To:	interRAI New Zealand Governance Board
From:	Brigette Meehan, National interRAI Services Manager Michele McCreadie, General Manager interRAI Services
Subject:	Agreements for use of the interRAI assessment system
Date:	1st August 2016

Purpose

The purpose of this paper is to summarise into one document the agreements about interRAI comprehensive clinical assessment use that have been made in New Zealand over the last eight years.

Recommendations

It is recommended that the interRAI New Zealand Governance Board:

- **Note** this summary of agreements
- **Note** that these have been collated from various documents and then approved by the Health of Older People Steering Group (22 June 2016)
- **Note** the 'What Assessment When' document (appendix 1) will be provided in a user friendly format on the interRAI New Zealand website
- **Endorse** the Agreements summarised in this document

Introduction:

The paper includes agreements made in New Zealand for the following:

For reference the paper also includes the following appendices:

1. 'What Assessment When' summary
2. Contact Assessment Telephone Assessment Protocol
3. Home Care – Assessing Community People who are in hospital – less than 90 day stay coding rules

To date agreements about interRAI assessment use have been recorded in several locations including the Age Related Residential Care Services Agreement (ARRC) and the Aged Residential Hospital Special Services Agreement (ARHSS); District Health Board (DHB) interRAI implementation contract; Ministry of Health (MoH) Guidance documents; interRAI New Zealand (NZ) Establishment Governance Board; and the Health of Older People (HOP) steering group.

This document recognises the:

- variability that arose during two national implementation projects to introduce interRAI assessment into DHBs and the aged residential care sector
- the absence of interRAI guidelines in the MoH Service Specifications for DHB Needs Assessment and Support Coordination (NASC) services
- the need for context when it comes to data interpretation for researchers and also to understand the trends across DHB's

Rationale for this paper:

interRAI Services now based within TAS arose from two projects: the DHB interRAI Implementation Project for home and community interRAI assessments (2008-2012) and the Comprehensive Clinical Assessment (interRAI) project introducing the Long Term Care Facilities assessment (LTCF) into ARC (2011-2015). Agreement about the operational use of interRAI assessments is required for consistent education and support to the sector, for the accurate interpretation of interRAI assessment data and to understand service performance.

The overall implementation of interRAI was defined in the (to be discontinued at end Sep 2016) MoH annual "interRAI Implementation Service" agreement held between the MoH and DHBs. Additionally, DHB interRAI agreements have been defined in the "what to use when" document (see appendix 1). These agreements were required, in part, because the Needs Assessment Service Coordination (NASC) service specifications were written in 2003 prior to the introduction of interRAI. Further, the current ARRC and the ARHSS agreements (clause D15A.4a) require the DHB's and ARRC/ARHSS facilities to observe and comply with all interRAI guidance issued by the interRAI New Zealand Governance Board (interRAI NZ).

interRAI planning guidance for the DHB and ARC sector is also provided in the "DHB Planning Priorities for Annual Plans and Regional Service Plans" 2015/2016, and 2016/2017. This guidance is provided by the MoH to assist DHBs to meet Ministerial expectations and is specific in direction regarding interRAI.

The national interRAI Data Analysis and Reporting Centre (DARC) is providing regular reports and has an approved interRAI Data Access Protocol enabling researchers to access data. A summary of interRAI agreements will enable recognition that differences in models of care, which in turn affect the interRAI assessment instrument selected, are taken into account when reviewing research and benchmark data.

The agreements for all interRAI assessment instruments and their use across the sectors are outlined in the first table, followed by agreements by assessment type: Contact Assessment (CA) which includes the Emergency Department (ED) screener; Community Health Assessment (CHA); Home Care (HC); Long Term Care Facilities (LTCF); Palliative Care (PC) and Palliative Care Hospice (PCH), and the source documents are also referenced.

The purpose of this paper is to summarise the agreements into one document and give the opportunity for the interRAI New Zealand Governance Board to provide their updated endorsement of these decisions.

1. InterRAI Assessments and their use across the sectors:

interRAI assessment is used to assess, at a minimum, the needs of older people (people 65 years of age and over and those being close in age and interest) for access to long-term publicly funded support in the community, or for entry into aged residential care. It is anticipated that DHB's use the assessments for wider purposes as well. Once a person is admitted to residential care it is used as the primary assessment to inform a resident's care plan.

	Agreement	Reference/Comment	Previously Endorsed or approved	Endorse Yes/No
1.1	Assessors using interRAI assessments must be health professionals for whom assessment is part of their scope of practice, and have current Annual Practicing Certificate (APC) or their discipline equivalent	Annual "interRAI Implementation Service" contract between the MoH and DHB's.	Approved by the interRAI NZ Establishment Governance Board	
1.2	Assessors must be trained by Educators accredited by the New Zealand interRAI Training Service (now TAS Education and Support Service)	Annual "interRAI Implementation Service" contract between the MoH and DHB's.	Approved by the interRAI NZ Establishment Governance Board	
1.3	Assessors must achieve and maintain the methodology training competencies and the software use competencies established by the New Zealand interRAI Training Service (now TAS Education and Support Service)	Annual "interRAI Implementation Service" agreement between the MoH and DHB's.	Approved by the interRAI NZ Establishment Governance Board.	
1.4	An interRAI assessment is required prior to accessing long term publicly funded Home and Community Support Services, for people aged 65 years or over or close in age and interest. The interRAI assessment instruments replace all existing non-specialist and non-standardised assessment mechanisms used to determine need for long-term support services for older people	Current MOH requirement in Annual "interRAI Implementation Service" contract between the MoH and DHB's.	Approved by HOP Steering Group 2016	
1.5	The interRAI assessment record is transferred with the person and remains with that persons' provider for the duration of care	Access & Transfer Model for the National interRAI software platform.	Approved by HOP Steering Group 2016	
1.6	Assessments are scaled for complexity and may only be scaled up: • If the Contact Assessment (CA) is completed and then the person's complexity increases and a Home Care (HC) assessment, Community Health Assessment (CHA) or Long Term Care Facilities (LTCF) assessment is completed it is not appropriate to revert back to a CA. • The exception being when a person scores 4 or more on the Urgency for Assessment scale in the CA when that person is recorded as "*A12 Hospital inpatient*" in that case a CA may be used.		interRAI International assessment methodology specification	
1.7	interRAI Assessments completed in the acute setting that result in the person entering aged residential care will NOT include the list of medications taken. • Proviso: a medication list is provided to residential care as part of the hospital	interRAI NZ Establishment Governance Board request to interRAI international for a New Zealand variation. Approved 2012.	Approved by interRAI NZ Establishment Governance Board.	

	discharge summary.			
1.8	New Zealand assessors will not record ICD 10 codes	interRAI NZ Establishment Governance Board request to interRAI international for a New Zealand variation. Approved 2012	Approved by interRAI NZ Establishment Governance Board.	
1.9	If a person is unsteady on their feet recording height and weight of home and community people is NOT mandatory: • When assessment shows that the person is unsteady on their feet their weight will not be recorded unless provided by GP; • Proviso: assessors will focus on unintended weight loss questions for these people; • Monitoring: report on the number of assessments with "% change" not recorded	interRAI NZ Establishment Governance Board request to interRAI international for a New Zealand variation. Approved 2012	Approved by interRAI NZ Establishment Governance Board.	

2. Contact Assessment (CA):

The CA is a shorter, screening assessment suitable for people living in the community with short term or non complex needs. Its main goals are to:

- support decision making related to the need and urgency for comprehensive assessment, support services and specialised rehabilitation services;
- provide minimum clinical information needed for short term services that may be put in place prior to further assessment
- record basic clinical information on persons who are unlikely to need additional comprehensive assessment.

Use in New Zealand:

The CA is used as above by Needs Assessment Service Coordination assessors in DHBs and in instances where DHBs have agreements with Home and Community Support Services (HCSS), the HCSS assessors use a CA to assess people with low needs e.g. who may require assistance with household management.

The Assessment Urgency Outcome (AUO) Scale:

The purpose of this scale is to determine whether or not the person needs further in-depth assessment. This score is calculated by assessment elements that relate to the person's physical health, person's mood, the family's ability to cope and the person's dependence with personal hygiene. The scale range is 1-6 with 6 being the most complex.

	Agreement	Reference/Comment	Previously Endorsed or Approved	Endorse Yes/No
2.1	The CA is used only if there is no previous HC/CHA/LTCF or ED screener (see scaling of assessments 1.6)		Approved by HOP Steering Group 2016	
2.2	A CA is used for home and community people with non complex needs. Clients who score 4 or more on the AUO scale must be followed up with a Home Care assessment.	What Assessment When. Version 11.	Approved by HOP Steering Group 2016	
2.3	The CA is used for people requiring reassessment where previously the AUO score was less than 4 and they continue to have non-complex needs. Note the CHA is a suitable alternative.	What Assessment When. Version 11.	Approved by HOP Steering Group 2016	
2.4	The CA is used for people previously assessed with CA in hospital and had an AUO Score of >=4 but are	What Assessment When. Version 11.	Approved by HOP	

	now likely to be non complex following the post acute recovery phase		Steering Group 2016	
2.5	The clinical response time for follow up assessment for people who have a CA AUO Scale score of 6, 5, or 4 is prioritised, with a score of 6 being more urgent than a score of 5 or 4.	Annual "interRAI Implementation Service" contract between the MoH and DHB's. DHBs are likely to have different response times for follow up and these were required by the MoH to be published. A close timeframe is desired.	Approved by HOP Steering Group 2016	
2.6	The CA can be used over the telephone according to the established MoH protocol (see appendix 2)	Annual "interRAI Implementation Service" contract between the MoH and DHB's. Established by the MoH and documented in the MoH interRAI Implementation Service Specifications with each DHB (2014/2015)	Approved by HOP Steering Group 2016	

3. Community Health Assessment (CHA):

The Community Health Assessment (CHA) is for people in the community who are considered/known to have low or moderate clinical complexity or mental health issues. It explores the level of complexity of need and identifies general health and living issues for people living in the community, so is useful if the persons profile is unknown.

The CHA is in two parts; a 'parent' and supplements. It is considered similar to the HC assessment because once parent and the functional supplement is completed all the data items are identical to the full HC assessment.

Everyone receives the parent assessment and only those with specific problem sets receive the relevant supplement. This modularized approach to assessment lets a person's needs and preferences be tracked using the fewest number of assessment items possible. The supplements in use are:

- The interRAI Functional Supplement (interRAI CHA-FS): this includes an expanded set of functional and clinical items.
- The interRAI Mental Health Supplement (interRAI CHA-MH): this includes an expanded item set on mental health- related diagnoses, symptoms, treatments, and life experiences. The items in this supplement describe the performance and capacity of the person in a variety of domains, with the majority of items serving as specific triggers for care planning. It provides an understanding about the person's mental health for a general assessor.

The CHA is like a Home Care Assessment which has been broken into two parts. Because the CHA (parent) and its supplements may be undertaken at separate times rules are required to protect data integrity.

	Agreement	Reference/Comment	Previously Endorsed or Approved	Endorse Yes/No
3.1	The CHA is required for people : a) with moderate clinical complexity or b) with a CA AUO scale score of > or =4 (unless a HC is selected instead, or a CA is appropriate for post acute reassessment)	What Assessment When. Version 11. Determined by the DHB's service delivery model.	Approved by HOP Steering Group 2016	
3.2	If the functional supplement (FS) option is triggered it must be completed at the same time as the CHA as an integral part of the assessment. a) If the FS has triggered (FS4a) then FS4b should	These rules are recommended by the national software service for data integrity in the software system.	Approved by HOP Steering Group 2016	

	= '1 Yes' b) If the FS has triggered (FS4a) and the FS is NOT going to be completed FS4b = '0- No' a note of explanation must be added to FS4 item c) Any supplement option must be completed within a very short time frame (if not possible on the same day).The Assessment Reference Date (ARD) must be the one documented in A8 for the 'parent' CHA assessment			
3.3	If the Mental Health option is triggered it is completed immediately or scheduled to be completed within two weeks and must use the Assessment Reference Date (ARD) detailed in A8 for the 'parent' CHA assessment. a) If the Mental Health option has been triggered and is not going to be completed a note of the clinical explanation should be entered in the ST1 section.	These rules are recommended by the national software service for data integrity in the software system.	Approved by HOP Steering Group 2016	
3.4	CHA reassessments are completed using the parent CHA and supplement options if they are triggered. Reassessing with supplement options alone is not endorsed.	Previously it was possible to reassess using the supplement only - as long as it was within a year of the CHA being completed. This use was not supported by interRAI international and was removed.	Approved by HOP Steering Group 2016	

4. Home Care Assessment (HC):

The HC is for people in the community who are considered to be clinically complex or have scored 4 or more on the Urgency for Assessment Outcome scale in the CA. It is also for people who have been in hospital for less than 90 days (using the adjusted 90 day coding, appendix 3) who are considered to be clinically complex or have scored 4 or more on the Urgency for Assessment Outcome scale in the CA. An interRAI HC is required for people who may require residential care, to rule out short term conditions that could be treated /reversed and ensure all home based options have been considered.

The assessment focuses on the person's functioning and quality of life by assessing needs, strengths, and preferences. It is generally used with frail older people or people with disabilities who are seeking or receiving formal health care and support services. It can be used to assess persons with chronic needs for care, as well as those with post-acute care needs (for example, after hospitalization or in a hospital-at-home situation). When used over time, it provides the basis for an outcome-based assessment of the person's response to care or services.

	Agreement	Reference/Comment	Previously Endorsed or Approved	Endorse Yes/No
4.1	A HC is used when there is known clinical complexity on referral or a CA AUO score in CA = 4 or > and the person is not in a post acute recovery phase	What Assessment When. Version 11.	Approved by HOP Steering Group 2016	
4.2	Assessments required prior to admission to ARC include a recent (within a maximum of 6 months) home care assessment. However the following are acceptable alternatives :CHA +FS or MH supplement or • Palliative Care (PC) assessment (these assessments are similar in clinical complexity)	ARRC and ARHSS contract section D16.1 2016 Annual Planning priorities item 3.	Approved by HOP Steering Group 2016	
4.3	An acute hospital inpatient who has a previous HC may be reassessed in hospital using the HC		interRAI International	

	and the < 90 days stay coding rules. (see appendix 3)		assessment methodology specification	
4.4	If a home care client is in residential care for respite care the ARC provider should have view access to the interRAI home care assessment and associated care plan.		Approved by HOP Steering Group 2016	
4.5	Should a home care client in ARC for respite care require interRAI reassessment use the HC assessment with *"HC< 90 Days Stay"* coding rules	What Assessment When. Version 11.	Approved by HOP Steering Group 2016	
4.6	If a person has been in Residential care for respite care for 90 days or more, a HC reassessment is not appropriate (LTCF assessment is used)	In interRAI Methodology long term care is defined as more than 90 days.	interRAI International assessment methodology specification	
4.7	For a person returning home from ARC placement a provisional package of supports is arranged with the HCSS and the HC assessment is completed (within two weeks is recommended)		Approved by HOP Steering Group 2016	

5. Long Term Care Facilities Assessment (LTCF)

The LTCF Assessment evaluates the needs, strengths and preferences of people who reside in residential care. It enables a health care provider to assess key domains of function, mental and physical health, social support and service use. Its use is mandated in the relevant clauses of the ARRC and ARHSS agreements. The interfaces with NASC are listed in the *"what assessment when v11"* document.

An LTCF is preceded by a HC assessment unless: a) the resident has had an interRAI Palliative Care (PC) or interRAI Palliative Care Hospice (PCH) assessment or b) the resident has been in Residential Care prior to the implementation of HC.

	Agreement	Reference/Comment	Previously Endorsed or Approved	Endorse Yes/No
5.1	A Subsidised Resident must have an interRAI LTCF assessment completed within 21 days of admission to a residential care facility Note: this applies to any person who has been needs assessed as requiring long-term residential care under the ARRC and ARHSS contracts regardless of subsidy entitlement.	ARRC and ARHSS contract section D16.2b Letter to all providers accompanying Variations Final May 2014	In the ARRC contract	
5.2	LTCF reassessments are completed at a minimum of 6 month intervals, or when at significant change in status has occurred.	ARRC and ARHSS contract section D16.4A	In the ARRC contract	
5.3	Residential Care people who are admitted to the acute hospital do not require a LTCF assessment while an inpatient. a) If they are discharged to the same facility (regardless of any change in level of care) the LTCF is completed at the facility b) If they are discharged to a different facility the LTCF is completed at the new facility.	What Assessment When. Version 11. Note: ideally the Acute Care (AC) tool would be used in the acute hospital setting but this is not yet available.	Approved by HOP Steering Group 2016	
5.4	The LTCF is used for re-categorisation of a resident's level of care within the residential care setting (reassessment due to significant change).	ARRC and ARHSS contract section D16.4A. aii	In the ARRC contract	
5.5	The LTCF may be used for assessing non ARRC and ARHSS residents in residential care as long as	interRAI methodology supports this decision.	Approved by HOP	

	the transfer of the interRAI assessment record is arranged and ongoing reassessment requirements are then met, and Additional assessments related to their specialist needs are undertaken; such as educational, vocational, or specialist mental health as required. (e.g: residents whose care is funded by Long Term Support for Chronic Health Conditions, Palliative care, those under 65 years of age, ACC)		Steering Group 2016	
5.6	The ARC facility may elect to complete an LTCF for respite residents to inform their care plan (especially if the person has recurring short periods of respite). In this instance the file is transferred to the ARC facility for the period of the assessment before being transferred back to the DHB as owner of the community client record. LTCF is not mandatory for respite residents in an ARC facility for <90 days	This is not common but may be useful to the provider if the resident is on a regular weekly stay arrangement eg every Friday.	Approved by HOP Steering Group 2016	
5.7	For Mental Health respite residents (aged 65 years or over or close in age and interest) residing in ARC requiring reassessment: a) If likely the person will transfer to HOP ARRC resident care a LTCF assessment is required. b) If likely the person will transfer to the community: i) use the HC with <90day stay coding or ii) use the LTCF if the person has been in residential care >90 days.	interRAI methodology supports this decision.	Approved by HOP Steering Group 2016	
5.8	Enrolled Nurses (EN's) are eligible to be trained as LTCF assessors. Once they reach competency they may complete as much of the assessment as the supervising Registered Nurse (RN) requests and sign off the sections they completed. The supervising RN takes responsibility for the assessment overall (even when wholly completed by the EN) and signs it off in the software.	Authorised by the Comprehensive Clinical Assessment (interRAI) project (LTCF) Steering Group (2015).	ARRC and ARHSS contract section D16.3A	

6. Palliative Care Assessment (PC) and Palliative Care Hospice Assessment (PCH):

(Currently used in a three DHB pilot). The Palliative Care Assessment is an alternative to the HC assessment. It provides a comprehensive assessment of the strengths, preferences, and needs of adults with a palliative care diagnosis or a recorded clinical prognosis of a year or less to live, in both facility-based and community-based hospice and palliative care programmes. There are two versions of the assessment. The interRAI PC Assessment contains the full assessment, whereas the Hospice Assessment consists of a subset of items from the PC Assessment and is more appropriate for persons with shorter prognoses. The prognosis must be made by a medical professional, with assessor clinical discretion as to which of the two assessments to select. There is no set standard for when or under what circumstances the different versions are used. The Palliative Care project team will make recommendations to the interRAI NZ Governance Board when the pilot is fully evaluated.

	Agreement	Reference/ Comment	Previously Endorsed Or Approved	Endorse Yes/No
6.1	The two palliative care assessments (Palliative Care Assessment and Palliative Care Hospice Assessment) can be used from 1 July 2016 by competent HC assessors who have achieved the PC competencies as established by the interRAI Services education and support service, during the course of the pilot.	On hold, awaiting review of the pilot (October 2016)	Approved by the interRAI NZ Establishment Governance Board.	
6.2	An LTCF can be used for people residing in residential care with palliative care needs.	Note: ideally the palliative care tool would be used but this is not yet available	Approved by HOP Steering Group 2016	

7. Security of interRAI data and data quality/integrity

The interRAI Education and Support Services have identified potential operational risks related to the security of people's clinical information and to service data quality /integrity. Remedies have been proposed to manage the potential risks however as the remedies may have implications for the sector workforce, endorsement of the Joint ARC Steering Group was obtained May 2016 and approval by the interRAI Governance Board is now sought.

	Agreement	Reference /comment	Endorsed or Approved	Endorse Yes/No
7.1	Security of Organisation/Facility Data (People's information): <u>Scenario a):</u> A user has left the organisation/facility and the organisation/facility has not contacted the interRAI service desk to discontinue access: Recommend: TAS provide advice to the sector reminding them to identify users requiring deactivation and complete Host notification paperwork prior to users leaving their organisation. <u>Scenario b):</u> A user has been found to have breached access permissions as outlined in the software "User set up" form and remedial action results in the recommendation to remove their access. Recommend: that TAS ensures full deactivation of the user's account in this circumstance.	The interRAI Education and support service has identified users who are no longer with an organisation yet their access has not been discontinued. Potentially a user could retain access as long as they changed their password every three months. An interRAI education and Support Service team member may identify the breach and advise the manager of the organisation. While performance management processes are in place as per the organisation's practices the user's access is deactivated.	Endorsed Joint ARC Steering Group 18 May 2016 Endorsed Joint ARC Steering Group 18 May 2016	
7.2	Data quality/integrity has been compromised: <u>Scenario a):</u> A "Direct Care" (able to complete all relevant assessments and care plan activities) user has failed the Annual Quality Review process and has not complied with the support requirements. Recommend: that the interRAI Education and Support service ensure the partial deactivation of this group of users through a change in level of momentum access to "Read and Clerical" (only able to add new persons to the system and view completed assessments)	The user is confirmed as not having maintained competency in the interRAI assessment methodology. They are no longer a competent interRAI assessor and the data input into the assessment is not valid. Changing to "Read and clerical" will eliminate the data quality risk.	Endorsed Joint ARC Steering Group 18 May 2016	

	Scenario b): A user is no longer a "Direct Care" level assessor and has not contacted the interRAI service desk to alter their level of access: Recommend: that the InterRAI Education and Support Service provides advice to the sector reminding them to identify users who are no longer assessors and to notify the National Software Service Host to partially deactivate the user to "Read and Clerical" level of access.	The interRAI annual competency process has identified users who roles no longer include completing assessments but still have the "Direct Care" level of access.	Endorsed Joint ARC Steering Group 18 May 2016	

8. Future planning

interRAI Services will maintain a centralised repository of nationally consistent agreements within the integrated interRAI Education and Support services. It will become a dynamic source document from which TAS can communicate agreed use of interRAI standards across the sector, understand sector performance and guide the interpretation of interRAI data.

	Agreement	Reference /comment	Previously Endorsed or Approved	Endorse Yes/No
8.1	New agreements, as required to support the use of interRAI assessments in New Zealand, will be presented to the board for endorsement			

References: Source Documents

1. Integrated "*what assessment when*" v11. A Guide for assessors to select the appropriate assessment instrument. Approved by the HOP Steering Group 11 March 2016. And April 2015 (LTCF in acute care scenarios for DHB's)
2. *Age Related Residential Care Services (ARRC) Agreement* : and Aged Residential Hospital Special Services (ARHSS) agreement (Psychogeriatric services). Contract specifications including agreed interRAI decisions. 1 July 2015
3. *1 July 2015 – 30 June 2016*. Contract specifications for the DHB implementation of interRAI and now superseded by the MOH CTAS MoU.
4. *MoH "Planning Priorities for Annual Plans and Regional Service Plans – 2016-2017*. Provided by the MoH to assist DHB and Shared Service Agency staff to meet Ministerial expectations. These are specific in their direction regarding interRAI business rules. December 2015
5. *Access and Transfer model for the National interRAI Platform v1.4*. for the interRAI Home Care (HC) & Long Term Care Facility (LTCF) record; approved by the interRAI Governance Board 28 March 2013
6. *MoU: MoH and TAS*. For the purpose of providing a national interRAI service. July 1 2015
7. *NZ interRAI Governance Board Meeting minutes* 20 November 2012
8. *CA Telephone contact protocol:* CA workbook v5 Dec 15 – appendix 7.
9. *Home Care >90 day stay coding rules.* HC workbook

Appendix 1: What assessment when V 11

What assessment to use when V 11 June 2

Appendix 2: Contact Assessment Telephone Assessment Protocol

- Contact Assessments should only be undertaken in instances where a full Home Care assessment is available should the Contact Assessment results indicate that this is required.
- Contact Assessments should only be completed by trained interRAI assessors who meet the 'Criteria for Training and Workforce Requirements' as listed in the Ministry's interRAI National DHB Project Implementation Plan (2008-2012).
- Good practice as well as the expectations of the Health and Disability Consumer rights requires that people must be clearly advised that an assessment or reassessment is planned. Ideally this is arranged with the older person by letter or alternatively, by a phone call to confirm an appointment time for a different occasion.
- At the beginning of the telephone call, the assessor would advise the person of the purpose of the call, outline what they can expect will happen during the call, and inform them they can seek a review of the assessment findings if they wish.
- The assessor should ask the person for the name and contact details of a family or whanau member that the assessor could also contact to discuss the assessment if required or if desired by the older person.
- The assessment phone call should be conducted like a conversation and be finished within 20-30 minutes.
- It is reasonable for the assessor to ask some clarifying questions to elicit the required information, however, the New Zealand interRAI Methodology group has yet to confirm additional questions required for the New Zealand context. It is anticipated that no more than 3-5 questions will be required.
- Sounding the person out about potential service planning arrangements or preferences is reasonable provided this is completed within the 30 minute time frame and does not pre-empt the analysis of the assessment results.
- Older people with significant hearing difficulties, visual, speech, language or cognitive difficulties such as dementia, or who have English as a second language should be assessed face to face. These issues are usually identified on the original referral for services letter. If not, the assessor should stop the call and make home visit arrangements.

Appendix 3: HC – Assessing Community People who are in hospital – less than 90 day stay coding rules

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