Overview of InterRAI

The InterRAI is a comprehensive person-centered review of the participant's health and functioning, in order to properly assess their *needs* for services

All questions need to be reviewed with the participant and/or their responsible parties to ensure accuracy at the time of the assessment

- InterRAI is completed in Function Portal. Once you have a visit scheduled in Function Portal you will be able to document the visit note (ie. see alert on the right hand side of the screen in FP). Once the visit note is submitted you will then see an alert to be able to document the InterRAI.
- All of the questions in the InterRAI must be answered.
    - **NEVER** guess or assume answers. If you are unsure about which answer to select, ask the participant more specific questions and then select the appropriate response.
- Start with broad questions about the section
    - Get more specific when needed based on the participant's answers
- Be consistent
    - There is a lot of overlap between sections of the InterRAI, and between other documents during your comprehensive needs assessment. Your answers need to match between the InterRAI, PCSP, HEDIS, HRA/DSNP, and the visit session.
- There are several different sections to the InterRAI session, below are some examples of information that is covered in the assessment
    - Demographic and General Information about the Participant
    - Participant's Health and Functioning (ADL/IADL's)
    - Informal supports and Formal Care
    - SPG Tool: This tool is automatically populated once you have completed all prior sections
- **Do NOT hit submit** once completed the InterRAI, when completed you hit "add session" and select "dismiss"

Helpful Tips & Examples

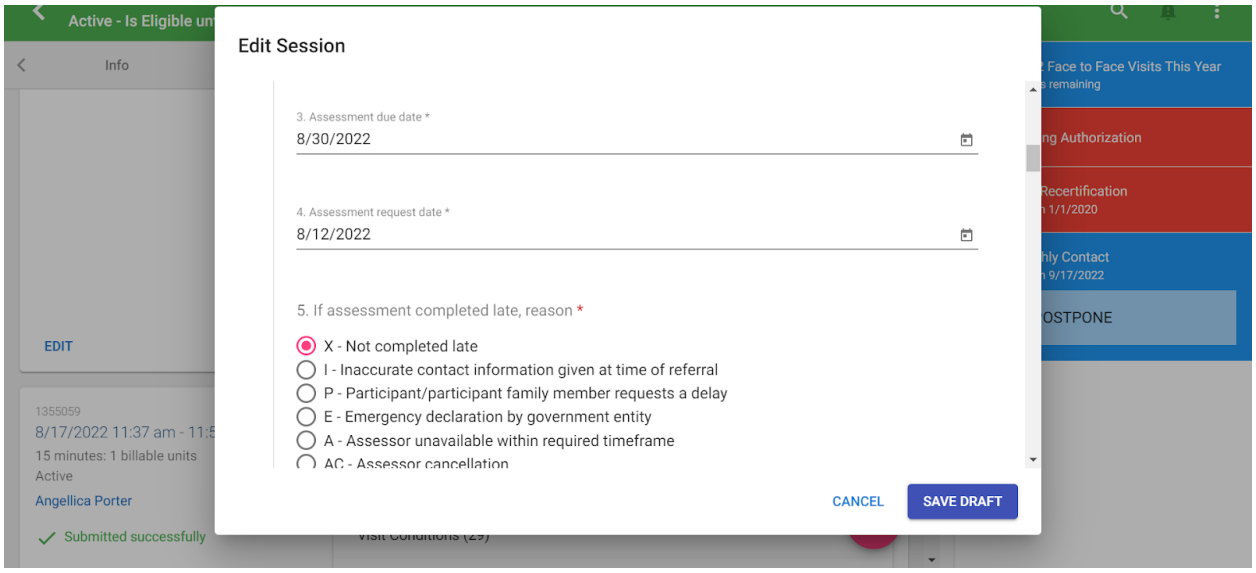
Identification Information

Demographic and other general information about the participant. Much of this information can be found on the participant's Info tab of Function Portal (this information is to be verified with the participant when you are doing the assessment and the information in the InterRAI and in the Info Tab must match)

Assessment Dates

The assessment due date is either indicated in Function portal in the alerts on the right hand side of the screen (for Annual and NPO visits) or it is within 14 days of the discharge from the hospital or the request for a visit from the participant (for Change Events). You MUST ensure the dates are correct and then select a corresponding reason.

Example:



Marital Status

- If the participant is listed as "Single" in Function Portal, double check if they have been married in the past (then change Function Portal if necessary)
- Partner/Significant Other are the same and include those the participant is romantically close to, without being legally married
    - They may even refer to each other as spouses even if they aren't actually married

Payment Sources

Select *Yes* or *No* based on if the participant uses the following payment sources for Services. Information from this section MUST match the Info Tab in Function Portal.

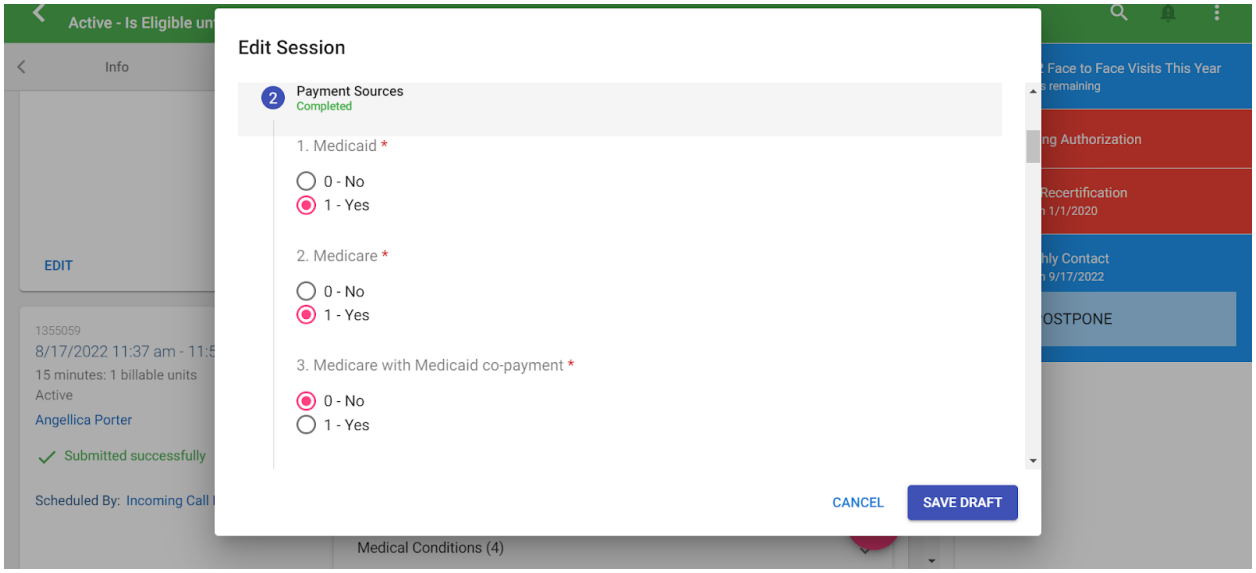
Medicaid – All participants use Medicaid. Therefore the answer should be **1-Yes**

Medicare – Answer will depend whether or not the participant has Medicare (check the Eligibilities tab in FP and verify with the participant during the visit

Medicare with Medicaid co-payment – Also known as the "Spend Down Program" Not common, answer is likely **0-No** (verify with participant during the visit

- It is NOT about having a copay.

Example:

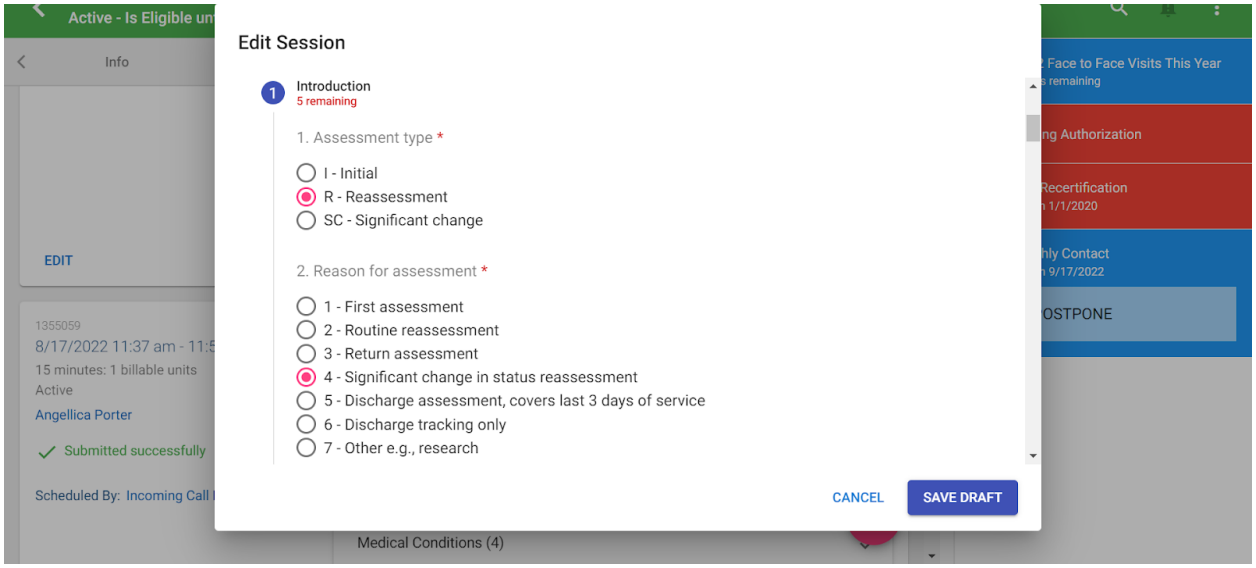


Reason for Assessment

Select the answer that applies to the type of visit you are completing, it must match

- New Participant Orientation (NPO) visits; answer is **1 – First Assessment**
- Annual Visit; answer is **2 – Routine Assessment**
- Change Event visit; answer is **3 – Return Assessment** or **4 – Significant Change** in Status Reassessment depending on why you are completing the visit.
    - If you are doing the visit because you need to address a participant requesting a change in services (with no change in their health), or to follow up on a critical incident that did not actually change the participant's health then select (3)
    - If you are following up because there was a change in their health or caregiver, select (4)

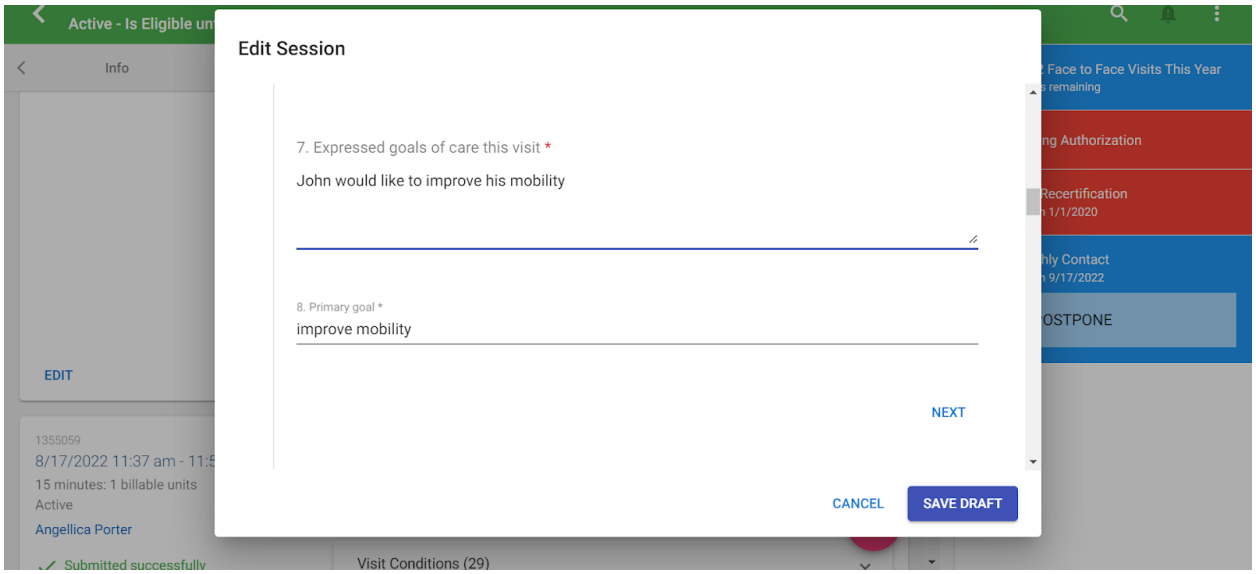
Example:



Person's Expressed Goals of Care

- State the participant's goal in having/receiving services and care in a full sentence.
- Then, state the goal again in just a couple of words below that

Example:



Intake and Initial History

More demographic and other general information about the participant.

Date Case Opened

This is the date the participant started with Amcord.

- This answer can be found in the participant's Info tab on Function Portal, stated under *Service Dates*

- You must ensure the information on the Info Tab matches in all assessments

Primary Language

State the participant's actual primary language. Not just the language they are speaking to you in, you need to verify this with the participant during the visit

Participant's health and functioning

Cognition

This section is made up of questions regarding the participant's cognitive ability to make decisions, maintain memory, and average awareness.

If you indicate on your InterRAI that the participant has any issues with Cognition then you need to ensure the PCSP indicates the same information (see Cognition Issues Guide for how to appropriately do so Amcord Care | Services Throughout Pennsylvania | Cognitive Issues Guide), as well as that the HRA/DSNP and the HEDIS match.

Higher scores means more significantly impacted cognitive performance

Memory Quiz – to test a participant's short term memory give them the following quiz. But, this is not a diagnostic tool. It just helps pave the way for better conversation on the topic if necessary.

1. Ask the participant to remember 3 random objects
2. Move on with more of the assessment, then in 5 min or so ask the participant if they remember the objects
    - If they forgot 2 or all 3 objects, then state they have a short term memory problem.
    - If they forgot only 1 object, then you can state their short term memory is ok (or have more of a conversation with them about it)
3. Ask the participant about the 3 objects again at the end of the assessment to test their Long Term Memory.

Mood and Behavior

Discussion about the participant's recent mental health and behavior.

Note: This section is specifically asking about indicators of ***the last 3 days***.

Locomotion and Walking

Timed 4-meter walk

- Have the participant walk a straight, unobstructed path, across a room (about 13 feet) and time them. Your answer is how many seconds it takes for them to do so.

- If the participant needs to stop for any reason, stop and put answer **77 – Stopped before test complete**
- If the participant refuses to do the walk, or you refuse to for any reason (including not being F2F) put **88 – Refused to do the test**
- If the participant is not capable of walking in any way, put answer **99 – Not tested**

Continence

Discussion about participant's bladder and bowel continence control and use of any incontinence supplies.

If the participant requires or is requesting incontinence supplies, this section should indicate the need for supplies if the participant is requesting them at the time of the visit

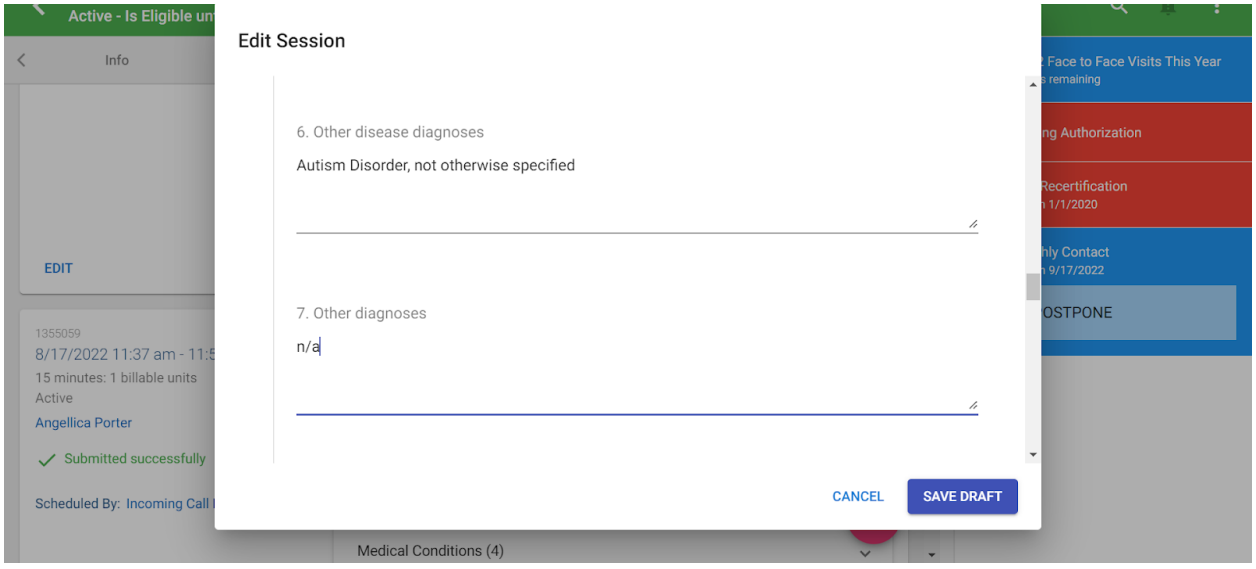
Diagnosis and Problems

Documentation of the participant's diagnoses. Pay close attention to the key/code and be sure to document any diagnoses the participant has.

- 0 – Not present – If the participant does not have the diagnosis
- 1 – Primary diagnosis – the primary reason why the participant requires care
- 2 – Diagnosis present, receiving active treatment – a diagnosis, besides the primary, for which the participant is currently being treated for
- 3 – Diagnosis present, monitored but no active treatment – a diagnosis, besides the primary, for which the participant is NOT receiving treatment for.

Other Disease Diagnosis – Listing any other diagnosis the participant has that was not listed in the previous questions

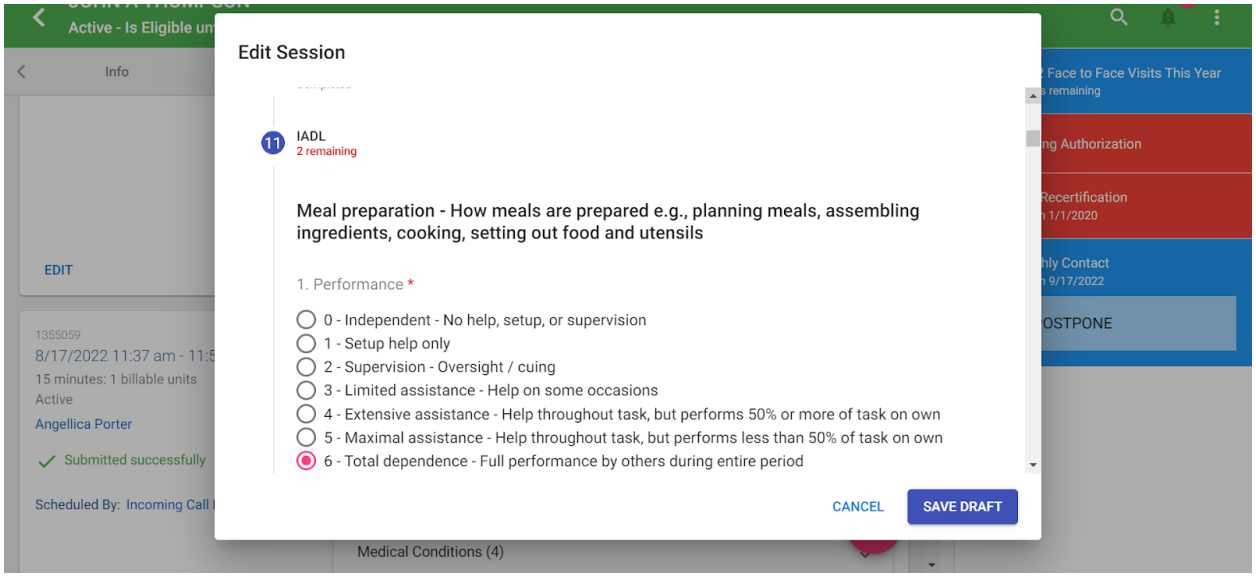
Example:



IADL's (Instrumental Activities of Daily Living)

These are activities that are done daily or regularly to take care of the participant and their home. IADL's require complex planning and thinking to complete. Discussion of how each activity is being performed currently should take place with the participant and their Person Centered Team, during the visit. Then select the option that most closely aligns.

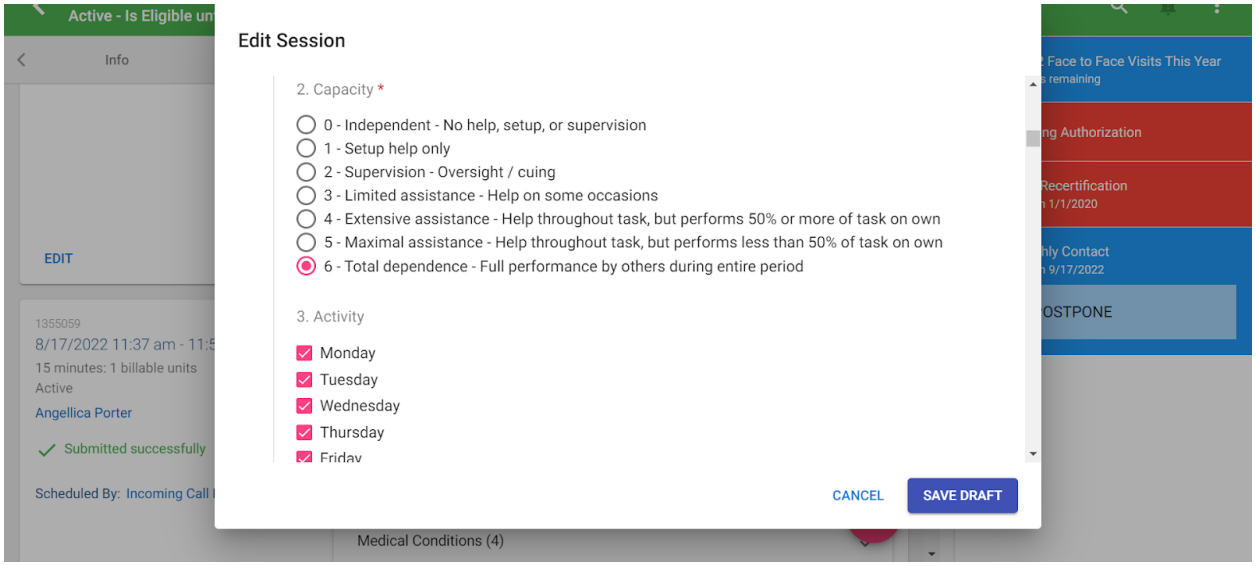
Example:



Discussion of what the participant's capacity is to perform that same activity and what days they require assistance with this activity each week. It is okay if there is a different between what is selected for "performance" and "capacity" (ie. A participant may have a daughter that currently makes all of the meals because she enjoys cooking for her mother, but the participant is capable of making small meals for herself at any time as well)

Please note: When selecting days of the week the participant requires assistance, this refers to ***ONLY*** days when formal assistance (ie. PAS hours) would be needed

Example:



Discussion of the need for additional support to what is currently in place (either formally or informally) should take place.

Additionally, rationale for all services must be included and this includes providing information on the following:

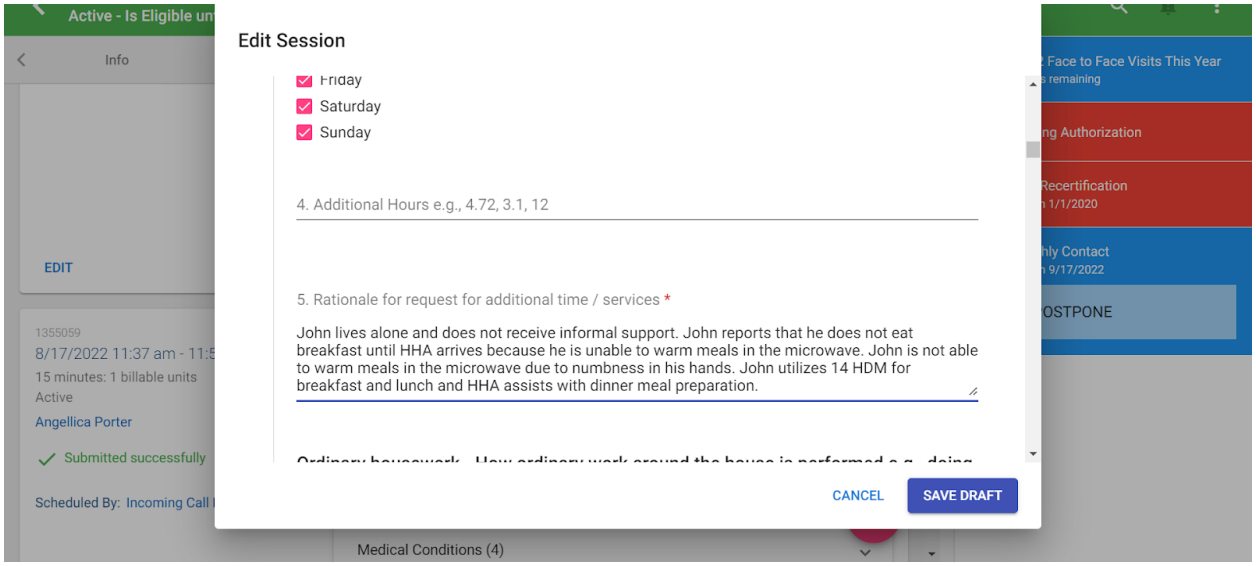
-informal support or not for the task

-what services are currently in place and what other services were offered (ie. shower chair was offered and accepted OR shower chair was offered and declined)

-information about diagnosis or needs that are relevant to this activity

-clearly statement on what the service that is put into place will be doing to assist (ie. HHA assists with meal preparation for dinner).

Example:



ADL's

These are basic self-care activities that are done daily or regularly to take care of the participant and their home. Discussion of self performance of each task should take place with the participant and their Person Centered Team, during the visit. Then select the option that most closely aligns.

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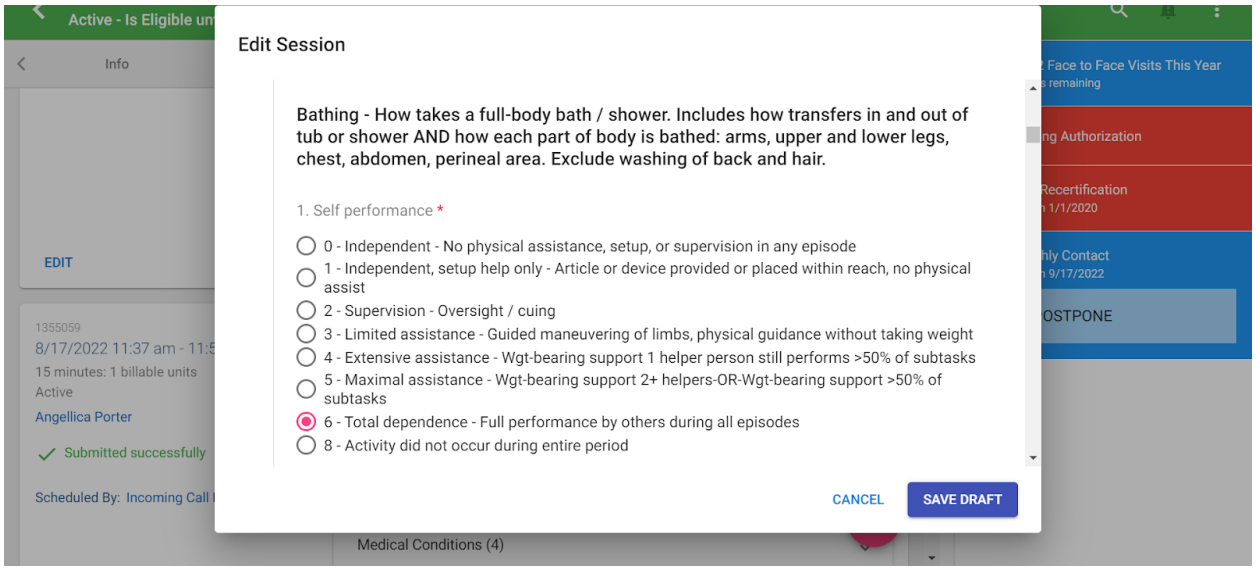
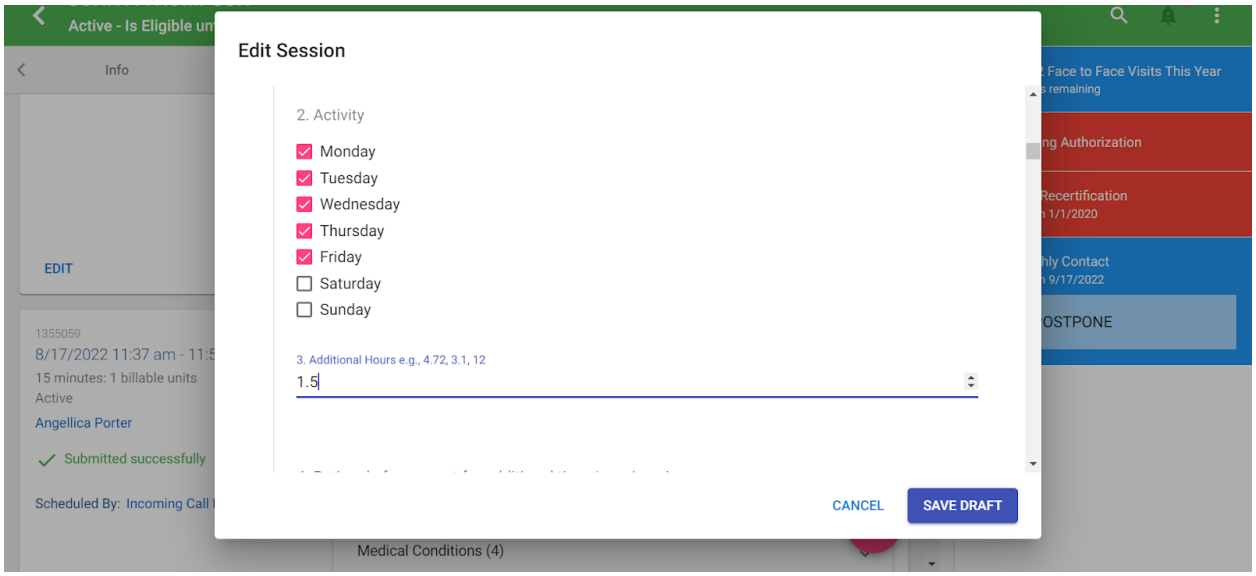


Discussion of days each week that the participant will need formal assistance should be discussed and selected. Additional hours can be added, but only with justification.

Example:



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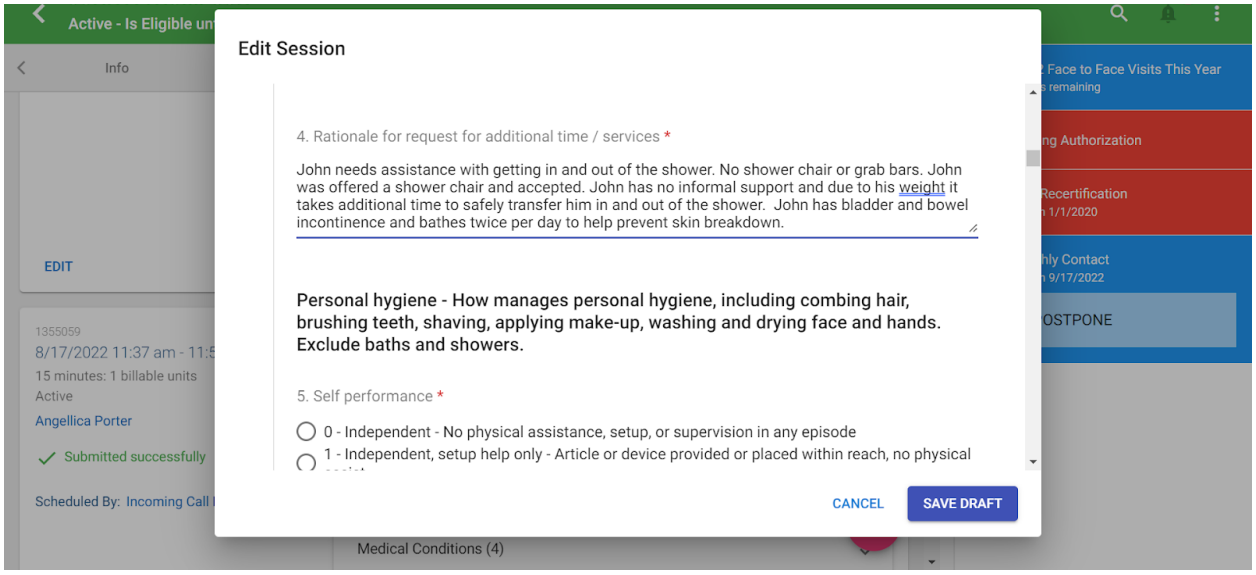
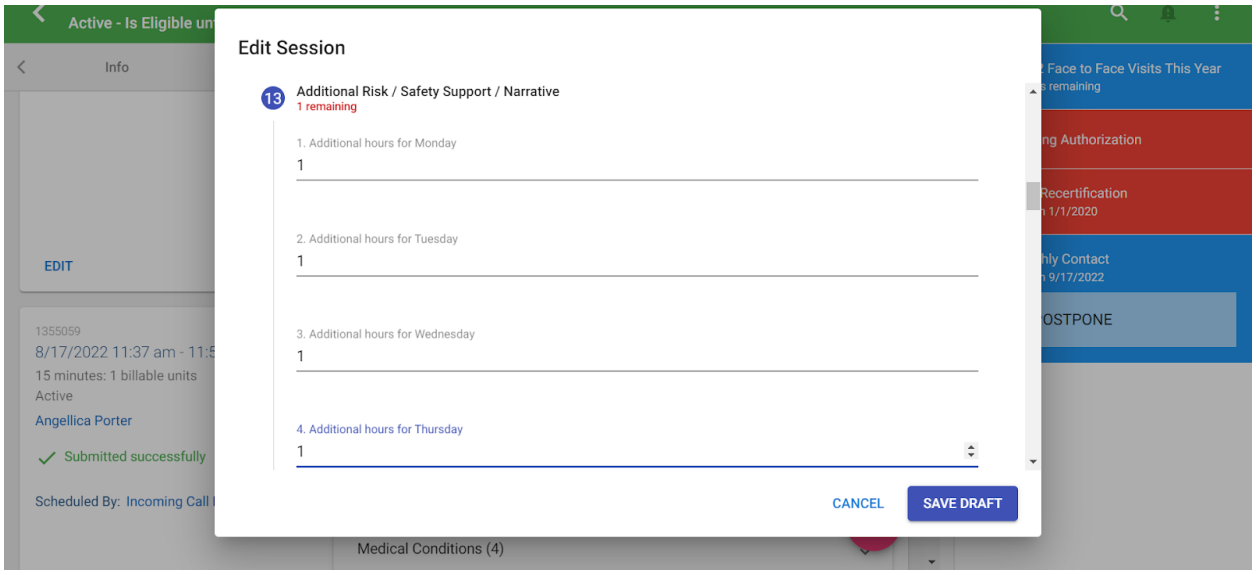
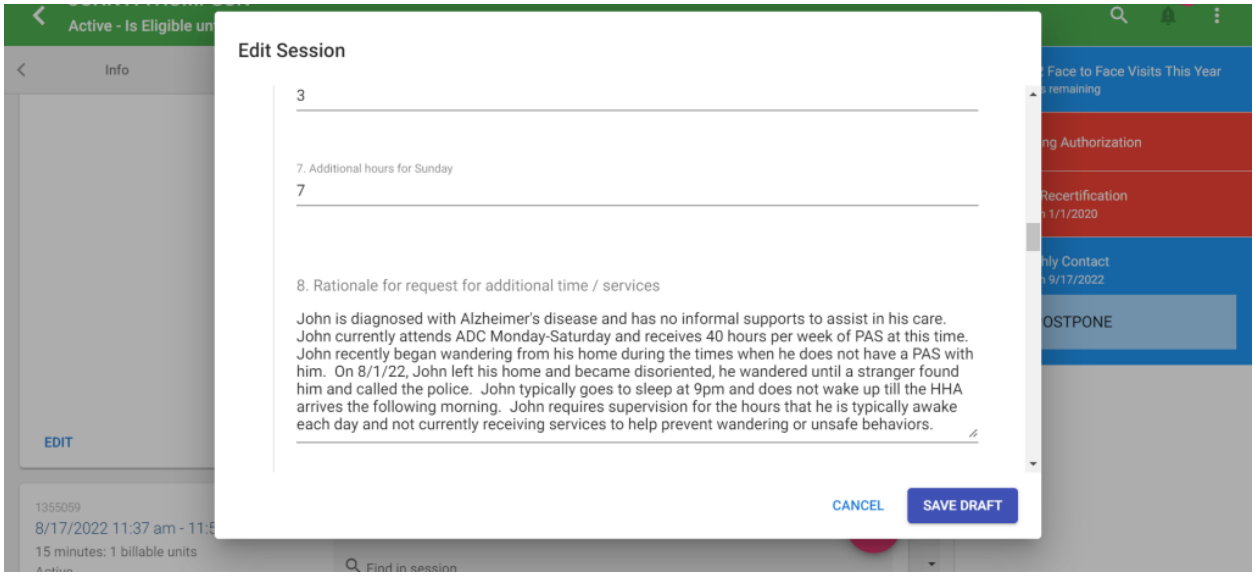


Additional Risk and Safety

Discussion of anything that does NOT fall under any of the ADL's and IADL's that would require additional hours, such as unsafe behavior (ie. turning the stove on and forgetting about it, wandering, etc) or high risk (ie. frequent falls and history of falls). There must be strong justification for what the presence of additional hours will resolve.

Example:

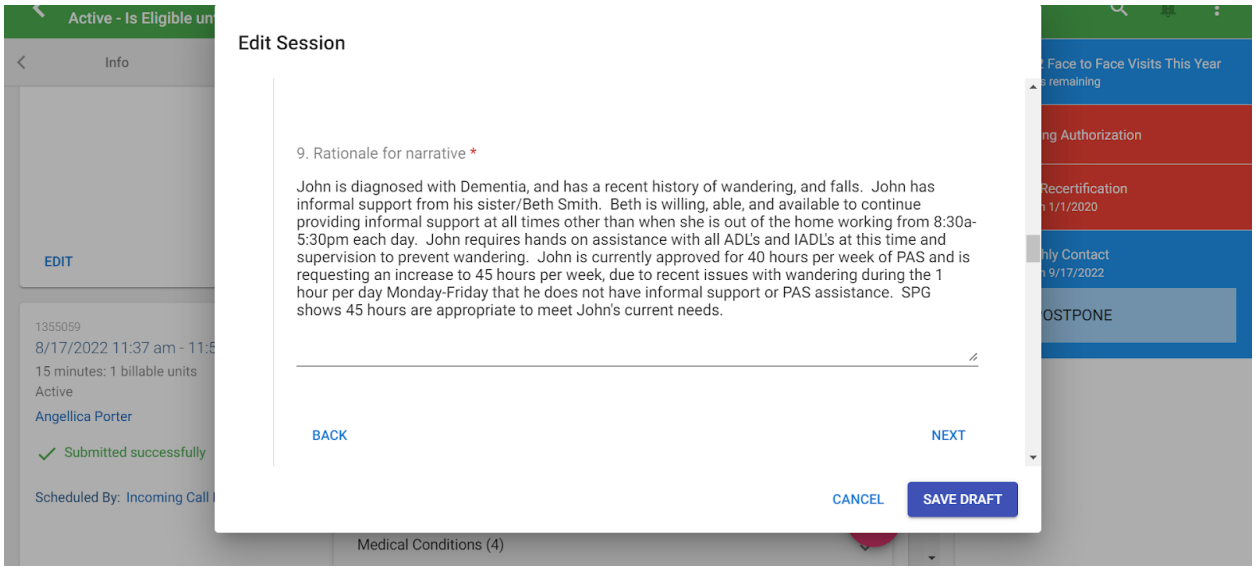




Narrative

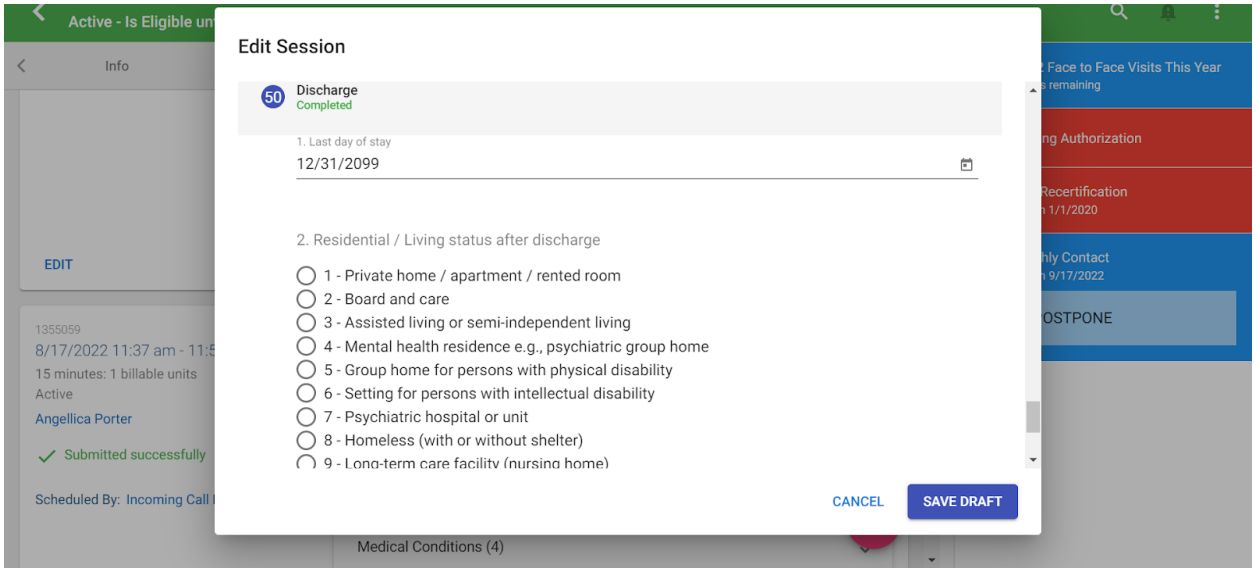
This is a brief summary statement of the participant's needs, their informal supports (must include "willing, able, available" language as well as name and relationship of informal), their current formal services, and what services they are asking for at this visit.

Example:



Discharge

If there was no hospital or NF stay then for "Last day of stay" you will type "12/31/2099"



If there was no hospital or NF stay then for “residential/living status after discharge”, you would select “other”