

interRAI Overview

- “Core items” assessment: Home Care Assessment (“HC”); screening tool
 - “items” important in all care settings (communication, self-care, behavior, cognition, medical, functional)
 - have identical definitions, observation time frames, and scoring across environments
 - a multi-track decision tree: certain answers are called “triggers” that move assessor to supplemental assessment tools

“Triggers”

- Numerical values indicate whether a problem exists and the degree of severity; sends the assessor to the next track (efficiencies here)
- Next tracks: Other possible Supplement Assessment tools, i.e.:
 - Functional Supplement
 - Mental Health Supplement

Home Care Assessment System

- Two parts: Screening and CAPs
- Compatible with the other interRAI assessment systems
- For adults in home and community-based settings

Home Care Assessment: Screening

- “Minimum Data Set” tool for screening in key domains of:
 - Function, health, social support, and service use
- Designed for use by clinical professionals, but with appropriate training can be done by persons without clinical background
- Requires communication with person (primarily) and caregiver/family member; in private
- Requires observation in home environment; 3 day observation period
- Requires record review

HC Assessment: Cognition Domain Example

Section C	
Cognition	
<p>It is important to determine the person's actual performance in remembering, making decisions, and organizing daily self-care activities. These items are crucial factors in many care planning decisions, in part because of their impact upon the person's ability to follow instructions and treatment regimens, and to make independent decisions in the community.</p>	
C1. Cognitive Skills for Daily Decision Making	
Intent	To record the person's actual performance in making everyday decisions about the tasks or activities of daily living. These items are especially important for further assessment and care planning in that they can alert the assessor to a mismatch between a person's abilities and his or her current level of performance, as the family may inadvertently be fostering the person's dependence.
Definition	<p>Here are some examples of decision-making tasks:</p> <ul style="list-style-type: none"> ■ Choosing items of clothing ■ Knowing when to eat meals ■ Knowing and using space in the home appropriately ■ Using environmental cues (such as clocks or calendars) to organize and plan the day ■ In the absence of environmental cues, seeking information appropriately (i.e., not repetitively) from family in order to plan the day ■ Using awareness of one's own strengths and limitations in regulating the day's events (for example, asking for help when necessary) ■ Making prudent decisions concerning how and when to go out of the house; where applicable, acknowledging the need to use a walker or other assistive device and using it faithfully
Process	Interview and observe the person, then consult with a family member or other caregiver. Review the events of each day. The inquiry should focus on whether the person is actively making decisions about how to manage tasks of daily living, and not whether the caregiver believes that the person might be capable of doing so. Remember that the intent of this item is to record what the person is doing (actual performance). When a family member takes decision-making responsibility away from the person regarding tasks of everyday living, or when the person chooses not to participate in decision making (whatever his or her level of capability may be), the person should be considered as having impaired performance in decision making.
Coding	Enter the single number that corresponds to the most correct response. If the person receives a score of "5", do not complete the rest of Section C or any of Sections D, E, or F; instead, skip directly to Section G.

- 0. Independent** — The person's decisions in organizing daily routines and making decisions were consistent, reasonable, and safe (reflecting life-style, culture, values).
- 1. Modified independence** — The person organized daily routines and made safe decisions in familiar situations, but experienced some difficulty in decision making when faced with **new tasks or situations only**.
- 2. Minimally impaired** — In specific recurring situations, decisions were poor or unsafe, with cues/supervision necessary at those times.
- 3. Moderately impaired** — The person's decisions were consistently poor or unsafe; the person required reminders, cues, or supervision at all times to plan, organize, and conduct daily routines.
- 4. Severely impaired** — The person never (or rarely) made decisions.
- 5. No discernable consciousness, coma** — The person is nonresponsive. (Skip to Section G.)

Memory/Recall Ability

NOTE: If the person received a score of "5" ("No discernable consciousness, coma") on Item C1, do not complete Items C2–C5 or any of the items in Section D, Section E, or Section F. Instead, proceed directly to Section G.

To determine a person's ability to remember recent and past events (short-term and situational memory) and to perform sequential activities (procedural memory).

- C2a. Short-term memory OK** — Seems, appears to recall after 5 minutes.
- C2b. Procedural memory OK** — Can perform all or almost all steps in a multi-task sequence without cues.
- C2c. Situational memory OK** — Both recognizes the names/faces of caregivers frequently encountered and knows the location of places regularly visited (bedroom, kitchen, etc.).
- C2a. Short-term memory OK** — Conduct a structured test of short-term memory (for the preferred approach, see the following "Example"). If this is not possible, ask the person to describe a recent event that you should both have knowledge of (for example, the election of a new political leader, a major holiday) or that you can validate with a family member (for example, what the person had for breakfast). **If there is no positive indication of memory ability, score this item "1" for "Memory problem."**
- C2b. Procedural memory OK** — This item refers to the cognitive ability needed to perform sequential activities. Dressing is an example of such an activity, as multiple steps are required to complete the entire task. The person must be able to perform or remember to perform all or most of the steps in order to be scored "0" for "Memory OK". If the person demonstrates difficulty in two or more steps, code as "1" for "Memory problem". Remember that persons in need of care in the home often have physical limitations that impede their independent performance of activities. Do not confuse such physical limitations with the cognitive ability (or inability) to perform sequential activities.

Example of a Structured Approach for Assessing Short-Term Memory

Ask the person to remember three unrelated items (such as book, watch, and table) for a few minutes. After you have stated all three items, ask the person to repeat them to you (to verify that you were heard and understood by the person). Then proceed to talk about something else, perhaps by going on to another part of the assessment. Do not be silent; do not leave the room. In 5 minutes, ask the person to repeat the name of each item. For persons with verbal communication deficits, nonverbal responses are acceptable (for example, when asked to point to items that are to be recalled, he or she can do so). **If the person is unable to recall all three items, Item C2a should be scored "1" for "Memory problem".**

C2c. Situational memory OK — This two-part measure of orientation assesses the person's cognitive ability to recognize both people and places. To be coded as OK, the person must **both** recognize the names/faces of frequently encountered family members or caregivers **and** know the location of places regularly visited (bedroom, dining room, places visited outside the home). It is not necessary for the person to know the street number of the house or apartment, but he or she should be able to find the way to his or her room, recognize the purposes of particular rooms, etc.

Coding

For C2a, C2b, and C2c, code for recall of what was learned or known.

NOTE: When you are coding C2c, the person must demonstrate positive abilities in BOTH types of situations (i.e., caregiver names/faces AND locations) to be coded as "0". If the person demonstrates difficulty in one or both areas, code "1" for "Memory problem".

0. Yes, memory OK

1. Memory problem

Examples of How to Code Memory/Recall Ability

Mrs. L is a 90-year-old former librarian who became a home care client 2 days ago, after being discharged from a rehabilitation hospital for continued occupational and physical therapy following surgical repair of a hip fracture. During the assessment Mrs. L was articulate about her recent health history (including the names of the acute and rehabilitation hospitals, orthopedic surgeon, and primary nurses). She enumerated her current medication list and when the medications were to be taken, and reported that she did this activity without help. She introduced her two visiting daughters to the assessor by name. She also provided a brief social history. This information was validated as accurate via a conversation with her daughters, a review of the hospital discharge summary, and a review of the labels on the medication bottles.

For Item C2a, Mrs. L should receive a score of "0" for "Yes, memory OK".

For Item C2b, she should receive a score of "0" for "Yes, memory OK".

For Item C2c, she should receive a score of "0" for "Yes, memory OK".

After Screening with HC Assessment

- HC screening can trigger thirty interRAI Clinical Assessment Protocols (“CAPs”)
 - Both detailed assessment of area of need and decision support for choosing goals
 - Average person triggers ten CAPs
- HC and the Functional Supplements together trigger the entire set of CAPs
 - Also trigger a variety of other interRAI “scales” and “quality indicators”
 - i.e., skin breakdowns

Screening branches out . . .

- Screening “triggers” CAPs (average person triggers 10 of 30 CAPs)
 - Clinical Assessment Protocols are more detailed assessment and also decision tool for goal-writing
- Screening and CAPs contribute to “Scales” (status and outcome measures), i.e.,
 - Aggressive Behavior Scale
 - ADL Hierarchy
 - Cognitive Performance Scales
 - Depression Rating Scale

Performance Scales, i.e.,



IADL Performance Scale

Score	IADLS
0-6	Meal preparation
0-6	Ordinary housework
0-6	Managing finances
0-6	Managing medications
0-6	Phone use
0-6	Stairs
0-6	Shopping
0-6	Transportation

Range: 0-48

Scoring in self-performance:

0 = Independent — No help, setup, or supervision

1 = Setup help only

2 = Supervision — Oversight/cuing

3 = Limited assistance — Help on some occasions

4 = Extensive assistance — Help throughout task, but performs 50% of task on own

5 = Maximal assistance — Help throughout task, but performs less than 50% of task on own

6 = Total dependence — Full performance by others during entire period

8 = Activity did not occur during entire period, Score = 6

Home Care Quality Indicators

- Home Care Quality Indicators, or HCQIs, includes twenty-two HCQIs covering nine domains
 - nutrition, medication, incontinence, ulcers, physical function, cognitive function, pain, safety/environment, and “other”

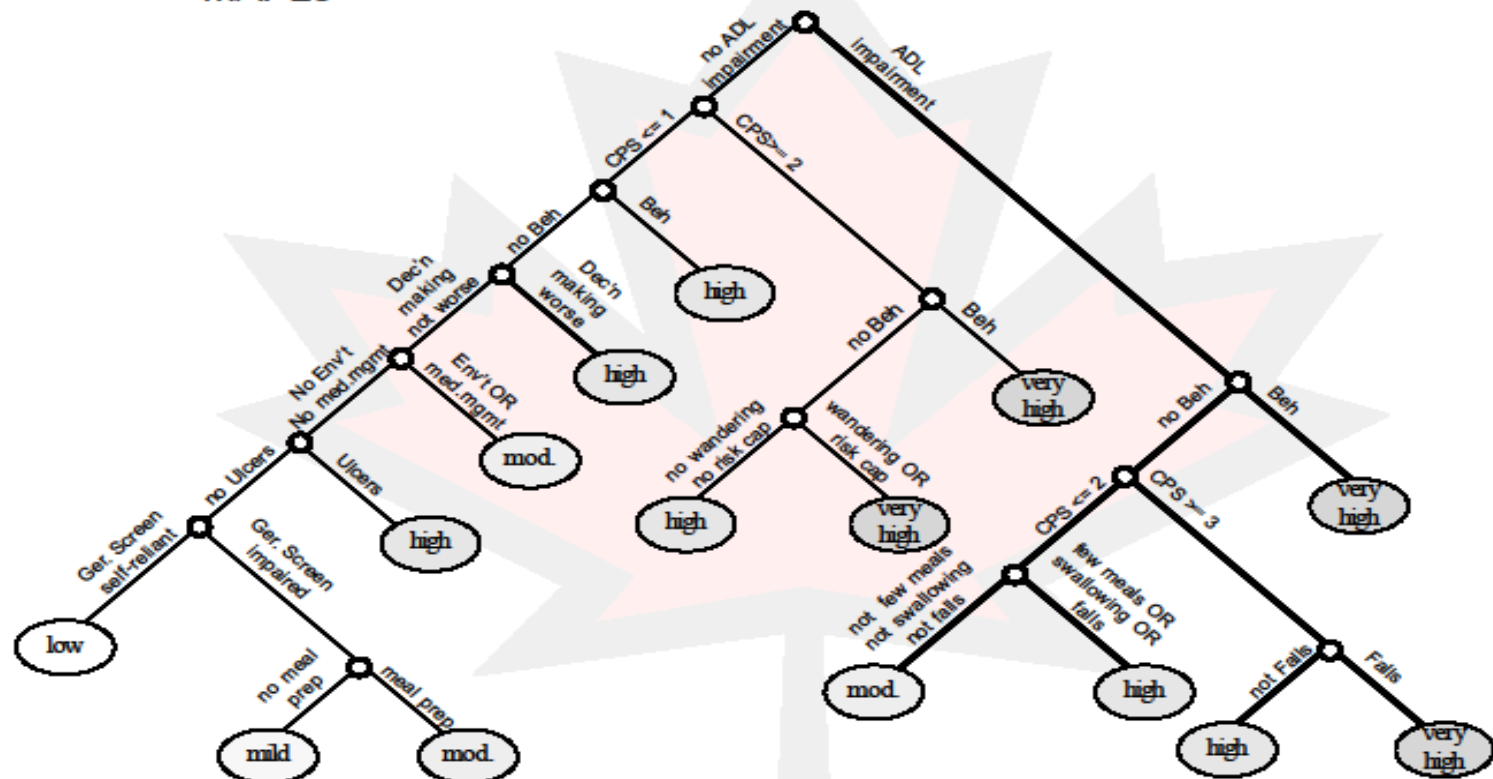
MAPLe

(Method for Assigning Priority Levels; Home Care Tool)

- Screening tool to differentiate service seekers/clients into five priority levels, based on their risk of adverse outcomes.
 - Lowest priority level have no major functional, cognitive, behavioral, or environmental problems and are considered self-reliant.
 - Highest priority level is based on presence of ADL impairment, cognitive impairment, wandering, behavior problems, and the interRAI nursing home risk CAP.
 - Research has demonstrated that the five priority levels are predictive of risk:
 - Individuals in the highest priority level are nearly nine times more likely to be admitted to a long- term care facility than are the lowest priority clients.
 - MAPLe also predicts caregiver stress.

Priority Levels

MAPLe



Clinical Assessment Protocols

- Strategies to address “problem conditions” and further detailed assessment
- Decision tool for goal-writing
 - i.e., includes guidelines, identifying strengths, addressing functional problems, cognitive status, preference alternatives, etc.
- Different in I/DD Assessments; “CAP” is “Collaborative Action Plans”

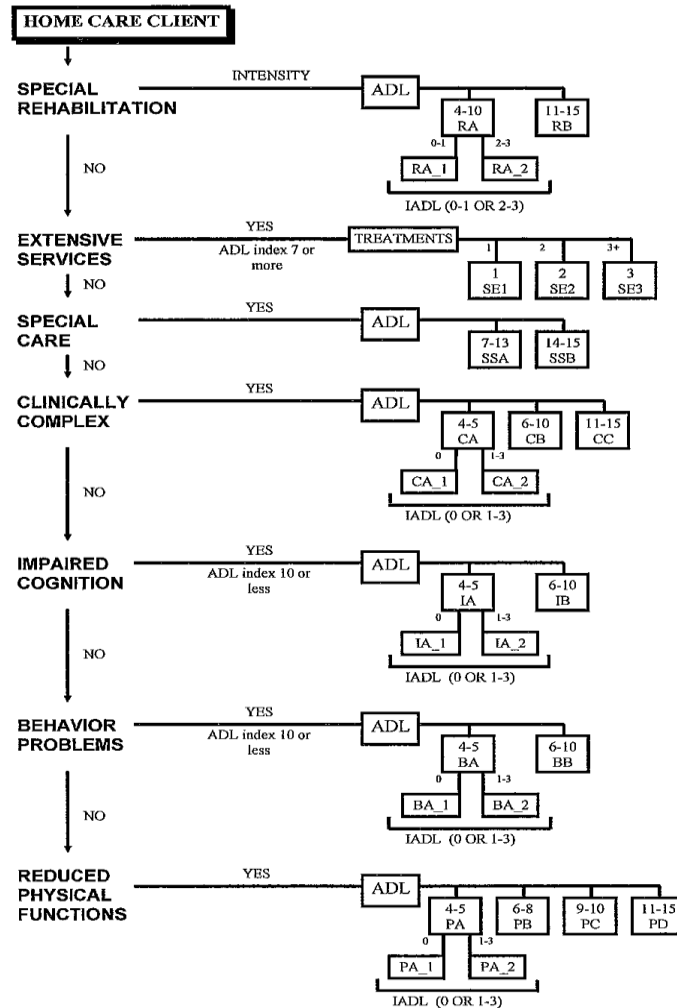
Case Mix Classification

- CAPs and Functional Supplements lead to decision support measures (numerical value for type of need and intensity of need)
- Algorithms group individuals into “homogenous” categories reflecting the relative costs of services and supports they are likely to use
 - Used for reimbursement, staffing plans, comparing populations within/across programs
- HC Case-mix Classification tool:
http://www.interrai.org/assets/files/Case-Mix%20Classification/rug-iihc_23_diagram.pdf

Case-mix Classification for HC



RUG-III/HC Home Care Classification



Assessment Instrumentation Used Across Health Care Sectors

- Smoother transitions and greater efficiencies because information derives from a single assessment system
 - Simultaneously use of varied services, i.e., use both mental health and personal assistance services
 - Sequential use of varied services, i.e., use community supports, then transfer to hospital, then transfer again to a post-acute care setting
 - Potentially no need to start over with assessing core items; things that don't change over time are identified

Things We Liked to Hear

- Individualized
- All interRAI instruments use the same methodology
 - same specified observation period
 - focus on observable behaviors
 - use of a few, “powerful questions” to assess areas of need
 - use of professional judgment to integrate multiple sources of information (records review, interviews, observation)
 - Good training and support
- Outcome measurement and continued data collection
- Capacity for adults to be followed across sectors and systems as they age
- Goal is coordinated service planning, seamless transition into other service sectors and systems

Things We Wanted to Know More About – Part 1

- What does a full interRAI assessment "system" actually look like; examples:
 - A data collection form is in the document packet
 - A user manual (I have read them; can answer questions)
 - Triggers list/information are in the CAPs
 - Algorithm for HC choice is on website;
http://www.interrai.org/assets/files/Screening%20Algorithms/mi_choice_diagram.pdf
 - Algorithm for priorities for all service seekers is the MAPle
 - Clinical Assessment Protocols, or CAPs
 - Status and outcome measures (like previous slide on IADL Performance Scale);
<http://www.interrai.org/assets/files/Scales/CHESS%20Scale.pdf>

Things We Wanted to Know More About – Part 2

- Case Mix Classifications and Individualization; how it translates to amount and types of services provided to individual
 - Result in a flat rate of benefit amount based on homogenous category? Do “utilization intensity categorizations” dictate service hours?
 - How will deviation from the resource amount be treated/funded?
 - Does the system perform automated determination of service hours?
 - Appeal process?

More Information

- Instruments overview from interRAI:
 - <http://interrai.org/instruments.html>
- Review in New Zealand 3/1/2017:
 - <http://insitemagazine.co.nz/2017/03/01/interrai-review-costs-outweigh-the-benefits/>
- For the data wonks:
 - <http://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-8-277>