Definitions

Care—Includes direct services and supports provided to the person (ADL and IADL support, training, socialization), the management of care received (for example, making medication schedules, planning for future needs), and the provision of therapeutic care by any paid agency or service provider. Does not include care that is provided without charge. Because the names used to describe home and community-based services often differ by jurisdiction, the assessor should seek clarification from agency leadership about how to code care that is not included in this list.

N3a. ADL aid/attendant care—Aides who traditionally provide "hands-on" ADL support and simple monitoring. This includes hospice, home health, or any other paid aid/attendant care.

N3b. Home nurse—Licensed or registered nurses who traditionally provide assessment and complex or invasive interventions (skilled treatments), education, and referral. Telemedicine nurse coverage is included if it is a paid service.

N3c. Homemaking services—Services that traditionally include IADL support, usually in the form of housekeeping services, shopping, and meal preparation.

N3d. Meals—Prepared meals that are delivered to the person for immediate or later consumption (for example, meals-on-wheels).

N3e. Physical therapy—Therapy services that are provided or directly supervised by a qualified physical therapist. A qualified physical therapy assistant may carry out a treatment plan developed by a physical therapist but may not supervise others giving therapy.

N3f. Occupational therapy—Therapy services that are provided or directly supervised by a qualified occupational therapist. A qualified occupational therapy assistant may carry out a treatment plan developed by an occupational therapist but may not supervise others (aides or volunteers) giving therapy.

N3g. Speech-language pathology or audiology services—Services provided by a qualified speech-language pathologist. Services may involve assessment of swallowing ability or communication and hearing ability, as well as providing swallowing therapy, speech therapy, communication therapy, providing hearing appliances, and education.

N3h. Psychosocial therapy—Therapy given by a licensed mental health professional, such as a psychiatrist, psychologist, psychiatric nurse, or psychiatric social worker.

N3i. Cardiac rehabilitation [Missouri Item]—a medically supervised program of exercise and education designed to improve cardiovascular health in persons that have experienced a heart attack, heart failure, or heart procedure/surgery.

N3j. Adult day care—A program in the community that provides structured therapeutic health services and supervised activities for persons with physical, mental, or intellectual disabilities. May include transportation to and from the facility.

Process

Ask the person or caregivers about the persons and agencies involved with care, the nature of the relationship, and the amount of time spent in providing care or care management. If possible, consult logbooks that the person may have in the home, and review agency documentation if available.

Coding

Code the number of days in the first column (maximum = 7) and the number of minutes in the second column, one digit per box. Based on the information available to you, select the best category for the type of support provided. **Do not code twice for the same service.** If the person did not get a particular form of care, enter **"0"** in the appropriate box(es).

Example of How to Code Formal Care

In the last 7 days, the person received 2 hours of home health aide service on 3 days to assist with bathing; visiting nurse service once for 1 hour and 15 minutes to review medications with the client and family and do a physical assessment; and a homemaker once for 3½ hours for cleaning. In addition, the person had a volunteer from the "visiting volunteer" agency for 1 hour on each of 3 days, as well as a privately paid speech therapist on 2 days, for 4½ hours total.

Code as follows:

	# of Days in Last Week	Total Minutes in Last Week		
N3a. Home health aide (Personal Care Attendant)	3	3	6	0
N3b. Home nurse	1	0	7	5
N3c. Homemaking services	1	2	1	0
N3d. Meals	0	0	0	0
N3e. Physical therapy	0	0	0	0
N3f. Occupational therapy	0	0	0	0
N3g. Speech-language pathology and audiology services	2	2	7	0
N3h. Psychosocial therapy	0	0	0	0
N3i. Cardiac rehabilitation	0	0	0	0
N3j. Adult day health care	0	0	0	0

N4. Long-Term Care Facility/Hospital Stay in the Last Year (or Since Last Assessment If Less Than 1 Year Ago)

Intent

To document the amount of time since the person's most recent stay as a measure of clinical instability and care trajectory.

Process

Ask the person. Review any available payment or similar record. If available, discharge summaries are generally the most efficient means to gather this information. If not documented elsewhere, consult with the person or family.

Coding

Code for the most recent instance in the **last 365 days**. Calculate the number of days between the most recent stay in the last 365 days and the assessment reference date. Code **"0"** if the person has not been hospitalized in the last 365 days.

0 No stay within 365 days

1 181–365 days ago

2 91–180 days ago

3 31–90 days ago

4 15–30 days ago

5 8–14 days ago

6 In last 7 days

7 Now in facility

N4a. Time Since Last Hospital Stay

N4b. Time Since Last Long-Term Care Facility/ Nursing Home Stay

N5. Hospital Use, Emergency Room Use, in Last 90 Days (or Since Last Assessment If Less Than 90 Days Ago)

N5a. Inpatient acute hospital with overnight stay

Intent

To record how many times the person was admitted to the hospital with an overnight stay in the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago).

Definition

The person was formally admitted as an inpatient (by physician's order) and stayed over 1 or more nights. It does not include admissions for day surgery, outpatient services, etc.

Process

Review prior hospitalizations with the person, family, and caregivers. If available, review the clinical record. Sometimes transmittal or billing records from recent hospital admissions are available.

Coding

Enter the number of hospital admissions in the box. Enter **"0"** in both boxes if no hospital admissions occurred in the last 90 days. If the code is a single digit, use a leading zero to fill in the first box.

N5b. Emergency room visit (not counting overnight stay)

Intent

To record if during the last 90 days (or since the last assessment, if the person was assessed less than 90 days ago) the person visited a hospital emergency room (ER) for treatment or evaluation, not including any ER visits that were accompanied by an overnight hospital stay.

Process

Ask the person, family, and caregivers; also review transmittal records if available.

Coding

Enter the number of ER visits in the last 90 days (or since last assessment). Enter **"0"** in both boxes if no ER visits occurred. Do not include instances in which the person was admitted to the hospital for an overnight stay after being seen in the ER. If the code is a single digit, use a leading zero to fill in the first box.

N6. Visits by Physician, Physician Assistant, Nurse Practitioner

Intent

To record the number of days during the last 90-day period a physician, physician assistant, or nurse practitioner examined the person (or since admission if less than 90 days ago). Examination can occur in the person's home, in the practitioner's office, or via telehealth link. In some cases, the frequency of such visits is indicative of clinical complexity. If multiple practitioners are present on a single visit (for example, a physician and a nurse practitioner), code only the physician.

Definitions

Practitioner — This item includes a broad spectrum of medical providers and specialists (for example, general practitioners and specialists such as geriatricians), who are either primary physicians or consultants. This item also includes a space to record a visit by an authorized physician assistant or nurse practitioner. An authorized physician assistant is a health care professional licensed to practice medicine with physician supervision. An example of an authorized practitioner is a nurse practitioner.

Exam — May be a partial or full exam at the person's home, or in the practitioner's office, or via a telehealth link. This does not include exams conducted in an emergency room. If the person was examined by a physician during an unscheduled emergency room visit, record the number of times this happened in the last 90 days in Item N5b, "Emergency room visit".

Coding

Total the number of visits for each of the three practitioner categories and record those numbers in the spaces provided. If no visits were made, enter **"0"** in both boxes. If the code is a single digit, use a leading zero to fill in the first box.

N7. Self-Reported Health Concerns

Intent

To identify whether unmet health needs are present and to subsequently facilitate a physician referral.

Process

Ask the question as phrased: "Do you have health concerns that should be discussed with a physician?"

Coding

Code for the appropriate response.

0 No

1 Yes

8 Person could not (would not) respond

N8. Monitoring of Mental Condition [Missouri Item]

Intent

To identify the amount and type of monitoring provided to a person with a diagnosed mental health condition.

Process

Determine if the person is currently receiving monitoring by a licensed mental health professional for a mental health condition. Determine the frequency of the monitoring and stability of the condition. If the person is receiving monitoring, determine who is completing the monitoring, how often the monitoring takes place, and the current stability of the person's mental condition.

Definitions

No Routine Monitoring— Person receives no monitoring or is monitored less than monthly for a mental health condition.

Minimal monitoring— Person receives monitoring at least monthly for a stable mental health condition.

Moderate monitoring— Person receives monitoring at least monthly for an unstable mental health condition.

Maximum monitoring— Person receives intensive monitoring for an unstable mental health condition.

Coding

0 No Routine Monitoring

1 Minimal monitoring

2 Moderate monitoring

3 Maximum monitoring

Section O

Responsibility

O1. Legal Guardian

Intent To determine if the person has a court-appointed representative.

Definition **Legal guardian**— A person legally responsible for the person being assessed.

Coding Code for the appropriate response.

0 No

1 Yes

Section P

Social Supports

P1. Informal Helpers

Intent

To record the number of family and friends who provided informal (unpaid) support to the person in the last 3 days, or who usually provide help but did not in the last 3 days. This is different from a formal (paid) relationship that the person may have with a home care agency.

Process

Ask the person (with family or caregiver help, if needed) to identify the number of persons who provide support to the person. For example, shape the questions with specific statements: "Who helps you shop?" "Who helps with cleaning around the house?" "Who helps you with your meals, bathing, dressing, etc.?" "Who helps you pay your bills?" "Who drives you when you need a ride?" If the person is not able to understand or respond, or gives responses that are unclear, evasive, or untrue (for example, refers to her husband when you know the husband is deceased), review the person's answers with caregiver.

It is important to understand that some helpers may not be described as such by the person. They do things consistent with "expected" social relationships — it is what the person expects a son or wife to "do." Thus, it is useful to focus the person's attention on who provides needed assistance or support, rather than using the label "caregiver."

In some jurisdictions, informal helpers may also be paid for part of their overall caregiving activities. In such situations, record paid activity under Item N3 and unpaid activity here.

Coding

Code number of helpers from **"0"** to **"9"** — the latter standing for nine or more, for each type of informal helper.

P1a. Child or child-in-law

P1b. Spouse/partner

P1c. Parent

P1d. Sibling

P1e. Other relative or friend

P2. Primary Helper

Intent

To identify the primary person (relative or friend) providing informal (nonpaid) support to the person.

Process

Ask the person (with family or caregiver help, if needed) to identify the person from among those identified under Item P1 above who provides the most care and could be relied upon should more help be required. If two or more persons are identified, the assessor will have to make a judgment as to which individual is the primary helper.

Again, as under Item P1 above, recognize that some persons may not use the term "helper" to describe those who in fact are providing help. The person or the helper may see what they do as natural in their role as a spouse or a child.

Coding

Code the number that corresponds to the primary helper.

1 Child or child-in-law

2 Spouse/partner

3 Parent

4 Sibling

5 Other relative or friend

8 No primary helper

P3. Travel Time Between Person and Primary Informal Helper

Intent

To identify the time required for the primary informal helper to reach the person. The shorter the time the more immediate the potential response in both daily care and in emergency situations.

Process

Ask the person (with family or caregiver help, if needed) to indicate the average time usually required for the primary informal helper to travel from his or her home to the home of the person. This could be based on walking, taking public transportation, on traveling in the helper's personal mode of transport (a bike, motorcycle, or car). Note: Use code **"0"** if the helper lives in the same building/residence.

Coding

Code for the appropriate response.

0 Live together — The helper and the person live in the same residence or building.

1 1–14 minutes

2 15–29 minutes

3 30–59 minutes

4 60+ minutes

8 No primary helper

P4. Primary Informal Helper Status

Intent

To assess the reserves and strengths relative to the person identified in Item P2 as the primary informal caregiver helper (support person).

Process

Ask the primary informal caregiver and person separately about the issues addressed in these items. If necessary, the formal home care workers may also be able to add useful information. These are sensitive issues and should be handled with tact. Listen carefully to what is being said.

Coding

P4a. Primary helper feels sense of self-worth in helping person — Other similar words include "self-respect," "pleasure," "considerable satisfaction," "self-esteem."

0 No

1 Yes

P4b. Primary helper finds it difficult to manage competing demands and the areas in which this occurs — The demands are in relation to any of the following.

0 No

1 Yes

P4ba. Work, job

P4bb. Family, children

P4bc. Attend school

P4bd. Make enough money to live on

P4c. Primary helper expresses feelings of distress and, if so, whether future help of person is in jeopardy

0 Not stressed

1 Stressed but no change in care expected

2 Stressed — crisis point reached, cut back in care expected — For example, visit less often, cut back in length of visit, cut back on certain tasks (e.g., housework), cut back to bare minimum.

3 Stressed — crisis point reached, will stop providing care

P4d. Primary helper feels he/she gets inadequate support from formal care services — Burden could be lessened were formal care services to be increased, but at the current time this does not seem possible.

0 No

1 Yes

P5. Hours of Informal Care and Active Monitoring During Last 3 Days

Intent

To capture the number of hours that informal helpers spent assisting the person in instrumental and personal activities of daily living, including active monitoring by looking in on the person, over the last 3 days.

Definitions

Informal helpers — Unpaid care by any person, including family, friends, neighbors, and others who provide assistance to the person (see Item P1).

Instrumental activities of daily living (IADLs) — These include meal preparation, housework, managing finances, etc.

Personal activities of daily living (ADLs) — These include mobility in bed, dressing, toilet use, etc.

Active monitoring — Presence for express purpose of performing a safety check as the person walks, performs IADLs, or performs ADLs. Does not include visiting or hanging out for purely social purposes.

Process

Consult with the person about hours of care. Confirm information with informal helpers.

Coding

Record the total amount of unpaid assistance the person received over the last 3 days. For example, if family members, friends, and neighbors provided 120 minutes (2 hours) each day, the total number of hours for help received during the last 3 days is 6. If more than one individual provided help, at the same time or at different times, add up the hours for each helper — for example, if two neighbors spent an hour together doing housecleaning for the person, this would count as 2 hours.

Round minutes to the nearest hour. For example, 12 hours and 45 minutes should be coded as 13 hours.

If the person did not receive any informal care during the last 3 days, enter **"0"** in all three boxes. If the number of hours is single-digit or double-digit, use leading zero(s) to fill in the first box(es).

Section Q

Environmental Assessment

Q1. Home Environment

Intent

To determine if the home environment is hazardous or uninhabitable.

Definitions

Q1a. Home in disrepair— For example, hazardous clutter, inadequate lighting, holes in floor, extremely dirty, infestation of rats or bugs.

Q1b. Inadequate heating or cooling— For example, too hot in summer or too cold in winter.

Q1c. Lack of personal safety— For example, fear of violence, a safety problem in going to the mailbox or visiting neighbors, or heavy traffic in the street. The person is (or feels) at risk for violence within or immediately outside of his or her home. This can include a real or perceived risk of someone breaking into the home, or of being attacked while getting mail or when leaving or returning home.

Q1d. Limited access to home or rooms in home— This item includes physical characteristics of the building that limit access— for example, the person has difficulty entering or leaving home, is unable to climb stairs to the only bathroom, or lives on the second floor and must enter or leave on unstable outside stairs, or the person lives in a multistory building in which the elevator is often broken, or in which stairs do not have the needed railings, or has difficulty maneuvering within rooms.

Process

Ask the person (or family member) for permission to walk through the home. Look for evidence of the problem areas noted in this section. Talk to the person (and family member if necessary) about any areas that you cannot assess yourself through visual inspection.

Coding

Code for the most appropriate response.

0 No

1 Yes

Q2. Finances

Intent

To determine if limited funds prevented the person from receiving essential medical and environmental support.

Definition

Limited funds— Because of limited funds during the last 30 days, the person made trade-offs among purchasing any of the following: adequate food, shelter, clothing; prescribed medications; sufficient home heat or cooling; necessary health care. Does not include poor choices made by the person due to addiction or other mental health problems that result in overexpenditures of available income.

Process

Ask the person, or caregiver, if prescribed medications, sufficient home heat, necessary medical care, or adequate food were not obtained due to insufficient funds. Asking financial questions can be a sensitive area. Questioning must be sensitive and respectful.

Coding

Code for the most appropriate response.

0 No

1 Yes

Section R

Overall Status

R1. Overall Self-Sufficiency Has Changed Significantly as Compared to Status of 90 Days Ago (or Since Last Assessment If Less Than 90 Days Ago)

Intent

To monitor the person's overall self-sufficiency over time. If this is the person's first assessment, include changes during the period prior to admission to the agency.

Definition

Overall self-sufficiency— The person's belief/perception that he or she can take care of him- or herself and be content, without dependence on others. Includes self-care performance, continence patterns, access to needed transportation, etc.

Process

Discuss with the person. If available, review clinical records, transmittal records (if new admission or readmission), previous assessments (if this is a reassessment), and any care plan notes if available. If necessary, discuss with a family member or caregiver.

Coding

Code for the most appropriate response.

0 Improved

1 No change

2 Deteriorated

Examples of How to Code for Changes in Self-Sufficiency

Mrs. T has had Alzheimer's disease for several years. In the last 4 months, her overall condition has generally improved. Although her cognitive function has remained unchanged, her mood is better. She seems happier and less agitated, sleeps more soundly at night, and is more socially involved with her husband and neighbors.

Code: R1 = "0" = "Improved".

Mr. D also has a several-year history of Alzheimer's disease. Although for the last year he was quite dependent on others in many areas, he was able to put on his own clothes, walk, and eat with supervision until recently. In the last 90 days, he can no longer walk without someone holding his arm. Additionally, he fell 2 weeks ago and has been unable to learn how to use a walker. He sits until someone gets the walker and accompanies him as he leaves his apartment. He is fearful of falling again.

Code: R1 = "2" = "Deteriorated".

Section S

Backup Plan

S1. Backup Plan [Missouri Item]

Process

Discuss with the person what their plans would be if services/supports could not be provided due to events such as a natural disaster, weather, or sickness.

Coding

Enter backup plan information in text box. Plans should include at a minimum the contact(s) first and last name, phone number, relationship to the participant, and assistance they would be able to provide if needed.

Section T

Assessment Information

T1. Signature of Person Coordinating/Completing the Assessment

Intent

The Assessment Coordinator (who will usually be the sole assessor in the home care environment) signs and certifies that the assessment is complete.

Coding

The Assessment Coordinator signs his or her name on line 1 and then puts the date that he or she signed the assessment as complete in box 2. This date can differ from the Assessment Reference Date (see Item A9). If the month or day is a single digit, enter a "0" in the first box.

T1a. Signature

T1b. Date assessment signed as complete — For example, December 11, 2022.

2	0	2	2		1	2		1	1
Year					**Month**			**Day**	

T2. Primary Mode of Assessment (Code for Mode Used for the Majority of Assessment Items)

Intent

To record the primary mode of interaction used to complete the assessment.

Definition

Virtual conference with video refers to communication between the assessor and the person where both parties, although not in the same location and meeting in person, have the potential to see each other and interact. This includes instances where the subject may be blind and thus lacks the capacity to see. Virtual conference audio only refers to communication where both parties can hear but cannot see one another. The type of equipment used to accomplish virtual conferences is not considered, only the effect: both parties must be able to view each other.

Process

To increase the accuracy of assessment information, interRAI has long recommended that assessments be conducted face-to-face. This enables the assessor to observe the person in his/her current living situation, and enhances whatever information can be learned from caregivers and/or health care records. However, in exceptional circumstances, such as a pandemic or extreme weather, or when the person lives in a remote location that cannot be visited timely by the assessor, it may be necessary to utilize video conferencing or telephone communication to complete the assessment, or to deploy all three modes.

Coding

Select the coding option that represents the mode most often used. If several different modes were employed, select the option that describes the mode used to complete the majority of the assessment information.

1 In person

2 Virtual conference with video

3 Virtual conference audio only

T3. Sources of Information Used to Complete the Assessment

Code only ONE PRIMARY source and ALL APPLICABLE SECONDARY sources.

Intent

To identify all information sources used to inform the assessment.

Definition

Primary refers to the information source most relied on throughout the assessment process. Secondary refers to any other source used by the assessor. Information sources includes both written and oral communication. For example, during the course of an assessment, the assessor may converse with the person and his/her spouse, have a telephone call with the person's paid support worker, and review hospital discharge notes.

T3a. Person

T3b. Spouse/partner

T3c. Parent/guardian

T3d. Child or child-in-law

T3e. Other relative

T3f. Friend or neighbor

T3g. Physician/physician assistant/nurse practitioner

T3h. Other health or social service provider

Coding

Enter the appropriate code after each possible source of information. Do not leave any item blank.

0 Not applicable

1 Primary

2 Secondary

List of Abbreviations

AC	Acute Care
ADL	Activities of Daily Living
AL	Assisted Living
CAPs	Clinical Assessment Protocols
CF	Mental Health for Correctional Facilities
CMH	Community Mental Health
CVA	cerebrovascular accident
GI	gastrointestinal
GU	genitourinary
HC	Home Care
IADL	Instrumental Activities of Daily Living
ICD-CM	International Classification of Diseases, Clinical Modification
ID	Intellectual Disability
LTCF	Long-Term Care Facilities
MDS	Minimum Data Set
MH	Mental Health
PC	Palliative Care
QDL	Self-Report Quality of Life
RAI	Resident Assessment Instrument
RUGs	Resource Utilization Groups