The *inter*RAI assessment system

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Demand for comprehensive geriatric assessment?

- Winograd (1988)
  - 18-24% of admissions >65 yrs
- Nosworthy & Campbell (2001)
  - More than 50% gen. medical patients dependent in ADL
  - 50% social issues affecting LOS
- • Flintoff (1998)
  - 20% of Ontario admissions “subacute”

Meta-analysis of Comprehensive Geriatric Assessment (CGA)

- reduced mortality at 6 months (OR 0.65)
- increased likelihood of living at home at 6 months (OR 1.8)
- reduced hospital readmissions (OR 0.82)
- physical function improved (OR 1.63)

Stuck et al, Lancet, 1993

The interRAI method

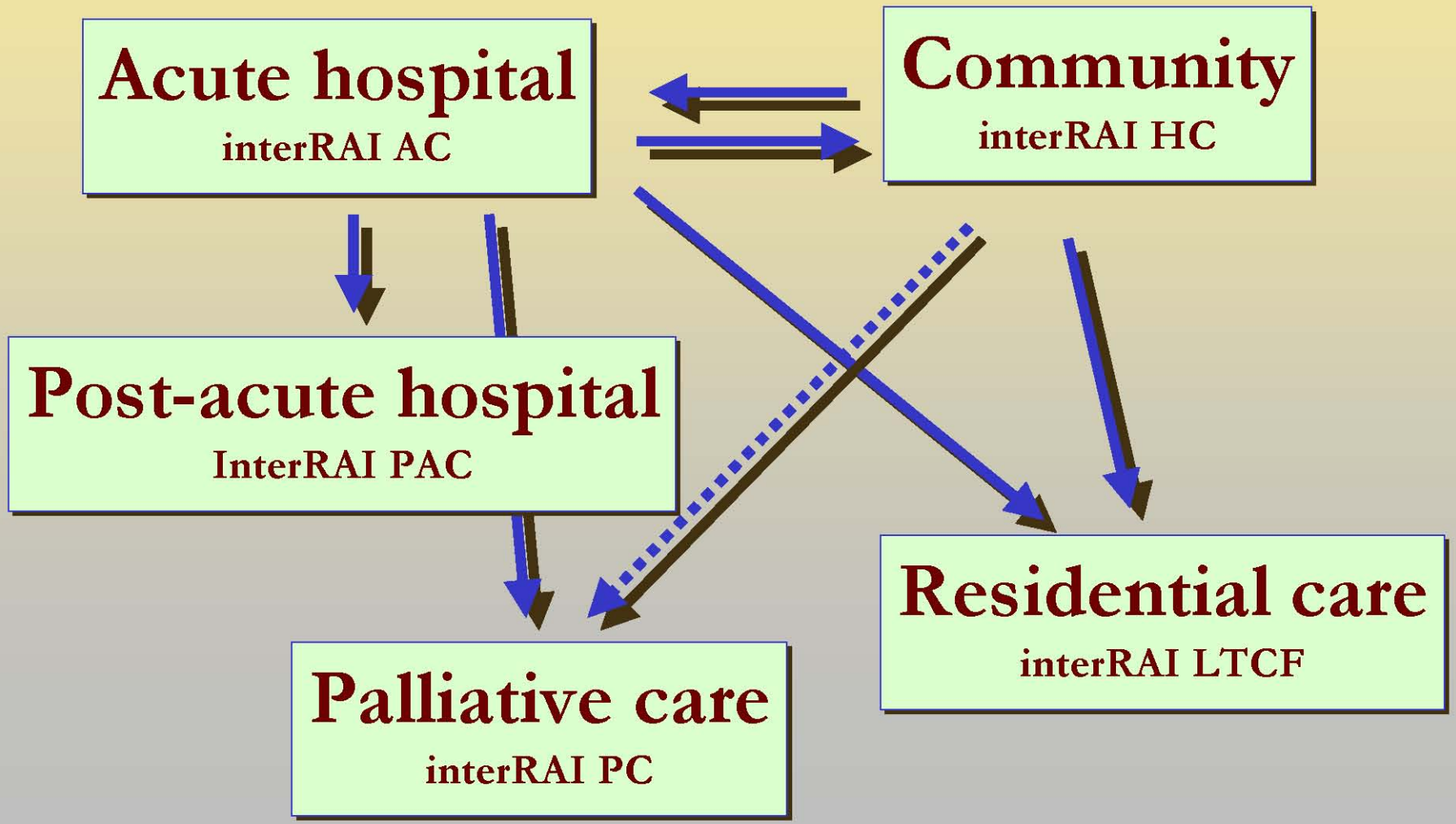
interRAI instruments are used primarily as clinical tools to assess individuals with a view to developing an effective care plan

The information is recorded in standardised format (Minimum Data Set)

The information collected “triggers” more in depth assessment of selected domains

The interRAI model

Care domains



Scales

1. Cognitive performance scale
2. Depression rating scale
3. Pain scale
4. ADL scales (long, short & hierarchical forms)
5. IADL scales (difficulty, involvement & summary scales)
6. CHESS (frailty & health instability)

But…most importantly…

ADL / Rehabilitation Potential	Nutrition
IADL	Oral health
Health Promotion	Pain
Institutional Risk	Pressure ulcers
Communication Disorders	Skin / foot problems
Visual function	Adherence
Alcohol Dependency	Brittle support system
Cognition	Medication management
Behavioural issues	Palliative care
Depression & anxiety	Preventive health measures
Elder abuse	Psychotropic drugs
Social function	Reduction in formal services
Cardio-respiratory	Environmental
Dehydration	bowel management
Falls	Urinary incontinence

InterRAI TARGET process

- ADL Short Form Scale
- ADL Self Performance Hierarchy Scale
- ADL Long Form Scale
- The Cognitive Performance Scale (CPS)
- Depression Rating Scale (DRS)
- IADL Difficulty Scale
- IADL Involvement Scale
- Pain Scale

Clinical Assessment Protocols
CAPS need to appear on a web page prior to developing ladder

Sub maximal items pre-populate (i.e. any areas that older person is not operating to maximum ability)

Final variables or items not finalised - awaiting ASPIRE statistical analysis

TARGET

Older person sees web page with items within it and is asked:

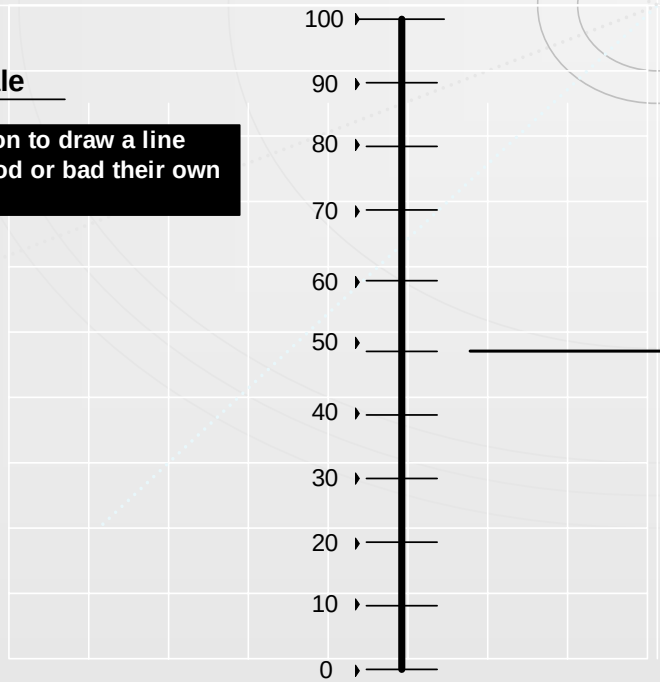
- to rank each item in relation to how important it is to them
- to order from 1 to 3 how much they would like to change that item (i.e. 1=no change, 2=a little change, 3=a lot of change)

GOAL LADDER

Client Goal

Temperature gauge / Visual Analogue Scale

Please ask the older person to draw a line corresponding to how good or bad their own health is today



Additional item within MDS-HC (Older person needs to see scale to add line)

interRAI in New Zealand

- Five DHBs trialing the tool: Canterbury, Hutt Valley, Capital and Coast, Waikato and Bay of Plenty.
- Universities of Auckland and Otago – contracted to evaluate the implementation
- Mixed method design: RCT in Bay of Plenty (n=324) NASC standard assessment vs. interRAI assessment
- Training evaluation
- Implementation evaluation and appropriateness to Maori
- Cost effectiveness

Training Evaluation

- Research questions:
  - What are the strengths and weaknesses of the existing training programme from the perspective of assessors?
  - Is their variability between assessors and what is the clinical significance of this variability?
- Methods: Survey and Focus group and rater reliability check of 23 clients and 5 assessors undergoing repeat assessments with a gold standard assessor

Case study approach

- Research question: How does the experience of MDS-HC differ from current practice
- 20 / 20 pre/post design in Capital and Coast and Canterbury and MDT review in Hutt and Waikato
- Hui with Kaumatua around effectives in Waikato and BoP

NURSE MAUDE ASSOCIATION

Capital and Coast Care Coordination Centre

QUALITY HEALTH ACCREDITED

Anushiya Ayingaran
Nurse Maude Association

Committed to Community Health Care

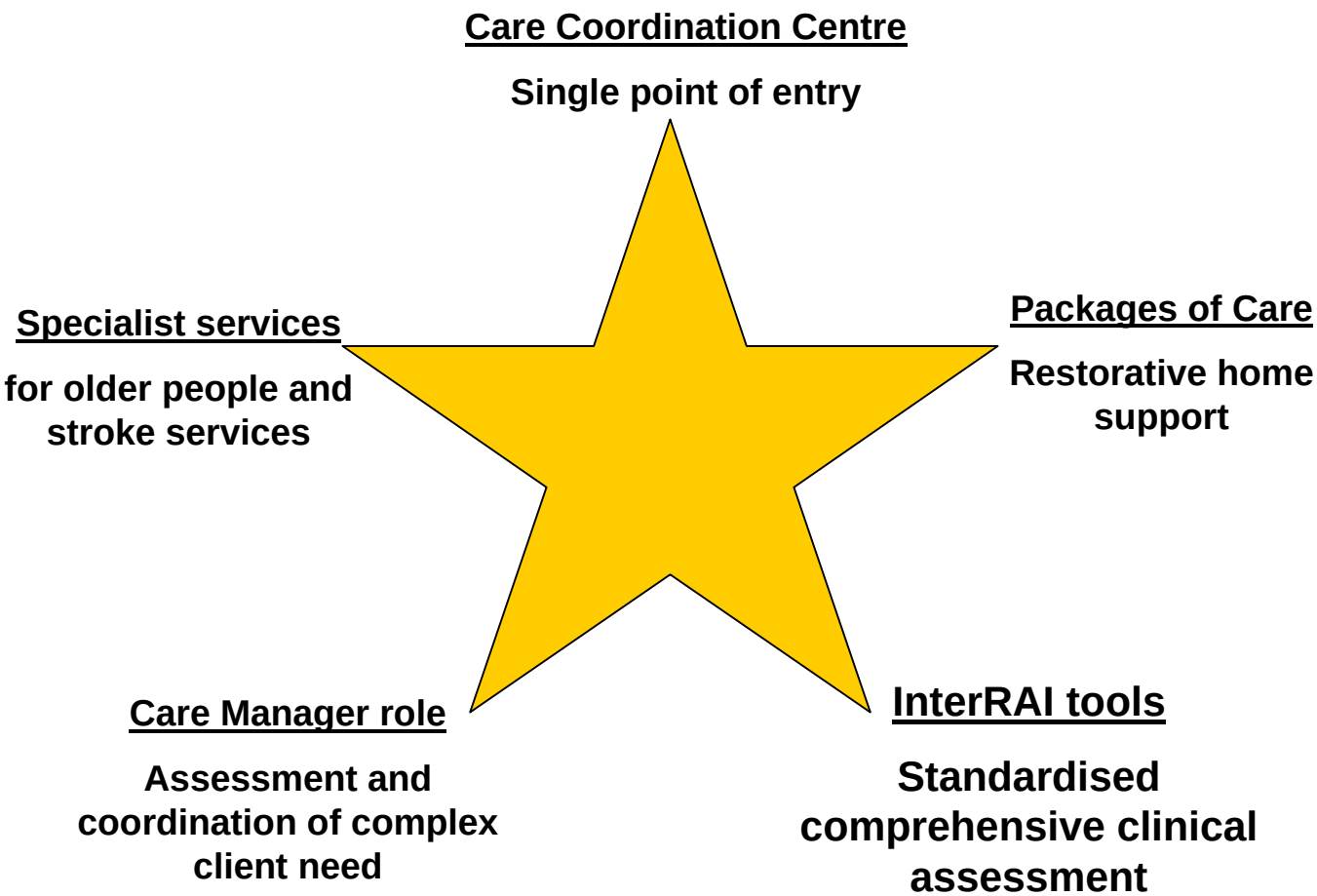
Introducing Nurse Maude Association

- Founded by Sybilla Maude pioneer of District Nursing in 1896
- Provide services in Canterbury, Kaikoura, Timaru
- Covers a population in excess of 400,000 employing in excess of 1300 staff
- District and Specialist Nursing 163,265 visits to 4,200 clients
- Home Care Services 738,000 hrs to 8,860 clients
- Palliative Care 30,000 hrs to 800 clients
- Stoma and Continence Services 28,300 visits to 4,840 clients
- Hospital 80 beds and Allied Health
- Hospice 11 beds
- Linen and Meals
- Established CCC in Wellington on 01 September 2005

What is the Care Coordination Centre?

- Single point of entry for all referrals requiring access to community based health services:
- Assessment for comprehensive identification of needs, and facilitated access to appropriate services
- Management and monitoring of indicative budgets and resources used for home, community and residential care services
- Information services for consumers, providers and funders

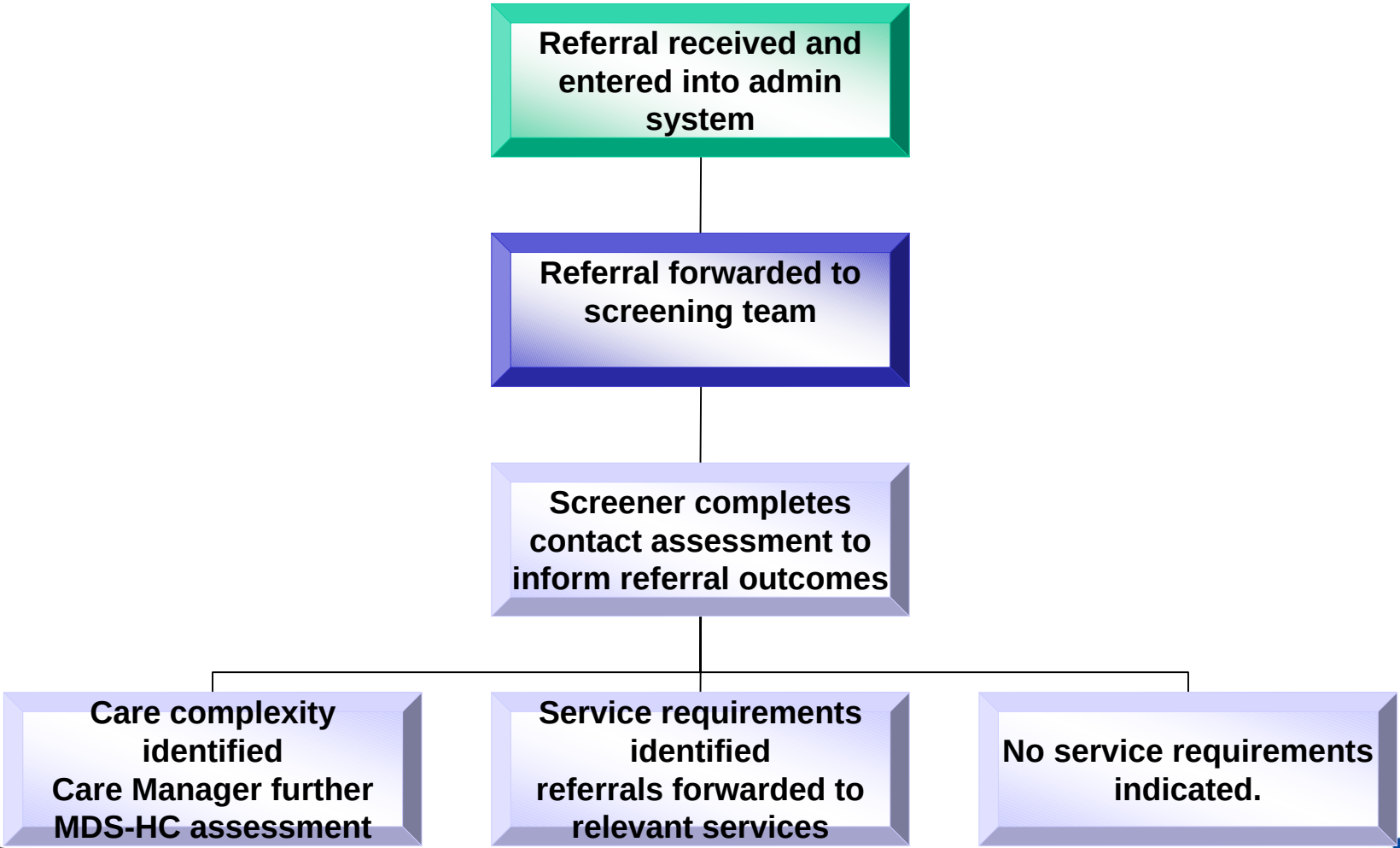
Integrated Home and Community Care



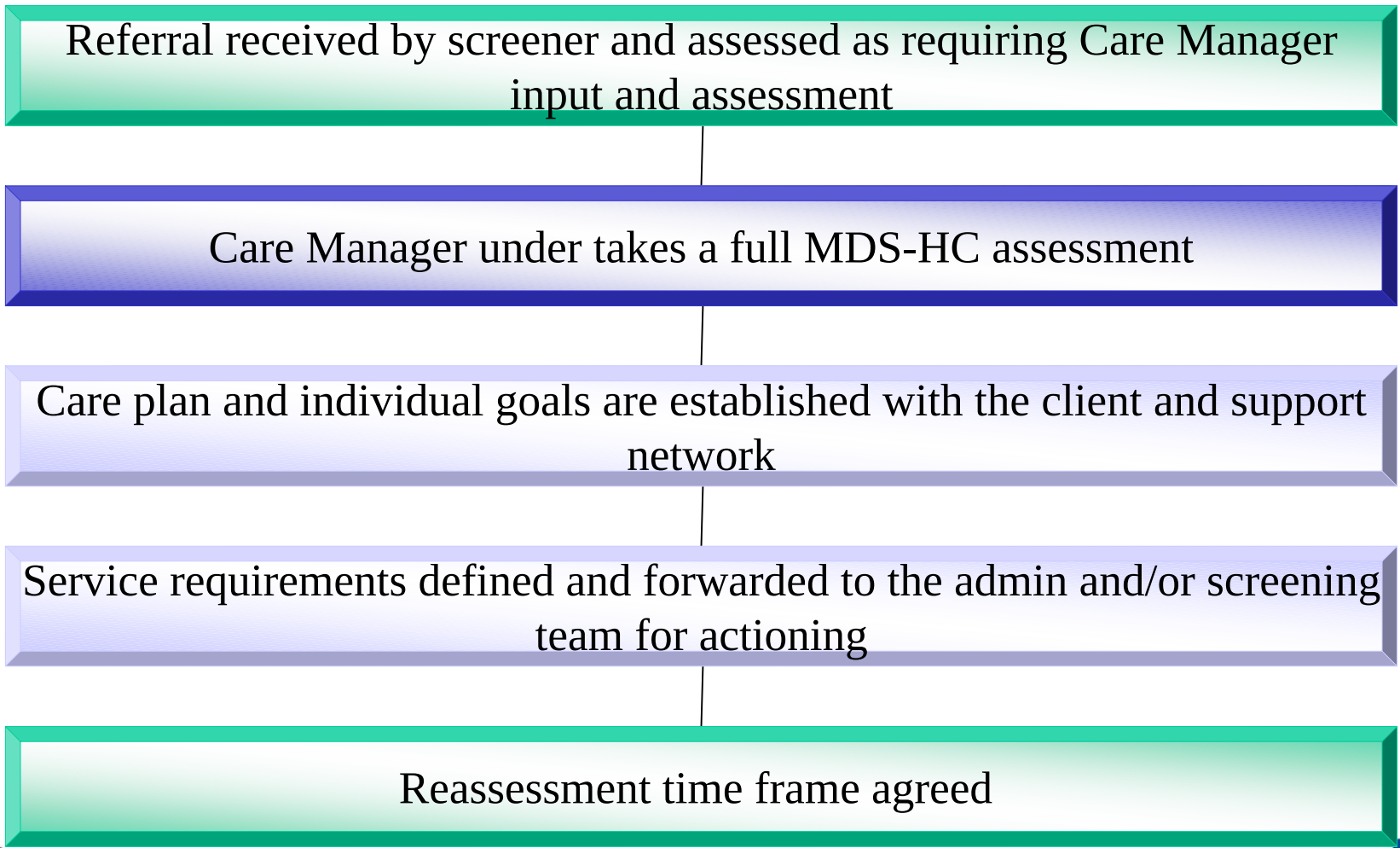
InterRAI and CCC

- MDS-HC introduced to Care Managers in November 2005
- Used for complex clients in the community
- Training external Care Managers & developing the interface with the CCC
- Contact Assessment introduced to Screeners in January 2006
- Assessments completed over the phone for non complex screening and assessment

Contact Assessment



MDS-HC


Referral received by screener and assessed as requiring Care Manager input and assessment
Care Manager under takes a full MDS-HC assessment
Care plan and individual goals are established with the client and support network
Service requirements defined and forwarded to the admin and/or screening team for actioning
Reassessment time frame agreed

The client journey: The referral

- A referral was received from Mrs Jones' GP requesting home help
- Mrs Jones is an 80 year old woman with extensive osteoarthritis who recently suffered a nasty dose of flu and is struggling to pick up again.
- She is primarily cared for in the home by her husband, due to limited function in her hands and shoulders.
- No supports are currently in place for this couple

The client journey: Assessment

- On receipt of the referral a screener rang Mrs Jones and completed a contact assessment
- The assessment identified that pain was a significant issue, and that Mrs Jones' ability to manage her own personal cares was impaired and deteriorating as a result
- The assessment also identified that Mr Jones is becoming tired and unwell himself, and struggling to manage the demands of caring for his wife on his own

The client journey: Care Management

- The screener recognises from the CA the need for a more comprehensive assessment and forwards the information to the Care Manager to arrange a home visit with the Jones family

- On visiting Mr & Mrs Jones the Care Manager completes an InterRAI MDS-HC assessment, using a laptop to access the electronic tool

- The assessment highlights that:
  - Mrs Jones has not understood the need to take her pain medication regularly
  - Mrs Jones has experiences a significant reduction in function in a short space of time
  - Mrs Jones feels there is room for improvement in her health
  - Mr Jones is fearful they may need rest home care if he is unable to manage or if he becomes unwell

The client journey: Outcomes

- The pharmacist is contacted to confirm what medications Mrs Jones should be taking.
  - All other medications are disposed of
  - Education is provided
  - GP updated

- A follow up appointment is made with the GP to ensure continued monitoring of Mrs Jones' pain levels and medication efficacy

- A package of care is agreed with Mr & Mrs Jones based on her personal goals to:
  - become independent with her personal cares
  - be able to return to weekly swimming with the Arthritis Foundation independently of her husband

The client journey: The package of care

- In order to achieve her goals Mrs Jones will need to be able to:
  - Manage her pain
  - Improve her stamina and general fitness
  - Focus on return of movement in upper body
  - Learn new strategies for managing daily activity

- The package of care recommended the following resources:
  - OT input to work with Mrs Jones on ADL function
  - Support worker input to:
    - build Mrs Jones fitness and confidence
    - support Mrs Jones to under take her own personal cares

The client journey: Services

- Mrs Jones was encouraged to use the following supports:
  - Home support provider agency to work towards achieving her goals through a package of care
  - Follow up care with the GP regarding pain management
  - Support from the Arthritis Foundation regarding management strategies with her arthritis, and encouragement to achieve her personal goal

- With this support in place Mr Jones felt better able to cope
  - Wife likely to improve in level of independence
  - Able to manage in their own home for longer than he thought possible
  - Able to take time out for himself to take on his own interests

Integrated Home and Community Care