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Getting to the rest of the story

The role of Self-Report CGA in the care of older persons living with frailty

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A land acknowledgement is a small step towards reconciliation and needs to followed by actions, such as education. We focus in this course on learning of the aging process and the experience of being an older adult, within the context of individual lives and our families, communities and health and social systems. We recognize aging as an embedded personal history, and the impact of history in the lived experience of older adults, particularly those with past and present histories of oppression and colonialism. We acknowledge the historical and current presence and land rights of Indigenous peoples within Canada. I recognize that as a settler I, and the older adults in my family, have benefitted from the land in the past and continue to do so.

We take this time to reflect, in the spirit of Truth and Reconciliation. I acknowledge that I live and work on the Territory of the Neutral, Anishinaabeg, and Haudenosaunee Peoples. The University of Waterloo is situated on the Haldimand Tract, the land promised to the Six Nations that includes six miles on each side of the Grand River.

Objectives

- Understand healthcare information needs in an aging world
- Making room for the person's narrative
- Understand the potential roles of the interRAI Check Up Self-Report instrument in efficiently meeting these information needs

Healthcare is about answering questions

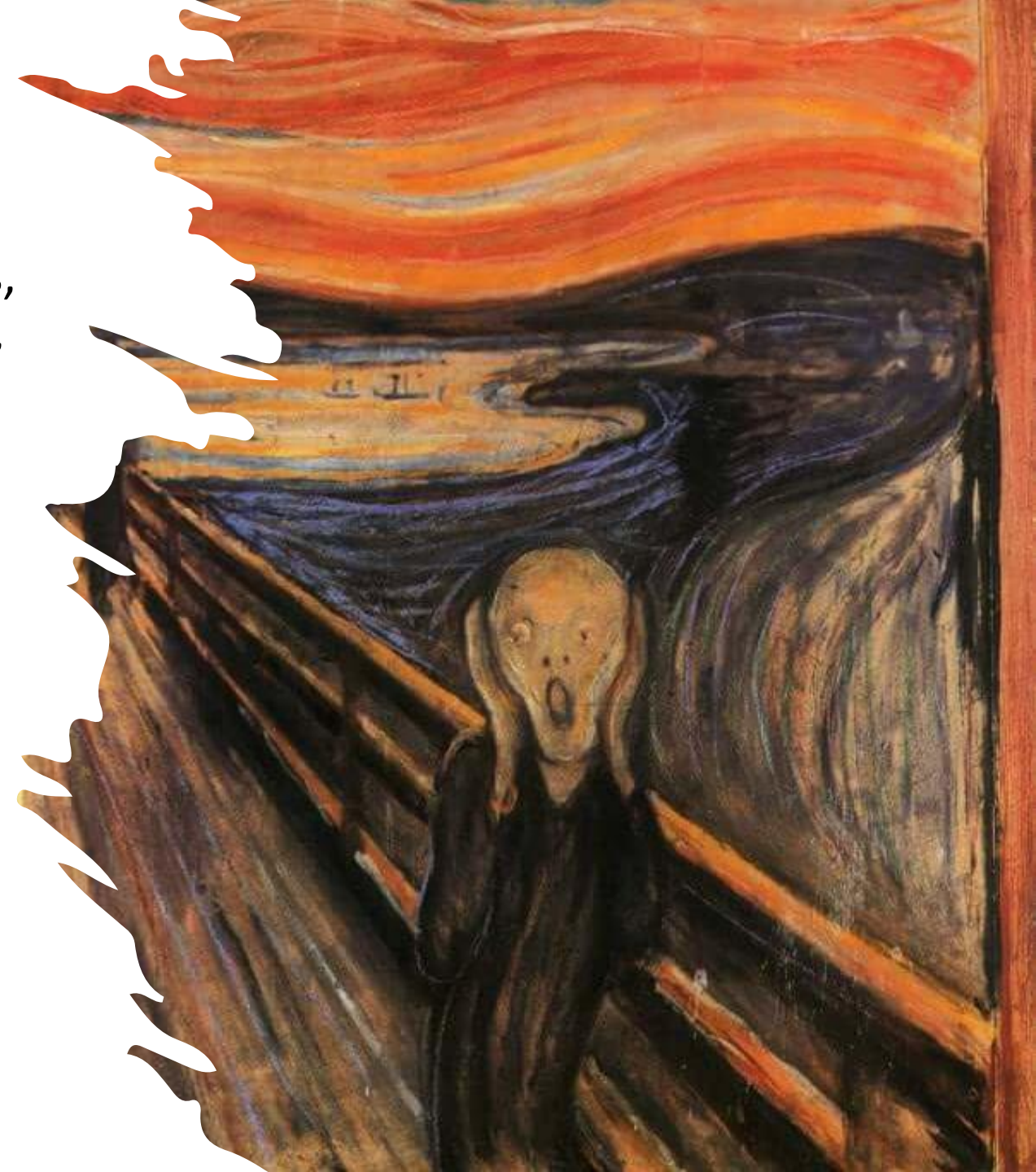
Dhaliwal & Detsky, JAMA 2013

Theme	Person's perspective	Physician's question
Risk	I need help!	Who do I see first?
Diagnosis	What is wrong with me?	What tests can I offer?
Prognosis	How will this problem affect what matters to me the most?	What do I know about how this impacts the person?
Management	How can I be as well as I can to meet my goals?	***What care options best meet the person's needs, goals and wishes?***

Answering these today is hard

Franco et al, 2022 https://cgjonline.ca/index.php/cgj/article/view/597

- Life course experiences, expectations, wishes, goals, socioeconomic considerations, culture, religion, language, gender
- Multimorbidity and polypharmacy
- Disability
- Geriatric syndromes: cognitive impairment, mood, pain, mobility, function, continence, caregiver burden, frailty
- “I Hope That the People Caring for Me Know About Me”



How can we capture complexity?

- Without missing any critical information
- In a sufficiently comprehensive way with existing resources
  - **need** to know vs. **nice** to know
- Make it comprehensible to clinicians and persons
- Support the development of a timely and optimal person-centered care plan
- And ideally for other data needs?

Standards and narrative both matter

- Amenable to standardization to minimize assessment burden: cognitive function, mood, pain, behaviours, ADLs, IADLs, frailty, health instability, caregiver burden

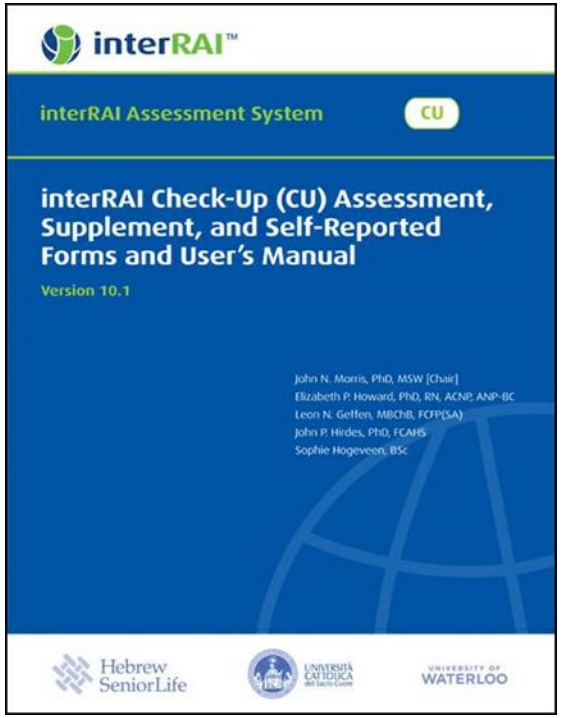
- Makes room for the personal narrative

- The more we can rely on standard, reliable and valid information, the more we can focus on the personal narrative

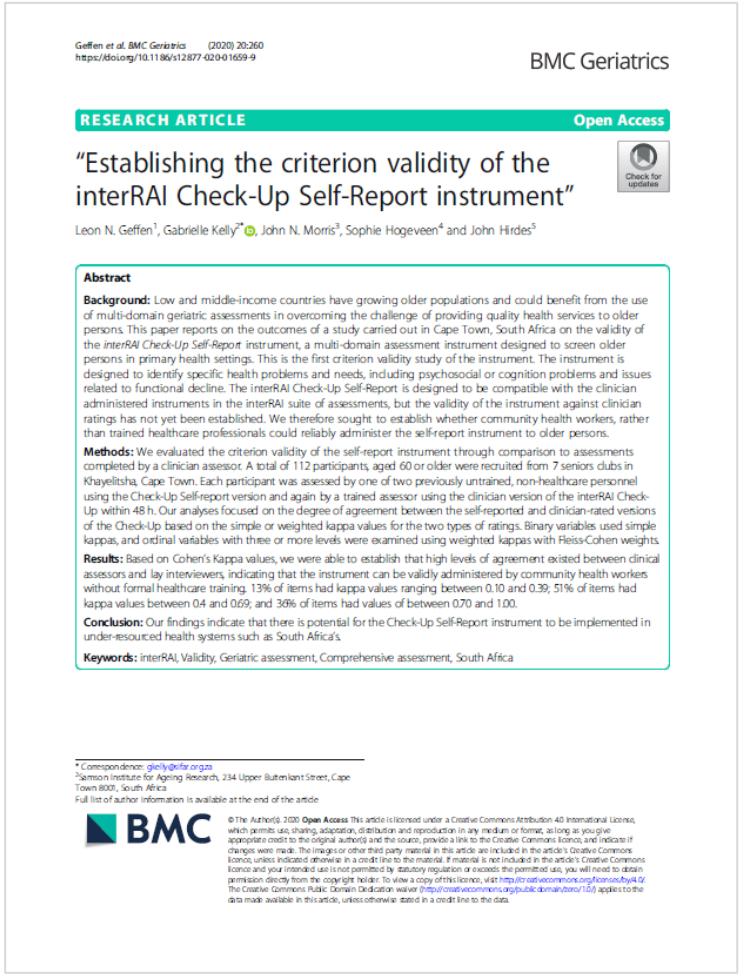
Lafortune et al, 2016: https://link.springer.com/article/10.1007/s40271-016-0193-9

Check-Up Outputs

- Severity scales:
  - Cognitive Performance
  - Self-rated mood
  - ADLs
  - IADLs
  - Pain
  - Communication problems
  - Vulnerability
- Flags:
  - Falls
  - Cardiorespiratory risk
- Risk scales
  - AUA: need for CGAM
  - CHESS: frailty related health instability
  - DIVERT: ED risk



Validity of interRAI Check Up Self-report



Geffen et al. BMC Geriatrics (2020) 20:260
https://doi.org/10.1186/s12877-020-01659-9

BMC Geriatrics

RESEARCH ARTICLE Open Access

"Establishing the criterion validity of the interRAI Check-Up Self-Report instrument"

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Abstract

Background: Low and middle-income countries have growing older populations and could benefit from the use of multi-domain geriatric assessments in overcoming the challenge of providing quality health services to older persons. This paper reports on the outcomes of a study carried out in Cape Town, South Africa on the validity of the *interRAI Check-Up Self-Report* instrument, a multi-domain assessment instrument designed to screen older persons in primary health settings. This is the first criterion validity study of the instrument. The instrument is designed to identify specific health problems and needs, including psychosocial or cognition problems and issues related to functional decline. The interRAI Check-Up Self-Report is designed to be compatible with the clinician administered instruments in the interRAI suite of assessments, but the validity of the instrument against clinician ratings has not yet been established. We therefore sought to establish whether community health workers, rather than trained healthcare professionals could reliably administer the self-report instrument to older persons.

Methods: We evaluated the criterion validity of the self-report instrument through comparison to assessments completed by a clinician assessor. A total of 112 participants, aged 60 or older were recruited from 7 seniors clubs in Khayelitsha, Cape Town. Each participant was assessed by one of two previously untrained, non-healthcare personnel using the Check-Up Self-report version and again by a trained assessor using the clinician version of the interRAI Check-Up within 48 h. Our analyses focused on the degree of agreement between the self-reported and clinician-rated versions of the Check-Up based on the simple or weighted kappa values for the two types of ratings. Binary variables used simple kappas, and ordinal variables with three or more levels were examined using weighted kappas with Fleiss-Cohen weights.

Results: Based on Cohen's Kappa values, we were able to establish that high levels of agreement existed between clinical assessors and lay interviewers, indicating that the instrument can be validly administered by community health workers without formal healthcare training. 13% of items had kappa values ranging between 0.10 and 0.39; 51% of items had kappa values between 0.4 and 0.69; and 36% of items had values of between 0.70 and 1.00.

Conclusion: Our findings indicate that there is potential for the Check-Up Self-Report instrument to be implemented in under-resourced health systems such as South Africa's.

Keywords: interRAI, Validity, Geriatric assessment, Comprehensive assessment, South Africa

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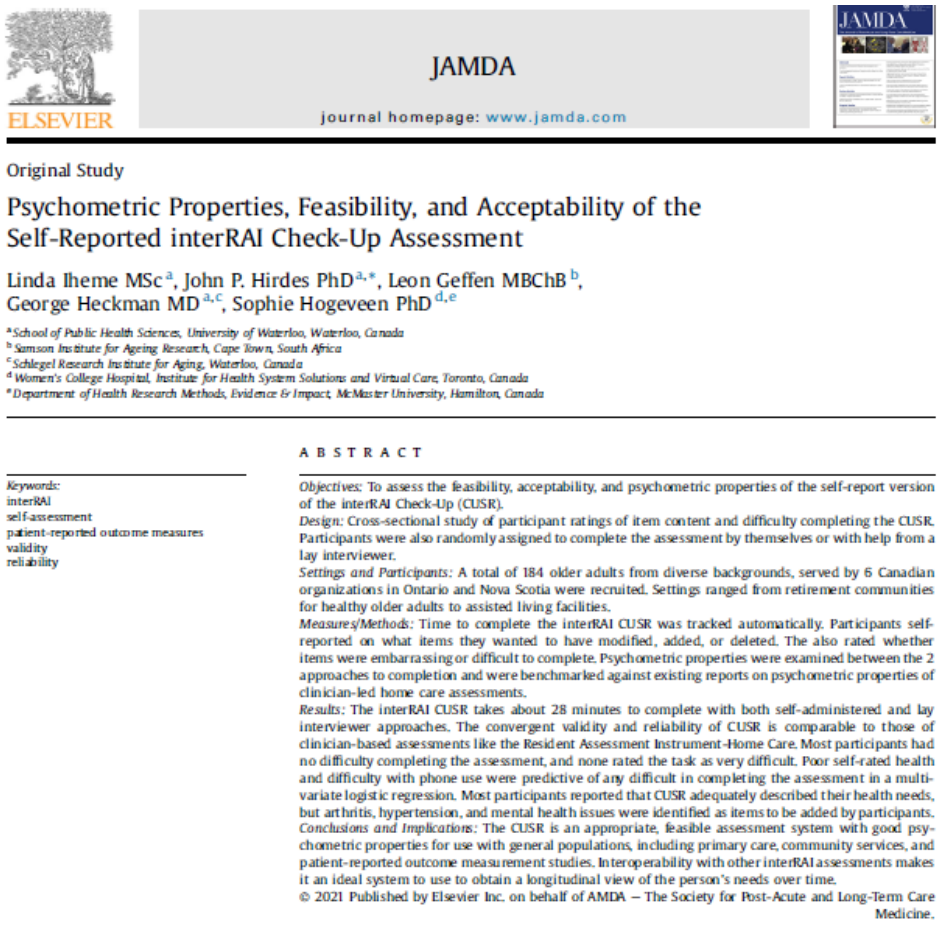
- 112 participants age 60+ in Khayelitsha South Africa
- Interviewed by trained lay-older adult health workers
- Reassessed by clinician in primary care clinic
- Good overall criterion validity in relatively healthy older persons

Canadian validation



JAMDA

journal homepage: www.jamda.com

Original Study

Psychometric Properties, Feasibility, and Acceptability of the Self-Reported interRAI Check-Up Assessment

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Keywords:
interRAI
self-assessment
patient-reported outcome measures
validity
reliability

A B S T R A C T

Objectives: To assess the feasibility, acceptability, and psychometric properties of the self-report version of the interRAI Check-Up (CUSR).
Design: Cross-sectional study of participant ratings of item content and difficulty completing the CUSR. Participants were also randomly assigned to complete the assessment by themselves or with help from a lay interviewer.
Settings and Participants: A total of 184 older adults from diverse backgrounds, served by 6 Canadian organizations in Ontario and Nova Scotia were recruited. Settings ranged from retirement communities for healthy older adults to assisted living facilities.
Measures/Methods: Time to complete the interRAI CUSR was tracked automatically. Participants self-reported on what items they wanted to have modified, added, or deleted. The also rated whether items were embarrassing or difficult to complete. Psychometric properties were examined between the 2 approaches to completion and were benchmarked against existing reports on psychometric properties of clinician-led home care assessments.
Results: The interRAI CUSR takes about 28 minutes to complete with both self-administered and lay interviewer approaches. The convergent validity and reliability of CUSR is comparable to those of clinician-based assessments like the Resident Assessment Instrument-Home Care. Most participants had no difficulty completing the assessment, and none rated the task as very difficult. Poor self-rated health and difficulty with phone use were predictive of any difficult in completing the assessment in a multivariate logistic regression. Most participants reported that CUSR adequately described their health needs, but arthritis, hypertension, and mental health issues were identified as items to be added by participants.
Conclusions and Implications: The CUSR is an appropriate, feasible assessment system with good psychometric properties for use with general populations, including primary care, community services, and patient-reported outcome measurement studies. Interoperability with other interRAI assessments makes it an ideal system to use to obtain a longitudinal view of the person's needs over time.

- 184 older adults from diverse backgrounds, served by 6 Canadian organizations in Ontario and Nova Scotia
- Confirms validity, reliability, acceptability and feasibility
- 28 minutes on average

Experience with the Check Up

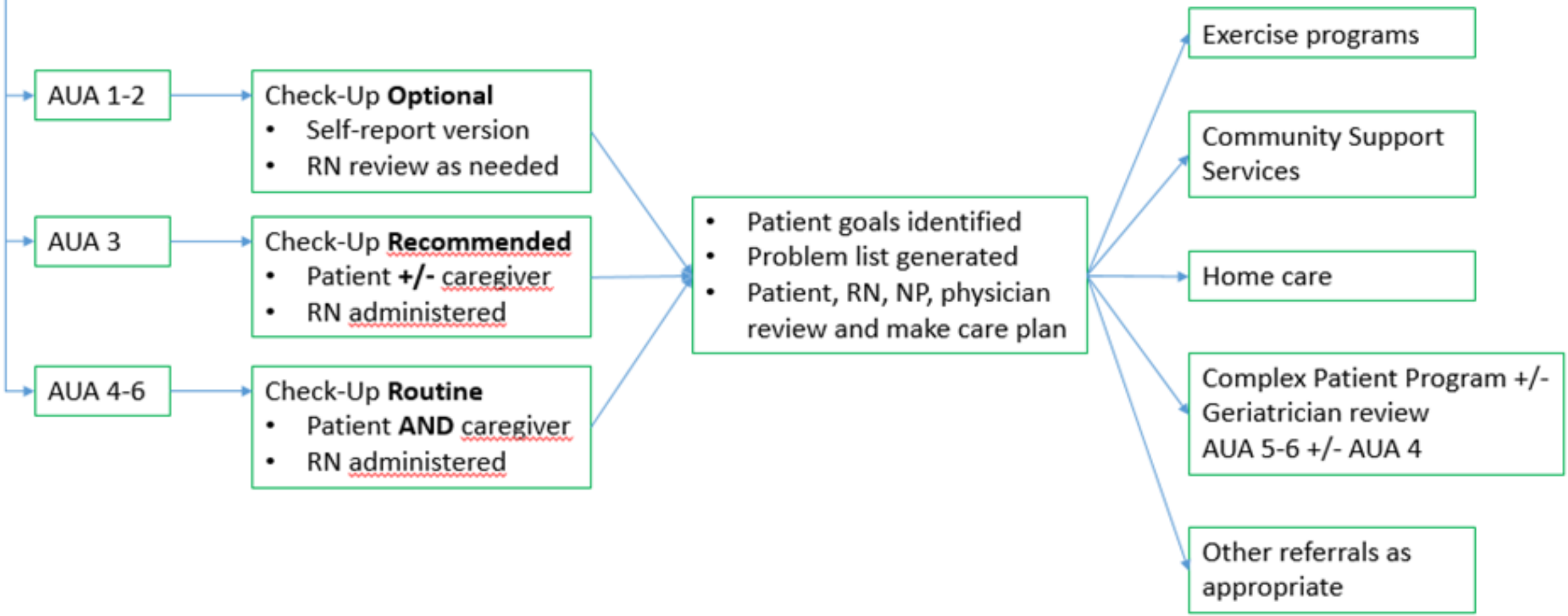
New Vision Complex Care Program

- Proactive, in-house, case-finding & CGA

- Unique features:
  - NP-led, shared care (geriatrician, pharmacist, family MD)
  - Use of interRAI CVS/AUA and Check-Up

- AUA & Check Up within EMR infrastructure
  - OCEAN, Practice Solutions

AUA	WHO?	SOURCE?
	- All over 75 years - 65 to 74 with ED visits, clinician judgment - Patient self-referral	- OCEAN tablets (self-administered) - EMR Practice Solutions (nurse) - Grand River / SMGH (ED/GEM)



Patient characteristics: Complex Care Program

	Total (76)	Man (22)	Woman (54)
Age (years)	81.8	82.9	80.3
ADRD	36 (47.4%)	11 (50%)	25 (36.3%)
Movement disorder	8 (10.5%)	4 (18.2%)	4 (7.4%)
Depression	20 (26.3%)	4 (18.2%)	16 (29.6%)
Coronary artery disease	18 (23.7%)	9 (40.1%)	9 (16.7%)
Hypertension	50 (65.8%)	15 (68.2%)	35 (64.8%)
Diabetes	29 (38.2%)	11 (50%)	29 (53.7%)
Atrial fibrillation	14 (18.4%)	6 (27.3%)	8 (14.8%)
Heart failure	13 (17.1%)	6 (27.3%)	7 (13.0%)
Stroke	18 (23.7%)	3 (13.6%)	15 (27.8%)
COPD/asthma	24 (31.6%)	7 (31.8%)	17 (31.5%)
Osteoporosis	36 (47.4%)	7 (31.8%)	29 (53.7%)
Incontinence (urine)	49 (64.5%)	13 (59.1%)	36 (66.7%)
Chronic renal failure	45 (59%)	17 (77.3%)	28 (51.6%)
Medications	12.8	11.6	13.3

Results: Quantitative

Outcome	Total (n=76)	Men (n=22)	Women (n-54)
Geriatrician encounter - Consult - eReview	63 (82.9%) 54 9	 16 3	 38 6
New community referrals	40 (52.6%)	12	28
Meds deprescribed #	32 (42%) (0.85)	10 (1.05)	22 (0.76)
Meds optimized #	46 (60.5%) (1.05)	12 (0.95)	34 (1.09)
ED visits (1 year before)	1.33	1.32	1.33
ED visits (1 year after)	0.67*	0.69	0.66

Meds stopped: NSAIDs, psychotropics, PPIs
Meds optimized: bone health, cardiovascular, acetaminophen
*p=0.00012.

Integrated Care Team Pilot

THE PROBLEM

THE UNMET POPULATION HEALTH NEEDS OF OLDER ADULTS in KW4

62,811
people are 65 years or older in KW4

175 days
is the average wait time to see a geriatrician

18%
of family physicians have access to an interdisciplinary team

THE PROPOSED SOLUTION

PATIENT & CLINICAL WORKFLOW

80% did Check Up online and on their own WITH care partners

REGISTERED PRACTICAL NURSE

- Contact patients from the SGS waitlist and their primary care providers

REGISTERED PRACTICAL NURSE

- Assess the patients and their caregivers using a standardized assessment tool; interRAI Check-Up by phone, email or in person

PHARMACIST

- Compiled a Best Possible Medication History and in most cases did a comprehensive medication review

NURSE PRACTITIONER

- Reviewed file and gathered additional information from all available sources

WEEK 1

ICT TEAM

- Develop care plan for each patient at weekly case conferencing
- Triage high-risk patients (comprehensive geriatric assessments)

WEEK 2

GERIATRICIAN (SHARED CARE)

- Both onsite and/or virtual consultation at New Vision FHT
- Formal and informal case consults

COMMUNITY RESOURCES

- Connected directly or recommendation made to primary care provider

WEEK 3-4

PRIMARY CARE PROVIDER

- All team recommendations and assessment information sent back to primary care provider
- Team contact info provided for any follow-up questions

In 6 weeks, we…

- Contacted 138 individuals of 445 on the wait list
- 97 of 138 available completed Check Up (80% self-report)
- 77 of 97 reviewed by the team

- Results
  - 95% med review
  - 77% new referral to community services
  - 50% seen by NP
  - 35% saw geriatrician
  - Very positive feedback

Virtual geriatric consults during pandemic

Virtual Geriatrician Consultation during pandemic

interRAI Check Up Self-report

- Implemented the self-report tool as part of the comprehensive geriatric assessment process
- Remotely assessed 195 clients referred to a geriatrician in first year of the pandemic

Courtesy Dr. Melissa Northwood

Virtual Geriatrician Consultation during pandemic

Findings

- Majority (72%) were in the most **urgent need of geriatrician assessment**
- A third had moderate to severe **cognitive** (34%) and **functional** (34%**) impairments**
- Half experienced **depressive** symptoms (53%) and **loneliness** (57%)
- A third (32%) had daily **pain**
- 46% of caregivers were **overwhelmed**
- 50% had **cardiorespiratory symptoms** that required assessment

- *"I find that it's good for ensuring that I don't leave out components of the geriatric assessment. I might forget to ask about smoking or alcohol, or I might forget to ask if they can do the stairs. I really like that on the Check-Up that it goes through that **good functional checklist**."*
- *"It's **very valuable for me to see my group of people that I've seen** over the year, to be able to see, wow, my average AUA [assessment urgency algorithm] is five, and boy, 30% of people are not cognitively independent."*

Courtesy Dr. Melissa Northwood

Retirement home

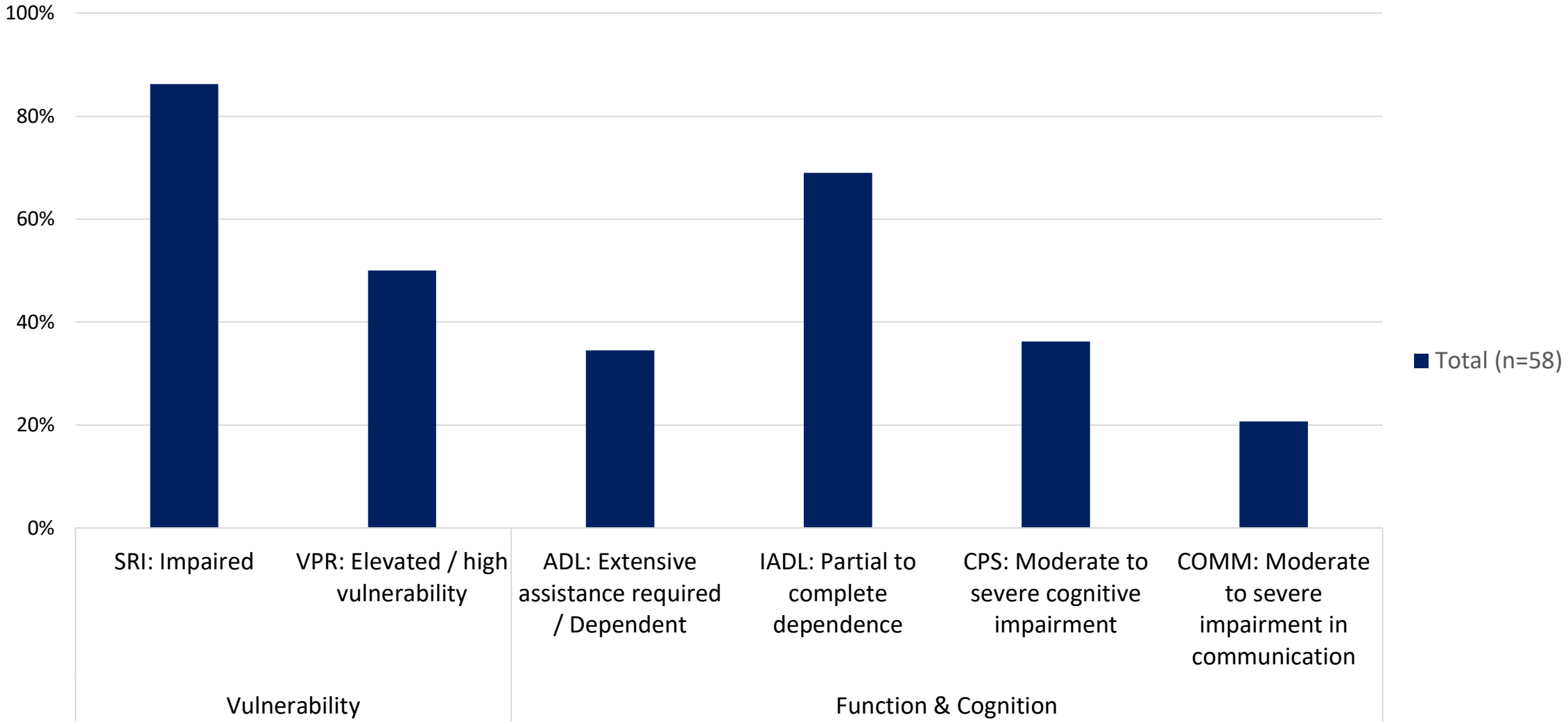
CU Assessments (n=58)

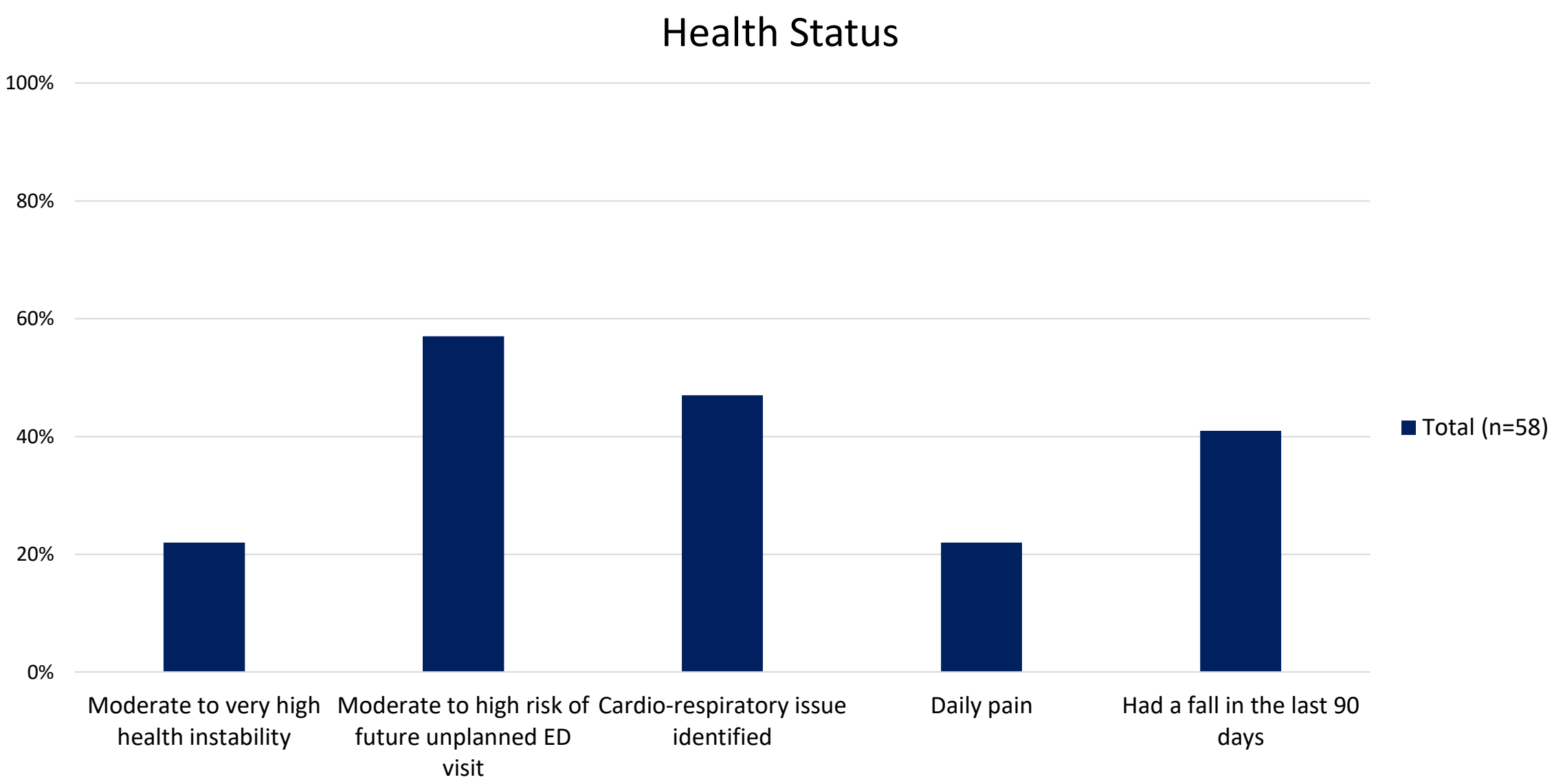
Higher needs (memory care, assisted living) residents and care partners complete Check-Up together on admission

- Average Age = 89
- Women = 60%

- ***I have a lot more time to get to know them***

Vulnerability, Functioning, and Cognition




Health Status
100%
80%
60%
40%
20%
0%
Moderate to very high health instability
Moderate to high risk of future unplanned ED visit
Cardio-respiratory issue identified
Daily pain
Had a fall in the last 90 days
Total (n=58)

Comparison across sectors

	Age	AUA 4-6	CHESS 3+	DIVERT 4+	CPS2 4+	Mood 3+	ADLH 4+	IADLH 4+	Pain 2-4	Falls 1+	CardioResp
CCP	81.8	68%	16%	22%	27%	37%	6%	44%	38%	35%	41%
ICT	81.3	63%	17%	21%	36%	45%	4.2%	54%	39%	42%	49%
Geriatrics	81	95%	29.2%	42%	CPS 3+ 33%	53.3%	8.2%	61%	32%	56%	52%
Retirement	n/a	88%	25%	Median 3	59%	Mean 3.42	22%		26%	47%	47%
Home care	n/a	n/a	22%	47%	CPS 3+ 10%	20%	4%	78%	n/a	n/a	n/a

The role of the self-report Check Up

- Feasible and acceptable (ensure care partner involved)
  - Software matters: OCEAN
- Reduces clinic assessment burden and more time for narrative
  - ***Ultimately person-centered***
- Provides standard language for interprofessional care:
  - Used in home care, CSS, LTC, inpatient mental heath.
- Supports proactive referrals, triage, care planning
- Retirement homes: current **NO** standards and worse outcomes
- Promotes learning across sectors, regions
- Next steps: quality indicators, fracture risk

Further reading

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Some late-night TV for you…

- https://interrai.org/#instruments-webtv--0

Thank you!