Job Aid | May 2023

Using Clinical Outputs to Support Care Planning

About this job aid

This job aid demonstrates how clinical outputs from a completed interRAI assessment can be used in the process of care planning.

It is not intended to be prescriptive. The information should be used in conjunction with clinical judgment, expertise and relevant best practice guidelines.

Overview of clinical outputs

Outcome scales are numerical scores derived from combinations of interRAI assessment items that describe a person in standardized clinical areas such as depression and pain.

Clinical Assessment Protocols (CAPs) are triggered when selected items in a completed interRAI assessment indicate either a risk of decline or potential to improve. They cover problems in functional performance, clinical issues, cognition and mental health, and social life.

What are the benefits of using clinical outputs?

Clinical outputs from a completed interRAI assessment can be used to create and maintain goals of care (e.g., referrals, programs and services, discharge planning). Over time, they provide evidence of the person's response to care or services.

CIHI

Using outputs for care planning

This diagram illustrates the sequence of steps taken to arrive at a care plan, beginning with the **completion of the interRAI assessment**. Once the assessment is complete, 2 types of clinical outputs are generated: outcome scales and CAPs.

The assessor should **review the outputs and flag adverse outcome scale scores and triggered CAPs**, which indicate where the person may be at a risk of decline or have a potential for improvement. If a previous assessment is available, the assessor should compare current and previous outputs to provide insight into areas of change.

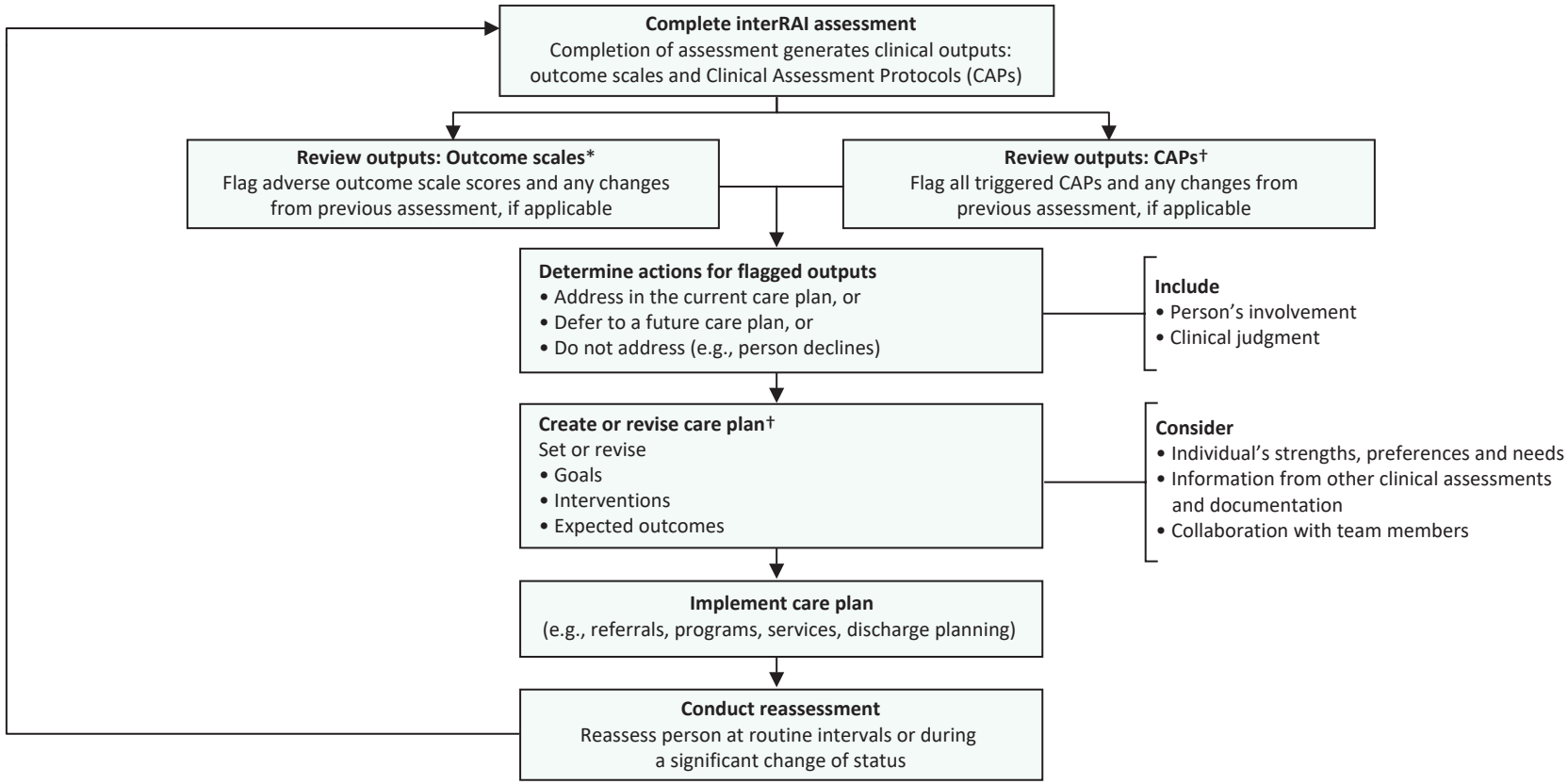
Next, the assessor should **determine actions for the flagged outputs:** address them in the current care plan, defer them to a future care plan or not address them in the care plan (e.g., because the person declined intervention). The assessor should consider the person's input and use clinical judgment in making their determination.

The next step is to **create or revise the care plan**. The assessor should determine goals for each problem area, suggest interventions to achieve the goals and describe expected outcomes of these interventions. The assessor should consider the individual's strengths, preferences and needs; and information from other sources, including clinical assessments and documentation, and family and other team members.

Implementing the care plan may include the initiation of programs and services, referrals or discharge plans.

The person should be **reassessed** at routine intervals (per jurisdictional policies) or when there is a significant change in status. The updated clinical outputs will be used to revise the current care plan accordingly.

Job Aid



How to cite this document:
Canadian Institute for Health Information. *Using Clinical Outputs to Support Care Planning* [job aid]. Ottawa, ON: CIHI; 2023.

33288-0523

Notes

* Refer to the appropriate guide to assess the severity of outcome scale scores:
- interRAI HC Outcome Scales and Screening Algorithms Reference Guide
- interRAI LTCF Outcome Scales Reference Guide
- Resident Assessment Instrument–Mental Health (RAI-MH) Outcome Scales Reference Guide

† Refer to the appropriate guide to review detailed descriptions of CAPs and associated care-planning suggestions:
- interRAI Clinical Assessment Protocols (CAPs) — For Use With interRAI's Community and Long-Term Care Assessment Instruments
- Resident Assessment Instrument–Mental Health (RAI-MH) Mental Health Clinical Assessment Protocols Reference Guide