to improve communication, help create a more common language around the concepts of dependency, and to help care planning, reporting and service planning.

The focus of current reform is about replacing current work practices based on informal (subjective) assessments with a system of formal (less subjective) assessments. In the ideal situation, common and more standardised, valid and reliable approaches to measurement might serve a number of different functions at the same time. Table 1 summarises some of these functions.

Table 1: Different functions for common tools

MDS items	Client contact details	Client characteristics
Program reporting	Sharing between agencies	Measuring client need
State & National monitoring	CIARR etc	Establishing the goal of care
Population group planning	Agency & area planning	Establishing priority for services
		Indicating required services
		Measuring client outcomes
		Agency comparisons
		State, regional comparisons

Standard assessment models are designed to result in more equitable decisions, allow for more objective and transparent measurement of need and to not result in additional burdens on staff.

In practice, only some of the necessary tools have been fully designed, tested and refined (including the functional tools outlined in this manual). The success of implementation will depend on replacing more cumbersome and less useful data collections with a smaller number of more useful data items. This goes somewhat against the popular tendency to continually add more on, regardless of the burden on both staff and consumers.

What functional dependency is

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.

This manual is simply about **functional** screening and assessment. It is not about comprehensive assessment. We recognise that a HACC or other aged care agency will routinely need and use other important information such as diagnoses, use of medications, carer availability, risk of falls, abuse and so on. But here we are looking solely at function and not at these other domains. Therefore, we are talking about:

- Whether the person is capable of performing the task (functional ability) AND
- The degree of functional burden that arises because of the person's functional limitations and circumstances.

This means we are concerned with whether a person can do a particular function, regardless of whether they in fact do it. For example, an ability to climb stairs is rated independently of the layout of a person's house.

What it isn't

As we said above, this manual is solely about measuring function. There are many other things that a HACC agency needs to know about a person such as their medical condition or specific disability, their use of medicines, carer availability, risk of abuse, safety factors and so on, before knowing what type and level of services a person needs. These are important items of information in themselves, but they are not being discussed here except in the broadest terms.

As a result, these functional tools (on their own) are not designed to measure the level of assistance specifically required from the HACC agency (ie the client's service need). **This manual starts from the assumption that the client should be assessed independently of their *service* need**.

Dependency

A measure of dependency is:

- an instrument that identifies areas in which a person requires assistance with daily living, and
- that quantifies the extent to which that person has to rely on someone else to help them carry out normal activities in their home and community.

Functional ability

- Whether the person is capable of performing the task.
- For example, in assessing a client's need for shopping assistance, a measure of functional ability assesses the extent to which the person is capable of shopping **without taking into account any external factors**.

Functional burden

- The degree of functional burden that arises because of the person's functional limitations and circumstances.
- Takes into account external factors such as the accessibility of public transport and the physical condition and layout of the house. It assesses the need for assistance with shopping, regardless of whether that assistance is required from a carer, friend or HACC agency.

Functional need for services

- The type and level of services a person needs is not just determined by function. Need to know more.
- The functional tools (on their own) are not designed to measure the level of assistance specifically required from the HACC agency (the client's service need).
- Functional need for services (a service-based approach) assesses the extent to which the person needs assistance with (say) shopping from a HACC agency and takes into account the availability of a carer or friend to assist with the shopping as well as external factors such as accessibility of shops.

Functional hierarchy - early loss and late loss ADLs (1)

- People loose functional abilities in the opposite order to which they acquire them
- 'Early loss' ADLs like housework, transport, handling money, managing medicines (domestic functioning) are gained last and lost first
- 'Late loss' ADLs like dressing, toileting, feeding and bed mobility (self-care) are gained 1st and lost last

Functional hierarchy - early loss and late loss ADLs (2)

- Functional measures in health & residential aged care sectors typically focus on late loss ADLs at the expense of early loss (therefore can't use the same instruments in the community)
- It is reasonable to assume that, if a person can do early loss ADLs, they can also do late loss (supports screening)
- Functional hierarchy is relevant to being a low, medium or high need client
- Domestic functioning is harder to measure than self-care because of cultural issues

Work on measuring the level of assistance specifically required from the HACC agency is in its early stages and more work in this area will need to be undertaken over time. For now, we are just interested in the best ways of measuring functional dependency in the community sector, irrespective of who will actually meet that need.

Likewise, this manual is simply about standard tools. **It is not about standard processes**. Which agencies and staff undertake Tier 1 screening and Tier 2 assessment is an issue that has to be decided locally, as do the mechanisms for referral, case management and case review. The key idea is that nationally consistent tools need to be adopted and incorporated into locally developed processes.

Why function is important

Early work in the late 1960s on assessing the competence of older people gave rise to one of the scales that has been consistently used and adapted since then to measure domestic function. In a later book chapter on the development and use of various scales, Lawton (1972), made a number of important points:

- The focus is on behaviour – what people do including **what they can and can't do**.
- The best indicators of competence are those for **loss of function**.
- The key time frame is **the present** – evaluate what occurs in contemporary time, and remember that competence is not an enduring dimension, it **varies over time**.
- A full definition takes into account the opportunities and constraints of the **environment**.
- The domains of competence are **hierarchically arranged** from simple (breathing, moving, grooming etc), to more complex (financial management, recreation etc).

This is a very useful set of ideas to inform the design of the screening and assessment tools and they apply not only to older people but to younger people with disabilities. The functional tools aim to capture the hierarchical relationship between domestic and self-care tasks, with domestic tasks generally being lost before self-care tasks. The inability to carry out some domestic tasks is often an indicator of cognitive impairment and, in some cases, challenging behaviour.

So, to summarise, function is of direct relevance to HACC services because:

- The focus is on what a person can and can't do now, irrespective of the reason.
- Function is the best predictor of the need for community care and the cost of that care. It is equivalent to the way that diagnosis works in health care. Both explain why a person needs a particular set of services. In community care, function is actually a better predictor than diagnosis (Eagar K, Green J and Adamson L 2001).
- Function is a good predictor of consumer outcomes (Eagar K, Green J and Adamson L 2001).

- Function is important to consumers and uses a language that makes sense to consumers (eg, 'I'm a lot better now, I can even make a cup of tea'. 'I can't manage any more, I can't even dress myself').

The HACC functional dependency study

This study (called the HACC Dependency Data Items Project) was carried out in 2000/2001. The project:

- Reviewed the suitability of existing instruments and scales to measure the dependency levels of the HACC target group; and
- Field tested the recommended instruments in a sample of HACC service provider agencies in Adelaide, Alice Springs, Melbourne and Newcastle/Lake Macquarie. A total of 105 staff from 40 participating agencies were trained in the use of the screening and assessment tools. During the data collection period, a total of 746 screens and 462 assessments were completed and compiled in a study database. Both a screen and an assessment form were completed on 456 clients. Some results from the field test are included in this manual to illustrate the type of information generated.
- Recommended a two tiered assessment process. The first tier consists of a quick and simple functional screen. The second tier consists of a more comprehensive functional assessment for those who require it.

The study found in the field test that:

- There was reasonable agreement between the assessments recommended by the screening tool and the judgements made by staff about the need for completing those assessments. However the screen was better able to identify clients requiring further self-care and domestic assessment than the interviewers. Interviewers were better able to identify clients requiring further behavioural assessments. There was no difference in the performance of the interviewers and the screen in recommending cognitive assessment;
- The amount of time taken to complete the screen was acceptable with 44% of screens being completed in less than 5 minutes and 73% being completed in less than 10 minutes;
- The burden on staff represented by the assessments was acceptable. The length of time was dependent upon the number of instruments completed. When 1 or 2 instruments were used, more than 50% of assessments were completed in less than 10 minutes. When 3 instruments were used, more than 60% of assessments were completed in less than 20 minutes.

The Tier 1 screen prior to assessment offers a number of advantages for planners, care managers and service providers. It can help them:

- decide whether a more comprehensive and costly full-assessment is required, thus conserving and better targeting their resources
- make a well informed referral to other services if appropriate
- identify clients or carers with urgent needs.

In the model of screening and assessment adopted and shown in Table 2 below, the first tier is a simple functional screening tool that is applied to all current and potential consumers by any service provider, irrespective of their background or qualifications. It contains screening and trigger items that could be collected on a routine basis.

Table 2: A two-tier model that separates screening and assessment.

	First Tier		Second Tier
	Eligibility Screen	**Functional Screen**	**Functional Assessment**
Purpose:	Determine whether client is eligible to receive services	To classify each person as low need, medium need and high need with respect to their functional ability. Only people screened as being of medium and high need would receive a more thorough functional assessment	To assess in detail the functional needs of consumers assessed as being in medium and high need
Performed on:	All those referred for service	All those accepted as clients.	All clients with problems as identified through problem screen.
Performed by:	Referring agency or HACC agency	Any service provider	Accredited assessor
Performed when:	Prior to being accepted for service	When referred to service	At least yearly or when there is a significant change in the person's functional needs (ie significant enough to necessitate a new package of community care services)
Methods:	Telephone or face to face interview		In-depth interview or examination, generally including home visit
Result:	Accepted or rejected for service	Functional problems identified and medium and high need clients referred for more detailed assessment	Determine functional needs and potentially also inform funding level and provision of specific interventions

This is not dissimilar to the problem screen included in current versions of the CIARR (Client Information and Referral Record) form. Some version of this model is increasingly required by the range of new 'call centre' developments, and is a logical next step as program-level tools come into line with each other. The end result might even be to simplify and improve the data that can be used for both program and population group planning.

The results of the Tier 1 functional screen should then trigger a more comprehensive assessment, but only for those who require it. This more comprehensive assessment forms the second tier in the assessment process. It would not be provided to all clients, but rather only to those clients with identified needs and functional limitations. The ideas are illustrated in Table 2.

Why it's important to screen and what you can do with the information you collect

The aim of the Tier 1 screen is to differentiate between people who:

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

This is based on a really important idea – that not everyone needs a full assessment and that it wastes precious resources assessing those that don't.

Functional Screen

- 4 domains measured through 9 questions:
  - ◆Domestic functioning - 3 questions (housework, travelling to places and shopping) to screen for domestic function & 2 questions (handling money and taking medication) that also act as a screen for cognitive or behavioural problems
  - ◆Self-care functioning - 2 questions (walking, bathing)
  - ◆Challenging behaviour - 1question
  - ◆Cognitive functioning - 1 question

A couple of other assumptions underpin the introduction of standardised functional screening and suggest why screening is important:

- Screening and assessment aren't new ideas in the HACC sector. What is new is the idea that these processes should be standardised and consistently applied.
- Consistency is required to achieve equity between clients – providers need to measure 'need' consistently if the consumer's need for HACC services is to be equitably measured. The 'need' of the consumer should not be influenced by the service that assesses them.
- Consistency is required to achieve equity between agencies and regions – agencies and regions need to measure 'need' consistently if their relative need for HACC resources is to be fairly evaluated.
- Consistency is required to measure changing 'needs' over time. Many HACC services believe that the 'needs' of their clients are increasing. But, without evidence, all they can do is present an opinion rather than the evidence.

So, why should HACC services support the introduction of standard approaches?

- The current approach is not in the best interest of clients. Clients referred between agencies undergo multiple screens and assessments and tell their story multiple times. In the absence of consistent standards, a client's 'need' may be assessed differently by different professionals and agencies, for no apparent reason.
- The current approach is inefficient. HACC services assess their clients and use that information to plan for their care. If the client needs to be referred to another agency, they complete separate referral information. Unrelated to all that, they also collect and report minimum data set information and, often, try and collect other information as well to demonstrate the needs of their clients. Why not bring these together and use the one set of information (screening and assessment information) for multiple purposes? The sector cannot afford to collect information (including assessment information) for only one purpose. The burden of data collection can only be minimised if the sector consistently collects a smaller and more useful set of information and learns how to use that information for multiple purposes.
- The current system is costly. Our estimate (Owen et al 2001) is that over 500 assessment tools are in common use, many the work of multiple working parties each of which have 're-invented the wheel'. Staff moving between agencies have to re-learn new procedures in each agency and clients moving between agencies have to be re-assessed.

- If everyone collected the same information, they would be able to produce the type of information shown in Table 3 below. This table shows some of the results from the national field trial that was undertaken in the development of the functional measures (see page 5). The power of such information, if routinely collected across the community care sector, goes without saying.

Table 3: Percentage of HACC clients in national field trial rated as requiring some help with self-care and domestic activities of daily living

Item	Completely independent	Requires any level of assistance
Housekeeping	8.5%	91.5%
Shopping	12.0%	88.0%
Laundry	14.9%	85.1%
Food preparation	18.6%	81.4%
Travel out of walking distance	21.7%	78.3%
Stairs	29.5%	70.5%
Ability to handle finances	29.8%	70.2%
Bathing	43.5%	56.5%
Dressing	44.6%	55.4%
Ability to manage own medicines	46.9%	53.1%
Telephone	52.6%	47.4%
Bladder	55.0%	45.0%
Transfer	61.5%	38.5%
Grooming	62.2%	37.8%
Mobility/walking	62.9%	37.1%
Toilet use	63.7%	36.3%
Feeding	64.7%	35.3%
Bowels	72.9%	27.1%

- Finally, these tools are supported by evidence about their reliability, validity, sensitivity and specificity. Adoption of evidence-based practice is in the interest of everyone.

How to undertake a Tier 1 Functional Screen

Purpose

A multi-dimensional functional assessment has an essential role in the determination of appropriate care for the frail aged and those with disabilities and their carers. However, such an assessment is time consuming and is unnecessary for a large number of clients.

A first tier screen allows service professionals to decide whether a more detailed or comprehensive assessment is required, thereby conserving and better targeting resources. It facilitates appropriate referral to other service providers and helps in the identification of clients with urgent needs.

What it is

The Tier 1 Functional Screen is a short telephone or face to face administered questionnaire. It consists of 9 carefully selected questions, which indicate client domestic, self-care, behaviour and cognitive functioning.

The Tier 1 Functional Screen 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). The literature also indicates that inability to carry out some domestic tasks may be an indicator of cognitive impairment (Cromwell et al 2002).

The Tier 1 Functional Screen does not attempt to capture all aspects of function. Rather, the 9 items in the screen have been selected because they are **good predictors** of how well a person is functioning in other aspects of their life.

Housework, travelling and shopping are *domestic tasks* that are generally lost early. A 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-care tasks such as feeding or toilet use (see Table 3 on page 8 for the percentage of the HACC population who were independent on the various tasks in the national field trial). A client who is independent in mobility and bathing does not generally require more detailed assessment of self-care tasks.

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

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

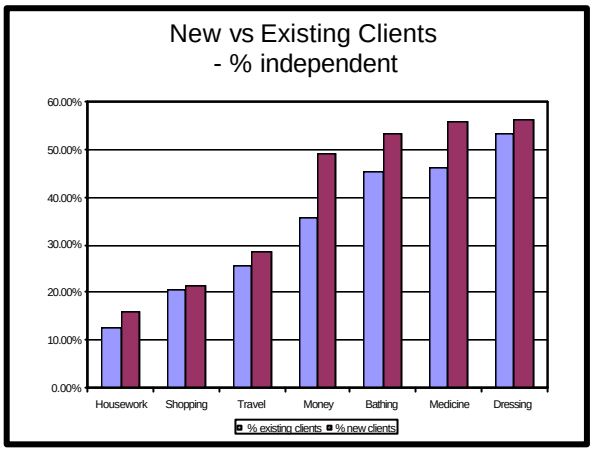
Who to screen

The screen should be applied in the following situations:

- When a potential client 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 client.
- When an existing client 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 client.

How often to screen

There are no national or state standards on this as yet and so it is essentially a decision for each agency. We have reproduced on the right the results of the national field trial. We found that the functional needs of existing HACC clients are much greater than those newly referred for services. The implication is obvious - if all you do is screen new referrals, you will significantly underestimate the functional needs of your clients.



As a rule of thumb, it makes sense to re-screen each 6 months or when a client's service needs change, whichever comes first. Clients requesting new services should also be re-screened.

How to undertake a Tier 1 Functional Screen

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

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

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

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

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

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

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

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

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

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

Answers are limited to specific categories but the structure for the 7 questions in part 1 is the same:

Can do without help	Score 2
Can do with some help	Score 1
Cannot do	Score 0

If the respondent does not answer with an option, or qualifies the option, the options should be repeated and the respondent asked to select the option which best describes the situation.

An example:
Can you get to places out of walking distance...

Without help (can drive your own car, or travel alone on buses or taxis)?	2	None
With some help (need someone to help you or go with you when travelling)?	1	Domestic function
Or are you completely unable to travel unless emergency arrangements are made for a specialised vehicle like an ambulance?	0	Domestic function

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

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

The items on the Tier 1 Functional Screening form

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

Unique client ID
Use your own agency identifier.

Date Screened
Date of the telephone or face to face interview.

Items 1 to 7:
These are self-explanatory. The questions should be read exactly as they appear. The respondent is to select only from the options provided.

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

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

Part Two: Questions for you to complete

Ratings (Items 8 and 9)
0 = yes (presence of reported cognitive or behavioural problem)
2 = no (no evidence of any cognitive or behavioural problem)

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

What to do with the Tier 1 Functional Screen information once you've collected it

- If the client has no functional limitations identified during the Tier 1 Functional Screen, consider whether the client actually meets the eligibility criteria for HACC services. But remember that a high score on the functional screen might not mean a client is ineligible for a service. They might for instance be the carer of a child with a disability in need of respite services, or someone with an episodic illness or fluctuating condition. However, most people with a perfect score on the screen will not meet eligibility criteria for HACC services.
- Use the guidelines on the form to guide your decision about whether the client needs a more comprehensive assessment. These guidelines come from the results of the national field trial and should be regarded as 1st generation at this stage. They are guidelines only and you should use your own judgement. These guidelines will inevitably be refined over time as screening becomes routine and as expertise develops. Practical issues such as the availability of comprehensive assessment services and the urgency of the person's needs should also guide your decision. Issues such as who you refer to for the subsequent assessment, the referral pathway and so on need to be decided locally.
- If the person has low or moderate functional needs and does not need further assessment, use the information to decide whether the client needs services and, if so, what it is they need. The Tier 1 Functional Screening results alone will not be sufficient for this as you will need a range of other information (eg, information about carers and social supports, financial resources). Use all of the information you have to develop a care plan.
- Enter the data into a database. There is no one method for how you should go about this and it needs to be resolved by each agency. But, if you want to understand how the needs of your clients are changing over time and have the opportunity to compare your client's with others, you will need to collect and analyse the information. The more the information is collected and used, the more valuable it will become.

An overview of comprehensive assessment

Comprehensive Assessment

The aim of the Tier 2 Functional Assessment is to measure the same four domains picked up by the screen, 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.

Functional Assessment

- 4 domains using 4 different instruments
- ***Functional*** assessment only, not comprehensive assessment
- HACC agencies will routinely need and use other important information:
  - diagnoses, use of medications, carer availability, risk of abuse, social and community support etc

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 information below is included to illustrate how functional assessment might be incorporated into a more comprehensive assessment model.

Victoria is taking a lead role and the Victorian Better Access to Services (BATS) project has taken a comprehensive approach across the whole of the primary and community care sectors (DHS 2001) that is already influencing directions in other jurisdictions. After an international literature review and a national practice review (Owen 2001), a range of tools were developed and have been field-tested to cover a wider set of domains of client characteristics (Australian Institute for Primary Care 2002). The scope of the tools was defined by those services, agencies and GPs involved in Victorian Primary Care Partnerships.

The field testing of the suite of tools resulted in some refinements to the original model proposed in the initial policy documents and the result is summarised in Table 4. This makes a distinction between the depth and scope of different activities, and it is the depth that defines the difference between screening and assessment. The HACC functional screen is undertaken as part of the INI (screen) while the HACC functional assessments are part of a comprehensive assessment.

Table 4: A tiered screening and assessment model – the Victorian approach

Activity	Depth	Scope	Used for referral purposes?	Status in Victoria
Initial Needs Identification (INI)				
Consumer Information	Shallow	Narrow	Yes	Required
Summary and Referral Information	Shallow	Narrow	Yes	Required for all referrals and should be used for intake summary functions
Supplementary Profiles	Shallow	Broad	Yes, where relevant	Optional, to be used at discretion of the professional, except in the case of HACC referrals where the living arrangements and functional profiles should be used (both to make and receive a referral)
Assessment:				
Service specific	Deep	Narrow	No	Undertake as part of service provision
Specialist	Deep	Narrow	No	Undertake when required by consumer
Comprehensive	Deep	Broad	Yes, where relevant	Undertake when required by consumer
Care Plan	Deep	Narrow	No	Local agency responsibility
Service Coordination Plan	Deep	Broad	Yes, where relevant	Should be used with consumers with both multiple agency involvement and complex needs

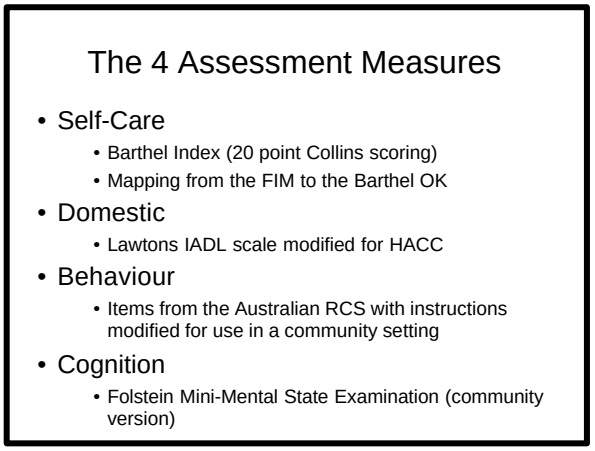
An important feature of the Victorian approach is that it is not limited to HACC but also includes community health, primary medical care and community care. One implication of this partnership model is that the scope of screening must necessarily be wide, leaving of course, plenty of scope for disagreement.

Variations on this type of approach are being increasingly considered by other jurisdictions and it now looks more likely that options for the future will be variations around this broad model. NSW is conducting a series of pilot studies during 2002 but the scope is mostly limited to HACC services. South Australia has a series of pilot projects in progress and is testing a model similar to that of Victoria in its ERA project (Department of Human Services South Australia 2002). Queensland is considering assessment issues in the context of its aged care strategy.

But, irrespective of how such systems will eventually evolve in different places, all involve functional screening and assessment and capture the domains discussed below.

The four functional domains in a comprehensive assessment

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 (Eagar 2001). The actual tools to capture the data items have been designed and modified for use in community settings. A description of each follows.



Who and how to assess

Tier 2 Functional Assessment tools should be used with those clients requiring assessment following their initial Tier 1 Functional Screen. Services should also consider re-assessment if a request is made for new or additional services, if a person's needs have changed, or as part of any regular or routine review process.

Tier 2 Functional Assessment should only occur face-to-face with clients, and should not be attempted by phone contact alone. The exception to this is where a service provider or care planner is getting information from a carer or other informant. You can't do a second hand Mini-Mental, but remember that the screening tool asks proxy respondents about memory problems and confusion (item 8).

Apart from the behaviour scale (which can only be done through a third party or by observation), the tools are suitable for administration either directly to a client, or to a carer, friend or other person. This might be a service provider who is contacting the care coordinator or a service provider on behalf of a client.

How self-care functioning is assessed in a Tier 2 Functional Assessment

Self-care is measured by a version of the Barthel Index (the 20 point Collins scoring). 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 screen and the other functional assessments, the higher the score, the more independent the person is. An example is shown in the box.

The FIM or Functional Independence Measure is the other main tool in use for measuring this domain and this can be successfully mapped to scores on the Barthel. Further details are available from the authors.

An example of the type of information you can expect to generate at the agency level is shown in the box. This shows a profile of the self-care functioning of clients in the national HACC field trial.

An example of the self-care scale - Mobility question

0	Immobile
1	Wheelchair independent including corners etc.
2	Walks with help of one person (verbal or physical)
3	Independent (but may use any aid, eg. stick)

Self Care Assessment Results

Item	Completely independent	Requires any level of assistance
9. Stairs	29.5%	70.5%
10 Bathing	43.5%	56.5%
8. Dressing	44.6%	55.4%
2. Bladder	55.0%	45.0%
6. Transfer	61.5%	38.5%
3. Grooming	62.2%	37.8%
7. Mobility	62.9%	37.1%
4. Toilet use	63.7%	36.3%
5. Feeding	64.7%	35.3%
1. Bowels	72.9%	27.1%

How to undertake a self-care assessment

Put in your unique client ID and date so you don't lose track of valuable information.

This set of items is the 20 point Modified Barthel Index (Collins scoring). The scoring instructions are on the form for each item.

Complete the assessment based on all information available to you. This will include:

- your judgement based on interviewing or observing the client,
- information contained in a referral letter,
- client notes and/or
- information provided by a proxy respondent, such as a friend, relative, carer or referring agency.

Mobility here (item 7) means mobility about the house or indoors. Outdoor mobility is covered in the domestic function assessment (item 6 on transportation). A person is rated as independent if they can use an aid or rail etc. This independent rating is applied in item 9 on stairs if they themselves can use an aid without help.

There is room on the form for a total score (out of 20).

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

1. Rate what the person is capable of doing rather than what they do. Take into account the help that is required and the amount of prompting – if someone can do something but has chosen to have someone else do it (like dressing), rate as independent. If help or prompting is involved, rate as 1 or 2. If unable to do the task, rate as a 0.

2. Where an item is not relevant (eg, no stairs), rate what the person would be capable of doing if the item were relevant to their situation.

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

How domestic functioning is assessed in a Tier 2 Functional Assessment

This is sometimes called Instrumental Activities of Daily Living – how a person gets around and what they can do in their domestic environment. The original Lawtons IADL Scale 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.

An example of the domestic scale - Mode of Transportation question

1	Requires manual assistance from more than 1 person or does not travel at all
2	Travel limited to taxi or automobile with assistance of one other person
3	Travels on public transportation when assisted or accompanied by another
4	Travels independently on public transportation or drives own car. Includes arranging own travel via taxi but not otherwise using public transport.

The structure of all questions is the same. Like the HACC screen and the other functional assessments, the higher the score, the more independent the person is. An example is shown in the box.

An example of the type of information you can expect to generate at the agency level is shown in the box. This shows a profile of the domestic functioning of clients in the national HACC field trial.

Domestic Assessment Results

Item	Completely independent	Requires any level of assistance
4. Housekeeping	8.5%	91.5%
2. Shopping	12.0%	88.0%
5. Laundry	14.9%	85.1%
3. Food preparation	18.6%	81.4%
6. Mode of transportation	21.7%	78.3%
8. Ability to handle finances	29.8%	70.2%
7. Medications	46.9%	53.1%
1. Telephone	52.6%	47.4%

How to undertake a domestic function assessment

There are eight items that score in the direction of worst or incapable (1) to best or most independent (4 or 3).

Remember the social and cultural context of the client is the point of reference throughout, but especially for items on food and housekeeping.

The shopping and transportation items can tend to get compounded, so shopping should be rated on what the person would be capable of doing if they could get to the shops. Transport is about what type of transport the person needs and how independent they are in getting around.

The rating instructions contain three main points and we can't emphasise them enough:

1. Rate what the person is capable of doing rather than what they do. Take into account the help that is required and the amount of prompting – if someone can do something but has chosen to have someone else do it (like shopping), rate as 4; if help or prompting is involved, rate as 2 or 3.

2. Where an item is not relevant – no phone, no shops, no transport – rate what the person would be capable of doing if the item were relevant to their situation.

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

How behavioural functioning is assessed in a Tier 2 Functional Assessment

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 important occupational health and safety implications.

The tool adopted as the national standard is a community modification from the Australian Residential Classification Scale, 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 covering how often the behaviour has occurred: extensively, intermittently or occasionally.

The structure of all questions is the same. Like the HACC screen and the other functional assessments, the higher the score, the more independent the person is. An example is shown in the box.

An example of the behaviour scale - Verbally Disruptive or Noisy question

Extensively	1	Requires monitoring for recurrence and supervision
Intermittently	2	Requires monitoring for recurrence and then supervision on less than a daily basis
Occasionally	3	Requires monitoring but not regular supervision
Not applicable	4	Does not require monitoring (consumer has not engaged in the behaviour in the past)

Behaviour Assessment Results

Item	Any level of problem reported	No problem reported
3. Physically aggressive	12.0%	88.0%
1. Problem wandering or intrusive behaviour	12.6%	87.4%
2. Verbally disruptive or noisy	19.3%	80.7%
5. Danger to self or others	22.3%	77.7%
4. Emotional dependence	39.0%	61.0%

An example of the type of information you can expect to generate at the agency level is shown in the box. This shows a profile of the behavioural functioning of clients in the national HACC field trial.

How to undertake a behavioural assessment

The rating instructions ask the scorer to take into account all sources of information, not just the assessment interview with the client or carer.

There are 5 items and they are scored from 1 to 3 (extensively, intermittently, occasionally), with 4 used where there is no evidence or information to make a rating. The implications for carers and service providers, in terms of levels of monitoring and supervision, are what the tool is trying to capture. The general rating instructions on the forms. They are:

1. Take into account all sources of information (discussion with the consumer and carers, staff etc as well as what you observe).
2. If you have insufficient information to make a rating, rate 4 'not applicable'.

3. **Not applicable** means that you learn of no circumstances in which the consumer has engaged in the behaviour in the past.
4. **Monitoring** means that you learn of circumstances in which the consumer has engaged in the behaviour in the past. Current and future service providers will need to observe the consumer, be aware when similar circumstances occur and take appropriate intervention to prevent the recurrence of the behaviour.
5. **Supervision** means that current or future service providers will need to ensure that specific situations or triggers which are likely to give rise to the behaviour do not occur, or are managed in ways to minimise the likelihood of occurrence.
6. **Daily** means during a twenty four hour period.
7. **Question 1** includes night wandering and also to the consumer wandering from home or, while wandering, interfering with other people or their belongings.
8. **Question 2** includes abusive language and verbalised threats directed at family, carers, neighbours or a member of staff. It also includes a consumer whose behaviour causes sufficient noise to disturb other people. That noise may be either (or a combination of) vocal, or non-vocal noises such as rattling furniture or other objects.
9. **Question 3** includes any physical conduct that is threatening and has the potential to harm a family member, a carer, a visitor or a member of staff. It includes, but is not limited to, hitting, pushing, kicking or biting.
10. **Question 4** is limited to the following behaviours: (a) active and passive resistance other than physical aggression (b) attention seeking (c) manipulative behaviour and/or (4) withdrawal.
11. **Question 5** refers only to high-risk behaviour. It includes behaviour requiring supervision or intervention and strategies to minimise the danger. Examples of such behaviour include unsafe smoking habits, walking without required aids, leaning out of windows, self- mutilation and suicidal tendencies. This question is about behaviour and does not apply where a consumer has a medical condition that might lead to injury, for example, through fitting or loss of consciousness. It does not apply to a range of behaviours which might in the longer term be considered as damaging or health reducing such as smoking generally or non-compliance with a specialised diet. It applies where there is an imminent risk of harm.

How cognitive functioning is assessed in a Tier 2 Functional Assessment

The scale described here is the community version of the Folstein Mini-Mental State Examination (the MMSE "30 point scale"). 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. Indeed, 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.

How to undertake a cognitive assessment

The MMSE should only be completed if the rater 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.

Frequently asked questions

Q: If I add them up, what does the total screening score mean?

A: The screen is designed specifically as a prompt for further assessment where necessary. While each item tells you something, the 'total score' on the screen isn't particularly meaningful because it is influenced by the number of items used to capture each domain (eg, there are 5 domestic items but only 2 self-care items). So, person who scores 10 is not necessarily more functional dependent than a person who scores 12, because it depends on the mix of activities that each person can and can't do. Having said that, a person who scores 2 will clearly be more functional dependent than a person who scores 16.

Q; My issue is not so much about the tools but about how we use them in practice. Is the intention to standardise local referral processes and case management systems?

There is no way that processes can be standardised across Australia, and no one to our knowledge is attempting this. The idea is to achieve nationally consistent domains and measures. But how these are actually implemented on the ground needs to be resolved locally, taking into account local needs and resources.

Q: The question is whether in all instruments the client's responses are recorded, or whether the worker's knowledge of the client is taken into account in rating the client? We understand it to be the latter but would like clarification of this.

A: The general rule is to rate based on how the client responds. If you already know the client and your perception differs from that of the client or carer, the screen is a good opportunity for a conversation between you to try and understand why you see things differently.

Q: My issue with the screen is how to determine whether someone is low, medium or high need. From what I understand, triggering an assessment for self-care would immediately classify the person someone of high/complex needs.

A: Not necessarily, because need is more complex than that. On page 3 we discuss what function is and isn't. The screen measures functional ability and functional burden and not functional need for services (a service-based approach). A person may have very poor function but, because they have good family and social support, have a low service need.

The thresholds for assessments have been designed so that you don't get either too many who get assessed unnecessarily or too many that should be assessed who miss out, rather than to automatically determine who is low, medium or high need.

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

A: Use Item 5 to rate mobility inside the house. If the client has trouble outside, this will be reflected in their ratings on other domestic items, such as getting to places out of walking distance and shopping. While the screening form does not capture most of the important environmental information, a self-care or domestic assessment may be triggered by the various items on the screen. After the screen, an assessment of self care (generally inside) and domestic (a mixture of inside/outside and getting around) function should be triggered.

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

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

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

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

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

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

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

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

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

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

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

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

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The HACC Functional Screening and Assessment Tools

(electronic copies of these tools in Acrobat format are available for downloading from the CHSD website: www.uow.edu.au/commerce/chsd)

National HACC Functional Screening Instrument

Part One: Questions to ask the client (or the person who represents the client)[1]:

Unique Client ID_____ Date screened_____

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

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

NOTES:

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

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

Part Two: Questions for you to complete

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

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

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

Recommended functional assessments based on this functional screen

Domestic

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

Self-care

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

Cognition

Refer for a cognitive assessment if:

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

Behaviour

Refer for a behavioural assessment if:

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

National HACC Functional Assessment Instrument

Part 1: Self Care Functional Assessment[2]

Unique Client ID_____ Date assessed_____

Item	Score	Item	Scoring instructions	Score
1: Bowels	0 1 2	Incontinent (or needs to be given enema) Occasional accident (once/week) Continent	Rate based on the last week. If needs enema from nurse, then incontinent. Occasional = once a week.	
2: Bladder	0 1 2	Incontinent, or catheterised and unable to manage Occasional accident (max. once per 24 hours) Continent (for over 7 days)	Rate based on the last week. Occasional = less than once a day. A person with a catheter who can completely manage the catheter alone is scored 'continent'.	
3: Grooming	0 1	Needs help with personal care Independent face/hair/teeth/shaving	Rate based on the last week. Refers to personal hygiene: doing teeth, fitting false teeth, doing hair, shaving, washing face. Implements can be provided by helper.	
4: Toilet use	0 1 2	Dependent Needs some help, but can do something alone. Independent (on and off, dressing, wiping). Should be able to reach toilet/commode, undress sufficiently, clean self, dress and leave.	With help = can wipe self and do some of the other listed activities.	
5: Feeding	0 1 2	Unable Needs help cutting, spreading butter etc. Independent (food provided in reach). Able to eat any normal food (not only soft food). Food cooked and served by others. But not cut up.	Help = food cut up, consumer feeds self.	
6: Transfer (from bed to chair and back)	0 1 2 3	Unable - no sitting balance Major help (one or two people, physical), can sit. Minor help (verbal or physical) Independent	Dependent = no sitting balance (unable to sit); two people to lift. Major help = one strong/skilled, or two normal people. Can sit up. Minor help = one person easily, OR needs any supervision for safety.	
7: Mobility	0 1 2 3	Immobile Wheelchair independent including corners etc. Walks with help of one person (verbal or physical) Independent (but may use any aid, eg. stick)	Refers to mobility about the house or ward, indoors. May use aid. If in wheelchair, must negotiate corners/doors unaided. Help = by one, untrained person, including supervision/moral support.	
8: Dressing	0 1 2	Dependent Needs help, but can do about half unaided Independent (including buttons, zips, laces, etc.)	Should be able to select and put on all clothes, which may be adapted. Half = help with buttons, zips, etc. (check!), but can put on some garments alone.	
9: Stairs	0 1 2	Unable Needs help (verbal, physical, carrying aid) Independent up and down	May carry any walking aid to be independent.	
10: Bathing (or showering)	0 1	Dependent Independent (or in shower)	Usually the most difficult activity. Must get in and out unsupervised, and wash self. Independent in shower = independent if unsupervised/unaided	
Total score (out of 20)				

[2] The 20 point Modified Barthel Index (Collins scoring)

Part 2: Domestic Functioning Assessment in Activities of Daily Living[3]

Unique Client ID_____ Date assessed_____

Item number	Item	Score	Task	Score
1	Telephone	1	Cannot use telephone at all	
		2	Can answer telephone but cannot dial	
		3	Can dial a few well-known numbers. Includes dialling only numbers that can be speed dialled.	
		4	Can operates telephone on own initiative - looks up and dials numbers etc. Includes use of TTY machine if no other assistance required.	
2	Shopping (do not include transport here –rate at item 6)	1	Completely unable to shop	
		2	Needs to be accompanied on any shopping trip	
		3	Can shop independently for small purchases	
		4	Can take care of all shopping needs independently	
3	Food preparation	1	Needs to have meals prepared and served	
		2	Can heat and serve prepared meals, or can prepare meals but not does maintain adequate diet (see note below)	
		3	Can prepare adequate meals if supplied with ingredients	
		4	Can plan, prepare, serve adequate meals independently	
4	Housekeeping	1	Cannot participate in any housekeeping tasks	
		2	Can perform some light daily tasks but not at a level necessary to maintain an acceptable standards of cleanliness (see note below)	
		3	Can perform light daily tasks eg dishwashing, dusting	
		4	Can maintain house independently	
5	Laundry (excludes ironing)	1	All laundry must be done by others	
		2	Can launder small items - rinses socks, stockings etc	
		3	Can do personal laundry but needs help with heavier items such as bedding and towels	
		4	Can do personal laundry completely	
6	Mode of transportation	1	Requires manual assistance from more than 1 person or does not travel at all	
		2	Travel limited to taxi or automobile with assistance of one other person	
		3	Can travel on public transportation when assisted or accompanied by another	
		4	Can travel independently on public transportation or can drive own car. Includes arranging own travel via taxi but not otherwise using public transport.	
7	Responsibility for own medications	1	Is not capable of dispensing own medication	
		2	Can take responsibility if medication is prepared in advance in separate dosages	
		3	Can take responsibility for taking medications in correct dosage at correct time	
8	Ability to handle finances	1	Incapable of handling money	
		2	Can manage day-to-day purchases, but needs help with banking, major purchases etc	
		3	Can manage financial matters independently (budgets, writes cheques, pays rent, bills, goes to bank), collects and keeps track of income	
Total score (out of 30)				

General rating instructions

1. Rate what the person is currently capable of doing rather than what they actually do. In assessing capability, take into account not only physical function but also cognition (such as problems caused by dementia or an intellectual disability) and behaviour (such as unpredictable challenging behaviour). Consumers able to complete a task with verbal prompting should not be rated as independent (and therefore should be rated as a 2 or a 3).
2. In rating an item that is irrelevant (for example, the person does not have a phone or has no shops in the vicinity or does not use any medications), rate based on what the person would be capable of doing if the item was actually relevant to their situation.
3. When assessing issues such as whether diet is adequate or there are acceptable standards of cleanliness, take into account the person's social and cultural context. Rate based on what is adequate or acceptable in that context and not in your own.

[3] Scale based on original Lawtons IADL scale, but modified by the CHSD specifically for use in the HACC program.

Part 3: Behavioural functioning assessment[4]

Unique Client ID_____ Date assessed_____

Number	Item	Score	Implications for carers and/or community service providers	Score
1	PROBLEM WANDERING OR INTRUSIVE BEHAVIOUR			
	Extensively	1	Requires monitoring for recurrence and supervision	
	Intermittently	2	Requires monitoring for recurrence and then supervision on less than a daily basis	
	Occasionally	3	Requires monitoring but not regular supervision	
	Not applicable	4	Does not require monitoring (consumer has not engaged in the behaviour in the past)	
2	VERBALLY DISRUPTIVE OR NOISY			
	Extensively	1	Requires monitoring for recurrence and supervision	
	Intermittently	2	Requires monitoring for recurrence and then supervision on less than a daily basis	
	Occasionally	3	Requires monitoring but not regular supervision	
	Not applicable	4	Does not require monitoring (consumer has not engaged in the behaviour in the past)	
3	PHYSICALLY AGGRESSIVE			
	Extensively	1	Requires monitoring for recurrence and supervision	
	Intermittently	2	Requires monitoring for recurrence and then supervision on less than a daily basis	
	Occasionally	3	Requires monitoring but not regular supervision	
	Not applicable	4	Does not require monitoring (consumer has not engaged in the behaviour in the past).	
4	EMOTIONAL DEPENDENCE			
	Extensively	1	Requires monitoring for recurrence and supervision	
	Intermittently	2	Requires monitoring for recurrence and then supervision on less than a daily basis	
	Occasionally	3	Requires monitoring but not regular supervision	
	Not applicable	4	Does not require monitoring (consumer has not engaged in the behaviour in the past)	
5	DANGER TO SELF OR OTHERS			
	Extensively	1	Requires monitoring for recurrence and supervision	
	Intermittently	2	Requires monitoring for recurrence and then supervision on less than a daily basis	
	Occasionally	3	Requires monitoring but not regular supervision	
	Not applicable	4	Does not require monitoring (consumer has not engaged in the behaviour in the past)	
Total score (out of 20)				

General rating instructions

1. Take into account all sources of information (discussion with the consumer and carers, staff etc as well as what you observe).
2. If you have insufficient information to make a rating, rate 4 'not applicable'.
3. **Not applicable** means thatyou learn of no circumstances in which the consumer has engaged in the behaviour in the past.
4. **Monitoring** means that you learn of circumstances in which the consumer has engaged in the behaviour in the past. Current and future service providers will need to observe the consumer, be aware when similar circumstances occur and take appropriate intervention to prevent the recurrence of the behaviour.
5. **Supervision** means that current or future service providers will need to ensure that specific situations or triggers which are likely to give rise to the behaviour do not occur, or are managed in ways to minimise the likelihood of occurrence.
6. **Daily** means during a twenty four hour period.
7. **Question 1** includes night wandering and also to the consumer wandering from home or, while wandering, interfering with other people or their belongings.
8. **Question 2** includes abusive language and verbalised threats directed at family, carers, neighbours or a member of staff. It also includes a consumer whose behaviour causes sufficient noise to disturb other people. That noise may be either (or a combination of) vocal, or non-vocal noises such as rattling furniture or other objects.
9. **Question 3** includes any physical conduct that is threatening and has the potential to harm a family member, a carer, a visitor or a member of staff. It includes, but is not limited to, hitting, pushing, kicking or biting.
10. **Question 4** is limited to the following behaviours: (a) active and passive resistance other than physical aggression (b) attention seeking (c) manipulative behaviour and/or (4) withdrawal.
11. **Question 5** refers only to high-risk behaviour. It includes behaviour requiring supervision or intervention and strategies to minimise the danger. Examples of such behaviour include unsafe smoking habits, walking without required aids, leaning out of windows, self-mutilation and suicidal tendencies. This question is about behaviour and does not apply where a consumer has a medical condition that might lead to injury, for example, through fitting or loss of consciousness. It does not apply to a range of behaviours which might in the longer term be considered as damaging or health reducing such as smoking generally or non-compliance with a specialised diet. It applies where there is an imminent risk of harm.

[4] Items from the Australian RCS with instructions modified by the CHSD for use in a community setting

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Part 4: The cognitive assessment[5]

Unique Client ID_____ Date assessed_____

(Complete only if you are trained in the MMSE. Otherwise leave blank)

ORIENTATION:	SCORE	POINTS
What is the year?	[ ]	1
What is the season?	[ ]	1
What is the date?	[ ]	1
What is the day of the week?	[ ]	1
What is the month?	[ ]	1
What city/town are we in?	[ ]	1
What state are we in?	[ ]	1
What country are we in?	[ ]	1
What town/suburb are we in?	[ ]	1
What is the address?	[ ]	1
REGISTRATION:		
Name three objects, taking one second to say each. Then ask the person to repeat them. Give one point for each correct answer. 'Apple Table Penny.'		
Repeat the answers (up to six times) until the person learns them	[ ]	3
ATTENTION AND CALCULATION:	[ ]	5
A Ask the person to subtract 7 from 100, then subtract 7 from he answer. Keep subtracting 7 until they reach 65. (93, 86, 79, 72, 65).		
B Ask the person to spell the word WORLD backwards		
NB *Subjects are given both A and B, record the highest score		
RECALL:		
Ask the person: "Now what were the three words I asked you to remember?	[ ]	3
LANGUAGE:		
Naming: What is this called? (Show the person a wrist watch)	[ ]	2
What is this called? (Show the person a pencil)		
Repetition: Have the person repeat "No ifs, ands or buts".	[ ]	1
Allow only one trial.		
Reading: Have the person read and do the following command as printed on the back of this form ('CLOSE YOUR EYES')	[ ]	1
3 stage command: Have the person follow a 3 stage command: 'Take a paper in your right hand, fold the paper in half using both hands, and put the paper down using your left hand'.	[ ]	3
Writing: Have the person write a short sentence. Do not dictate a sentence, it is to be written spontaneously. It must contain a subject and verb and be sensible. Correct grammar and punctuation are not necessary.	[ ]	1
Copying: Now copy the design that you see printed (design on back of this form). The results must have 5 sided figures with intersection forming a four sided figure. Ignore tremor and rotation	[ ]	1
TOTAL	[ ]	30

[5] The Mini-Mental State Examination (community version)

CLOSE YOUR EYES