interRAI HC (IRRS): Disease Diagnoses (Sections I1 and I2)

Intent of sections I1 and I2

To document the presence of any diseases or infections that are relevant to the person's current activity of daily living (ADL) status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring or risk of death.

Steps for recording disease diagnoses

Step 1: Gather information

Consult the clinical record and the primary physician or talk to the person and family and validate their statements with the physician.

Step 2: Complete Section I1 (Diseases)

Select the most appropriate disease code for each diagnosis listed. Do not include conditions that have been resolved or no longer affect the person's functioning or care needs. There can be more than one primary diagnosis coded to support and justify services being provided.

Step 3: Complete Section I2 (Other Disease Diagnoses)

Enter the diagnosis, the appropriate disease code and the ICD-10-CA code for diseases and infections that are **not recorded in Section I1**. You may also record more specific designations for general disease categories listed in I1. Do not include signs and symptoms that are **manifestations** of an underlying disease.

Example

A person is admitted with a diagnosis of multiple sclerosis and hypertension. The reason for admission to home care is identified as "frailty" and "deconditioning," with loss of autonomy for completing self-care activities.

The assessor records the following primary diagnosis/diagnoses for the current stay:

- Section I1: *Multiple sclerosis*
- Section I2: *Hypertension (benign), unspecified* (ICD-10-CA code I10.0)

Important: No ICD-10-CA code is recorded for "frailty" or "deconditioning" as these are manifestations of the underlying disease (multiple sclerosis). Loss of functional self-performance and capacity is captured in Section G (Functional Status).

Job Aid

Health conditions that contribute to an output calculation

The table below lists health conditions that should be captured in the interRAI Home Care (HC) assessment to ensure that the clinical outputs accurately reflect the person being assessed:

Diagnosis	ICD-10-CA code	Output impacted
I1a Hip fracture	n/a	Activity of Daily Living CAP, Urinary Incontinence CAP, Bowel Conditions CAP, QI (percentage of persons with new injuries and break)
I1b Other fracture	n/a	QI (percentage of persons with new injuries and break)
I1c Alzheimer's disease	n/a	MAPLe, Cognitive Loss CAP
I1d Dementia other than Alzheimer's disease	n/a	MAPLe, Cognitive Loss CAP
I1e Hemiplegia/hemiparesis	n/a	RUG-III-HC
I1f Multiple sclerosis	n/a	MAPLe, RUG-III-HC
I1i Quadriplegia	n/a	RUG-III-HC
I1j Stroke/CVA	n/a	DIVERT
I1k Coronary heart disease	n/a	DIVERT
I1l Chronic obstructive pulmonary disease	n/a	DIVERT
I1q Pneumonia	n/a	DIVERT, Activity of Daily Living CAP, Urinary Incontinence CAP, Bowel Conditions CAP, RUG-III-HC
I1r Urinary tract infection	n/a	DIVERT
I1t Diabetes mellitus	n/a	DIVERT, RUG-III-HC
Sepsis, unspecified (septicemia)	A40, A41, R65	RUG-III-HC
Cerebral palsy, unspecified	G80.9	RUG-III-HC

Notes
n/a: Not applicable.
RUG-III-HC: Resource Utilization Groups version III for Home Care.
MAPLe: Method for Assigning Priority Levels.
DIVERT: Detection of Indicators and Vulnerabilities for Emergency Room Trips.
CVA: Cerebrovascular accident.
CAP: Clinical Assessment Protocol.

How to cite this document:
Canadian Institute for Health Information. *interRAI HC (IRRS): Disease Diagnoses (Sections I1 and I2)*. Ottawa, ON: CIHI; 2022.