



Regional Geriatric Program of Eastern Ontario
Programme gériatrique régional de l'Est de l'Ontario

Addressing Health Care Needs for Frail Seniors Using interRAI Tools

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Raising Awareness! A Geriatric Education Day
March 4 2015

Disclosures

- Associate Fellow of interRAI and collaborator within interRAI Canada and the interRAI Network of Excellence in Acute Care (iNEAC)
- Consultant / speaker fees from Astra Zeneca, Merck, Servier
- Schlegel Research Chair in Geriatric Medicine (Schlegel University of Waterloo Research Institute for Aging)
- Cardiac Care Network of Ontario
- Unrestricted funding from CIHR, HSFO and the Alzheimer's Society of Canada



82 year old from home

- Cognitive Performance Scale **2/6** (MMSE ~ 20)
- Depression Rating Scale **1/14** (MDE unlikely)
- Caregiver is unable to continue in caring activities **No**
- Caregiver expresses feeling of distress **Yes**
- ADL Hierarchy Scale **1/6** (Supervision required)
- Health instability (CHESS) **1/5** (mild instability)
- Pain Scale **2/3** (daily but not severe)
- MAPLe **High**

THOUGHTS?

Brief profile

- Requires assistance from spouse with all his ADL's. Has already given financial issues to his son for taxes. Client manages daily bills, writes cheques , but more difficulty with writing, fine motor grasp. Client states that his SOB may be related to his anxiety but is not sure.
- 4 years deconditioned as legs weaker; has exercise regime, does not follow, lacks motivation. Client determined to maintain independence , takes approx 2 hours to get dressed. Wife assists at times with buttons. Client declining assistance with personal care. Wife supervises showers, afraid of him falling.
- Has Parkinson's, malnourished, high anxiety, depressed, currently being seen by Geriatric Day hospital at Civic, he's had multiple falls in the past.

That frailty thingy...

WHY WE DO COMPREHENSIVE ASSESSMENTS?

Frailty

Bergman 2007

- State of reduced physiologic fitness and reserve resulting in vulnerability to stressors and leading to poor outcomes



How do we operationalize this clinically?

Deconstructing frailty

- Risk arises from multiple & interacting deficits
 - Multimorbidity
 - Disability
 - Geriatric syndromes
- Shared characteristics
 - All more common with age
 - All associated with poorer outcomes and health service use

Kungsholmen Project

Marengoni et al, J Int Med 2008

1099 pts 77 to 100 years old (mean age 84 years), 77% women

Followed ~ 3 years
52% with 2 or more chronic illnesses

Risk of disability increased by 30% for each additional illness

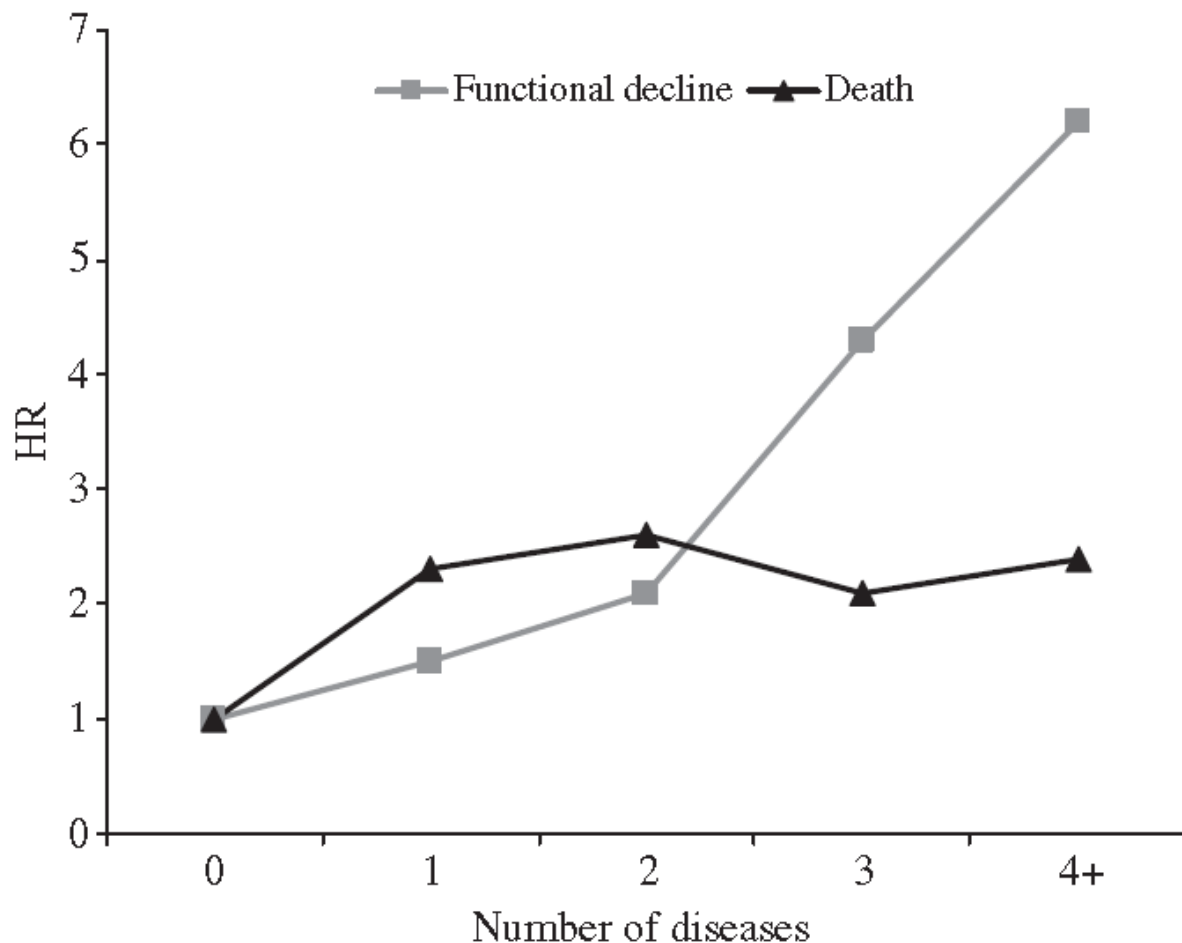


Fig. 1 Hazard ratios (HR) of functional decline and death during follow-up due to increasing number of coexisting diseases versus no disease. Adjusted for age, gender, education and disability at baseline.

Geriatric “conditions”

Ann Intern Med 2007;147:156-64

- Health and Retirement Study
 - 11093 Americans 65 years and over
 - Community and nursing homes
- Assess association between disability and
 - Chronic diseases (active or severe)
 - Geriatric “conditions”:
 - Hearing/vision impaired
 - Dizzy
 - Incontinence
 - Injurious fall
 - Cognitive impairment
 - Low BMI

HRS: Disability



Condition	Risk ratio of disability
Number of geriatric conditions	
1	2.1
2	3.6
3+	6.6
Stroke	3.0
Diabetes	1.3
Heart disease	1.2
Cancer	1.0

Determinants of risk for adverse outcomes encompasses interacting ...

- Multimorbidity
- Disabilities
- Geriatric syndromes

- The more there are things going wrong, the worse the outcomes
 - Rockwood's thesis: Deficit accumulation = Frailty

Appendix 1: List of variables used by the Canadian Study of Health and Aging to construct the 70-item CSHA Frailty Index

- Changes in everyday activities
- Head and neck problems
- Poor muscle tone in neck
- Bradykinesia, facial
- Problems getting dressed
- Problems with bathing
- Problems carrying out personal grooming
- Urinary incontinence
- Toileting problems
- Bulk difficulties
- Rectal problems
- Gastrointestinal problems
- Problems cooking
- Sucking problems
- Problems going out alone
- Impaired mobility
- Musculoskeletal problems
- Bradykinesia of the limbs
- Poor muscle tone in limbs
- Poor limb coordination
- Poor coordination, trunk
- Poor standing posture
- Irregular gait pattern
- Falls
- Mood problems
- Feeling sad, blue, depressed
- History of depressed mood
- Tiredness all the time
- Depression (clinical impression)
- Sleep changes
- Restlessness
- Memory changes
- Short-term memory impairment
- Long-term memory impairment
- Changes in general mental functioning
- Onset of cognitive symptoms
- Clouding or delirium
- Paranoid features
- History relevant to cognitive impairment or loss
- Family history relevant to cognitive impairment or loss
- Impaired vibration
- Tremor at rest
- Postural tremor
- Intention tremor
- History of Parkinson's disease
- Family history of degenerative disease
- Seizures, partial complex
- Seizures, generalized
- Syncope or blackouts
- Headache
- Cerebrovascular problems
- History of stroke
- History of diabetes mellitus
- Arterial hypertension
- Peripheral pulses
- Cardiac problems
- Myocardial infarction
- Arrhythmia
- Congestive heart failure
- Lung problems
- Respiratory problems
- History of thyroid disease
- Thyroid problems
- Skin problems
- Malignant disease
- Breast problems
- Abdominal problems
- Presence of snout reflex
- Presence of the palmomental reflex
- Other medical history

Comprehensive Geriatric Assessment

Abellan 2010

Multidimensional interdisciplinary process focused on determining a frail older persons' medical, psychological and functional capacity in order to develop a coordinated and integrated plan for treatment and long-term follow-up

1. comprehensive data collection
2. development of a comprehensive management plan
 - **Tailored to patient need and overall fitness / frailty**

Fundamental Equations of geriatrics

- Frailty = Vulnerability
- Frailty x Stressor \approx *Risk* of a bad outcome
- Stressors include
 - Iatrogenesis fulminans
 - Caregiver stress and other socioeconomic factors
 - System fragmentation

Sociodemographic	<p>Living situation and means of transportation</p> <p>Informal Caregiver and other social supports</p> <p>Elder abuse</p> <p>Advance directives</p>
Cognition	<p>Overall performance</p> <p>Behavioural issues and psychosis</p>
Psychiatric	<p>Mood and Anxiety</p>
Function	<p>Basic Activities of Daily Living (BADLs)</p> <p>Instrumental Activities of Daily Living (IADLs)</p>
Mobility	<p>Gait problems and gait aids</p> <p>Falls</p>
Senses	<p>Vision and Hearing</p>
Elimination	<p>Bladder and bowel function</p>
Health indicators	<p>Nutrition</p> <p>Pain</p> <p>Cardiorespiratory</p> <p>Skin integrity</p> <p>Substance abuse</p>
Medical	<p>Primary prevention (e.g. immunization)</p> <p>Secondary, tertiary (optimal chronic illness management)</p> <p>Polypharmacy / medication review</p>

CGA is a good thing in appropriately identified patients

- Improved prescribing
- Fewer hospitalizations
- Lower institutionalization rate
- Improved function, cognition
- Reduced falls
- Lower mortality
- Cost-neutral to cost-reducing

First generation CGA

- Usually ad hoc selection of instruments to form a battery
 - E.g. MMSE / MoCA; GDS; Barthel /Index; Zarit; other items
- Tools are generally psychometrically sound
 - “other items” less so, e.g.
 - “Home is cluttered/poorly kept ”
 - “Furniture cruising”
 - “Pain: yes/no”
- Problem: Lack of standardization
 - Lack of common tools between/within programs / sites
 - Lack of standardized approach to instrument completion
 - **“I DON’T BELIEVE YOUR MMSE SO I WILL REPEAT IT”**

Health care system fragmentation

Bergman 1997; Hebert 2003; Heckman 2013

- Canadian health care challenges include
 - multiple entry points
 - service delivery influenced less by patient need and more by available contracted services
 - piecemeal care planning
 - reactive approach
 - ***duplicated assessments, limited use of standardized tools, inadequate information sharing***

Example from local hospital interRAI

- HOBIC (x2)
 - **ADLs**, Contenance, Pain, Fatigue, Dyspnea, Nausea, **Falls**, Pressure ulcers
- **FIM**
- Berg Balance Scale
- MoCA, CAM, MMSE, RUDAS, Glasgow Coma Scale, Canadian Neurological Scale
- Charlson Comorbidity Index
- Type & duration of therapy
- Demographics
- **Falls**
- Missing...
 - Mood
 - Behaviours
 - Communication / senses
 - Social engagement
 - Others

MDS 2.0

Why is this a problem?

- Under-reporting of important issues, redundant documentation of others
- Barriers to information sharing leading to repeated assessments and inefficiency
 - Burden on patients and assessors
- Missed opportunities: summarize data, risk algorithms, assist with care planning
- Prevents system managers from conducting cross-sector evaluations to understanding how to allocate funding and improve the health care system

Generations of assessment systems in Geriatric Medicine

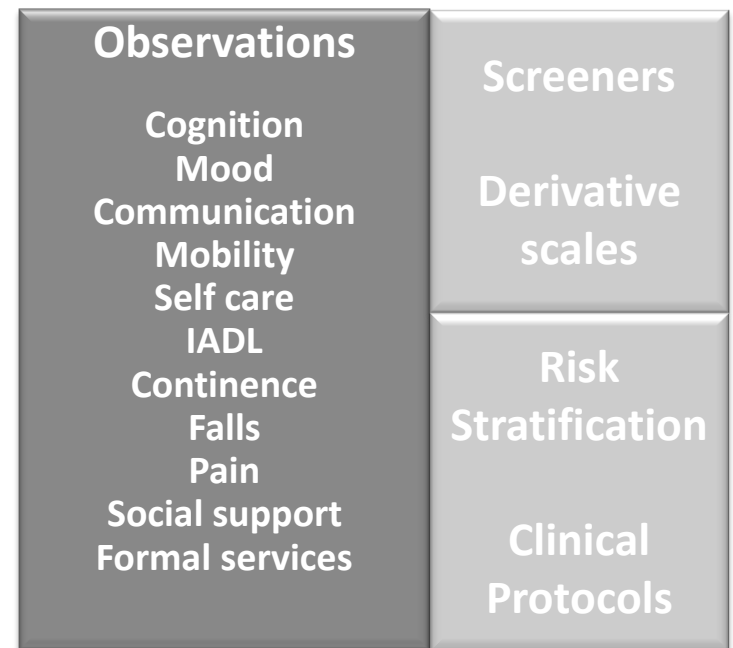
Clinical domains (presence & risk)

- Cognition**
- Mood**
- Self care**
- Mobility/falls**
- Continence**
- Nutrition**
- Pressure ulcer**

First generation assessment

- MMSE/CAM**
- GDS**
- Barthel**
- TUG / Berg**
- ?**
- MNA**
- Waterlow**
- FILLER**

Second generation assessment



Prof. Len Gray

interRAI instruments

WWW.INTERRAI.ORG

RAI / MDS

Hawes et al Age Ageing 1997

- Developed in response to 1987 US Omnibus Budget Reconciliation Act addressing quality of nursing home care and need for standardized assessment
- Targets frail seniors, disabled adults in LTC homes
- Terminology
 - MDS: Minimum Data Set
 - RAI: Resident Assessment Instrument (2nd generation built upon MDS)

interRAI

- Who?
 - International, not-for-profit network of ~85 researchers and health/social service professionals
- What?
 - Comprehensive assessment of strengths, preferences, and needs of vulnerable populations
- How?
 - Multinational collaborative research to develop, implement and evaluate instruments and their related applications

Courtesy Dr. John Hirdes

interRAI Countries

North America

Canada

US

Mexico

Europe

Iceland, Norway, Sweden, Denmark, Finland,
Netherlands, France, Germany, Switzerland,
UK, Italy, Spain, Czech Republic, Poland,

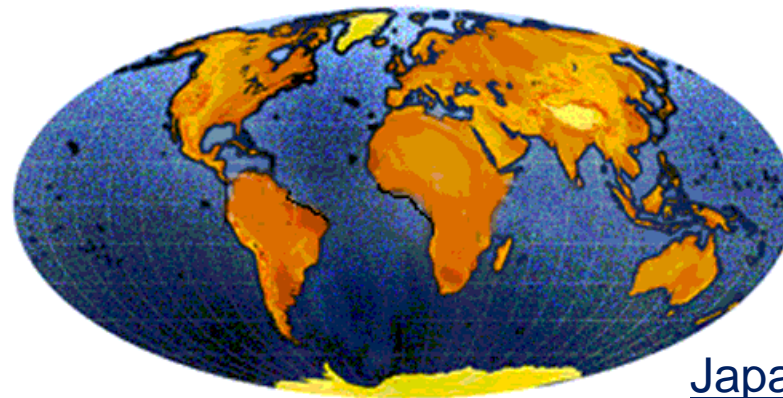
Estonia, Belgium, Lithuania, Russia

Portugal, Austria

Central/ South America

Brazil, Chile

Peru



South Asia, Middle East & Africa

India, Israel, Lebanon, Qatar

South Africa, Ghana

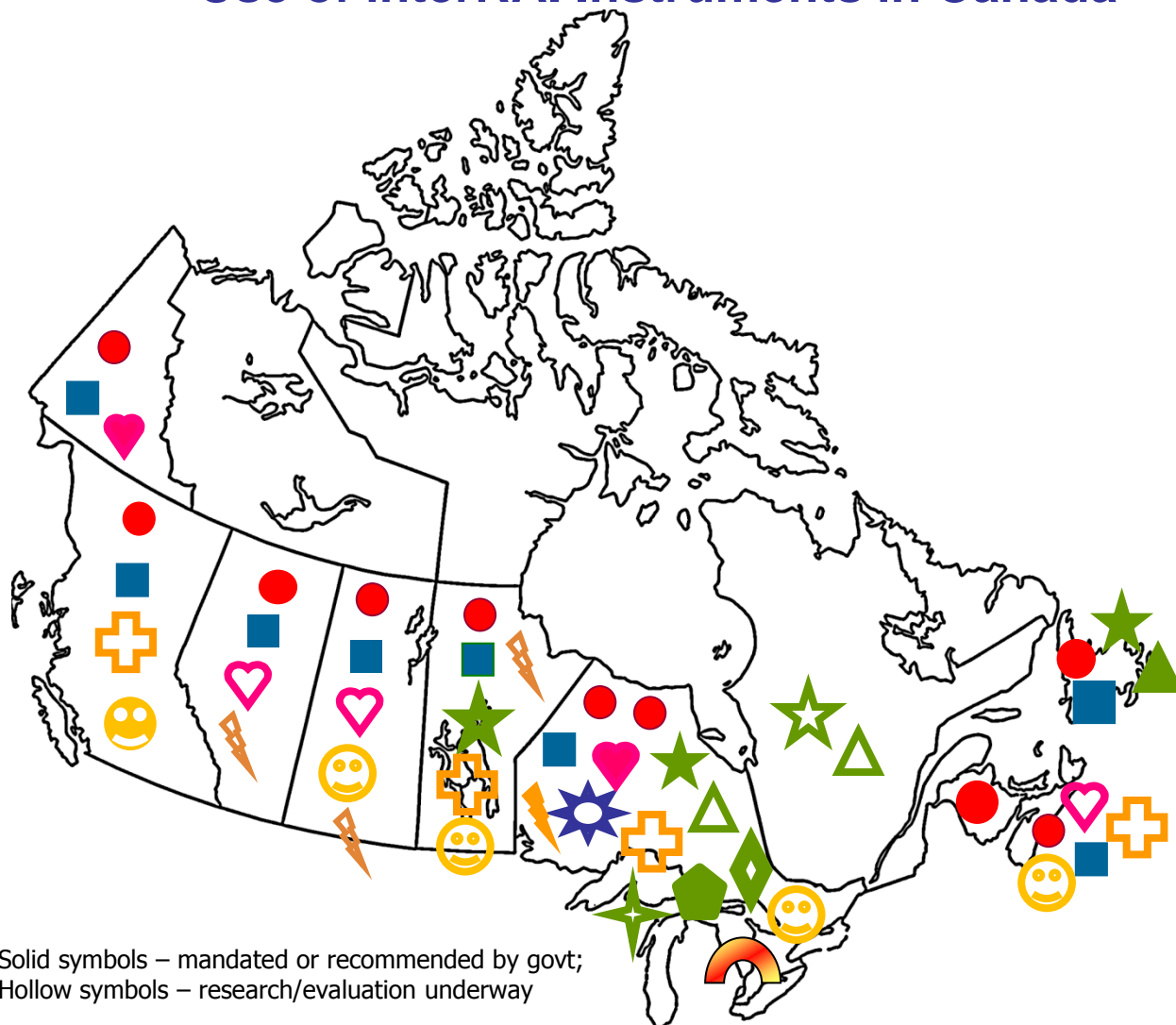
Pacific Rim














Japan, China, Taiwan,
Hong Kong, South Korea,
Australia, New Zealand
Singapore



interRAI

Use of interRAI Instruments in Canada



-  RAI 2.0/ interRAI LTCF
-  RAI-HC
-  RAI-MH
-  interRAI CMH
-  interRAI ESP
-  interRAI BMHS
-  interRAI ChYMH
-  interRAI ID
-  interRAI PC
-  interRAI ED/AC
-  interRAI CA
-  interRAI CHA
-  interRAI SQoL

Solid symbols – mandated or recommended by govt;
 Hollow symbols – research/evaluation underway

interRAI in Canada by the numbers

(Based on CIHI Reporting Systems only)

- **10** provinces and territories use interRAI instruments (9 mandated, 1 pilot)
- **15,000 clinicians in 1,900** organizations use interRAI assessments
- **> 1.5 million** Canadians assessed in-person by end of 2014
 - 352,190 in nursing homes
 - 232,679 in CCC hospitals
 - 731,716 in home care intake
 - 804,132 in long stay home care
 - 284,211 in mental health
- **7,863,346** in-person assessments by end of 2014
 - 3,026,267 in nursing home
 - 566,405 CCC hospitals
 - 1,145,626 in home care intake
 - 2,217,577 in long stay home care
 - 907,471 in mental health

Approach: One instrument, multiple applications

- Key concepts and applications
 - Outcome measures and scales
 - Facilitate care planning
 - Risk algorithms and prioritization
 - Protocols
 - Quality indicators
 - Resource allocation
 - Case mix
- Promote evidence-informed decision-making support across care continuum

An Overview of an interRAI Instrument

- Core assessment items important in all care settings
 - common items have identical definitions, observation time frames, and scoring
 - additional items specific to a particular care population / setting
- Fully realized interRAI assessment "system" consists of
 - data collection form and user manual
 - triggers for Clinical Assessment Protocols, or CAPs
 - status and outcome measures
 - quality indicators
 - case-mix algorithms
- **Rely on the SAME data set for all functions**

Courtesy Dr. John Hirdes

interRAI instruments form basis for system integration

- Common data collection methods
 - standardized training emphasizes professional assessment skills
 - clinical judgment of best information source
- Common clinical emphasis: functional assessment rather than diagnosis
- Common language: consistent terminology across instruments
- Common core elements across all sectors: (e.g., ADL, cognition)
- Common care planning protocols for sectors serving similar populations

Development

- Identification of key clinical issues for a given population
 - Consultation with clinicians, experts, policymakers, advocates, consumers, and purchasers
- Testing
 - extensive validity and reliability trials
 - studies of clinical acceptability and longitudinal studies of care outcomes are done to test the instruments in real-life settings
- Data reviewed by *Systems and Instrument Development Committee* before instrument approved for implementation in everyday clinical process

Courtesy Dr. John Hirdes

Clinical Assessment Protocols

- Identify major issues triggered by the assessment
- Brief, concise written material to assist in care planning
 - produced by a team of expert authors
 - drawing on patient data whenever possible
 - help front-line clinicians think through
 - what is known about a given issue
 - how the problem is experienced by the individual
 - why it is present
 - review possible prevention and treatment options
 - help evaluate whether further evaluation is needed

Courtesy Dr. John Hirdes

Other development

- Provide software code to enable automation
 - production code for core scales, CAPs, QIs, Case-mix algorithms
- Ongoing Quality Improvement
 - Instruments regularly updated with changes in
 - scientific knowledge
 - needs of health care consumers
 - health care system itself changes
 - New versions contain improvements in item structure, measurement definitions, CAP triggers, etc., identified from previous research and practice
- Opportunities for locally derived algorithms to be validated more broadly

Courtesy Dr. John Hirdes

interRAI Fellows/Associate Fellows in Canada

- **Fellows in “Main” interRAI Network**
 - John P. Hirdes, Ph.D., University of Waterloo
 - Katherine Berg, Ph.D., University of Toronto
 - Trevor Smith, Ph.D., Nipissing University
- **Associate Fellows in iNE Mental Health**
 - Howard Barbaree, Ph.D., Waypoint Mental Health Centre
 - Gregory Brown, Ph.D., Nipissing University
 - Shannon Stewart, Ph.D., Child and Parent Resource Institute
 - Lynn Martin, Ph.D., Lakehead University
 - Chris Perlman, Ph.D., University of Waterloo
- **Associate Fellows in iNE Acute Care**
 - George Heckman, M.D., University of Waterloo
 - Samir Sinha, M.D., Mount Sinai Hospital
 - Marie-Jeanne Kergoat, M.D., University of Montreal
 - Andrew Costa, Ph.D., ICES/Mount Sinai/McMaster University

Courtesy Dr. John Hirdes

National Reporting Systems through CIHI

- Continuing Care Reporting System (CCRS)
 - Based on RAI 2.0
- Home Care Reporting System (HCRS)
 - Based on RAI-HC and interRAI Contact Assessment (incl ED Screener)
- Mental Health Reporting System (MHRS)
 - Based on RAI-MH
 - Also supporting interRAI CMH & MH implementation in NFLD and MB
- Canada Health Infoway standard for EMR

Courtesy Dr. John Hirdes

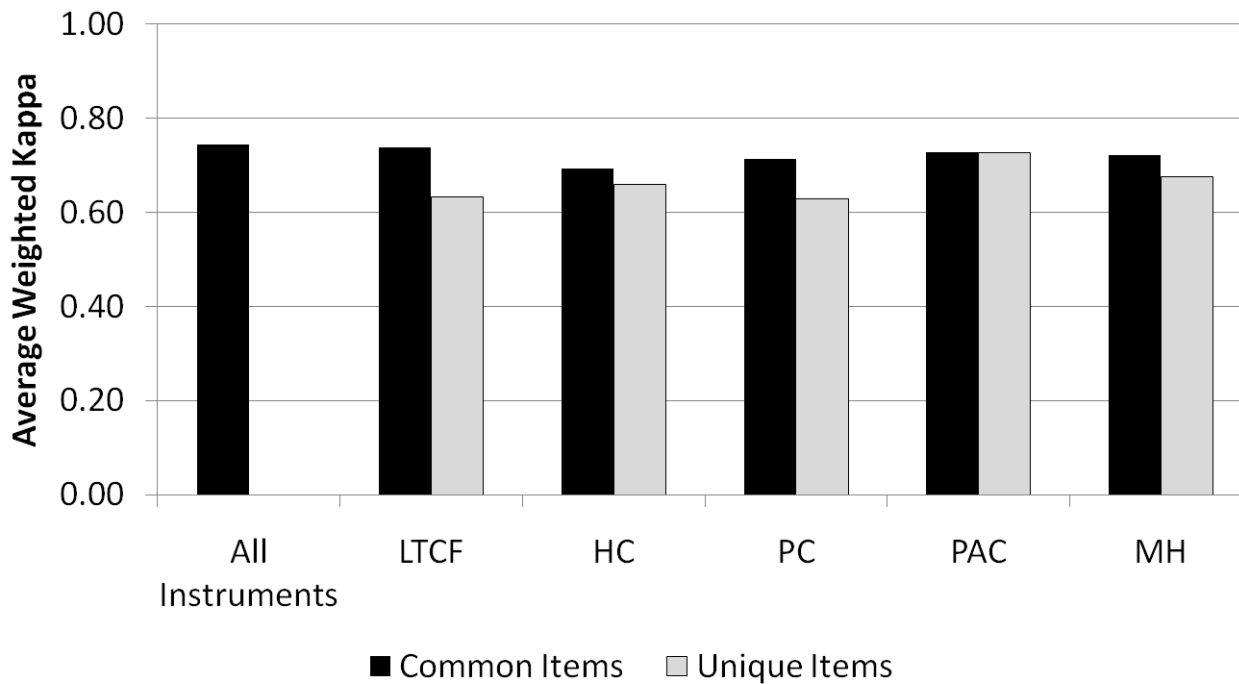
SPECIFIC SCALES

International reliability study

Hirdes et al BMC Health Services Research 2008

- 12 countries
- Trained individuals completed dual assessments on 783 individuals
 - RAI-LTCF 8 countries 31% of assessments
 - RAI-HC 6 28%
 - RAI-PAC 5 16%
 - RAI-PC 4 13%
 - RAI-MH 1 11%
- Canada 147 individuals assessed
- 2 blinded assessments within 72 hours

Figure 1. Average weighted kappa value by interRAI instrument and type of item



Kappa

Measure of degree of agreement

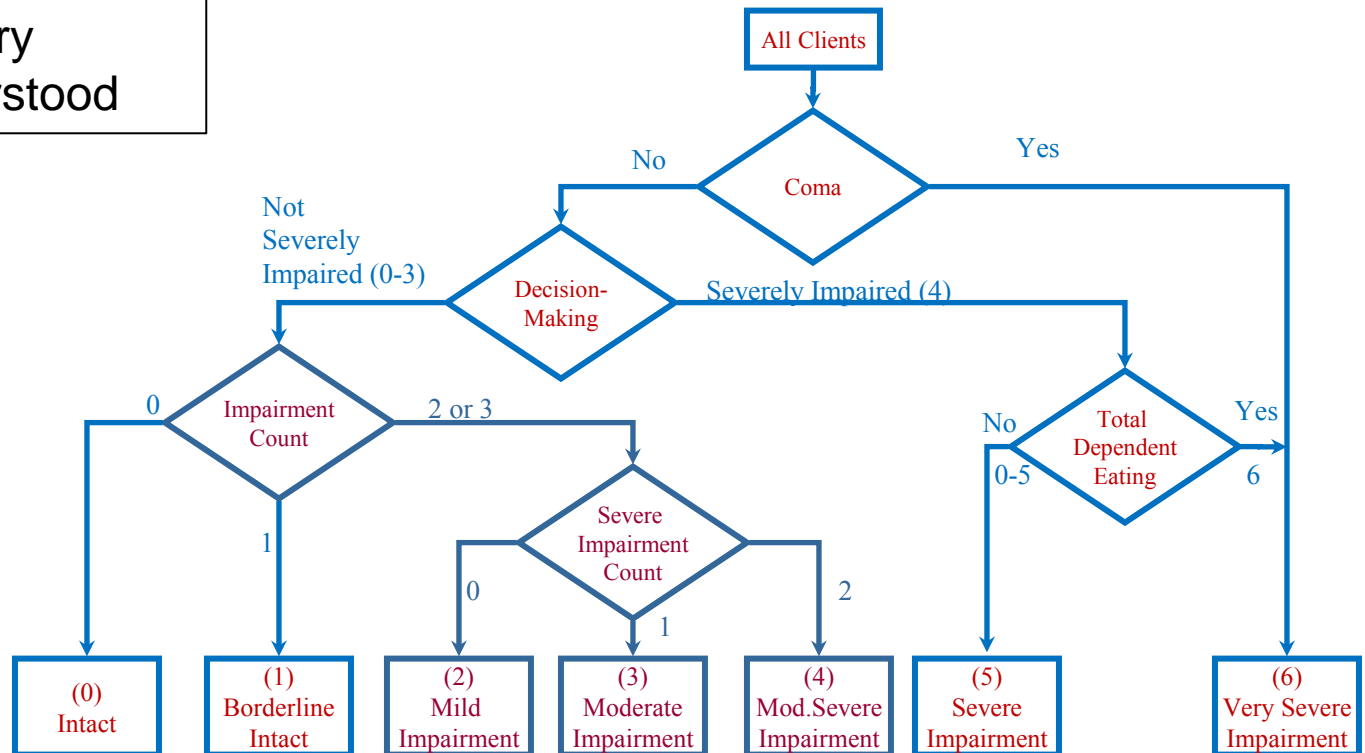
- <0.40 poor
- 0.41-0.60 moderate
- 0.61-0.80 substantial
- >0.81 excellent

Landis & Koch, Biometrics 1977

Cognitive Performance Scale

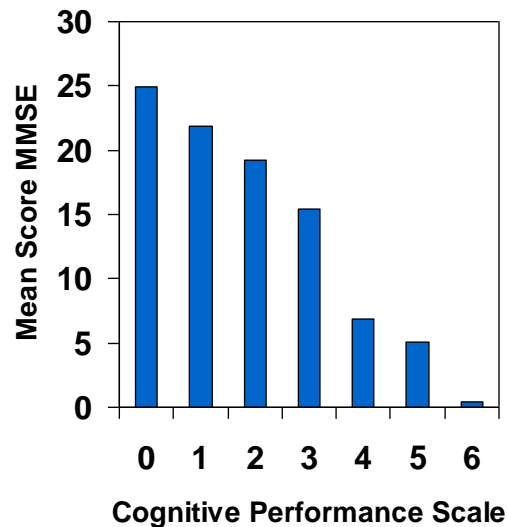
Severe Impairment Count:

- Decision-making
- Short term memory
- Making self understood



Courtesy Dr. John Hirdes

CPS Validity



Original paper:

- Morris JN et al. MDS Cognitive Performance Scale, *Journal of Gerontology: Medical Sciences*, 49: 174-182, 1994.

Home care validation:

- Landi F et al. Minimum data set for home care: a valid instrument to assess frail older people living in the community. *Medical care*, 38(12), 1184, 2000.
- CPS also validated against MoCA: Jones et al, *Can J Psychiatry* 2010.

Courtesy Dr. John Hirdes

Depression Rating Scale (DRS)

- Summary score for items on
 - negative statements
 - persistent anger
 - unrealistic fears
 - repetitive health complaints
 - repetitive anxious complaints
 - sad facial expressions
 - crying, tearfulness
- Scoring items
 - 0 if not present
 - 1 if present at least once in last 30 days or up to 5 days /week
 - 2 if 6-7 days a week
- Score of 3 or more indicates *potential* depression

Original article

Burrows, A. B., Morris, J. N., Simon, S. E., Hirdes, J. P., & Phillips, C. A. (2000). Development of a minimum data set-based depression rating scale for use in nursing homes. *Age and ageing*, 29(2), 165-172.

Validated against Hamilton and Cornell Scales, psychiatrist ratings

Courtesy Dr. John Hirdes

Pain Scale

- Summary score for items on
 - Frequency of pain
 - Intensity of pain
- Scores range from
 - 0 → No pain
 - 3 → Daily, horrible or excruciating pain
- **Validated against Visual Analogue Scale (VAS)**
 - Fries, B. E., Simon, S. E., Morris, J. N., Flodstrom, C., & Bookstein, F. L. (2001). Pain in US Nursing Homes Validating a Pain Scale for the Minimum Data Set. *The Gerontologist*, 41(2), 173-179.

Courtesy Dr. John Hirdes

Activities of Daily Living



ADL Short Form

- Sum of ADL Items
 - Scores range from 0-16
- Based on four items:
 - Early Loss
 - Personal hygiene
 - Middle Loss
 - Toileting
 - Locomotion
 - Late Loss
 - Eating

ADL Hierarchy Scale

- Measure of progressive stages of ADL loss
- Four items:
 - Personal hygiene → early loss
 - Toilet use → intermediate loss
 - Locomotion → intermediate loss
 - Eating → late loss

Courtesy Dr. John Hirdes

ADL Long Form

- Sum of all seven ADL items in Physical Functioning
 - Scores range from 0-28
- More sensitive to clinical change than ADL Hierarchy or ADL Short Form
- Home care validation vs Barthel:
 - Landi et al (2000). Minimum data set for home care: a valid instrument to assess frail older people living in the community. *Medical care*, 38(12), 1184.

Courtesy Dr. John Hirdes

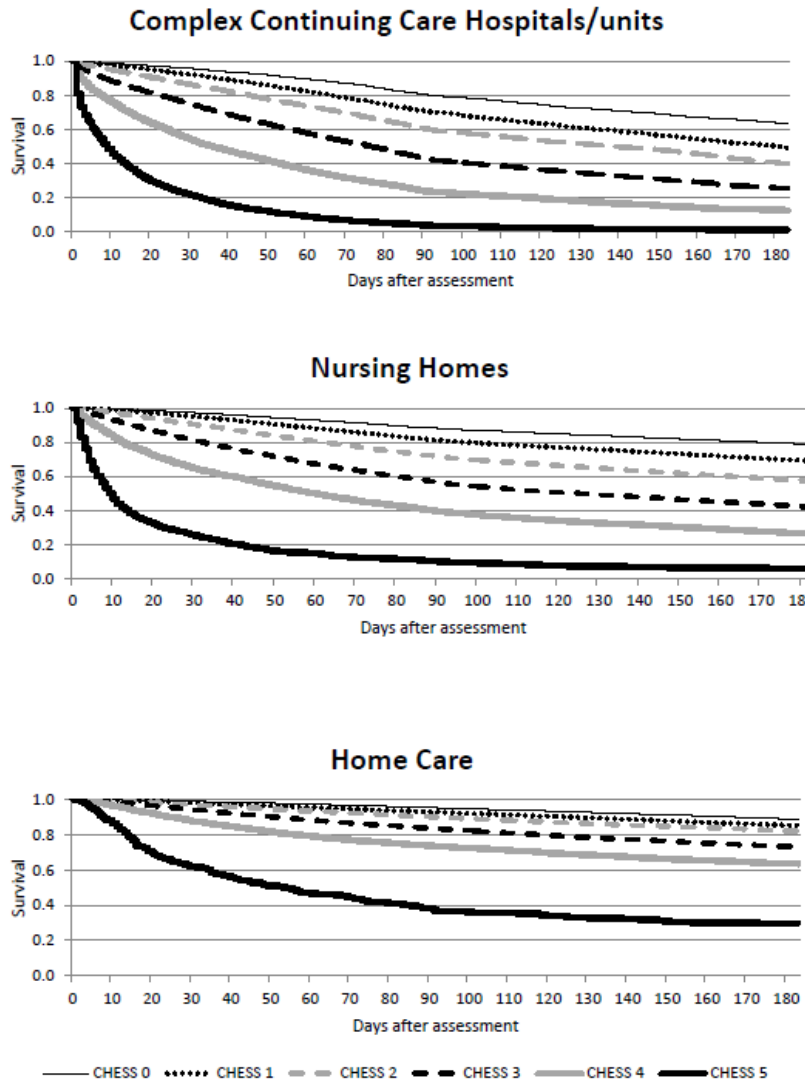
CHES Scale

- Changes in Health, End-stage Disease, Signs and Symptoms of Medical Problems
- Scores range from:
 - 0 → No instability in health
 - 5 → Highly unstable
- Predictive algorithm
 - 1 point each for declines in ADL (H3) and Cognition (B2b)
 - 1 point for end-stage disease (K8e)
 - Up to 2 points for count of signs and symptoms
 - Insufficient fluids (L2c), Edema (K3d), Shortness of breath (K3e), Vomiting (K2e), Weight loss (L1a), Decrease in food eaten (L2b)

Courtesy Dr. John Hirdes

CHES and mortality persons with neurological conditions

PLOS Medicine 2014



Courtesy Dr. John Hirdes

Aggressive Behaviour Scale (ABS)

- Summary score of
 - Verbal abuse
 - Physical abuse
 - Socially inappropriate behaviour
 - Resisting care
- Scores range from
 - 0 → No aggressive behaviour
 - 12 → Daily aggressive behaviour of all types
- Validated against the Cohen-Mansfield Agitation Inventory
 - Perlman, C. M., & Hirdes, J. P. (2008). The aggressive behavior scale: A new scale to measure aggression based on the Minimum Data Set. *Journal of the American Geriatrics Society*, 56(12), 2298-2303.

Courtesy Dr. John Hirdes

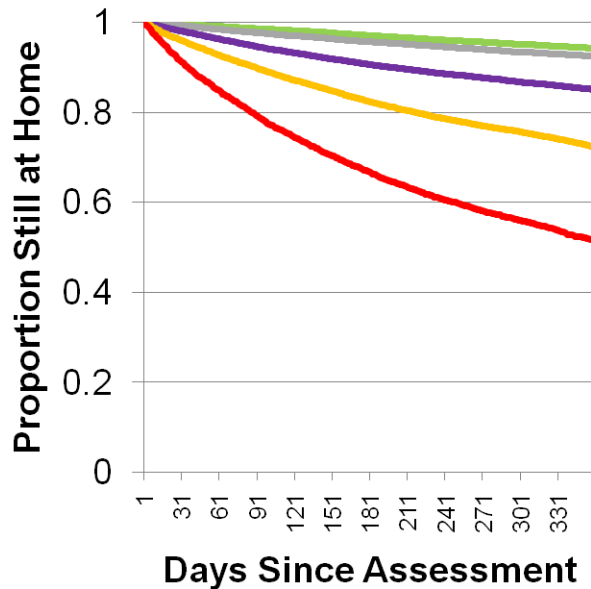
MAPLe: Method to Assess Priority Levels

- Decision support tool for interRAI HC to establish priority for access to community and nursing home services
- Developed to predict three key outcomes
 - Caregiver distress
 - Nursing home placement
 - Person considered “better off elsewhere”

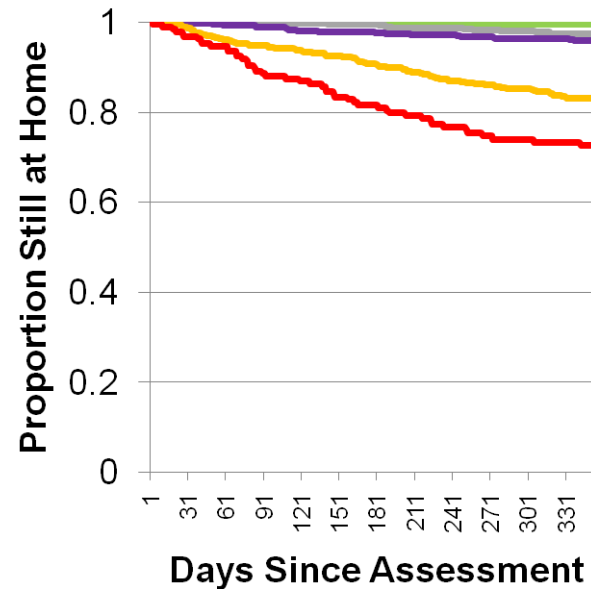
Courtesy Dr. John Hirdes

LTC Home Placement Among Home Care Clients by MAPLe Level, Ontario and WRHA

Ontario



WRHA



— Low — Mild — Moderate — High — Very High

Courtesy Dr. John Hirdes

Comprehensive geriatric assessment works ...

DOES CGA USING RAI TOOLS WORK TOO?

Italian MDS HC RCT

Landi et al JAGS 2001

- 187 community-dwelling frail seniors
- All eligible for regional geriatric program
 - Assessed by nurse case manager
 - Care plan: MD, nurse, therapy, home support
- Randomized to
 - MDS HC
 - Barthel, Lawton-Brody, MMSE, and other tools as assessed by case manager

Table 1. Baseline Characteristics of Subjects in the Intervention and Control Groups

Characteristics	Intervention (n = 88)	Control (n = 88)	P-value
Age (years), mean \pm SD	77.4 \pm 9.1	77.1 \pm 9.5	.83
Women (%)	68.2	67.0	.5
Marital status (%)			.08
Never married	21.6	10.3	
Married	28.4	38.6	
Widowed	50.0	51.1	
Living alone (%)	19.5	18.2	.2
ADL—Barthel Index [*] , mean \pm SD	43.1 \pm 33.75	41.1 \pm 32.2	.69
IADL—Lawton Index [†] , mean \pm SD	24.7 \pm 5.6	23.4 \pm 6.4	.17
MMSE scale [‡] , mean \pm SD	16.8 \pm 10.4	18.1 \pm 11.5	.45
Number of medical conditions, mean \pm SD	4.0 \pm 2.5	3.6 \pm 1.6	.14
Number of medications, mean \pm SD	4.7 \pm 3.1	4.0 \pm 2.6	.09

Note: Quantitative variables are expressed as mean \pm SD.

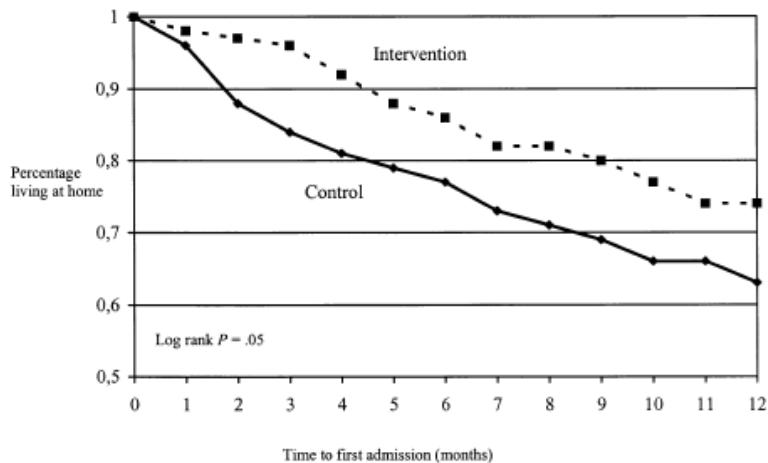
^{*}Activities of Daily Living (ADL) Barthel Index score: range 0–100. Higher number indicates less impairment.

[†]Instrumental Activities of Daily Living (IADL) Lawton Index score: range 0–29. Higher number indicates greater impairment.

[‡]Mini-Mental State Examination (MMSE) score: range 0–30. Higher numbers indicate less impairment.

Table 2. Functional Outcomes After 1-Year Follow-Up in the Intervention and Control Groups

	Intervention (n = 61)	Control (n = 62)	
	Adjusted Mean* (\pm SD)		P-value
ADL—Barthel Index	51.7 \pm 36.1	46.3 \pm 33.7	0.05
IADL—Lawton Index	23.5 \pm 5.9	21.9 \pm 6.6	0.4
MMSE scale	19.9 \pm 8.9	19.2 \pm 10.7	0.03



- 21% reduction in overall costs
- *The difference was the use of the standardized assessment*

ACCESS AND USE

Personal Health Profile

Name:
Assessment Reference Date:

Health Card Number:
Date PHP Printed:



RAI HC (CCAC)

Personal Information	
Age	Marital status [BB4]
Sex [BB1]	Primary language [BB5a]

Health Profile		
Mental Health		
Cognitive Performance Scale (CPS)		
Depression Rating Scale (DRS)		
- possible depression		
Psychotic symptoms [K3f or K3g]		
Potential problem related to psychotropic drugs		
Communication		
Making self understood [C2]		
Ability to understand others [C3]		
Behaviour Patterns		
Wandering [E3a]		
Verbally abusive [E3b]		
Physically abusive [E3c]		
Socially inappropriate/disruptive [E3d]		
Resists care [E3e]		
Social Functioning		
At ease interacting with others [F1a]		
Social Support		
Caregiver is unable to continue in caring activities [G2a]		
Caregiver expresses feeling of distress, anger or depression [G2c]		
Elder Abuse		
Potential problem with elder abuse		
Physical Functioning		
Transfer [H2b]		
Locomotion in home [H2c]		
Eating [H2g]		
Swallowing [L3]		
ADL Self-performance Hierarchy		
Potential for improvement in ADLs		
Potential problem related to falls		
Medical Complexity		
CHES		
Pain		
Pain Scale		
Lifestyle		
Smoked or chewed tobacco daily [K7c]		
Potential problem related to alcohol dependence		
Skin Care		
Potential problem related to pressure ulcer		
Special Treatments		
Oxygen [P2a]	Respirator [P2b]	Dialysis [P2g]
Intravenous [P2h, P2i]	Ostomy [P2k]	Tracheostomy [P2m]
Tube feeding [L2d, L3]		

Resource Utilization for Facilities
Method for Assigning Priority Levels (MAPLe)
Resource Utilization Groups III/HC (RUG III/HC)

Uptake challenges

- Inter-what?
- Implementation burden on front-line staff
 - Need to evaluate assessment redundancy and streamline: CAMH
- Purchasers are administrative: tool seen as imposed rather than clinical
 - Need to require from purchasers more user friendly software
- Tyranny of the tool
 - My tool is better than your tool
 - Tools used as substitutes for clinical judgement
 - **RAI score: NOT an approved interRAI scale**
- Professional inertia:
 - CME support required
 - What's in it for me?
- *Issues not specific to interRAI instruments*

Why does this matter?

- Patients are over-assessed
- *Sine qua non* for true system integration
- Clinical information relevant to *support* care planning
- Implementation widespread in Ontario: use would reduce documentation burden for patients, caregivers, and staff
- Promotes system integration, seamless care transitions, and rational planning, and ultimately better data driving better outcomes

- Functional information derived from a clinical assessment
- All interRAI data made available to SGS in WWLHIN
- I use it when possible
 - In LTC, increases efficiency by 50%
 - In primary care
- My own parents assessed by CCAC
 - 60-70 minutes for a CGA
 - Based on sound clinical skills
 - Yielded information that would have been useful to Geriatric Day Hospital



Clinician's perspective



Not only am I a fellow, I'm also a user!!

Thank you!

QUESTIONS?