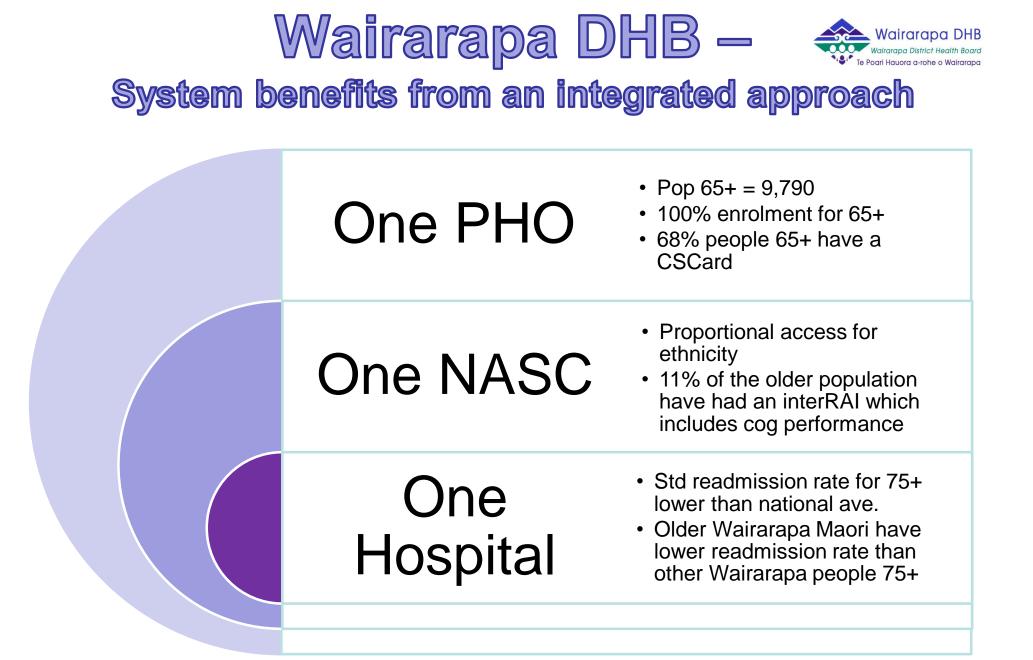
interRAI based analysis of the use of services by people with cognitive impairment (2019)

Informing targeted service development

Joanne Edwards Wairarapa District Health Board March 2020









- interRAI assessment HC & LTCF Last assessment conducted for individuals and their Cognitive Performance Score (CPS) - groups
 - 0 = no impairment
 - 1-2 = some impairment (at risk of or having a form of dementia)
 - 3 + = significant impairment (significant cognitive decline)
- 2. interRAI CPS data matched by NHI to

Dementia Read Code in PHO National Minimum Data Sets (NMDS) Disability Support Services Report (HSR113) Primary Care Hospital Services Support Services

Findings



- 84% of people receiving Health of the Older Person funded support services in Wairarapa have some degree of cognitive impairment
- 2. Of those residents in care, 83% are assessed with some degree of cognitive impairment
- 3. 43% RC residents indicate significant cognitive impairment

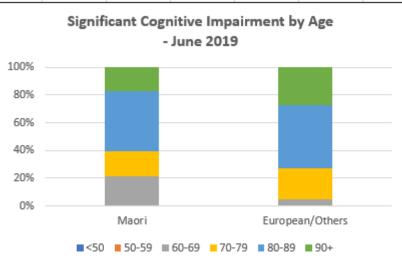
Findings



- 4. Significant cognitive impairment tended to occur for Māori at a younger age than others.
- 5. At least one in five older people interacting with hospital services (ED or inpatient) have been assessed as having some degree of cognitive impairment.
- 6. There appears to be significant under diagnosing of dementia in primary care.

Ethnicity





ED/Hospital

2018-19 Average ED visits per person over 65

No interRAI Assessment	Have had interRAI Assessment
1.6	2.2

The veneer of mild cognitive impairment wararapa District He re poort Hausra - rohe o

- 7. It is those people over 65 years with mild cognitive impairment rather than those with significant cognitive impairment who
 - attend ED more frequently than others and
 - have more admissions to hospital per person.
 - Of those with mild cognitive impairment,
 - the 65 to 69 age group stay longer than older people.
 - 25% of people in this cognitive impairment group are readmitted within 28 days.



- Importance of workforce development in dementia across all services, especially in ARC (not just secure care)
- Work with PHO to promote the use of the Dementia Health Pathway (diagnosis and management)
- 26 month post discharge project for people who have routine discharge from hospital and "who fly under the radar" but who are at risk of readmission.



We would be keen to see a comparative study in another DHB

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