



Margaret Milne, interRAI Services
September 2026

Objectives



What is interRAI



interRAI Assessments



Patient Journey



Using interRAI Data

What is an interRAI assessment?

What it is

A standardized, internationally used assessment that builds a full picture of an older person's health, function and everyday needs.

Who gets one

Older New Zealanders being considered for funded home support or a move into aged residential care — usually arranged through their GP or a needs assessor.

Why it matters

One shared assessment guides the care plan, decides funding and eligibility, and feeds the national data used to plan services across Aotearoa.

A standardized assessment that maps an older person's needs and opens the door to funded support and residential care.



interRAI in Aotearoa New Zealand

Assessment	Description
Contact Assessment	Screening tool for first contact or known low-complex clients in the community
Acute Care	Non-acute Rehabilitation Path (NARP) clients in acute hospital care
Home Care (HC)	Complex clients in the community
Community Health Assessment (CHA)	Low number usage. Core assessment plus Functional supplement triggered by complexity of need, equivalent to HC
Long Term Care Facilities (LTCF)	Residents in Aged Residential Care
Palliative Care (PC)	Known palliative persons in community, ARC or hospice care

80/20 Rule



Dementia and the interRAI assessment

Each year interRAI assessments map the needs of older New Zealanders. Dementia is now the leading diagnosis among people living in residential care.



135,000

**interRAI assessments completed
across Aotearoa each year**



#1

**Dementia is the most common
diagnoses in residential care**



1.4 million

**Completed assessments in the
Health NZ Health Data platform**



606

**Median length of stay in ARC
(days)**

Assessment Outputs

Algorithms

Evidence of the person's complexity, service needs and potential for rehabilitation

CAPs

Collaborative Action Plans

Research based algorithms that

- identify potential to prevent decline and
- facilitate improvement

Identify those who are likely to benefit from a care intervention

Outcome Scales

Evidence of the person's abilities and dependency levels in a wide range of domains

e.g., personal care, pain, cognition

Client Journey

**Diagnoses:**

Cognitive decline
Hypertension
Osteoporosis
Osteoarthritis
Slight hearing loss left ear

**Assessment
Type:**

Contact
Assessment (CA)

Contact Assessment Outcomes

Outcome Scale	Score and meaning
Assessment Urgency	4/6 = 1 meaning least urgent to 6 for the most urgent
CHESS	2/5 = low health instability
Pain Scale	1/4 = less than daily pain
Personal Support Algorithm	2/6 = low need
Rehabilitation Algorithm	3/5 = 1 meaning least urgent to 5 for the most urgent
Self rated Mood	0/9 = no issues
Self-reliance index	1/1 = not self reliant
Service Urgency Algorithm	1/4 = least urgent

Home Care Assessment Outcomes

Outcome Scale	Score and meaning
Caregiver Risk Evaluation (CaRE)	3/4 = high risk
CHESS	2/5 = low health instability
Cognitive Performance Scale 2	3/8 =borderline intact/Mild cognitive impairment
Depression Rating Scale (DRS)	1/14
First Fall Risk	3/6 = medium risk for fall
Fracture Risk Scale	6/8 = higher scores indicate higher risk for hip fractures within one year
IADL Capacity Hierarchy Scale	2/6 = Some difficulties with complex tasks (finances, medications)
MAPLe	4/5 = High priority for services
Self-reliance index	1/1 = not self reliant

Falls



Home Care Assessment #2 Outcomes

Outcome Scale	Score and meaning
Caregiver Risk Evaluation (CaRE)	3/4 = Elevated caregiver stress/distress
CHESS	2/5 = higher as health instability develops
Cognitive Performance Scale 2	5/8 = moderate to severe cognitive impairment
Depression Rating Scale (DRS)	1/14
Fall Risk	3/6 = medium risk for fall
Fracture Risk Scale	6/8 = higher scores indicate higher risk for hip fractures within one year
IADL Capacity Hierarchy Scale	5/6 = Significant impairment in medication, finances and decision making
MAPLe	4/5 = High priority for services
Self-reliance index	1/1 = not self reliant

Long Term Care Facility Outcomes

Outcome Area	Likely Presentation
Cognitive Performance Scale (CPS)	4/6 Moderate to severe cognitive impairment
ADL Hierarchy / ADL Long Form	11/28 Increasing dependence with personal cares, mobility and transfers
CHESS	3/6 Mild to moderate health instability
Depression Rating Scale (DRS)	3/14 Moderate, depending on adjustment and social engagement
Self-Reliance	No longer self-reliant for decision-making and daily management
Caregiver Risk	Reduced following admission because care burden transfers to facility staff
Falls Risk	Moderate to high
Fracture Risk	5/8 Often elevated
Behavioural CAP	1/12 May trigger in people with dementia-related behaviours

Clinical Progression

Following one client as their needs increase, from living independently to full-time residential care.

ONE PERSON'S JOURNEY — NEEDS INCREASE AT EVERY STAGE

1

CONTACT ASSESSMENT

Living at home, managing with some support

2

FIRST HOME CARE ASSESSMENT

Needs help with everyday tasks at home

3

SECOND HOME CARE ASSESSMENT

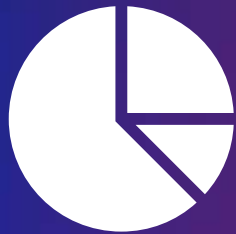
Needs constant supervision; family can no longer cope

4

LONG TERM CARE FACILITY ASSESSMENT

Moves into 24-hour residential care

What about the data?



- Part of the Health Data Platform which is available to HNZ analysts
- Informs clinical practices, plans benchmarking and resource allocation
- Assessment generates outcome measures, called SCALES and CAPs
- Mandated assessment means information is captured for the entire 65+ demographic in NZ who seek help in aged care
- Used by researchers, clinicians, analysts, district and regional staff
- Used to determine the quality of care delivered by providers, through measures called Quality Indicators

Benefits for planning and research

- Validated outcome measures comparable over time and reassessment
- National research recognised internationally
- Over 1.4 million assessments in current database across six instruments
- Four NZ interRAI Fellows enabling collaboration in ongoing development and design



Research

Analysing Realistic effects of modifiable risk factors for dementia
National Dataset

Charlotte Mentzel^a, Pat

Performance of the Cognitive Performance
Resident Assessment Instrument (interRAI Home Care)
Dementia amongst Older Adults in the

Incidence, Prevalence, and Risk for Urinary
Incontinence for People with Dementia in
the Community in Aotearoa New Zealand

An interRAI Study

Vanessa Burholt PhD^a, Gary Cheung^a
Julia MNurs(Hons)^a

Using Big Data to Estimate Dementia Prevalence
New Zealand: Protocol for an Observational Study
Claudia Rivera-Rodriguez¹, Gary Cheung², Sarah Cullum²

Epidemiology of Faecal Incontinence for People with
Dementia Living in the Community in New Zealand: A Retrospective Cohort Study Using
interRAI Home Care Assessment Data

Estimating the incidence of dementia in a
study applying capture-recapture modelling to
collected linked health datasets
Vanessa Burholt^{1,2}, Avinash Pillai³, Gary Cheung⁴
Eunice Moku, Sarah Cullum, Noorheed Mukadam, Daniel Davis, Claudia Rivera-Rodriguez, and

Individual risk factors for
possible undetected dementia
amongst community-dwelling
older people in New Zealand

Adrian Martinez-Ruiz
National Institute of Geriatrics of Mexico, México
Ying Huang
University of Auckland, New Zealand
Susan Chan
Can

Caregiving burnout of community-dwelling people with dementia in Hong
Kong and New Zealand: a cross-sectional study
Crystal Y Chan¹, Gary Cheung², Adrian Martinez-Ruiz^{3,4}, Patsy Y K Chau¹, Kailu Wang¹, E K Yeoh¹, Eliza L Y Wong

University of Auckland, New Zealand

What the trend means for services



Rising Demand

More people will need assessment and care each year, concentrating pressure on interRAI teams and aged residential care.



Earlier Support

Well-funded community and home-based support keeps people independent longer and eases costlier hospital and residential care.



Equity by Design

Services must be built for Māori, Pacific and Asian communities, where dementia is growing fastest and often diagnosed later.

Questions?

For more information, visit www.interRAI.co.nz