

RETHINKING THE RESIDENT ASSESSMENT PROTOCOLS

To the Editor: We are writing on behalf of interRAI, a 26-country research network whose members developed the Nursing Home Resident Assessment Instrument and the 18 Resident Assessment Protocols (RAPs) for the Minimum Data Set, Version 2.0 (MDS V2.0). The recent article by Dosa et al.¹ raises some interesting issues related to the RAPs, but it would be useful to take a somewhat broader view than was presented in the article.

The authors point to some valid and useful criteria by which RAPs can be considered. Without impugning their credentials, it is important to recognize that this study simply represents the ratings and opinions of two self-selected individuals, rather than a sample of independent raters who are representative of any population. Thus, the conclusions need to be considered with care.

In developing the MDS V2.0 RAPs, many of the criteria suggested by Dosa et al. were considered. Nevertheless, several of their criteria may be inappropriately applied. Four specific examples illustrate this point. First, it is not clear that there is a singular, appropriate level of detail that would apply uniformly to the care planning activities of *all* potential users, ranging from sophisticated physicians and registered nurses to other staff with less training, fewer resources, and substantial time limitations. Thus, “clarity” is a subjective consideration that needs to be evaluated from the perspectives of multiple users. Second, in designing the triggers—the algorithms involving MDS items that indicate which of the 18 care planning areas should be considered—there was an explicit government-requested criterion that lead to overtriggering. The emphasis was on triggers that were sufficiently sensitive to provide a broad “safety net” to capture all the potential needs of nursing home residents. Experience has shown that this is not as effective as a more-targeted approach that emphasizes specificity. Although RAPs are being used around the world in care planning, these efforts are often overwhelmed with too many triggered RAPs. Third, when these initial RAPs were developed, there was no sufficient evidence base and too much variability in resident situations to provide a highly structured set of recommendations (e.g., a checklist or flowchart, as suggested by Dosa et al.). Thus, RAPs were designed to provide suggestions of how to “think about the problem” rather than narrow practice guidelines that would lead to a criticism of “cookie-cutter care-planning” or, eventually, reliance on outdated protocols. International experience has shown that the RAP approach provides motivation for care staff to provide better care.² Finally, authors were acknowledged for all RAPs in early versions, but the U.S. government omitted them as standard policy.

The authors are correct that the set of RAPs they evaluated was the most recent set *adopted by the U.S.*

government, but these are not the only RAPs available. The U.S. federal requirements stipulate that the care planning process has to be at least as thorough as that represented by the approved 18 RAPs, but clinicians are allowed to substitute replacements that improve upon them. InterRAI is engaged in a multinational effort to develop and promulgate updated RAPs that incorporate new clinical insights into the domain areas addressed and a new approach to care planning based on a more-targeted triggering methodology. This development is part of the design of a more-sophisticated “suite” of assessment instruments that span a much broader set of care environments that include not just nursing homes, but also postacute care, assisted living, home care, palliative care, inpatient mental health, community mental health, intellectual disability, and acute care.³ In addition, these instruments are designed to be used around the world, in different cultures. The suite has “titrated” items from the RAI and other earlier interRAI instruments so that any item used in multiple assessment systems will be identical and thus provide the ability to compare populations in all care settings and follow individuals across these settings. As part of the suite development, all of the RAPs are being reconsidered. The extensive databases that are accumulating from international adoption of the interRAI instruments provide a strong scientific basis for the new triggers. The care planning protocols are now called Clinical Assessment Protocols (CAPs), in recognition of their applicability to more populations than nursing home residents alone.

In this redevelopment, interRAI has considered many of the same criteria as those that Dosa et al. suggest. In particular, our triggering approach now seeks to identify two types of persons. First are those who have a higher-than-expected likelihood of declining—a typical scenario for long-stay nursing home residents. Second are persons who have a high likelihood of improving, including those declining because of a recent acute problem (e.g., delirium, psychosis, fall, pneumonia) and whose symptoms would be alleviated when the problem was addressed. Using this approach, it was possible to cut the proportion of CAPs triggered for follow-up by more than half for the 18 areas represented by the current RAPs. Finally, interRAI is updating the approach to care instructions provided in each of these problem areas, focusing where possible on clinical concerns and strategies that have been empirically demonstrated to lead to positive outcomes. We see this as a continuing effort to refine the guidelines as knowledge—ours and others—improves.

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PREDICTORS OF MOBILITY IN MEDICALLY UNSTABLE ELDERLY PATIENTS WITH HIP FRACTURES: A PRELIMINARY STUDY IN A GERIATRIC WARD

To the Editor: Hip fractures are among the most common causes of disability and hospitalization in older people. The overall prognosis for older adults with hip fractures might be unfavorable because of comorbid medical problems, malnutrition, and high mortality rates. The purpose of this study was to investigate the possible predictors of mobility in medically unstable elderly patients with hip fractures. Thirty-five patients aged 65 and older operated on for unilateral postfall hip fracture, hospitalized in Baskent University, Yaprak Geriatric Rehabilitation Center from January 2003 to January 2006 were included. Age, sex, length of stay (LOS), comorbid medical problems, presence of dementia, and depression (diagnosed by Departments of Psychiatry, Neurology, or both), incontinence at admission, and presence of decubitus ulcers were noted. The Charlson Comorbidity Index was used to evaluate general comorbid conditions.¹ This index takes into account the number and seriousness of comorbid conditions. Myocardial in-

farction, congestive heart failure, peripheral vascular disease, dementia, chronic pulmonary disease, connective tissue disease, ulcers, mild liver disease, and diabetes mellitus are each assigned a score of "1"; hemiplegia, moderate and severe renal disease, diabetes mellitus with end-stage organ damage, tumors, leukemia, and lymphoma are each assigned a score of "2"; moderate and severe liver diseases are each scored as "3"; and metastatic solid tumor and acquired immunodeficiency syndrome are each scored as "6." Serum albumin levels were assessed upon admission. An unfavorable treatment outcome was defined as inability to walk with or without any assistive devices. Physical therapy included static and dynamic control of position, balance skills, weight shift, and activities of daily living.

SPSS, version 11.0, was used for statistical analysis (SPSS Inc., Chicago, IL). Results are expressed as means \pm standard deviations. The chi-square test was used to examine the relationship between categorical variables. Patients younger than 85 were compared with patients aged 85 and older. A Charlson Comorbidity Index score greater than 2.8, which was the mean value of the study group, was used as the cutoff for defining patients with high comorbidity. The cutoff for serum albumin level was 3 g/dL.

Thirty-five patients with a primary diagnosis of hip fracture were rehabilitated over a 3-year period. Five patients were excluded from the study; four had early discharges (LOS <1 week), and one could not be rehabilitated because of multiple fractures. The mean age of the study group (18 women and 12 men) was 82.3 ± 6.6 (range 69-96). Mean LOS was 43.4 ± 33.4 days (range 7-130). Mean Charlson Comorbidity Index was 2.8 ± 1.7 .

Despite similar rehabilitation efforts, presence of incontinence ($P = .006$), decubitus ulcers ($P = .004$), and atrial fibrillation ($P = .04$) were the factors that emerged as strong negative determinants of ambulation. Other factors such as sex, high comorbidity index scores, aged 85 and older, serum albumin levels less than 3 g/dL, presence of dementia, and depression did not affect rehabilitation outcome significantly.

Our findings suggest that even the oldest-old patients with comorbid health problems have the potential to become ambulatory. Previous research has also demonstrated that patients with dementia display similar functional gains as their counterparts,^{2,3} although another study⁴ reported that dementia and the number of prevalent vertebral fractures are predictors of walking ability, but their patients were aged 90 and older. Similar to our findings, another study⁵ found that age does not influence functional recovery after hip fracture. However recently it has been reported that age itself is predictor of frailty, which determines functional outcomes, and therefore patients aged 85 and older need more support in the rehabilitation setting.⁶ Frail patients with decubitus ulcers, incontinence, and atrial fibrillation need more consideration and care than old patients in rehabilitation programs.

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