# Medicaid Community Options

## Course 3: InterRAI Assessments

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MARYLAND
Department of Health

# How Does a Person Become Medically Eligible?

- All participants are assessed when they start the program and then again annually.
  - Children under the age of 18 receive the InterRAI-PEDS
  - Anyone 18 years and older is assessed using the InterRAI-HC
- The assessment is completed by a trained Local Health Department nurse and/or social worker.
  - An assessment can be requested by MDH, the MAP site or a supports planner using the LTSSMaryland system.

# How Does a Person Become Medically Eligible?

- The assessment is used to:
  - Determine if the person meets a nursing facility level of care (required for CO/CFC/MDC)
  - Determine if the person meets a CPAS level of care (required for CPAS)
    - Fewer needs than NF LOC
  - Provide information to develop a plan of service

# What is the InterRAI Assessment Like?

- Typically, the assessment takes between two and three hours (depending on the person).
- A LHD nurse will schedule the assessment in the participant's home.
- It involves some physical activity and certain parts are hands-on.
- The nurse will assess the person, the person's support system and the home itself.
- The nurse will write a recommended plan of care to go along with the InterRAI.
  - The recommended plan of care is not developed in conjunction with the participant. It tends to be medically-based.

# How is PEDS different from HC?

- Tool is developed to better capture information relevant to the pediatric population
- PEDS uses a 7 day look back period vs. 3 day
- HC assesses “Performance” and “Capacity”
- PEDS assesses “Performance” and “Effect”
  - “Effect” helps to better determine if performance of a task is related to age or to medical condition

# InterRAI Information Collected

## Section A – Identification Information

- To collect basic information including name, birth date, MA number- as well as reason for assessment, living status and arrangement

## Section B – Intake and Initial History

- Captures ethnicity and race, language and residential history

## Section C – Cognition

- Cognitive skills assessed using the Cognitive Performance Scale (CPS) and Brief Interview for Mental Status (BIMS)

## Section D – Communication and Vision

- Making self understood, understanding others as well as hearing and vision questions

# InterRAI Information Collected

## Section E – Mood and Behavior

- Looks for indicators of possible depressed, anxious, or sad mood; self reported mood and behavior symptoms assessed as well

## Section F – Psychosocial Well-Being

- Social relationships and activities, time spent alone and life stressors are recorded in this section

## Section G – Functional Status

- To measure IADL and ADL performance, locomotion, activity level, and physical function improvement potential

# InterRAI Information Collected

## Section H - Continence

- Collects information on bladder and bowel continence and devices used

## Section I – Disease Diagnosis

- Captures all health diagnoses with ICD codes

## Section J – Health Conditions

- Collects data on health and mental health related symptoms including problem frequency and pain scale

## Section K – Oral and Nutritional Status

- Records current height and weight and assess nutritional issues, mode of intake, and dental issues

# InterRAI Information Collected

## Section L – Skin Condition

- To determine ulcers, pressure ulcers skin tears/cuts, changes in skin condition and any other major skin issues

## Section M – Medications

- Listing name, dose, units, route of administration, frequency of medications along with drug allergies and compliance

## Section N – Treatment and Procedures

- Determining medical tests performed in last 1-5 years, treatments and programs received, formal care provided in days/minutes and any recent hospital stay

# InterRAI Information Collected

## Section O – Responsibility

- Determines Legal Guardian

## Section P – Social Supports

- Identifies informal helpers, type and hours of help provided, and relationship with family

## Section Q – Environmental Assessment

- Assesses the condition and accessibility of the home and begins financial questioning; Employment; Education Level

# InterRAI Information Collected

## Section R – Discharge Potential and Overall Status

- Gathers info on goals met, status changes and relationship to IADLs and ADLs

## Section S – Discharge/Service Period

- Collects date of last stay and living status at the time of the assessment

## Section T – Assessment Information

- Signature and date required; Length of time to complete; professional degree, addition recommendations to include.

## Personal Health Summary

**Name:** Eric Test **Assessment Date:** 04/01/2013

| Personal Information | | | | |
|---|---|---|---|---|
| **Age:** 31.1 | **Height:** 72 in. | **Weight:** 185 lbs. | **Sex:** Male | **Marital Status:** Never Married |

| Health Profile | |
|---|---|
| **Mental Health** | |
| Cognitive Performance Scale (CPS)<br>0-6 range; Intact, Borderline, Mild, Moderate, Moderate / Severe, Severe, Very Severe | 6; Very Severe Impairment |
| Depression Rating Scale (DRS)<br>0-14 range; Score of 3 or greater suggests possible depression | 6; Possible Depression |
| Brief Interview for Mental Status (BIMS) Score | 1 |
| **Communication and Vision** | |
| Making self understood | Sometimes understood |
| Ability to understand others | Sometimes understands |
| Hearing | Severe difficulty |
| Vision | Severe difficulty |
| **Social Functioning, Social Support & Home Situation** | |
| Concern with Caregiver Distress<br>0-3 range; Caregiver unable to continue, Caregiver distress, Caregiver overwhelmed | 3; Caregiver unable to continue, Caregiver distress, Caregiver overwhelmed |
| Lives Alone | Yes |
| Home Environment Concerns<br>0-5 range; Home disrepair, Squalid conditions, Poor heating/cooling, Unsafe, Poor access | 5; Home Disrepair, Squalid Conditions, Poor Heating/Cooling, Unsafe, Poor Access |
| **Physical Functioning** | |
| ADL Self-performance Hierarchy<br>0-6 range; Early, middle & late loss ADLs; Hygiene, Toilet Use, Locomotion and Eating | 6; Extensive Assistance Required — 1 |
| Transfer | Total dependence |
| Locomotion in Home | Total dependence |
| IADL Performance<br>0-8 range; Meals, Housework, Money, Meds, Phone, Stairs, Shopping, Transportation | 48; High IADL Dependence |
| **Pain** | |
| Pain Scale<br>0-3 range; Pain Less than Daily, Daily Moderate, Daily Severe, Daily Excruciating | 0; No pain |
| **Continence** | |
| Bladder Continence | Frequently incontinent |
| Bowel Continence | Infrequently incontinent |
| **Fall Risk** | |
| Falls | One fall in last 30 days |
| **Symptom Review:**<br>Difficult or unable to move self to standing position unassisted, Difficult or unable to turn self around and face the opposite direction when standing, Dizziness, Unsteady gait, Hallucinations, Difficulty falling asleep or staying asleep; waking up too early; restlessness; not-restful sleep | |

| Medications: |
|---|
| **Disease Diagnoses:**<br>Hip fracture, Other fracture, Alzheimer's disease, Dementia other than Alzheimer's disease, Anxiety, Depression |

| Assessment Results | |
|---|---|
| **LOC Results** | |
| Recommended LOC Result | Yes |
| **RUG-III Results** | |
| Result | Extensive Special Care 2 / ADL > 6 |
| HC Group Code | SE2 |

**Eric Test: Clinical Assessment Protocols**

| | |
|---|---|
| **Abusive Relationship CAP**<br>Person is at risk for abuse or neglect. | TRIGGERED - HIGH RISK |
| **Behavior CAP**<br>Person has daily behavior problems, or problems not easily altered. | TRIGGERED - REDUCE DAILY BEHAVIOR |
| **Bowel CAP**<br>Facilitate improvement in bow status & prevent worsening. | TRIGGERED - RISK OF DECLINE |
| **Cardio-Respiratory CAP**<br>Need to assess for possible cardio-respiratory problems. | TRIGGERED |
| **Cognitive CAP**<br>Maintain independence for persons with reasonable cognitive skills. | TRIGGERED - PREVENT DECLINE |
| **Dehydration CAP**<br>Person is dehydrated or has insufficient water intake. | TRIGGERED - HIGH LEVEL |
| **Delirium CAP**<br>Person has active symptoms of delirium. | TRIGGERED |
| **Environmental Compensation CAP**<br>Person's home environment has problematic features. | TRIGGERED |
| **Falls CAP**<br>Person is at risk for falls. | TRIGGERED - LOW RISK |
| **Mood CAP**<br>Person has pre-existing depression diagnosis or depressed mood. | TRIGGERED - HIGH RISK |
| **Pain CAP**<br>Needs assessment and management of pain. | TRIGGERED - HIGH PRIORITY |
| **Physical Activity Promotion CAP**<br>Person engages in low levels of physical activity. | TRIGGERED |
| **Pressure Ulcer CAP**<br>Person has pressure ulcers or is at risk for pressure ulcers. | TRIGGERED - HAS STAGE 2 ULCER |
| **Smoking and Drinking CAP**<br>Need strategies to cease smoking & reduce drinking. | TRIGGERED |
| **Institutional Risk CAP**<br>Person is at risk of institutional placement. | TRIGGERED |
| **Informal Support CAP**<br>Person's family is challenged to respond fully to person's needs. | TRIGGERED |

# Sample Nurse Recommended Plan of Care

**Maryland Department of Health and Mental Hygiene**
**Comprehensive Evaluation - Part II - Clinical Assessment**
**Statewide Evaluation and Planning Services (STEPS)**
**Preadmission Screening and Annual Resident Review (PASRR)**
**Local Health Department (LHD)**

**Client's Name:** Jane Doe
**Social Security #:** 101-22-9876

**Date:** 2/2/15

## Plan of Care

**Significant Findings and/or Rationale**

- Individual has some complex medical needs and is young, would also ensure goals are met to assist person to remain as independent as possible. On most recent interRAI, it is stated client has 7th grade education & hopes to obtain his GED, initial POC notes recommendation of vocational services on it through 2010 POC. Anxiety, depression, diabetes by history, asthma, neurogenic bladder, s/p placement suprapubic catheter, hx left femur fracture, hx and rx pneumonia , acid reflux, hx MRSA, hx recurrent UTI'S, T3 incomplete paraplegia due to gunshot wound, and chronic pain syndrome

**Recommendations / Needed Services**

| Service | Item Description | Service Type | Units | Frequency | Reason for Service Details |
|---|---|---|---|---|---|
| Nurse Monitoring | once per month | Community First Choice | (N/A) | (N/A) | |
| Personal Assistance | | Community First Choice | (N/A) | (N/A) | |
| Disposable Medical Supplies | over-bed trapeze; incontinent supplies | State Plan Service | 0 items | 0 weeks | |
| Medical Day Care | | Waiver Service | 5 days per week | 0 weeks | |
| Other | | Community Service | 0 hours | 0 weeks | |
| Supports Planning | to be determined by SP | Community First Choice | (N/A) | (N/A) | |
| Transportation | | State Plan Service | 0 days per week | 0 weeks | |

MARYLAND Department of Health

# How Should a Supports Planner Use the InterRAI?

- Review the InterRAI, recommended plan of care and summary page before meeting the participant.
- Discuss the findings and recommendations made by the nurse.
- Reference findings in the InterRAI, the nurse's notes or the plan of care when completing the Plan of Service.
  - The Department relies on the InterRAI assessment and nurse's recommendations when it approves services.
  - If the Department feels that service requests aren't supported by medical documentation, the participant's Plan of Service may be denied or additional information may be requested.