

Selecting an interRAI Assessment Type

Which assessment and when to use it

General guidelines and policy

interRAI offers a suite of assessment instruments supporting continuity of care. The following are guidelines for the use of interRAI assessments.

- Ensure that you are currently competent to complete the assessment type selected.
- To access funded support services for older people the person must be a New Zealand citizen, be 65 years of age or older, (55 years of age or older for Māori) or deemed close in age and interest. An interRAI assessment is required to demonstrate the need for funded community services or entry to funded residential care.
- Home Care Assessment (HC) and Contact Assessment (CA) are mandated for use across New Zealand. In some districts, community care provision is based on a Case mix devised from both the CA and HC interRAI assessment outputs.
- The Contact Assessment (CA) is designed for use where a person is known to have non-complex needs or to screen for complexity. It does not provide sufficient information for planning long term care where complex needs exist. It is therefore unsuitable for the allocation of respite or entry to residential care, or end-of-life care needs.
- The Long-Term Care Facilities Assessment (LTCF) is mandated for informing care planning in aged residential care (ARC) facilities.
- Other assessments such as the Community Health Assessment (CHA) and Palliative Care Assessment (PC) have been adopted for use in some regions but not nationally and are currently not mandated.
- The Acute Care (AC) Assessment is mandated for use in the acute hospital setting for all Accident Compensation Corporation
 (ACC) Non-Acute Rehabilitation Pathway (NAR) clients who are be managed with the ACC Case Mix. Some hospitals also adopt
 this for other patient groups. The AC is not currently accepted as an assessment for entry to residential care.
- An interRAI assessment may also be appropriate for other individuals depending on the model of care. This may include, for
 example, people under 65 years of age who have a Long-term Support Chronic Health Condition diagnosis, people who qualify
 for disability funding, privately funded individuals, or ACC clients. Te Whatu Ora Health New Zealand, may use interRAI
 assessments for wider purposes.

Health New Zealand

Te Whatu Ora



- Population data derived from interRAI assessments is most useful to organisations for planning, research, and resourcing when the appropriate assessment type has been completed for the individual being assessed.
- Maintaining assessment information within the interRAI software is preferable for the person's journey across the health sector. If
 you are unable to determine the best course of action from reading this document, please contact interRAI Services and ask for
 advice from our team. interrai@tas.health.nz or phone 0800108044 option 3.
- Further information is available on the following sites:

https://www.interrai.co.nz/assets/Documents/Sequencing-interRAI-Community-Assessments-April-2023.pdf

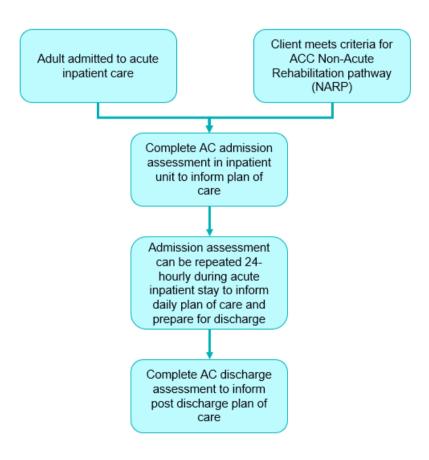
For more information, please contact interRAI Services:

Email: interRAI@tas.health.nz Phone: 0800 10 80 44 option 3 Web: www.interrai.co.nz

Select the appropriate assessment from the scenarios provided below.



interRAI Acute Care Assessment (AC)



Complete AC admission and discharge assessment to inform recategorisation of ARC level of care for LTCF clients



interRAI Contact Assessment (CA) Not suitable for Community referral of community clients in new or existing CA client respite care. Use with suspected low HC/CHA/PC to identify complex needs when community dwelling is no longer viable CA completed in home, Inter-NASC Transfer hospital or by phone (see received with CA guidelines) completed Assessment Urgency AUA = 4, 5 or 6Algorithm AUA = 1, 2 or 3(AUA) No Score? Is there Develop short-term or any short-term Develop short-term plan rehabilitation potential long-term plan of care (if of care and wait-list for (Rehabilitation Urgency required) Home Care (HC) Algorithm assessment [RUA] = 4-5?Develop short-term Re-assess when care rehabilitation plan while

needs change (no longer

than 3-year intervals)

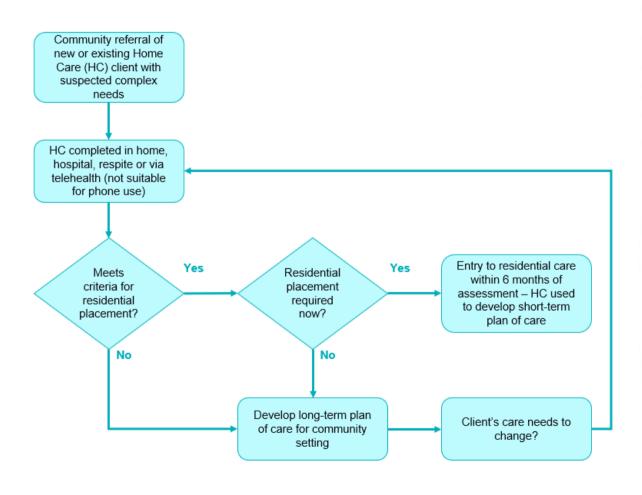
waitlisted for HC.

Repeat CA at 6 weeks.

Yes



interRAI Home Care Assessment (HC)

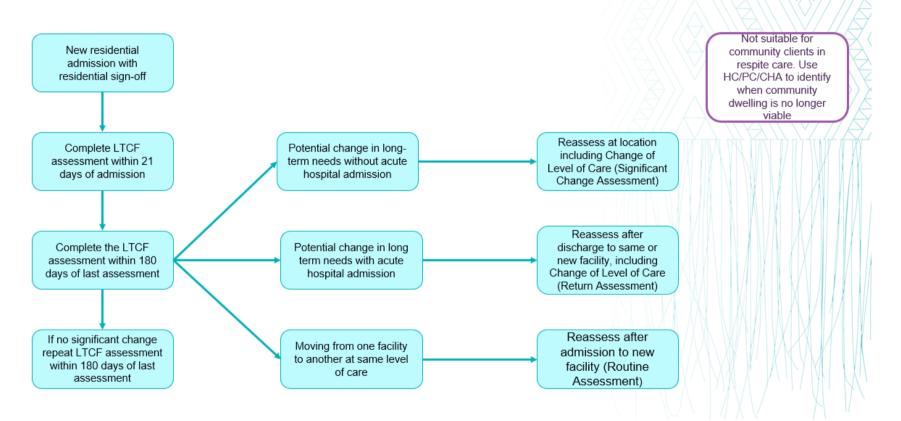


Suitable for community clients in respite care to identify when community dwelling is no longer viable

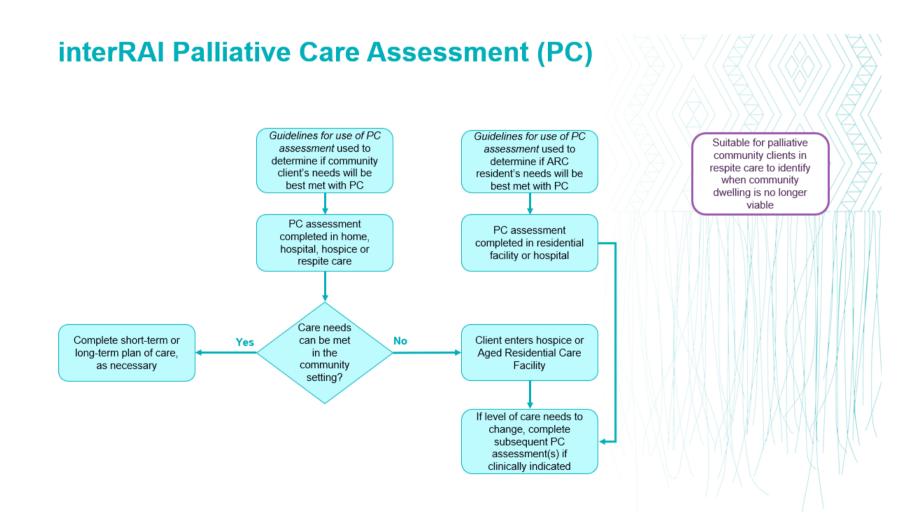
Re-assess when referral received or change in care needs indicated (no longer than 3-year intervals)



interRAI Long Term Care Facilities Assessment (LTCF)





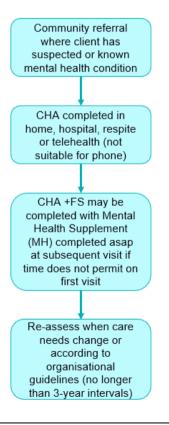




Assessment (CHA)

Community referral where client has suspected moderately clinically complex needs CHA core plus FS = HC CHA completed in home, hospital, respite or telehealth (not suitable for phone) CHA + FS suitable for community clients in CHA core may be respite care completed with **Functional Supplement** (FS) completed asap at subsequent visit if time does not permit on first CHA + FS can be visit completed for entry to residential care Re-assess when care needs change (no longer than 3-year intervals)

interRAI Community Health interRAI CHA plus Mental Care **Health Supplement (CHA +MH)**



Designed to expand assessor's understanding of the person's mental health status

CHA + MH suitable for community clients in respite care

CHA + MH can be completed for entry to residential care