



CHANGING
Maryland
for the Better

Medicaid Community Options

Course 3: InterRAI-HC Assessment

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Department of Health and Mental Hygiene

Presented to: New Supports Planner Training
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How Does a Person Become Medically Eligible?

- All participants are assessed when they start the program and then again annually.
- The assessment is completed by a trained Local Health Department nurse and/or social worker.
 - An assessment can be requested by DHMH, the MAP site or a supports planner using the LTSSMaryland system.
- 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 (fewer needs than NF LOC).
 - Provide information to develop a plan of service.



What is the 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.



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 in last 3 days, 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

- 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) <small>0-6 range; Intact, Borderline, Mild, Moderate, Moderate / Severe, Severe, Very Severe</small>	6; Very Severe Impairment
Depression Rating Scale (DRS) <small>0-14 range; Score of 3 or greater suggests possible depression</small>	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 <small>0-3 range; Caregiver unable to continue, Caregiver distress, Caregiver overwhelmed</small>	3; Caregiver unable to continue, Caregiver distress, Caregiver overwhelmed
Lives Alone	Yes
Home Environment Concerns <small>0-5 range; Home disrepair, Squalid conditions, Poor heating/cooling, Unsafe, Poor access</small>	5; Home Disrepair, Squalid Conditions, Poor Heating/Cooling, Unsafe, Poor Access
Physical Functioning	
ADL Self-performance Hierarchy <small>0-6 range; Early, middle & late loss ADLs; Hygiene, Toilet Use, Locomotion and Eating</small>	6; Extensive Assistance Required — 1
Transfer	Total dependence
Locomotion in Home	Total dependence
IADL Performance <small>0-8 range; Meals, Housework, Money, Meds, Phone, Stairs, Shopping, Transportation</small>	48; High IADL Dependence
Pain	
Pain Scale <small>0-3 range; Pain Less than Daily, Daily Moderate, Daily Severe, Daily Excruciating</small>	0; No pain
Continence	
Bladder Continence	Frequently incontinent
Bowel Continence	Infrequently incontinent
Fall Risk	
Falls	One fall in last 30 days
Symptom Review:	
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: 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 Person is at risk for abuse or neglect.	TRIGGERED - HIGH RISK
Behavior CAP Person has daily behavior problems, or problems not easily altered.	TRIGGERED - REDUCE DAILY BEHAVIOR
Bowel CAP Facilitate improvement in bow status & prevent worsening.	TRIGGERED - RISK OF DECLINE
Cardio-Respiratory CAP Need to assess for possible cardio-respiratory problems.	TRIGGERED
Cognitive CAP Maintain independence for persons with reasonable cognitive skills.	TRIGGERED - PREVENT DECLINE
Dehydration CAP Person is dehydrated or has insufficient water intake.	TRIGGERED - HIGH LEVEL
Delirium CAP Person has active symptoms of delirium.	TRIGGERED
Environmental Compensation CAP Person's home environment has problematic features.	TRIGGERED
Falls CAP Person is at risk for falls.	TRIGGERED - LOW RISK
Mood CAP Person has pre-existing depression diagnosis or depressed mood.	TRIGGERED - HIGH RISK
Pain CAP Needs assessment and management of pain.	TRIGGERED - HIGH PRIORITY
Physical Activity Promotion CAP Person engages in low levels of physical activity.	TRIGGERED
Pressure Ulcer CAP Person has pressure ulcers or is at risk for pressure ulcers.	TRIGGERED - HAS STAGE 2 ULCER
Smoking and Drinking CAP Need strategies to cease smoking & reduce drinking.	TRIGGERED
Institutional Risk CAP Person is at risk of institutional placement.	TRIGGERED
Informal Support CAP 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	



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.

