MFP/BIP - interRAI

April 3, 2012

Assessments and Nursing Facility Level of Care

- Currently, information is collected through various assessments. Providers then complete a departmental form (3871B) and submit it to a DHMH contractor for nursing facility level of care (NF LOC) approval.
- The current standards used to determine NF LOC come from Nursing Facility Transmittals 213, 237 and federal regulations.
- DHMH's goals
  - Use interRAI collected information to determine NF LOC and replace the 3871B.
  - Pilot current standards with interRAI collected information.

The Pilot

- DHMH will be training selected counties who have volunteered to take part in the pilot.
- DHMH will be focused on results that compare the current process for determining NF LOC with results from the interRAI.
- DHMH will not move forward with implementing a new approach to determining NF LOC until we are confident that determinations are consistent with current standards.

Cross-walking Assessments

- DHMH workgroup cross-walked the information captured in the 3871 B with the interRAI – HC
- Certain items were added to the interRAI assessment based on that review process
- Nursing Home Transmittal No. 213 was used to guide detail of information gathered

Nursing Home Transmittal 213

Skilled Nursing Services and Rehabilitation Services

- Medical eligibility requirements for nursing facilities – skilled nursing or rehabilitation service is required on a daily basis (defined as 5 to 7 days per week)
- Skilled nursing or rehabilitation services – ordered by a physician, and require the skills of technical or professional personnel such as RNs, LPNs, PTs, OTs and speech pathologists or audiologists

Nursing Home Transmittal 213

Health-Related Services Above the Level of Room and Board

1. Hands-on assistance for 2 or more ADLs as a result of a medical condition
2. Supervision for 2 or more ADLs + cognitive deficits + assistance with 3 IADLs
3. Supervision of 2 or more ADLs + supervision/redirection for behavior problems (wandering, hallucinations/delusions, aggressive/abusive behavior, disruptive/socially inappropriate behavior, self-injurious behavior)

Section A – Identification Information

Purpose – To collect basic information including name, birthdate, MA number as well as reason for assessment, living status and arrangement

Additions –

11. Street Address

15. Phone Number

Section B – Intake and Initial History

Purpose – Captures ethnicity and race, language and residential history

- No changes made

Section C – Cognition

Purpose – Cognitive skills assessed using the CPS

Additions – Brief Interview for Mental Status (BIMS)

Section D – Communication and Vision

Purpose – making self understood, understanding others as well as hearing and vision questions

- No changes made

Section E – Mood and Behavior

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

Additions –

E.3.g. Self-injurious behavior question along with a time frame of previous month

Section E – Mood and Behavior

- 3.b. Verbal abuse, 3.c. Physical abuse, 3.d. Socially inappropriate or disruptive behavior, 3.e. Inappropriate public sexual behavior or public disrobing
- interRAI measures: not present, present but not exhibited in last 3 days, exhibited on 1–2 of last 3 days, and exhibited daily in last 3 days
- Added how many times in previous seven days

Section F – Psychosocial Well-Being

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

- No changes made

Section G – Functional Status

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

- No changes made

Section H - Continence

Purpose – Collects information on bladder and bowel continence and devices used

- No changes made

Section I – Disease Diagnosis

Purpose – Captures all health diagnoses with ICD codes

- No changes made

Section J – Health Conditions

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

Additions – How many times in previous seven days

- 3.h. delusions, 3.i. hallucinations
- Current measures: not present, present but not exhibited in last 3 days, exhibited on 1 of the last 3 days, exhibited on 2 of last 3 days, exhibited daily in last three days

Section K – Oral and Nutritional Status

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

- No changes made

Section L – Skin Condition

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

- No changes made

Section M – Medications

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

- No changes made

Section N – Treatment and Procedures

Purpose – 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

Additions –

6. Does the complexity of the patient or existence of multiple conditions require the need of skilled services not otherwise captured within this assessment? If yes, please explain briefly.

Section O – Responsibility

Purpose – Determines Legal Guardian

Additions –

2. Do you have an Advanced Directive? If yes, please provide details.

Section P – Social Supports

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

- No changes made

Section Q – Environmental Assessment

Purpose – Assesses the condition and accessibility of the home and begins financial questioning

Additions –

5. Employment – Are you currently employed or involved in volunteer/educational/training activities?

5.c. Are you interested in any employment, volunteer or education and training program?

6. Education Level

Section R – Discharge Potential and Overall Status

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

- No changes made

Section S - Discharge

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

- No changes made

Section T – Assessment Information

Purpose – Signature and date required

Additions –

3. How long did this assessment take to complete?

a. In person – hours/minutes

b. Additional – hours/minutes

4. Professional degree, 5. Organization

6. Additional questions to add to interRAI - HC