



UNIVERSITY OF WATERLOO
FACULTY OF APPLIED HEALTH SCIENCES
School of Public Health and Health Systems



Use of interRAI assessments to identify and respond to mental health needs of older adults across the continuum of care

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Agenda

- Overview of interRAI research on mental health systems
- Examples of applications of interRAI systems
 - Outcome measurement
 - Care planning
 - Evaluation of impact of COVID-19

interRAI

- Who
 - International, not-for-profit network of ~140 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

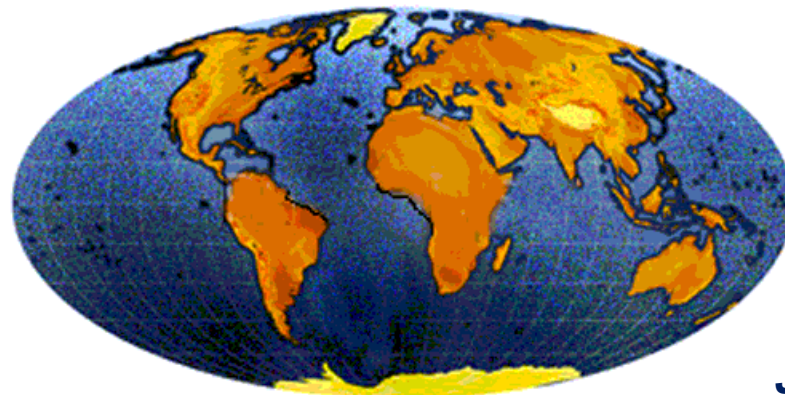
interRAI Countries

Bold & italics=countries involved in mental health network

North America

Canada
US

Central/
South America
Brazil, Chile



South Asia, Middle East &
Africa

India, Israel, Lebanon, Qatar
South Africa, Rwanda

Europe

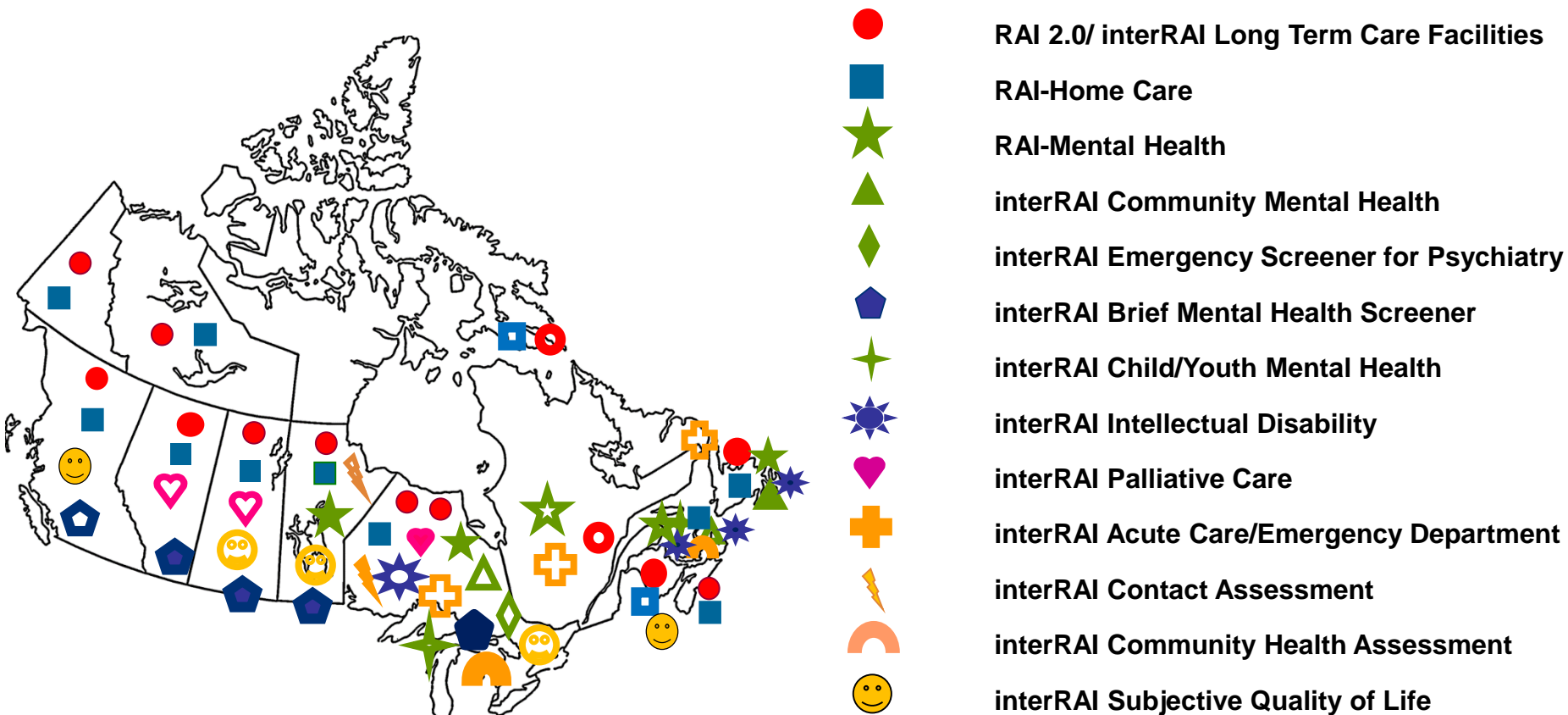
Iceland, Norway, Sweden, Denmark, *Finland*,
Netherlands, France, Germany, *Switzerland*,
UK, *Italy*, *Spain*, Czech Republic, Poland,
Estonia, *Belgium*, Lithuania, Ireland

Pacific Rim

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

Use of interRAI Instruments in Canada

20 million+ assessments
6 million+ individuals



Solid symbols refer to implementations that have been mandated by government
Hollow symbols refer to research, pilot studies, or implementation planning underway



Why did interRAI begin working on mental health systems?

- **It's personal**
 - 20% of Canadians experience problems with mental health or addiction
 - Half will experience mental health problems by age 40
 - NZ Dunedin cohort study suggests that only 17% of people will live a lifetime free from mental illness (Schaefer et al., 2017)



Why did interRAI begin working on mental health systems?

- **It's complicated**

- 70% of mental health problems begin in childhood/adolescence
 - For some these will endure for a lifetime
- Aging associated with many conditions/experiences affecting mental health
- Causes AND consequences of mental illness include
 - Physical health and disability
 - Unemployment, poverty, deprivation, homelessness
 - Substance use
- Social relationships can protect us from stress, support our recovery





Why did interRAI begin working on mental health systems?

- **It has widespread impact**

- All countries of the world are affected
- WHO: mental illness and substance use disorders are world's leading cause of disability
 - 32% of years lived with disability
 - Depression 4th leading cause of total disease burden in 2000
- Stigma associated with mental illness leads to social exclusion
- **“There is no health without mental health.”**
 - US Surgeon General David Satcher

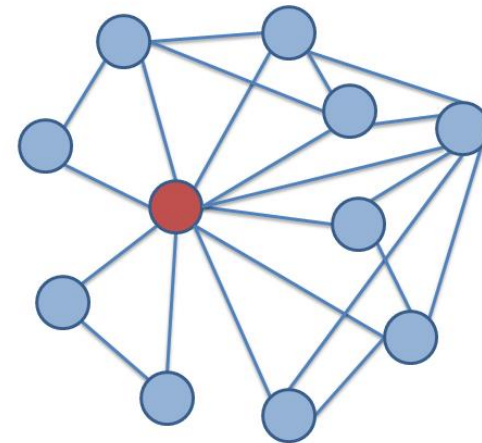




Why did interRAI begin working on mental health systems?

- **It needs a systems approach**

- Every part of the health and social service system deals with persons living with mental illness
 - Health care
 - Education
 - Welfare
 - Criminal Justice





Why did interRAI begin working on mental health systems?

- **We had a head start**
 - All interRAI instruments contain mental health items
 - Initial nursing home instruments already included measures of:
 - Depression, anxiety, bipolar disorder, schizophrenia diagnoses
 - Depression and anxiety symptoms
 - Delirium, cognitive impairment
 - Behavioural issues
 - Psychosis
 - Interpersonal conflict



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What did interRAI do?



interRAI Mental Health Suite

- Overview of all adult mental health instruments in interRAI suite
- Hirdes, John P., Coline Van Everdingen, Jason Ferris, Manuel A. Franco, Brant E. Fries, Jyrki Heikkila, Alice Hirdes et al. "The interRAI Suite of Mental Health Assessment Instruments: An Integrated System for the Continuum of Care." *Frontiers in Psychiatry* 10 (2019): 926.

REVIEW
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The interRAI Suite of Mental Health Assessment Instruments: An Integrated System for the Continuum of Care

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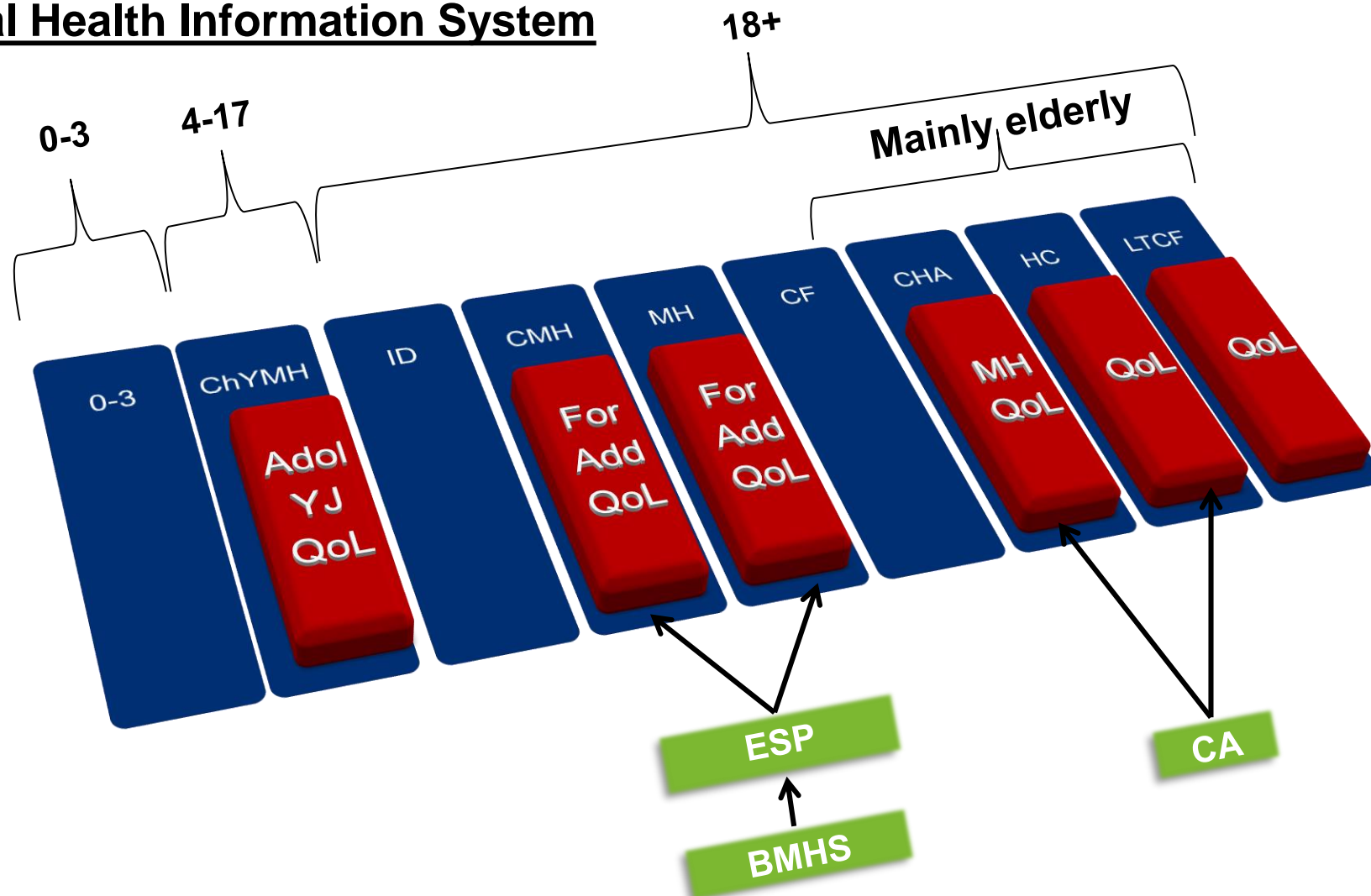
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Development of interRAI Mental Health Systems

- 25+ years of research
- 250+ clinicians, researchers, policy experts engaged in development of instruments and care planning protocols
- Patient engagement in design of feedback systems
- Analyses of
 - > 1.5 million assessments from mental health settings
 - + additional 12.5 million assessments from other interRAI instrument in Canada alone!

Integrated Mental Health Information System





What Makes interRAI Instruments an Integrated System?

- Common language
 - consistent terminology across instruments
- Common theoretical/conceptual basis
 - triggers for care plans
- Common clinical emphasis
 - functional assessment rather than diagnosis
- Common data collection methods
 - professional assessment skills
 - clinical judgment of best information source
- Common core elements
 - some domains in all instruments (e.g., ADL, cognition)
- Common care planning protocols
 - for sectors serving similar populations





System level inter-rater reliability

12-country study

Independent assessors

Demonstrated high reliability
within AND between health settings

BMC Health Services Research



Research article

Open Access

Reliability of the interRAI suite of assessment instruments: a 12-country study of an integrated health information system
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Abstract

Background: A multi-domain suite of instruments has been developed by the interRAI research collaborative to support assessment and care planning in mental health, aged care and disability services. Each assessment instrument comprises items common to other instruments and specialized items exclusive to that instrument. This study examined the reliability of the items from five instruments supporting home care, long term care, mental health, palliative care and post-acute care.

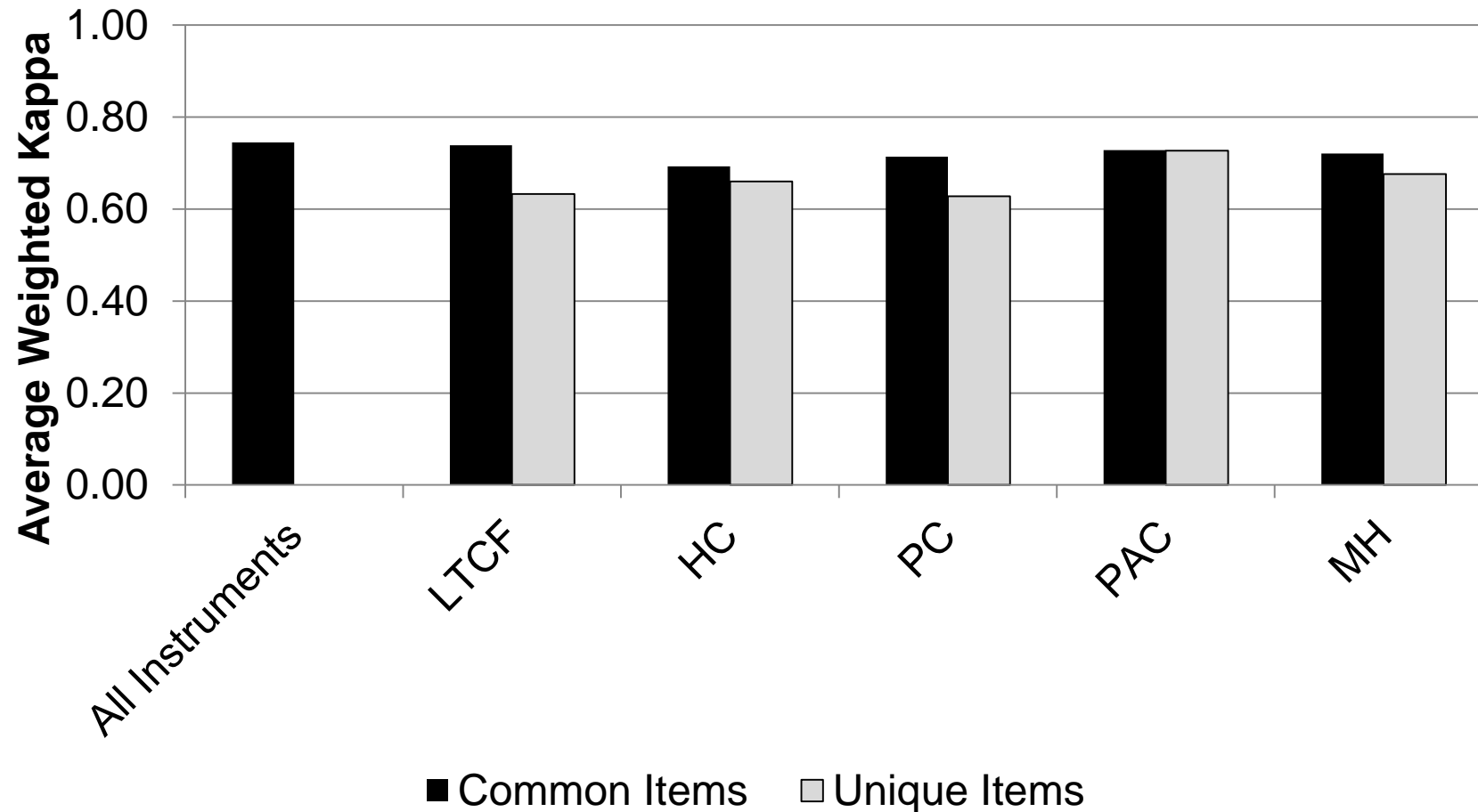
Methods: Paired assessments on 783 individuals across 12 nations were completed within 72 hours of each other by trained assessors who were blinded to the others' assessment. Reliability was tested using weighted kappa coefficients.

Results: The overall kappa mean value for 161 items which are common to 2 or more instruments was 0.75. The kappa mean value for specialized items varied among instruments from 0.63 to 0.73. Over 60% of items scored greater than 0.70.

Conclusion: The vast majority of items exceeded standard cut-offs for acceptable reliability, with only modest variation among instruments. The overall performance of these instruments showed that the interRAI suite has substantial reliability according to conventional cut-offs for interpreting the kappa statistic. The results indicate that interRAI items retain reliability when used across care settings, paving the way for cross domain application of the instruments as part of an integrated health information system.

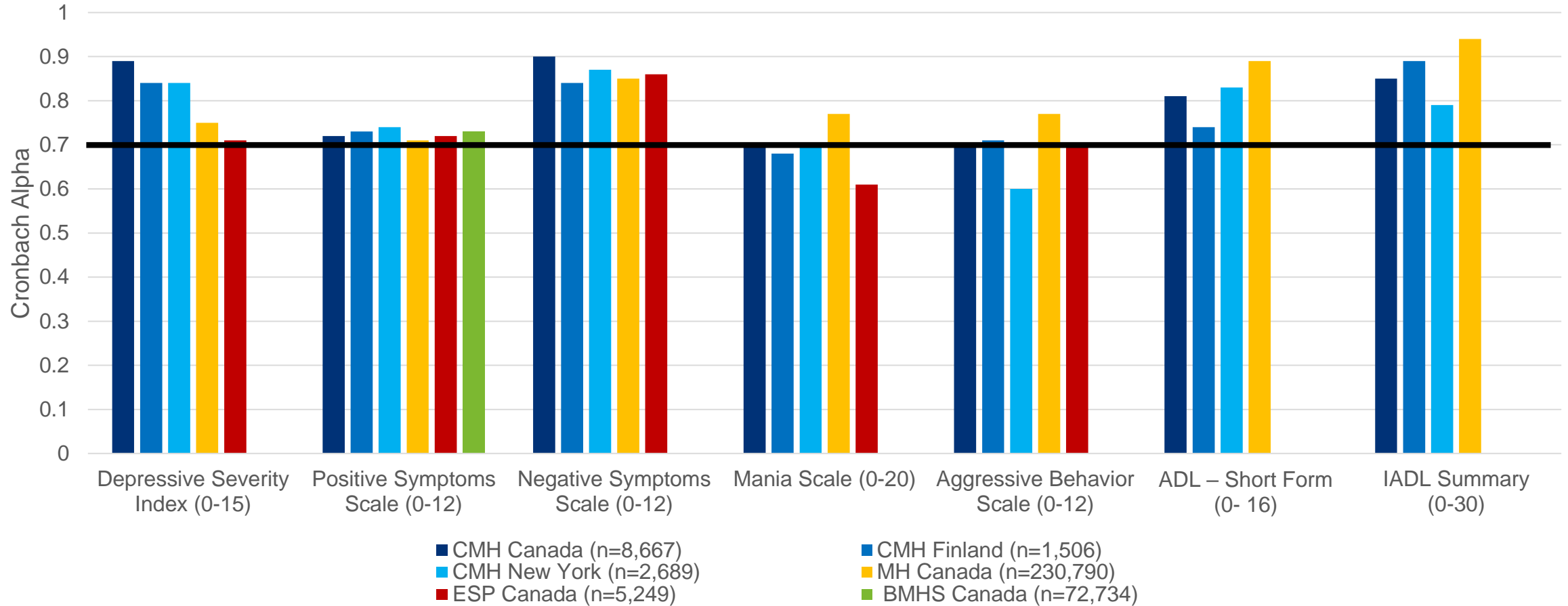


Average weighted kappa value by interRAI instrument and type of item





Reliability of interRAI Mental Health Suite Scales



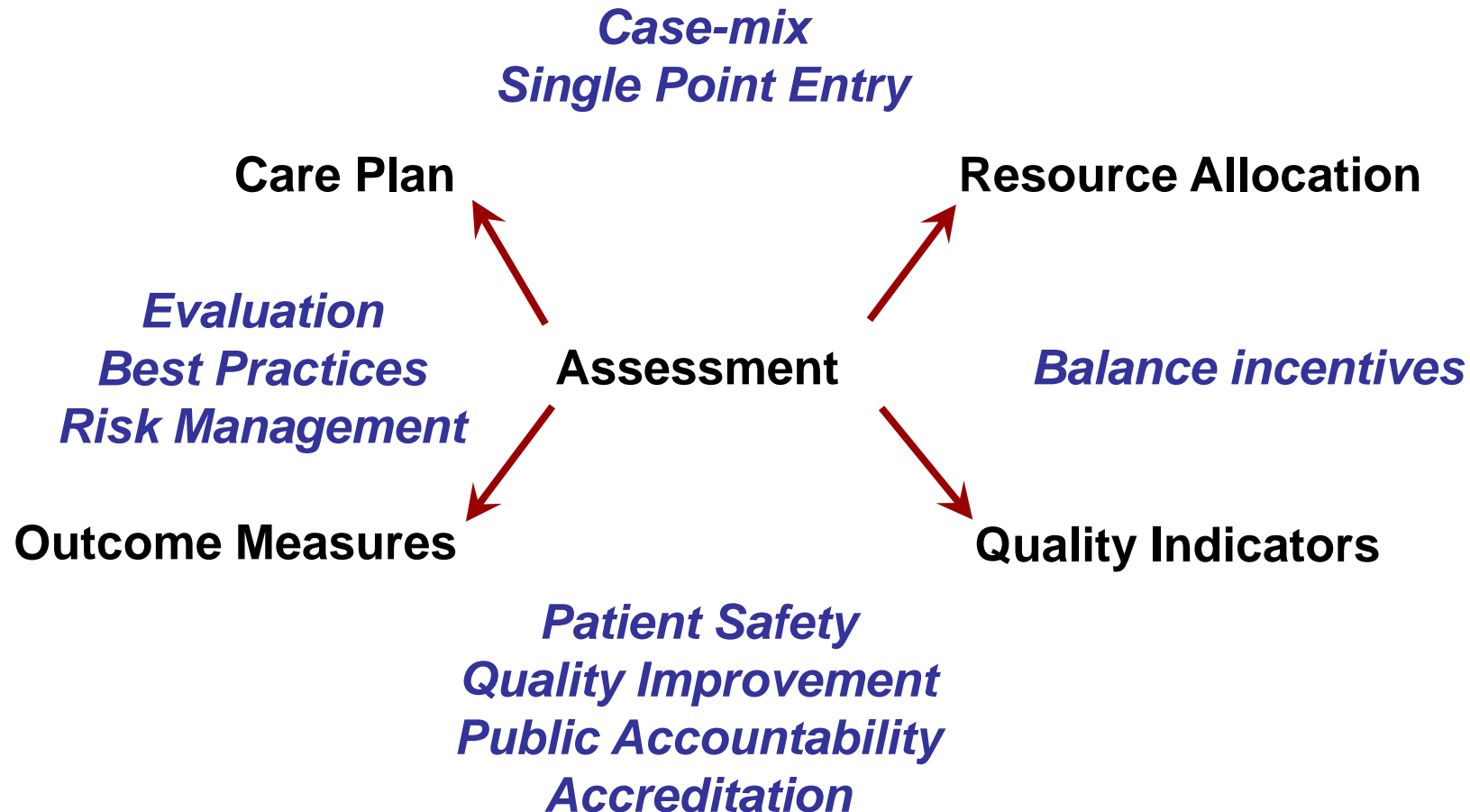
Convergent Validity (c statistic):

Symptoms and Provisional Diagnosis by Care Setting

Provisional Diagnosis	Covariate(s)	ESP (n=5,235)	CMH (n=11,641)	MH (n=230,790)
Neurocognitive	Cognitive Performance Scale	.82	.82	.86
Substance & addictive	Misuse prescription meds Count of current substances used Days drank to intoxication in last 5+ drinks in single sitting CAGE crosswalk score	.79	.78	.87
Schizophrenia & other psychotic	Positive Symptoms Scale Insight to MH condition	.84	.71	.80
Depressive	Depressive Severity Index Social Withdrawal Scale	.64	.70	.65



Applications of interRAI's Assessment Instruments: One assessment ... multiple applications



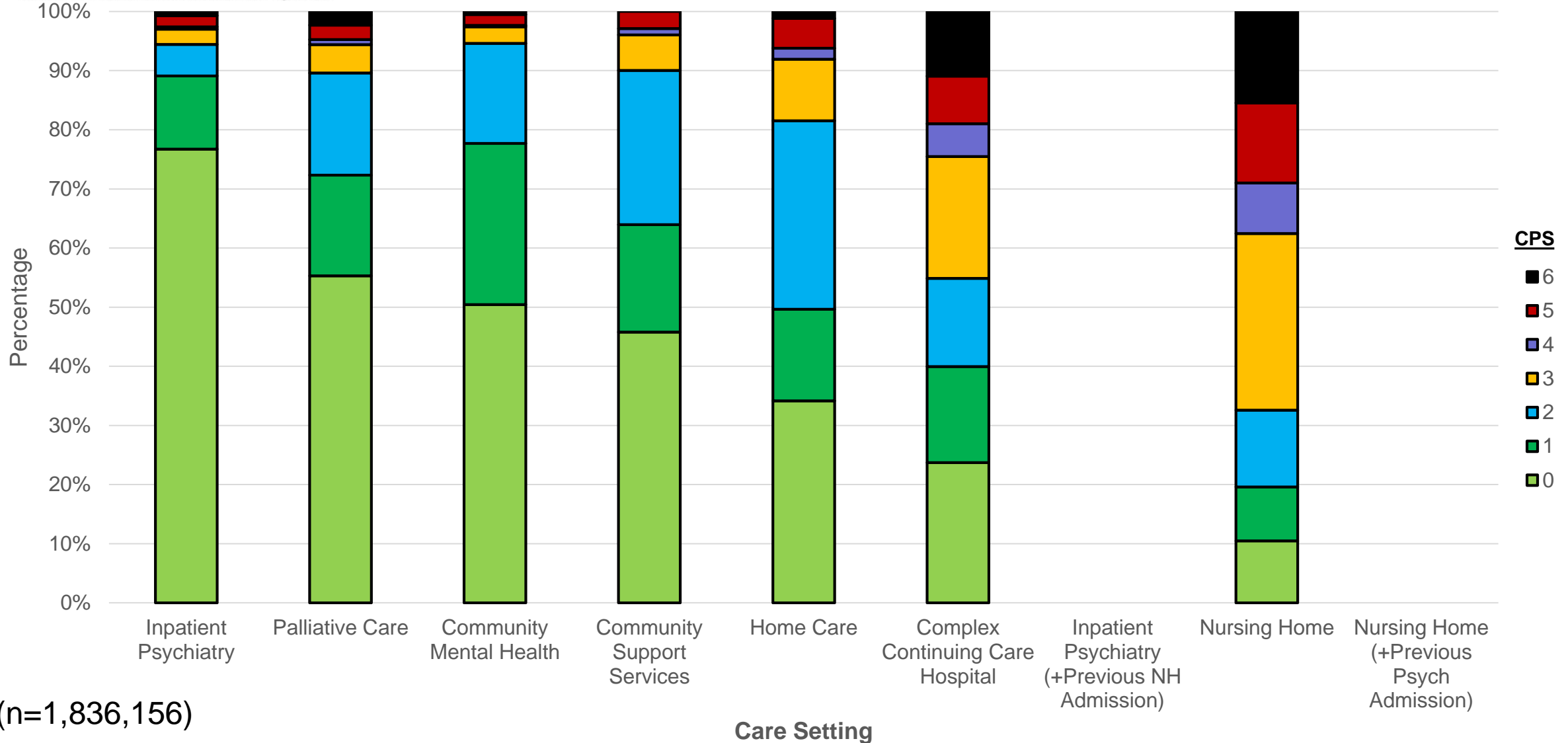


Outcome Measures Related to Mental Health

- Measure severity of symptoms
- Track changes over time
- Starting point for many decision support tools
- Cross-sector comparisons/evaluation
- Examples
 - Cognitive Performance Scale
 - Composite Mood Scale & Self-reported Mood Scale

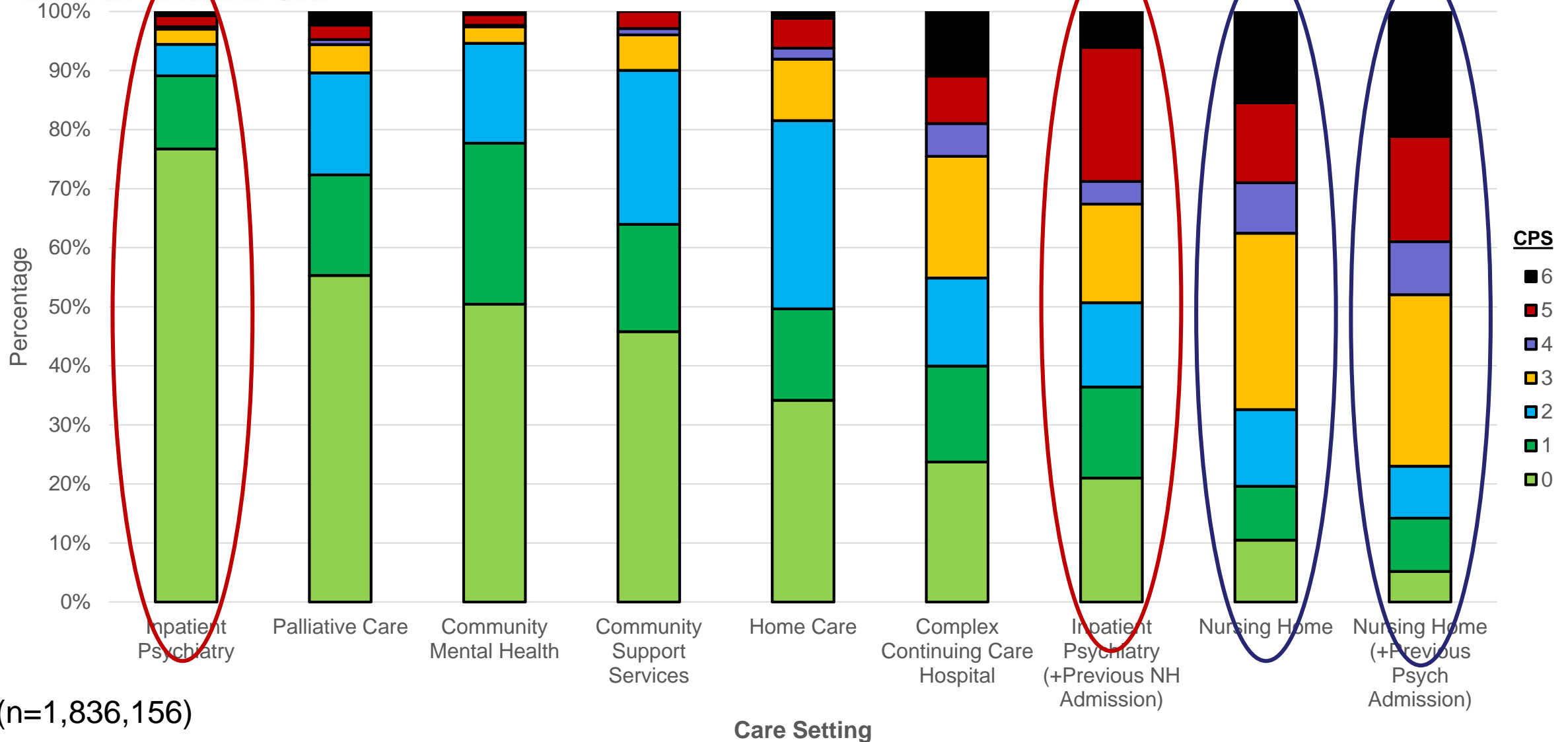


Cognitive Performance Scale by Care Setting, Canada





Cognitive Performance Scale by Care Setting, Canada





Mood Disturbances Across the Continuum of Care Based on Self-Report and Clinician Rated Measures in the interRAI Suite of Assessment Instruments

John P. Hirdes, John N. Morris, Christopher M. Perlman, Margaret Saari, Gustavo S. Betini, Manuel A. Franco-Martin, Hein van Hout, Shannon L. Stewart, Jason Ferris

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Mood Disturbances Across the Continuum of Care Based on Self-Report and Clinician Rated Measures in the interRAI Suite of Assessment Instruments

John P. Hirdes^{1*}, John N. Morris², Christopher M. Perlman¹, Margaret Saari³, Gustavo S. Betini¹, Manuel A. Franco-Martin⁴, Hein van Hout⁵, Shannon L. Stewart⁶ and Jason Ferris⁷

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Background: Mood disturbance is a pervasive problem affecting persons of all ages in the general population and the subset of those receiving services from different health care providers. interRAI assessment instruments comprise an integrated health information system providing a common approach to comprehensive assessment of the strengths, preferences and needs of persons with complex needs across the continuum of care.

Objective: Our objective was to create new mood scales for use with the full suite of interRAI assessments including a composite version with both clinician-rated and self-reported items as well as a self-report only version.

Methods: We completed a cross-sectional analysis of 511,641 interRAI assessments of Canadian adults aged 18+ in community mental health, home care, community support services, nursing homes, palliative care, acute hospital, and general population surveys to develop, test, and refine new measures of mood disturbance that combined clinician and self-rated items. We examined validity and internal consistency across diverse care settings and populations.

Results: The composite scale combining both clinician and self-report ratings and the self-report only variant showed different distributions across populations and settings with most severe signs of disturbed mood in community mental health settings and lowest severity in the general population prior to the COVID-19 pandemic. The self-report and composite measures were strongly correlated with each other but differed most in populations with high rates of missing values for self-report due to cognitive impairment (e.g., nursing homes). Evidence of reliability was strong across care settings, as was convergent validity with respect to depression/mood disorder diagnoses, sleep

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Development of new mood scale for interRAI suite

- Depression Rating Scale (DRS) widely used, but some limitations
 - No items on anhedonia
 - Clinical ratings provide different results from self-rated tools
- Focus is on identification of mood disturbance
 - Not a diagnostic scale
 - Could be on-going or transitional state
- Aim is to provide a compatible approach to measurement that works across care settings and populations



Characteristic	CMH (n = 7,256)	HC (n = 352,161)	CHA (n = 28,302)	CUSR (n = 4,930)	LTCF (n = 8,237)	PC (n = 106,759)	EDCA (n = 1,432)	Community surveys	
								Telephone (n = 643)	On-line (n = 1,921)
Region	Ontario	Ontario	Ontario	Ontario	New Brunswick	Ontario	Ontario, Quebec	Waterloo Region	Canada
Setting	Community mental health	Long-stay home care	Community supports	Home care wellness check	Nursing homes	Palliative home care	Emergency departments	General population	General population
Basis for use	Regional implementation	Provincial mandate	Provincial mandate	Regional implementation	Provincial mandate	Provincial mandate	Research pilot	Research	Research
Years	2005–2019	2018–2021	2016–2017	2020–2021	2016–2020	2011–2021	2017–2018	2011	2021
Age									
18–44	55.0	2.8	3.1	3.7	0.5	2.6	0.0	37.2	49.5
45–64	34.0	11.5	10.4	15.0	4.8	24.1	0.0	38.8	34.7
65–74	6.2	16.2	16.6	19.4	12.4	26.3	12.4	1	12.0
75–84	3.3	29.5	31.7	27.8	28.4	27.7	38.6	124.0	2.4
85+	1.5	40.0	38.1	34.0	54.0	19.2	49.1	1	0.4
Female	52.1	60.5	68.4	59.9	65.4	41.6	58.9	59.6	56.7
Married	29.3	37.7	26.7	37.9	28.8	60.0	NA	NA	57.6
Depression/ mood diagnosis	54.2	24.0	18.6	NA	27.5	NA	NA	NA	34.2
CPS							NA	NA	NA
0	67.5	19.0	44.1	33.7	6.7	53.2			
1–2	28.8	55.1	47.1	50.1	31.4	36.2			
3–6	3.7	25.8	8.7	16.2	61.9	10.7			

The 2011 Waterloo Region general population survey did not have adequate sample size to allow breakdown of older adults into further subgroups. The

511,641 assessments
Nine different settings



Three Scale Variants

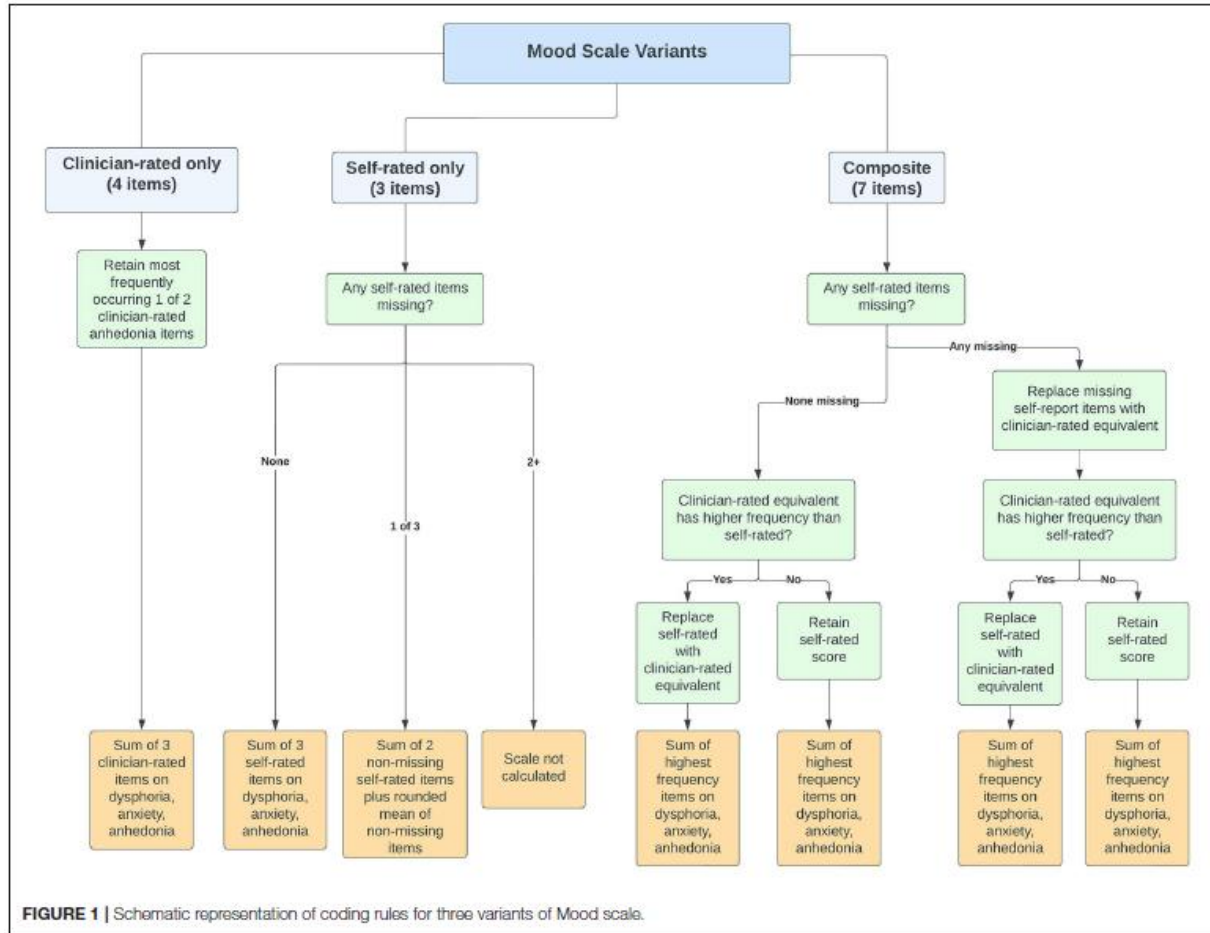


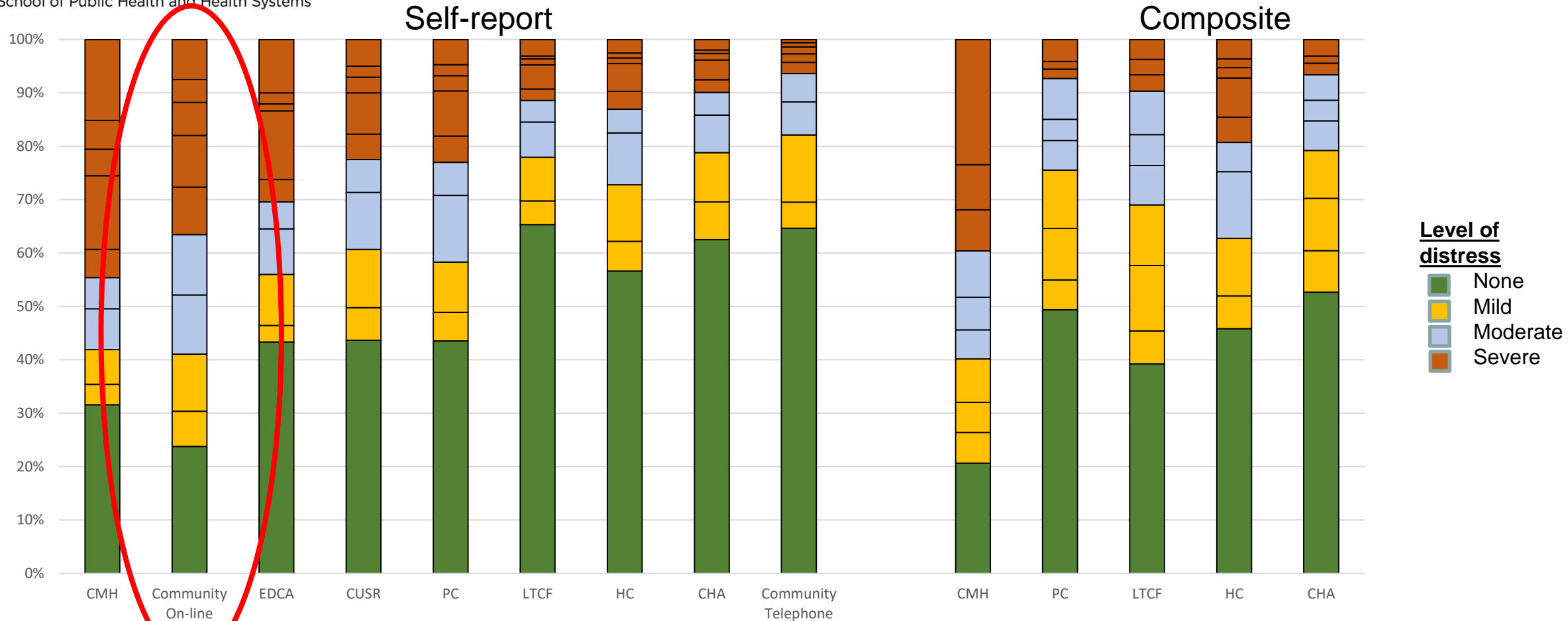
FIGURE 1 | Schematic representation of coding rules for three variants of Mood scale.

- Clinician-rated
 - 4 items
 - Used with legacy instruments
- Self-rated
 - 3 items
 - Used with surveys, self-report systems
- Composite
 - 7 items (4 clinician, 3 self-report)
 - Use self-report first
 - Substitute clinician rating if
 - Self-report missing
 - Clinician rating higher
- All three have scores of 0-9
 - 0 ~ no indicators
 - 9 ~ worst mood disturbance

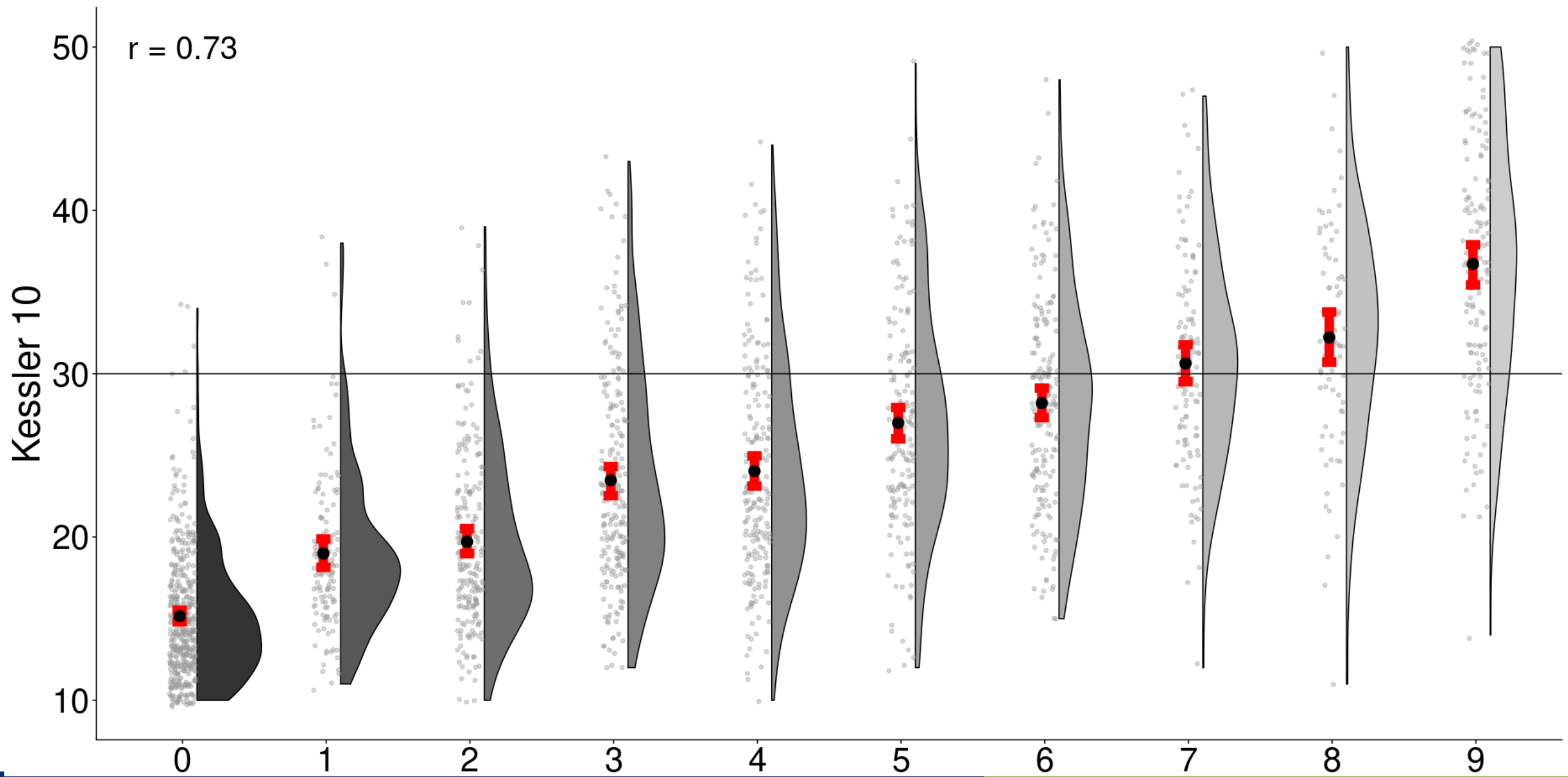


Psychometric testing

- Reliability
 - Previous research showed inter-rater reliability of items across care settings
 - Good-excellent Cronbach's alpha values for internal consistency
- Validity
 - Content validity → indicators of dysphoria, anxiety, anhedonia
 - Convergent validity → association with diagnosis, sleep disturbance, self-harm
 - Criterion validity → association with Kessler-10 psychological distress scale
 - Predictive validity → future research



Note: Colors reflect similar levels of mood disturbance for each scale based on cut-points reported in Table 4. Horizontal lines within the stacked bars reflect single point increments in the scale value within each setting. The specific scale values (and text labels) in the stacked bars are: a) green (none) – 0 for both self-report and composite version; b) orange (mild) – 1-2 for self-report and 1-3 for composite; c) grey (moderate) – 3-4 for self-report and 4-6 for composite; and d) red (severe) – 5+ for self-report and 7+ for composite version.





Key take away points

- New scales provide capacity for common assessment of mood disturbance across broad range of populations and settings
- Recommended as alternative to DRS
 - Addresses main criticisms and limitations of DRS
 - DRS still available in older instruments, discontinued in Version 10.0
- Future work
 - International replication of validity and reliability testing
 - Evaluation of predictive validity for future diagnosis and self-harm
 - Testing in additional populations (e.g., ID, child/youth)
 - Development of quality indicators, use in case-mix systems



interRAI Mental Health Clinical Assessment Protocols (CAPs)

interRAI™

**interRAI Mental Health
 Clinical Assessment Protocols (CAPs)**

MH CMH ESP

**For Use with Community and
 Hospital-Based Mental Health
 Assessment Instruments**

**Version 9.1
 Canadian Edition**

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Basic Principles for MH CAPs

- Evidence-based triggers and assessment guidelines
- Incorporate recovery principles
- Collaborative decision-making involving person and, where appropriate, informal support network
 - Not a robotic care planning library
- Focus on enhancing person's quality of life in all domains possible
 - Multidimensional intervention strategies (person, family, community)
 - Not a diagnostic system
- Support autonomy of person and take into account **strengths, preferences, and needs**
- Calibrate approach to person's current level of functioning



interRAI Mental Health CAPs

- **Safety**
 - Suicidality and Purposeful Self-Harm *
 - Harm to Others *
 - Self Care *
- **Social Life**
 - Social Relationships
 - Social Support (CMH)
 - Support Systems for Discharge (MH)
 - Interpersonal Conflict
 - Traumatic Life Events
 - Criminal Activity
- **Economic Issues**
 - Personal Finances
 - Education and Employment
- **Autonomy**
 - Medication Management & Adherence
 - Rehospitalization
 - Control Interventions (MH)
- **Health Promotion**
 - Smoking *
 - Substance Use
 - Exercise
 - Weight Management
 - Sleep Disturbance
 - Pain
 - Falls

* Also available in ESP



Suicide Prevention ROP

REQUIRED ORGANIZATIONAL PRACTICES 2016

RISK ASSESSMENT

SUICIDE PREVENTION

For the following sets of standards: Aboriginal Community Health and Wellness Services, Aboriginal Integrated Primary Care Services, Aboriginal Substance Misuse Services, Child Welfare Services, Community-Based Mental Health Services and Supports, Correctional Service of Canada Health Services, Emergency Department, Long-term Care, Mental Health Services, Provincial Correctional Health Services, Remote/Isolated Health Services, Residential Homes for Seniors, and Substance Abuse and Problem Gambling.

Clients are assessed and monitored for risk of suicide.

GUIDELINES

Every year close to 3,700 people in Canada commit suicide. Many of these deaths could be prevented by early recognition of the signs of suicidal thinking and offering appropriate intervention.

TESTS FOR COMPLIANCE

Major Clients at risk of suicide are identified.
Major The risk of suicide for each client is assessed at regular intervals or as needs change.
Major The immediate safety needs of clients identified as being at risk of suicide are addressed.
Major Treatment and monitoring strategies are identified for clients assessed as being at risk of suicide.
Major Implementation of the treatment and monitoring strategies is documented in the client record.

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• Accreditation Canada Required Organization Practices- Suicide

- Multiple sectors required to assess and monitor for suicide risk
 - Identify clients at risk of suicide
 - Risk of suicide assessed at regular intervals
 - Immediate safety needs addressed
 - Treatment and monitoring strategies
 - Implementation of those documented in record

• *How can interRAI help?*

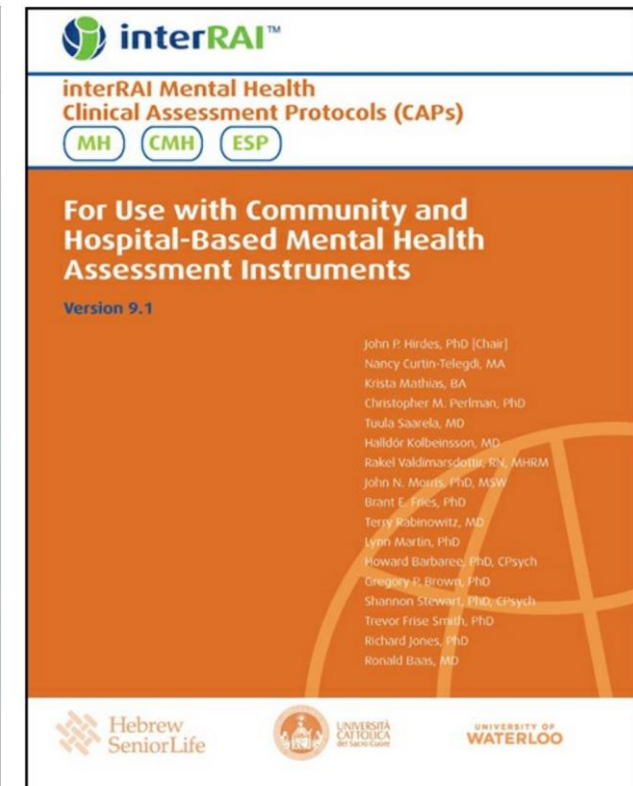
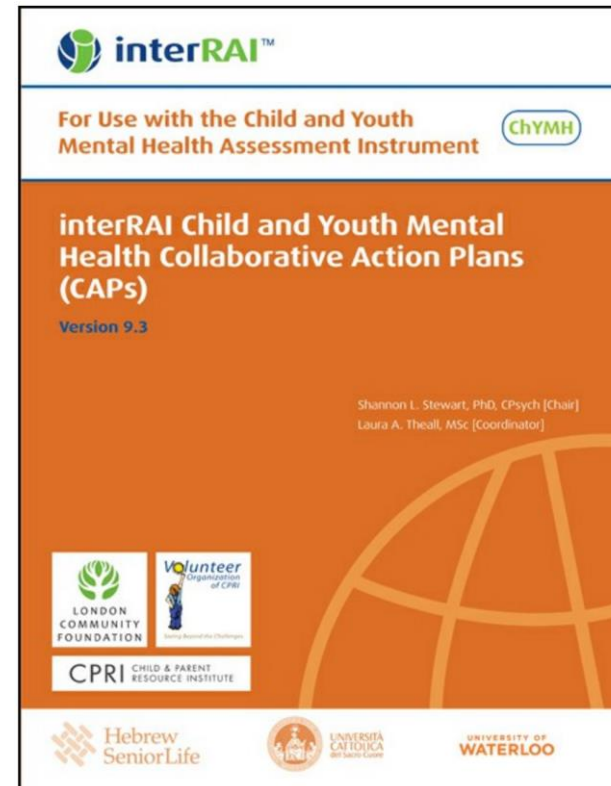


Assessment of suicide risk

- Directly measured
 - Emergency screener for psychiatry (ESP)
 - Mental health (MH)
 - Community mental health (CMH)
 - Child/Youth Mental Health (ChYMH)
- Less directly measured
 - Long term care facility (LTCF)
 - Home Care (HC)
 - Community Health Assessment (CHA)

Intervention and Monitoring

- Clinical Assessment Protocol: Purposeful Self Harm

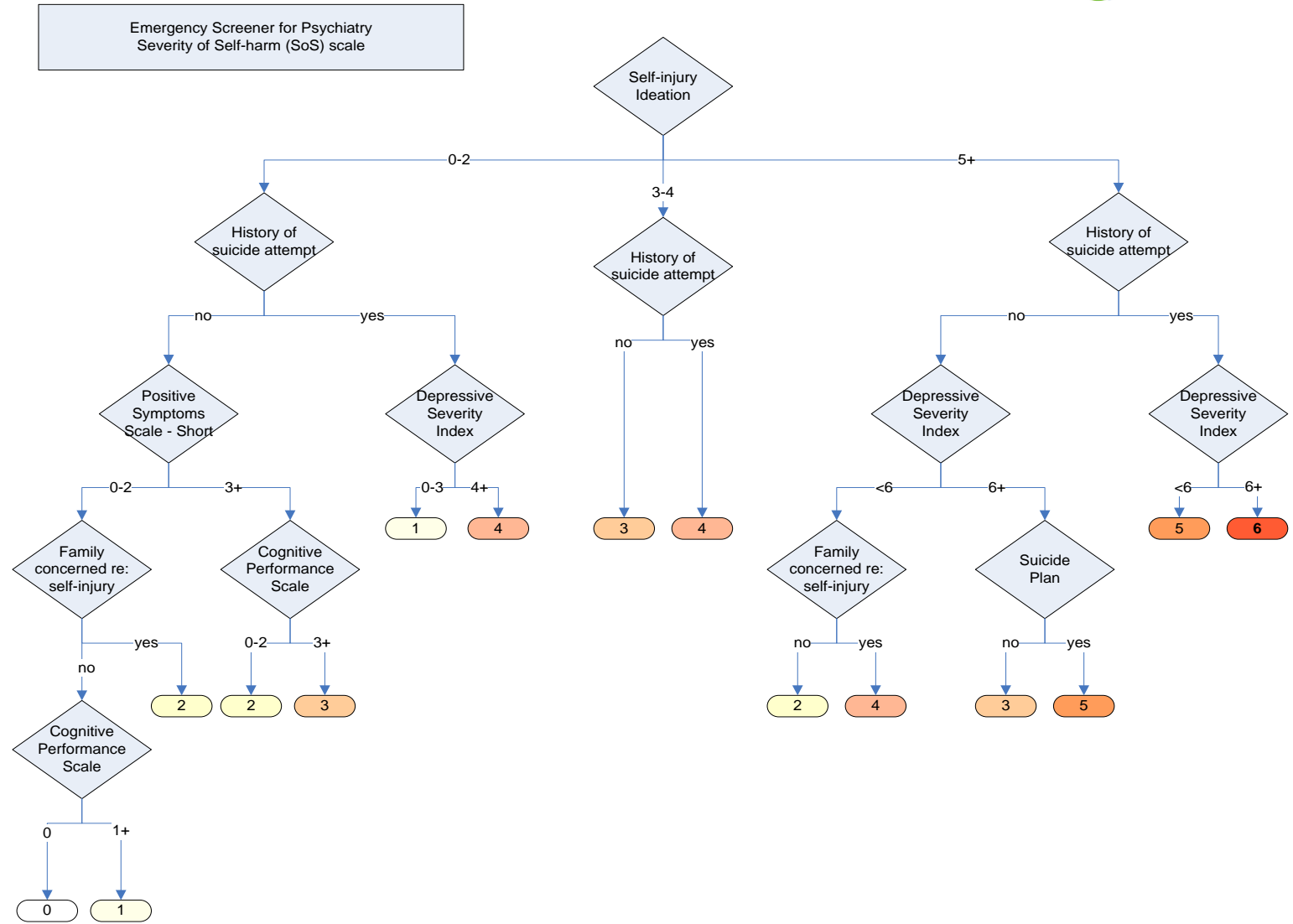




Severity of Self-harm scale

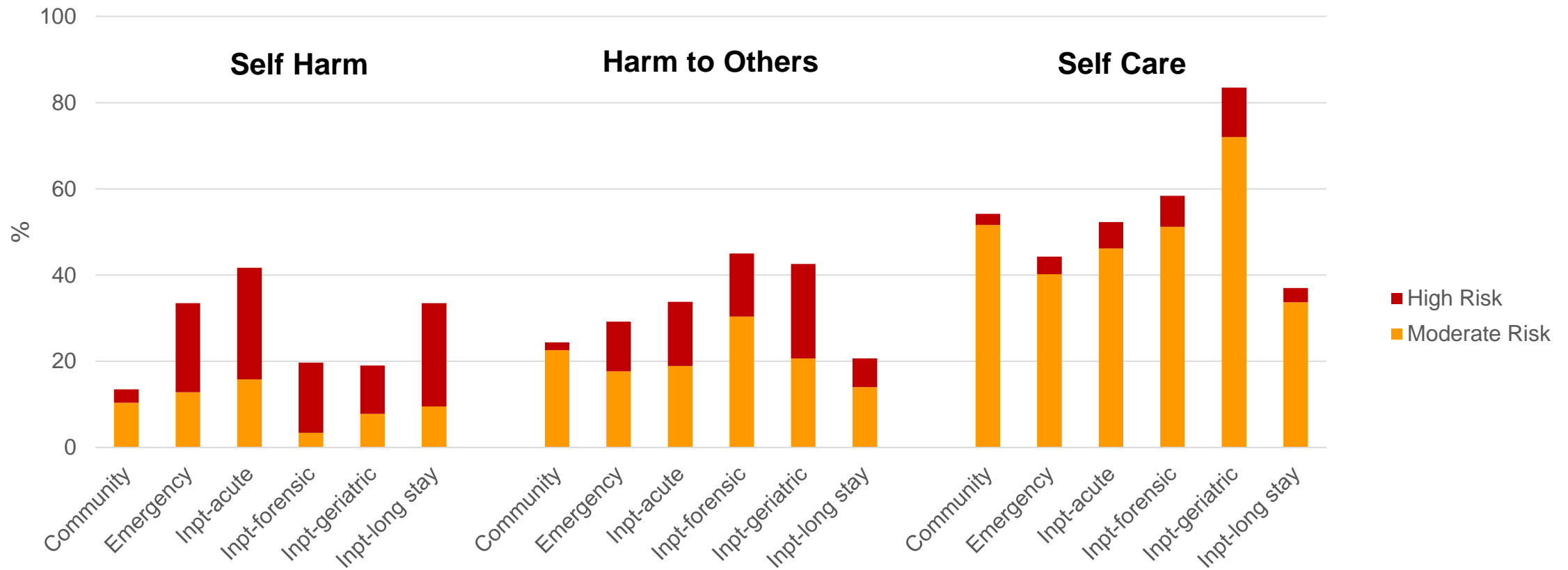
Items and scales used:

- Self injury ideation
- History of suicide attempts
- Family concerned re: self injury
- Depressive Severity Index
- Positive Symptoms Scale
- Cognitive Performance Scale





Risk levels by care mental health care setting and type of risk





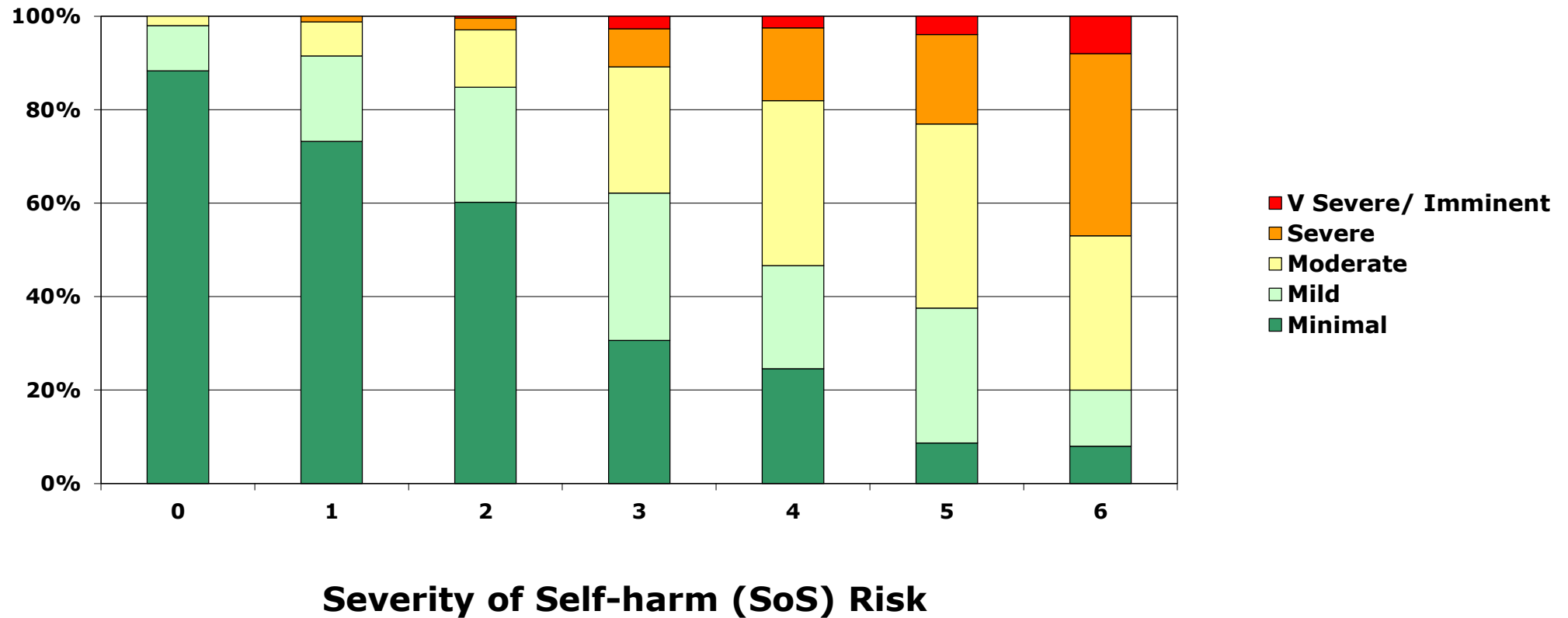
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What's the evidence that the Severity of Self-harm scale works?



Staff Ratings of Severity of Risk of Harm to Self by Severity of Self-harm (SoS) Scale, interRAI ESP Pilot





Association of SoS scale with reason for admission = risk of self harm, OMHRS

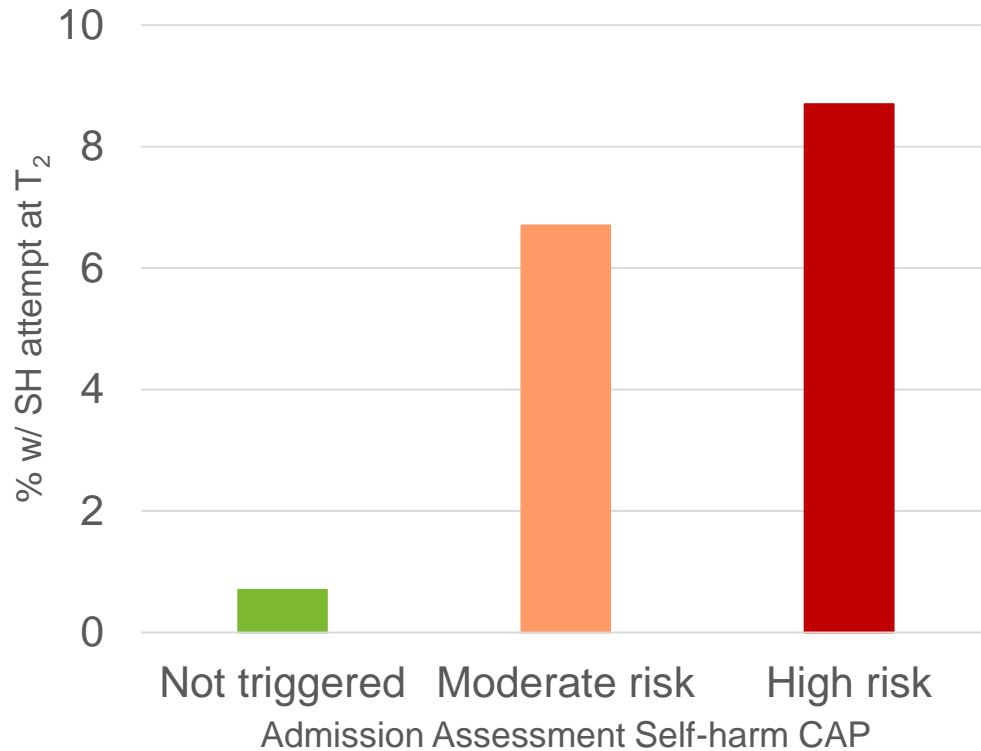
Age group	Odds ratio	95% CL	c Statistic
10-17	1.99	1.90-2.09	0.799
18-44	1.71	1.70-1.73	0.754
45-64	1.69	1.68-1.71	0.754
65+	1.75	1.73-1.78	0.726

Like a coin that gets heads 80% of the time

6 pt difference in scale = 64 times increased odds



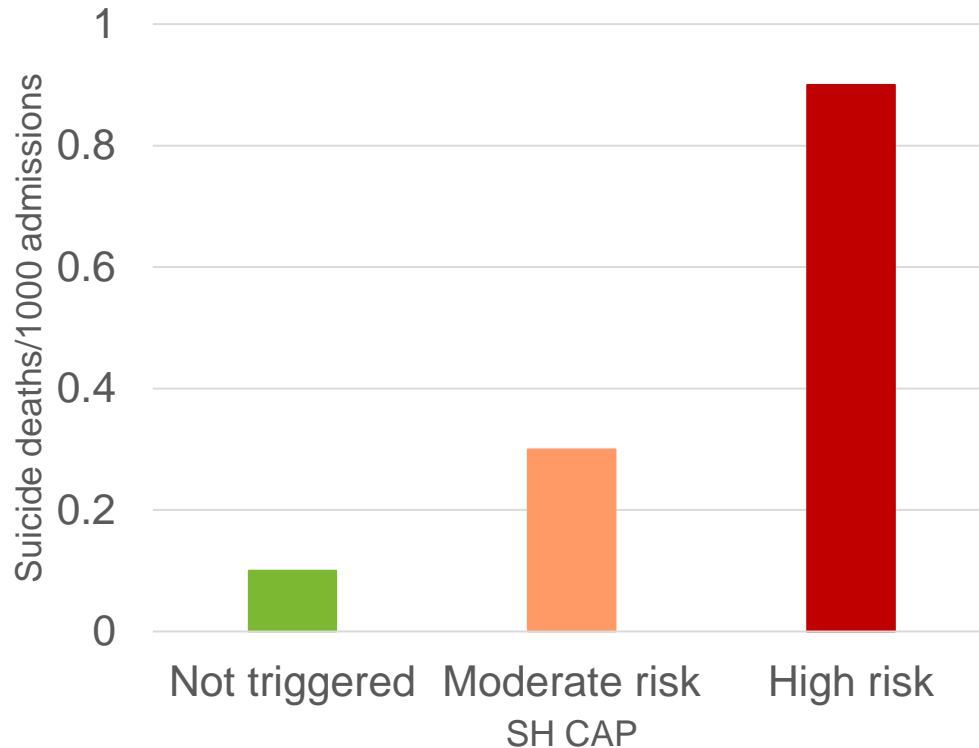
Predicting inpatient self-harm attempts at discharge/reassessment, OMHRS



SH CAP	OR	(95% CL)
Not triggered	1.00	--
Moderate risk	9.88	8.31-11.75
High risk	13.11	11.28-15.24
c Statistic: 0.779		



Predicting inpatient deaths by suicide (n=90 deaths), OMHRS



SH CAP	OR	(95% CL)
Not triggered	1.00	--
Moderate risk	2.52	1.15-5.52
High risk	6.82	4.32-10.77
c Statistic N/A		



So what do we know about the self-harm CAP?

- It predicts
 - Clinical opinion of risk
 - Reason for admission
 - Inpatient self-harm attempts
 - Inpatient deaths by suicide
- CAP guidelines developed by multinational team of experts
 - Demonstrated predictive validity of triggers
 - International best practice guidelines for intervention and monitor



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Evaluating the Impact of COVID-19 in Long Term Care Homes

Twitter: @interrai_Hirdes

www.interrai.org



The Impact of COVID-19 on Long-Term Care in Canada

Focus on the First 6 Months



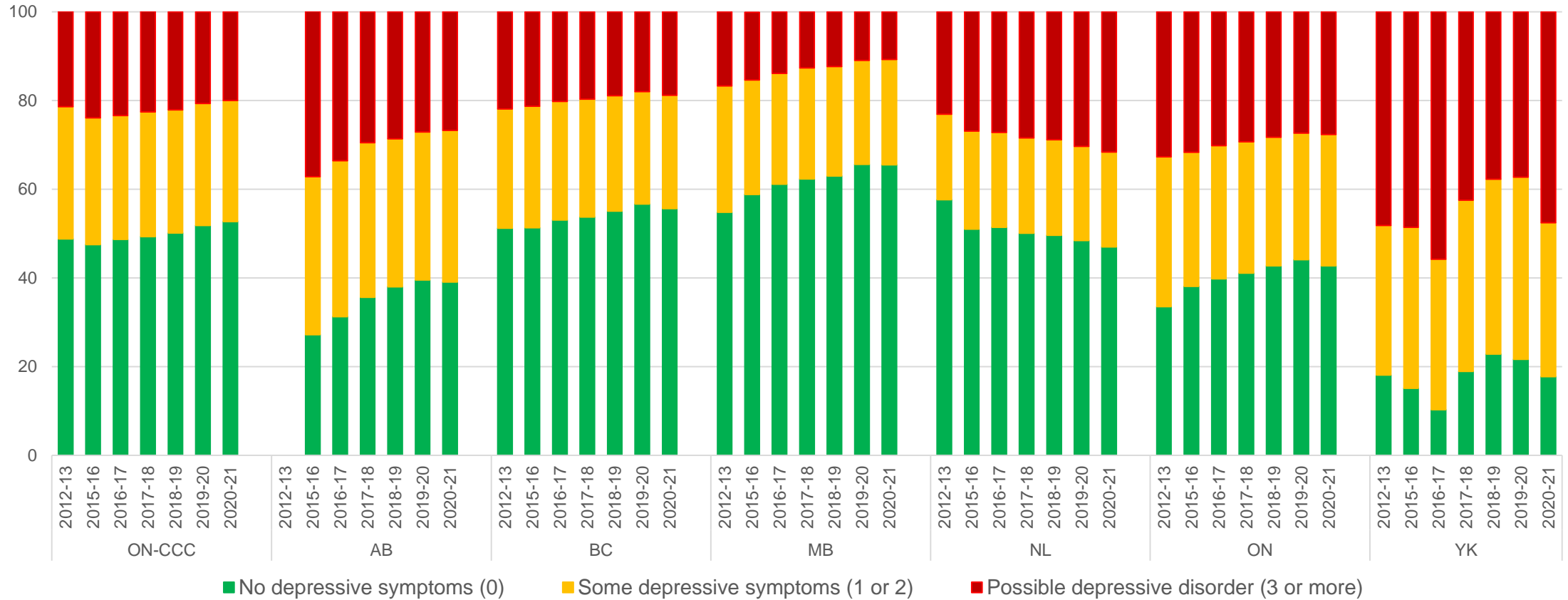
Table 1 Number of COVID-19 outbreaks, cases and deaths in Canada's LTC and retirement homes,* by pandemic wave[†]

COVID-19 in LTC and retirement homes	Wave 1	Wave 2	Pandemic total (to date)
Number of homes with COVID-19 outbreaks	1,171	1,389	2,560
Number of resident cases	21,140	34,270	55,410
Number of resident deaths	7,260	7,479	14,739
Percentage of resident deaths relative to number of resident cases	34%	22%	27%
Percentage of resident deaths relative to number of total COVID-19 deaths in Canada	79%	60%	69%
Number of staff cases (deaths) [‡]	12,005 (16)	11,105 (12)	23,110 (28)

About 10,000 deaths in nursing homes



Historical Trends in Changes Depression Rating Scale (DRS) score of assessed residents, by Facility and Year, Data Source: CIHI Quick Stats





Wave 1: Lockdown in New Brunswick

- Lockdown period had either NO effect or protective effect on
 - Behaviour disturbances, depression, delirium
- These models controlled for effects of
 - Historical, demographic, diagnostic, symptom several and facility
- What did homes in NB do during wave 1?
 - Increased recreation resources, hired students, deployed tablets, communicated with family

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Special Article

Evaluating the Effect of COVID-19 Pandemic Lockdown on Long-Term Care Residents' Mental Health: A Data-Driven Approach in New Brunswick

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ABSTRACT

Long-term care (LTC) residents, isolated because of the COVID-19 pandemic, are at increased risk for negative mental health outcomes. The purpose of our article is to demonstrate how the interRAI LTC facility (LTCF) assessment can inform clinical care and evaluate the effect of strategies to mitigate worsening mental health outcomes during the COVID-19 pandemic. We present a support analysis of the effects of lockdown in homes without COVID-19 outbreaks on depression, delirium, and behavior problems in a network of 7 LTC homes in New Brunswick, Canada, where mitigative strategies were deployed to minimize poor mental health outcomes (eg, virtual visits and increased staff volunteerism). This network meets regularly to review performance on risk-adjusted quality of care indicators from the interRAI LTCF and share learning through a community of practice model. We included 409 assessments from 765 LTC residents between January 2017 to June 2020 and modeled the change within and between residents for depression, delirium, and behavioral problems over time with longitudinal generalized estimating equations. Though the number of residents who had in-person visits with family decreased from 73.2% before to 13.0% during lockdown (chi square, $P < .001$), the number of residents experiencing delirium (4.2%–3.5%, $P = .51$) and behavioral problems (35.5%–30.2%, $P = .19$) did not change. The proportion of residents with indicators of depression decreased from 19.9% before to 15.5% during lockdown ($P < .002$). The final multivariate models indicate that the effect of lockdown was not statistically significant on depression, delirium, or behavior & problems. Our analyses demonstrate that poor mental health outcomes associated with lockdown can be mitigated with thoughtful intervention and ongoing evaluation with clinical information systems. Policy makers can use outputs to guide resource deployment and researchers can examine the data to identify better management strategies for when pandemic strikes again.

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On March 11, 2020, the World Health Organization declared the outbreak of COVID-19 to be a pandemic. As we put pen to paper, the World Health Organization is reporting more than 30 million cases and more than 1,000,000 deaths in 216 countries (<https://www.who.int>).

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Changes in inappropriate anti-psychotic use through collaborative interventions



Original Study
A Canadian Cohort Study to Evaluate the Outcomes Associated with a Multicenter Initiative to Reduce Antipsychotic Use in Long-Term Care Homes

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ABSTRACT

Objectives: To evaluate the impact of a multicenter intervention to reduce potentially inappropriate antipsychotic use in Canadian nursing homes at the individual and facility levels.
Design: Longitudinal, population-based cohort study to evaluate the Canadian Foundation for Healthcare Improvement's Spreading Healthcare Innovations Initiative to reduce potentially inappropriate antipsychotic use in 6 provinces/territories.
Setting and Participants: Adults in nursing homes in 6 provinces/territories in Canada between 2014 and 2016. The sample involved 4927 residents in 45 intervention homes and 122570 residents in 1193 control homes in the first quarter of the study.
Measures: Assessment data based on the Resident Assessment Instrument 2.0 were used in both settings to track antipsychotic use and to obtain risk-adjusters for a quality indicator on potentially inappropriate use.
Intervention: Quality improvement teams in participating organizations were provided with education, training, and support to implement localized strategies intended to reduce antipsychotic medication use in residents without diagnosis of psychosis.
Results: At the resident level, we found that the odds of remaining on potentially inappropriate antipsychotics were 0.75 in intervention compared with control homes after adjusting for age, sex, aggressive behavior, and cognition. These findings were evident within the pooled Canadian data as well as within provinces. At the facility level, the intervention homes had greater improvements in risk-adjusted quality indicator performance than the control homes, and this was true for the worst, median, and best-performing homes at baseline. There was no major change in the quality indicator for worsening of behavior symptoms.
Conclusion/Implications: The Canadian Foundation for Healthcare Improvement intervention was associated with a reduction in potentially inappropriate antipsychotic use at both the individual and facility levels of analysis. This improvement in performance was independent of secular trends toward reduced antipsychotic use in participating provinces. This suggests that substantial improvements in medication use may be achieved through targeted, collaborative quality improvement initiatives in long-term care.
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 The authors declare no conflicts of interest.
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The need to reduce use of antipsychotics in nursing homes has become a focus of worldwide attention.¹⁻³ Their use may be justified in the presence of diagnoses such as schizophrenia or Huntington's disease, or with symptoms like hallucinations or delusions. However, antipsychotic use in the absence of those conditions is considered a quality problem in long-term care¹³⁻¹⁶ because they are associated with increased risk for mortality¹⁷⁻¹⁹ and adverse events like falls,

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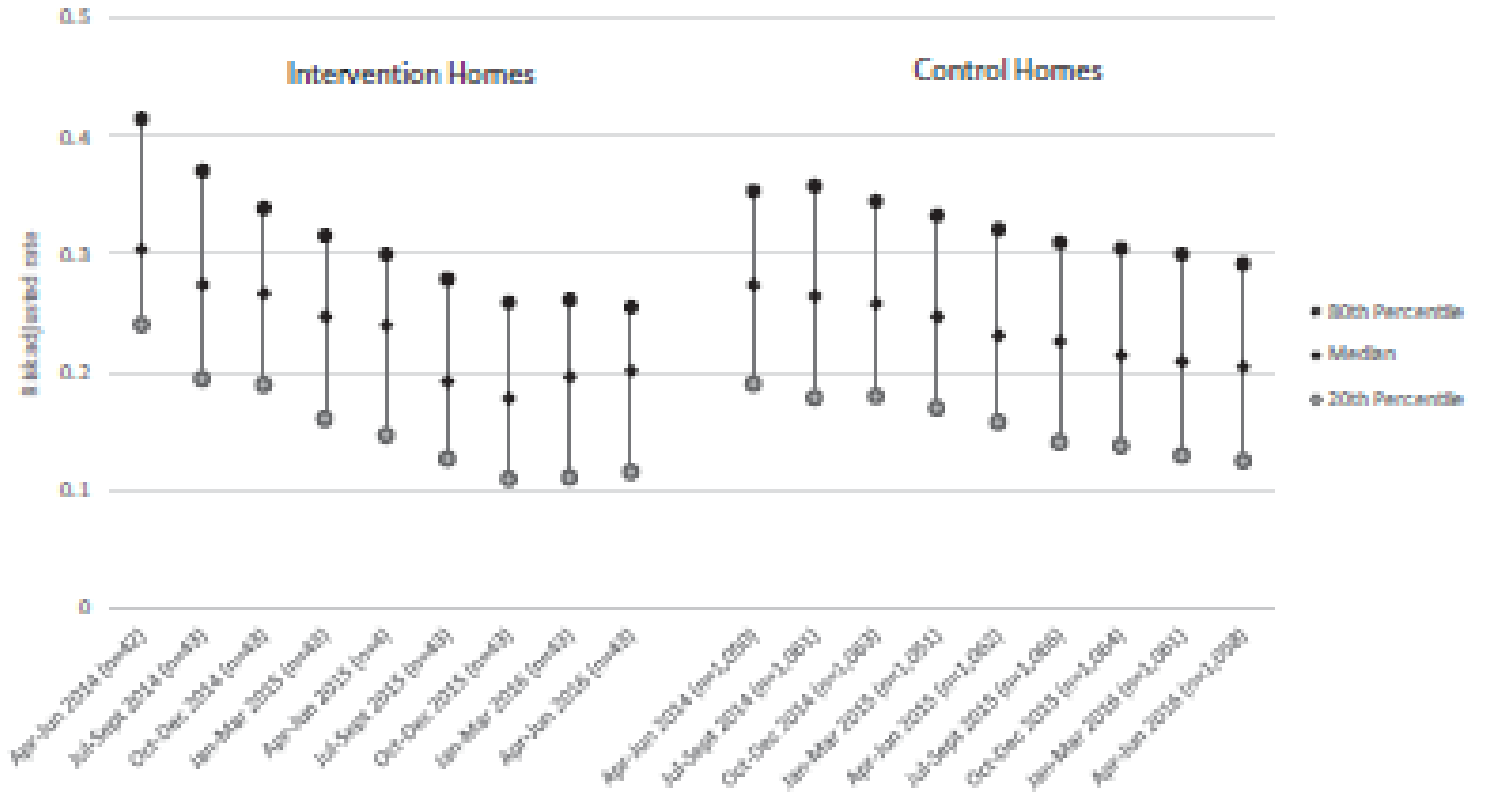
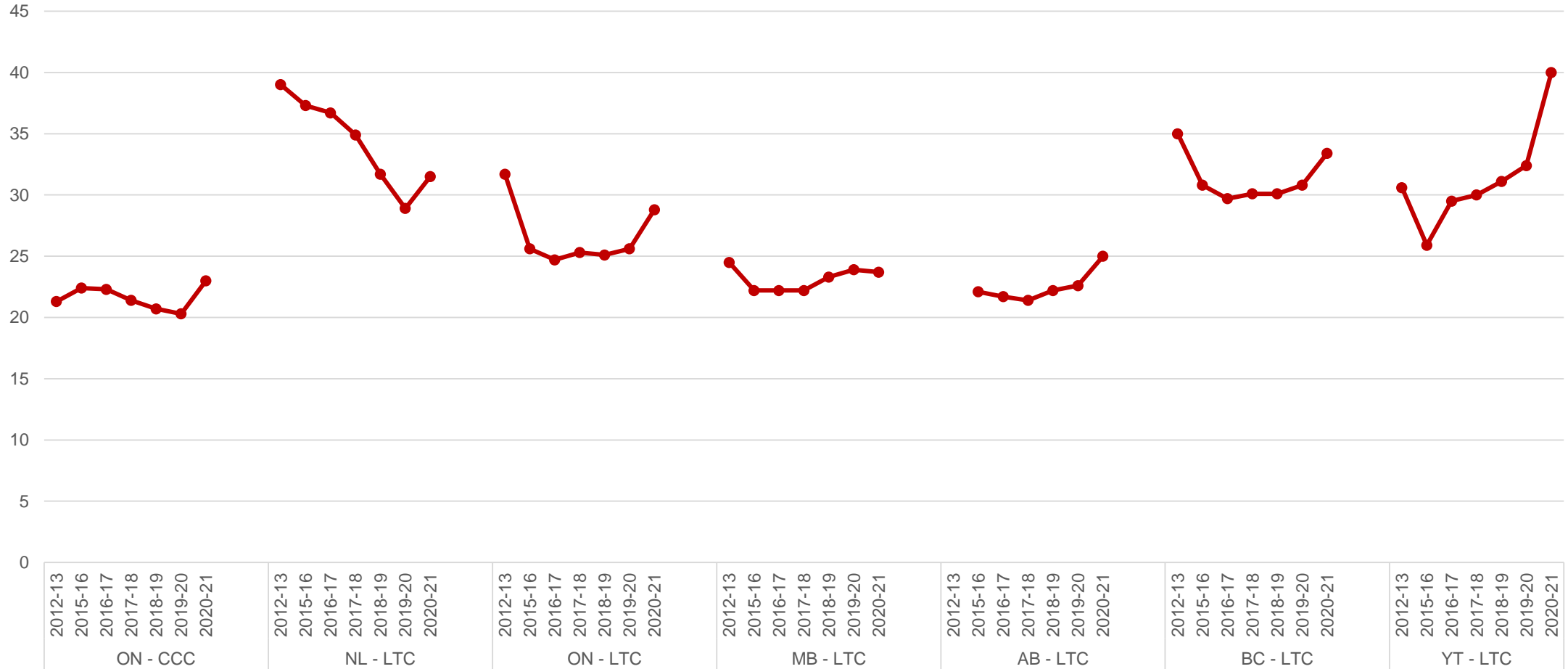


Fig. 1. Proportion of residents in intervention and control homes triggering risk-adjusted quality indicator for potentially inappropriate antipsychotic use.



Historical Trends of Antipsychotic Medications received by assessed residents, by Facility type and year





Concluding Comments

- interRAI assessments allow you to identify and respond to mental health concerns
 - Within specific health sectors
 - Across care settings
 - Over life course
- Multiple uses for multiple stakeholders
 - Most important application is clinical response to needs



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Thank you

Questions/comments?

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