Which interRAI assessment to use and when to use it

Information for assessors

Introduction

An extract from Ministry of Health and District Health Board interRAI Service Specifications

The purpose of the Services is to use the relevant interRAI assessment to assess, at a minimum, the needs of older people (people 65 years of age and over[1]) for access to long-term publicly funded support in the community or for residential care.

The assessment replaces all existing non-specialist and non-standardised assessment mechanisms used to determine need for long-term support services for older people.

Relevant is determined as:

- The Contact Assessment for all clients with non-complex needs or who need short term support until a Community Health Assessment or Home Care Assessment can be completed, for example to support discharge from hospital for clients who have not had a interRAI assessment previously. Non-complex is defined as scoring less than 4 on the Urgency for Assessment outcome scale in the Contact Assessment. DHBs may determine the timeframe between obtaining a Contact Assessment Urgency for Assessment score of 4 or more and a CHA or HC being completed with the client, provided the timeframes for 4, 5 or 6 are published *(in their Agreement report*). A close timeframe is desired.

- The Contact Assessment over the telephone to identify clients for whom a face to face visit is indicated. When used over the telephone the assessment must be completed according to the protocol set out in (*section 8 Service Components below*).

- The Community Health Assessment (CHA) for clients who are considered to have moderate clinical complexity or have scored 4 or more on the Urgency for Assessment Outcome scale in the Contact Assessment. The supplements to the CHA (mental health / functional) must be completed as soon as possible (for example within 2 weeks) if they are triggered within the CHA. Note; reassessments may be completed using a supplement only as long as it is within a year of the CHA being completed[2] using the previous CHA as a basis.

- The Home Care assessment for clients who are considered to be clinically complex or have scored 4 or more on the Urgency for Assessment Outcome scale in the Contact Assessment.

[1] And those assessed as being close in age and interest
[2] The CHA is not required to be completed by DHBs who may choose to use the Home Care assessment instead.

- The Home Care assessment for clients who have been in hospital for less than 90 days (using the adjusted 90 day coding) who are considered to be clinically complex or have scored 4 or more on the Urgency for Assessment Outcome scale in the Contact Assessment.

- The Home Care assessment for clients who are entering residential care permanently.

- The Long Term Facility Assessment for client's in permanent residential care needing reassessment in the facility or in an inpatient setting[3].

[3] The LTCF is not a requirement in an inpatient setting if the resident has not had a previous LTCF.

interRAI Methodology

A Summary Guide to Which Assessment to Use When

The following table provides guidance about which interRAI assessment tool to use for assessing older people for long term funded[4] support services, such as Home Based Support Services, Respite Care or Carer Support type services; or for residential care[5].

Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)[6]	Use Home Care (HC)	Use Long Term Care Facility (LTCF)	Use Palliative Care	Comment
Community referral. Unknown profile.	If 'urgency for assessment score' is < 4 proceed to developing a support plan[7]. If >4 escalate, allocate services and assess with HC[8].	CHA is useful for determining complexity leading to a care plan.				DHBs are likely to have different response times for an HC follow up following an outcome score of 4 or 5 or 6 from the Contact Assessment.
Community referral. Appears non complex[9].	If 'urgency for assessment score' is < 4 proceed to developing support plan. If >4 escalate to HC.					.
Community referral. Some		And proceed to care plan or use Functional Health	And proceed to care plan			

[4] An interRAI assessment is required prior to accessing long term publicly funded support services. In this instance long term is defined as 6 weeks from the 1st date of receiving HBSS in the home.
[5] It is anticipated that DHBs may use the assessments for wider purposes as well.

[6] Qualifications to be trained in the CHA are the same as for home care.
[7] A support plan describes a home based support services response to need. A care plan is a holistic response that may or may not include home based support services.
[8] It is anticipated that DHBs will have a (publishable) timeframe for when escalated assessments will be completed.
[9] Non complex clients may be identified from the referral as there will be no reports about shortness of breath, no need for dressing or personal hygiene help and no signs of low mood or carer stress.

Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)[6]	Use Home Care (HC)	Use Long Term Care Facility (LTCF)	Use Palliative Care	Comment
complexity known.		Supplement if triggered in software because of client's complexity and proceed to care plan.				
Community referral. Complexity known.			And proceed to care plan.		Only for client with a clinical prognosis of a year or less to live and only for those DHBs with competent palliative care assessors, otherwise use the interRAI Home Care assessment.	Prognosis must be made by a medical professional or Clinically if you asked 'would you be surprised if this person still with us in a years time" i.e assessor clinical discretion to select appropriate assessment.
Community referral. Mental health issues suspected.		Proceed to care plan or assessor will continue assessing using the CHA Mental Health supplement if triggered, and proceed to care plan.				Mental Health supplement provides understanding about the client's mental health for a general assessor.
Community referral. Significant mental health issues known[10].			To determine need for HBSS or ARC. A specialist assessment for mental health issues may also be undertaken.			DHB specific service models will differ. If under joint funding arrangements and HBSS is accessed then interRAI assessment applies.

[10] In instances where the DHB is accessing NASC type services for long term HBSS or similar. It is not a requirement for services funded via other sources e.g. special mental health funding.

Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)[6]	Use Home Care (HC)	Use Long Term Care Facility (LTCF)	Use Palliative Care	Comment
Palliative care in ARC				And proceed to care plan		
Community referral. Entry to residential care is being considered.			Home care required to confirm community support is no longer appropriate.			
Respite care			If person is in respite care and needs assessment use HC < 90 Days Stay coding.			The ARC provider will have access to the CHA or HC assessment and associated care plan [11].
Inpatient discharge to community. (Previously unknown to needs assessment services).	Support plan to get client home and proceed to care plan.	At scheduled date if CA 'urgency for assessment score' is > 4.				Once client is assessed with CHA a CA is no longer appropriate. i.e. interRAI assessments may only be scaled up.
Inpatient discharge to community. (Previously known to needs assessment services).	If previous CA with urgency for assessment score <4		Reassess using < 90 Days Stay coding and proceed to care plan.			

[11] Access to the care plan is contingent on the assessor using the Momentum care plan. Alternate ways of sharing care plan will need to be considered by DHBs or providers who use other software. Care planning on paper where the Ministry funded Momentum care plan is available is not supported.

Older person's location and profile	Use Contact Assessment (CA)	Use Community Health Assessment (CHA)[6]	Use Home Care (HC)	Use Long Term Care Facility (LTCF)	Use Palliative Care	Comment
Inpatient referral. Entry to residential care is being considered.			Home care required to confirm community support is no longer appropriate[12]. Use HC < 90 Days Stay coding.			
Within residential care by residential care nurses				And proceed to care plan		Facility uses their current assessment until LTCF is adopted.
Re-categorisation of level of care within residential care.				And proceed to care plan [13].		Once facility has LTCF the DHB use that assessment rather than undertake another.
Re-categorisation of level of care during inpatient stay.				And proceed to care plan		Ideally the acute care tool is used, but it is not yet available. Alternatively NASC endorse the inpatient teams decision but uses an administration form not LTCF, new provider will complete LTCF on admission to facility.

[12] All older people accessing residential care require a home care assessment first.
[13] DHB assessors working in this area should be trained to use LTCF.

Additional scenarios related to an inpatient stay

#	Scenario	inpatient LTCF	Rationale	Recommended action
1	A person at one care level is admitted and returns to the same facility at the same level of care	No	Person is returning to same carer and no change of level decision required by NASC	When the person returns the provider will complete an LTCF assessment related to change in status (i.e. the acute episode).
2	A person from a rest home level care is admitted and returns to *same facility* but now hospital level care is recommended by inpatient team	No	Person is returning to same carer.	When the person returns the provider will complete an LTCF assessment related to change in status (i.e. the acute episode).
3	A person from a rest home level care is admitted and returns to a *different facility* but now hospital level care is recommended by inpatient team	No	Person is returning to different carer.	The provider will complete an LTCF assessment related to new admission when the person is admitted.

Where can I get further support?

You can contact the interRAI Education and Support team at any time about any issues or concerns – they are there to help.

Email: interRAI@dhbss.health.nz
Phone: 0800 10 80 44

For more information about interRAI in general and updates for trained nurses, please visit the website: www.interrai.co.nz.