interRAI Contact Assessment in Transitional Care
a pilot study to investigate the usefulness of functional status based on the patient population
Marielys Figueroa-Sierra M.S., Niharika Suchak M.D., and Suzanne Baker M.A.
Department of Geriatrics, Florida State University College of Medicine, Tallahassee, Florida

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.

Traditional care is a broad range of post-discharge services designed to promote continuity of care and patient safety is patient 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 unimproved, underserved, or lack a primary care provider in order to decrease the possibilities 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.
- The in-past, year in Tallahassee alone, there was no post discharge care coordination for over 300 elderly (age 55+) visits to the ER.

METHODS
- Identify if Eligible to Participate (screening instruments: 32 items, not computationally intensive)
- Patient Interested in Participating
- Health Provider Introduces Assessor
- Usual Method
- Patient and Family Interaction
- interRAI CA Form
- Medical Records
- interRAI CA Form
- Patient Interview
- Student Assessor Begins Interview (interRAI-CA form)
- Patient Signs Consent Form
- As part of signed consent form given to patient
- Patient Scared with Manual Algorithm (data validated in pilot study)

RESULTS
- No decline in Functional Status
  - Assessment Urgency Scores
    - Assessment Urgency
  - Percentage of Urgency
    - Low
    - Medium
    - High
  - With decline in Functional Status
  - Assessment Urgency Scores
    - Assessment Urgency
  - Percentage of Urgency
    - Low
    - Medium
    - High

SAMPLE CHARACTERISTICS
- Age Groups of Study Participants [n]
- Primary Disease Category for Visit
  - Females
  - Males

REFERENCES

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