interRAI Contact Assessment in Transitional Care

a pilot study to investigate the usefulness of the assessment based on functional status of the patient population

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ABSTRACT

Patients with multiple chronic conditions are at a greater risk for hospital readmissions. The older populations are at even higher risk due to care fragmentation. These patients are continuously transferred between health care settings and thus often do not receive the best care possible. Staying at the hospital actually increases the older population's functional decline; therefore, they are in need of supportive care.

Transitional care is a broad range of post-discharge services designed to promote continuity of care and patient safety as patients transfer between different health care settings or levels of care. If patients can be identified earlier in the transitional care setting, then appropriate services can be provided to decrease their risk for readmission. The Tallahassee Memorial Hospital Transition Center (TMH-TC) was developed and serves to treat patients recently discharged from the hospital who are uninsured, underserved, or lack a primary care provider in order to decrease the possibility of a hospital readmission.

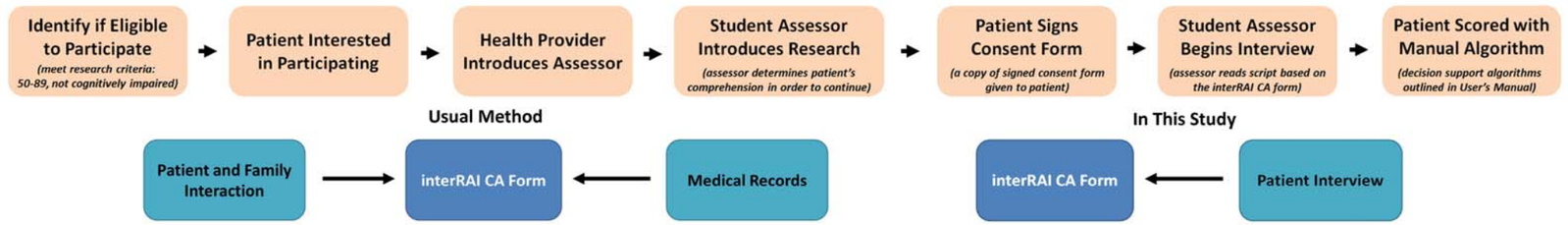
The interRAI suite of instruments is comprised of compatible assessment instruments that could be used across care domains. In this pilot study, an instrument that was developed to identify patients in need of short-term services - interRAI Contact Assessment (CA) - was used in the TMH-TC. Using the interRAI CA instrument in an outpatient transitional care setting seemed most relevant because no assessment instrument has been developed for this specific care setting.

The usefulness of this tool was to be determined based on the urgency of needing services calculated from patients' responses. The tool was found useful in identifying patients who are in need of further in-depth assessments and specialized services (e.g., rehabilitation), but not necessarily supportive services. If this tool can be refined to suit the TMH-TC, then it can be used as part of an overall strategy to lower readmission rates.

BACKGROUND

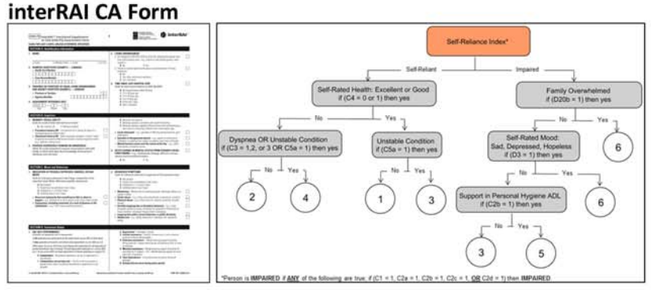
- Hospital costs in US in 2004 for preventable readmissions was $729 million ($7400 per admission).
- Older patients with chronic conditions are at a higher risk for readmission.
- Presence of multiple chronic conditions negatively impacts elderly's functional status.
- In the past year, in Tallahassee alone, there was no post discharge care coordination for over 300 elderly (age 55+) visits to the ER.

METHODS



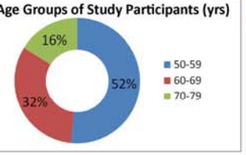
DATA ANALYSIS

interRAI CA Form



SAMPLE CHARACTERISTICS

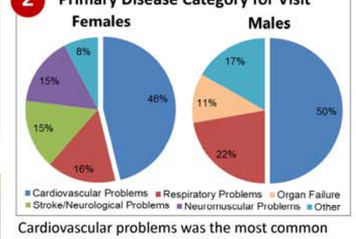
1 Age Groups of Study Participants (yrs)



Disease Category	Prevalence
Cardiovascular Conditions	55%
Respiratory Conditions	29%
Organ Failure	13%
Stroke/Neuromuscular Disorders	16%
Cancer	6%
Arthritis	6%
Fracture/Surgery	13%
Depression/Anxiety	3%
Diabetes	19%
Infections	6%
Other	23%

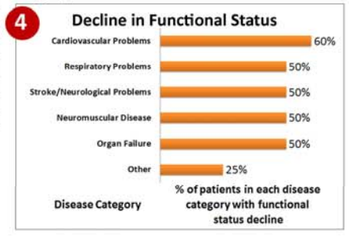
3 50% of the study participants had 2 or more diseases.

2 Primary Disease Category for Visit



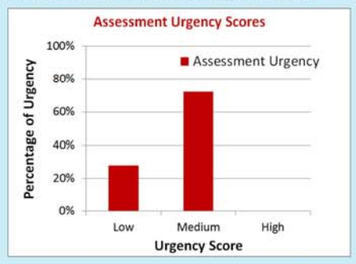
Cardiovascular problems was the most common category, in both males and females.

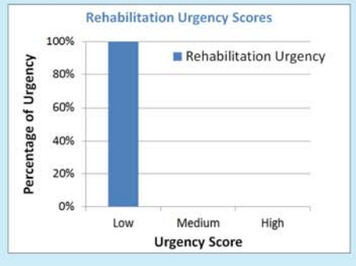
4 Decision in Functional Status



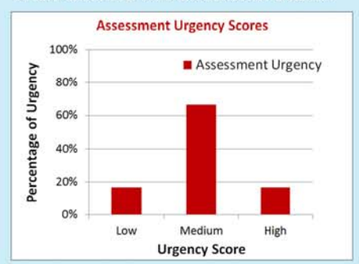
RESULTS

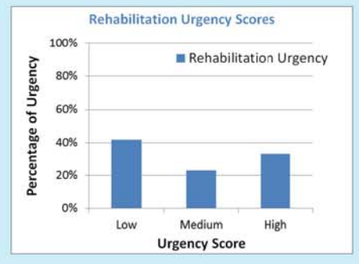
No decline in Functional Status





With decline in Functional Status





CONCLUSIONS

- As expected, patients with no decline in functional status had scores in the low to medium category for assessment urgency and rehabilitation urgency.
- In comparison, patients with decline in functional status had scores spread into the high urgency category for assessment urgency and rehabilitation urgency.
- The tool may have not been sensitive enough to identify patients who are in need of supportive services given that many of them had caregivers.
- Given our small sample size and cross-sectional descriptive data, we cannot make any definite conclusions.

FUTURE DIRECTION

- Comparison of data retrieved from medical records and data obtained via patient interview
- Refine the instrument to better suits the transition center population
- Include larger number of participants
- Longer duration of study with follow up for a defined duration of time

REFERENCES

- Friedman, B., & Basu, J. (2004). The rate and cost of hospital readmissions for preventable conditions. *Med Care Res Rev, 61*(2), 225-240. doi: 10.1177/1077558704263799
- Garcia-Caballos, M., Ramos-Diaz, F., Jimenez-Moleon, J. J., & Bueno-Cavanillas, A. (2010). Drug-related problems in older people after hospital discharge and interventions to reduce them. *Age Ageing, 39*(4), 430-438. doi: 10.1093/ageing/afq045
- Hirdes, J. P., Curtin-Telegdi, N., Poss, J. W., Gray, L., Berg, K., Stolee, P., & Costa, A. P. *interRAI Contact Assessment (CA) Form and User's Manual: A Screening Level Assessment for Emergency Department and Intake from Community/Hospital.*

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