North East LHIN | RLISS du Nord-Est

Implementing the interRAI Home Care
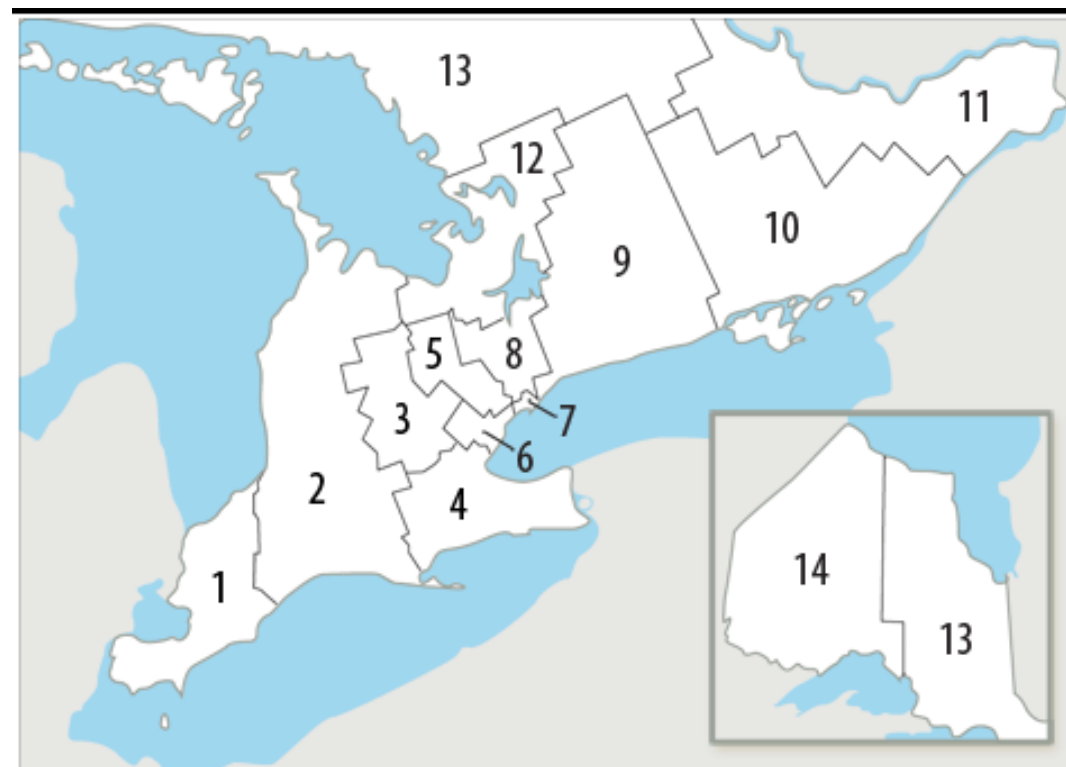
The North East LHIN Experience

Ontario
Local Health Integration Network
Réseau local d'intégration des services de santé

Local Experience with a Provincial Approach

- Local Health Integration Networks plan, fund and integrate local health care

- 14 distinct regions with multiple sub regions

- One support system

Who is North East LHIN Home and Community Care?

➢ 20.6% of the population is over 65 years old

➢ 395,920 square kilometres

➢ 44% of Ontario land mass

➢ 4.1% of Ontario's population
   (551,795 Census population)

➢ 7834 Adult Long Stay Patients

➢ Approximately 250 assessors/Care Coordinators

➢ 150 health service providers who deliver about
   200 programs
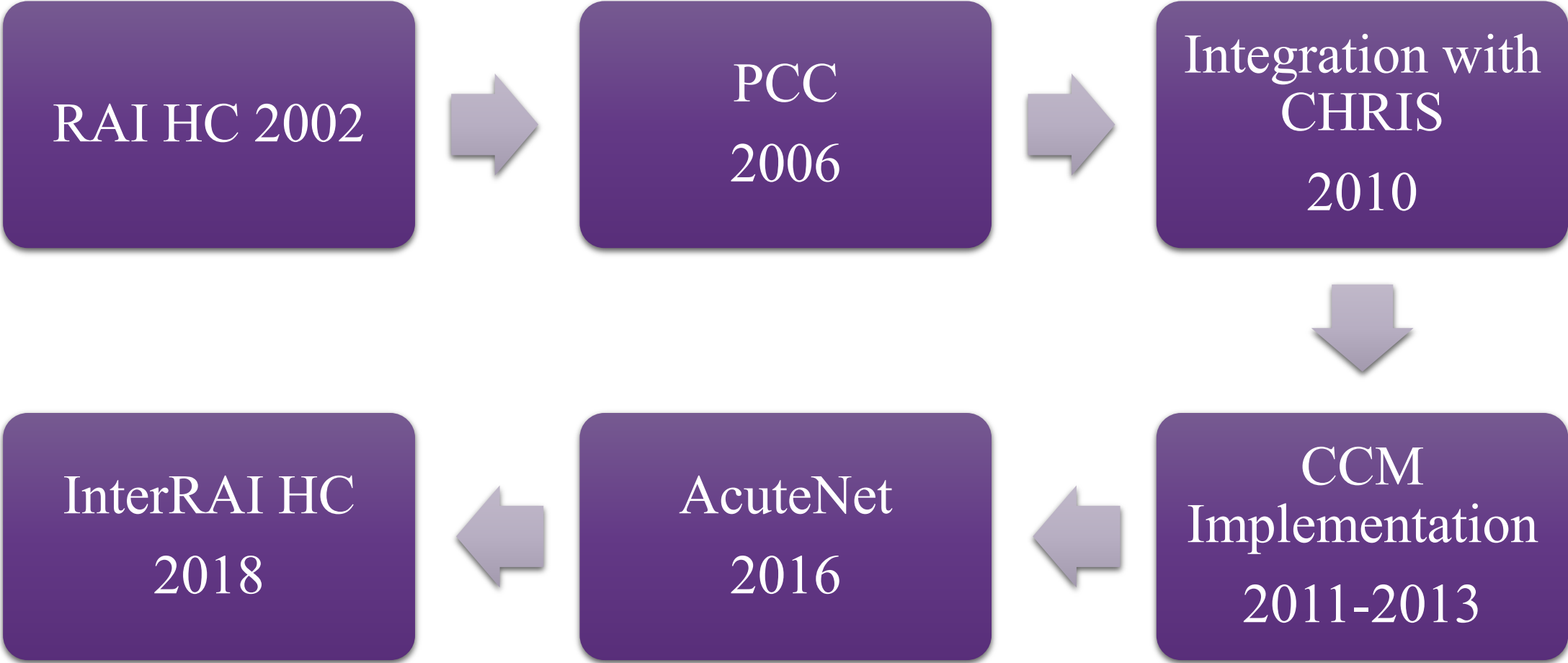
What do we use our assessments for?

- Referral to internal and external service providers for Nursing, Personal Support, Rehabilitation Services

- Referral to Community Support Services

- Eligibility determination and referral to Assisted Living, Adult Day Away Program, and Long Term Care Homes

- Ongoing Care Coordination

- Access Care Coordination

A case for change-the RAI HC assessment

- Less reliable outputs

- IADL Difficulty versus Capacity

- Clinical Assessment Protocols 2002

- RAI Aggregate Score

- Lacking behavioural outputs

- Inconsistent use for Long Term Care Home Placement decisions

Staying the Same	No Longer Available	New
Method for Assigning Priority Levels (MAPLe) score with no sub-levels	RAI Aggregate Score	IADL Capacity Heirarchy, IADL-ADL Functional Hierarchy Scale
Changes in Health, End Stage Disease, Signs and Symptoms Scale (CHESS Score)	IADL Difficulty	Timed Four Metre Walk
Depression Rating Scale/Pain Scale	IADL Involvement Scales	Cognitive Performance Scale 2
ADL Hierarchy, Long Form, Short Form	CAPs 2002	CAPs 2008
Pressure Ulcer Risk Scale		Deaf-Blind Severity Index
		Detection of Indicators and Vulnerabilities for Emergency Trips (DIVERT) Scale
		Communication Scale
		InterRAI HC-Hospital Addendum

Our Journey to a Provincial Assessment Tool

RAI HC 2002 → PCC 2006 → Integration with CHRIS 2010 → CCM Implementation 2011-2013 → AcuteNet 2016 → InterRAI HC 2018

Provincial Home Care Assessment Modernization

- Three distinct provincial working groups with representatives from all 14 LHIN began meeting 2 years prior to implementation

- Completion of an analysis of current state use of outputs for the RAI HC

- Determined what tools were required to support provincial consistency in care coordination approach
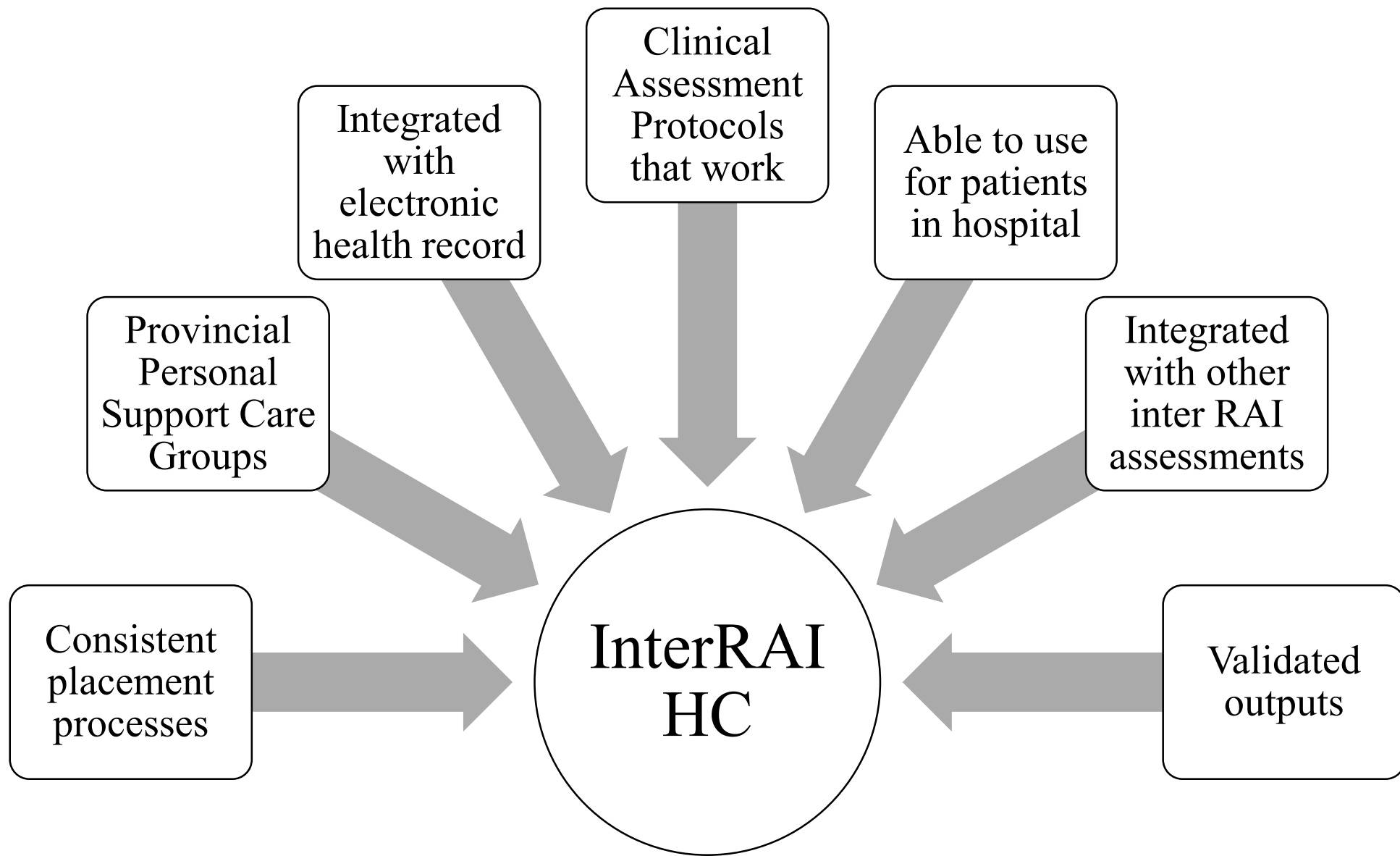
What new tools did we needed to make interRAI HC work for us?
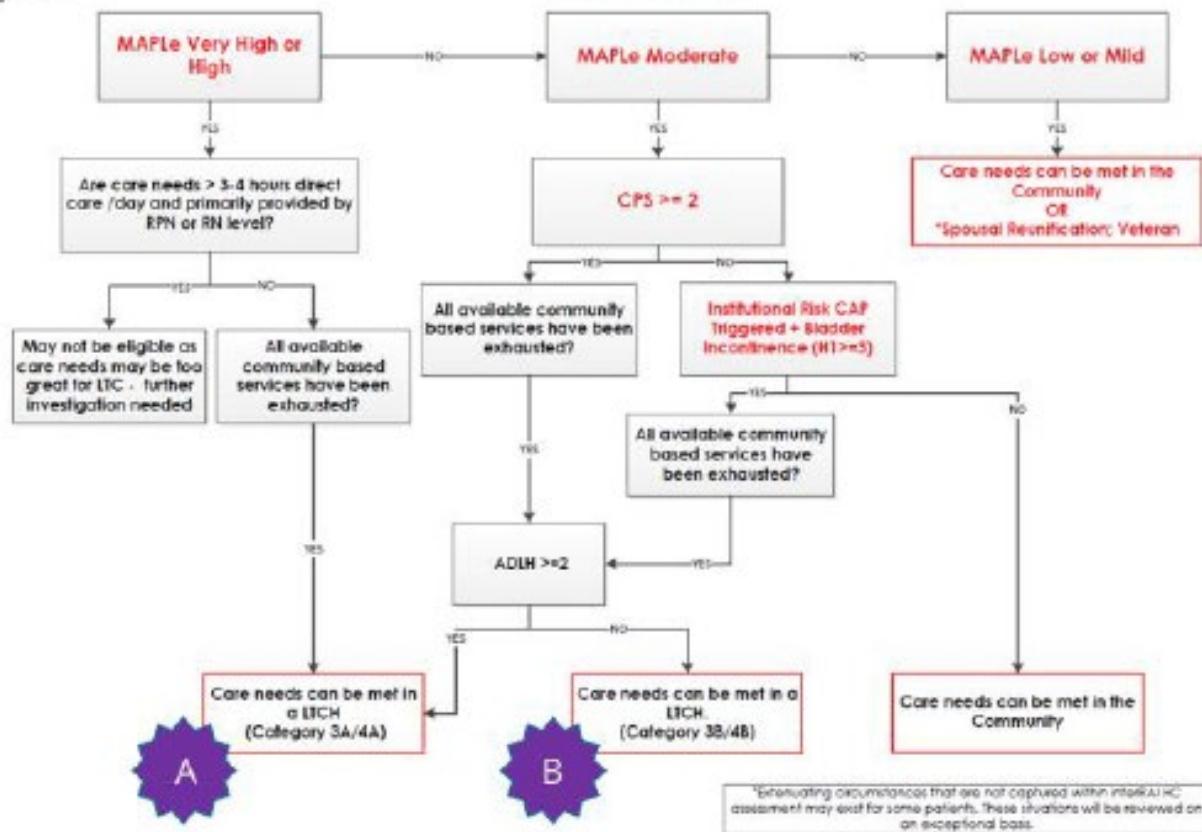
Appropriateness of Care

CRISIS Algorithm

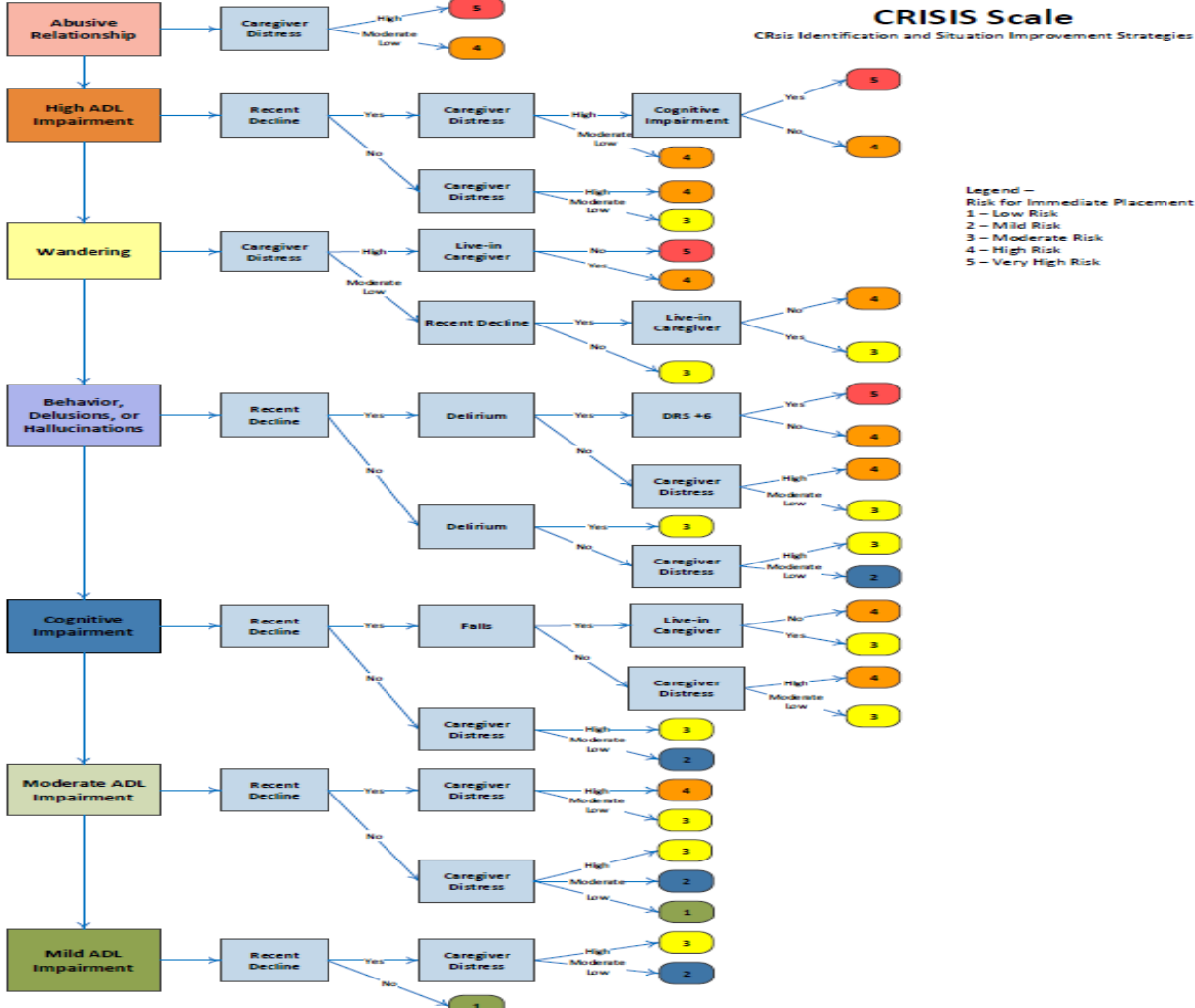Personal Support Care Groups

interRAI HC- Hospital Addendum

Appropriateness of Care Algorithm

CRISIS Algorithm

CRISIS Scale
CRsis Identification and Situation Improvement Strategies

Legend –
Risk for Immediate Placement
1 – Low Risk
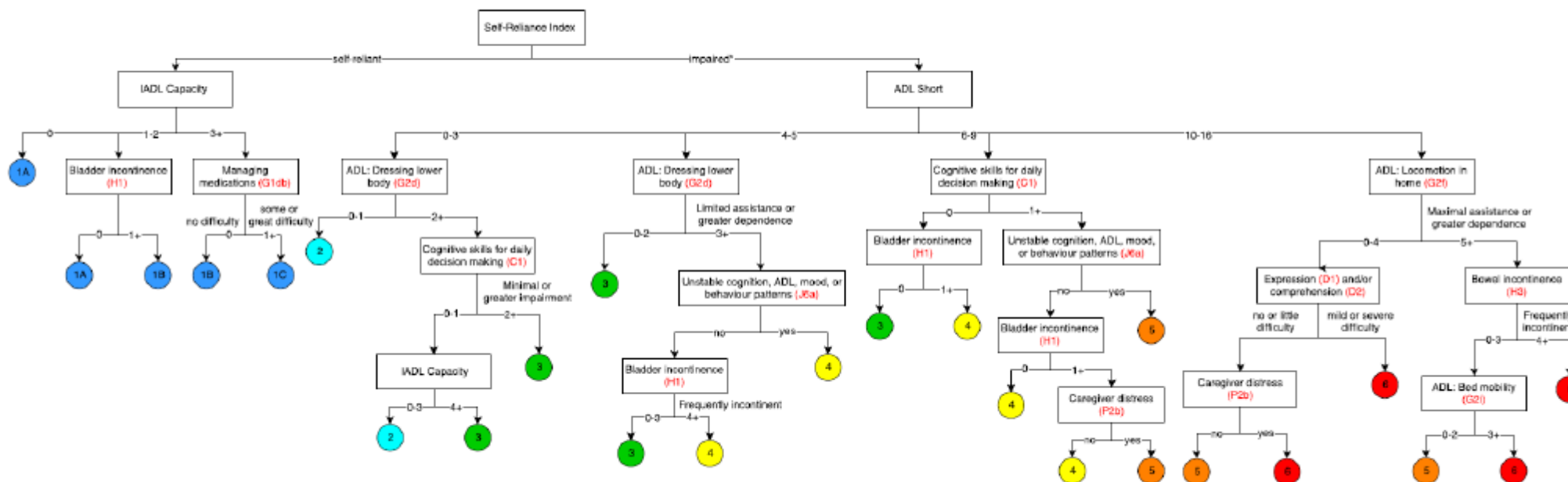2 – Mild Risk
3 – Moderate Risk
4 – High Risk
5 – Very High Risk

Personal Support Algorithm and Care Groups

Personal Support Algorithm
Last revised October 6, 2016

Canadian interRAI HC crosswalk in red
(translated February 15, 2018)

Care Group 1

Self-Reliance Index	*Self-Reliant*- Patient is independent functionally and cognitively specific to daily decision making *(Ability to make decisions about tasks of daily life, Locomotion, Dressing Lower Body, Personal Hygiene and Bathing)*		
IADL Capacity Score:	**No Difficulty (Score = 0)** *No Difficulty* – No Difficulty in any of the following IADLs: Meal preparation, ordinary housework and phone use.	**Some Difficulty (Score = 1-2)** *Some Difficulty* – Some difficulty in up to 2 of the 3 following IADLs: Meal preparation, ordinary housework and phone use.	**Great Difficulty (Score = 3+)** *Great Difficulty* – Ranging from Some difficulty in all 3 ADLs up to Great Difficulty in all 3 of the following IADLs: Meal preparation, ordinary housework and phone use.
Identifiers	**Profile 1A**	**Profile 1A**	**Profile 1B**
	• IADL Capacity Score - Patient has *no difficulty* in meal preparation, housework and phone use.	• Bladder Incontinence – Patient is *continent*	• Managing Medications – Patient is independent with medication management
		Profile 1B	**Profile 1C**
		• Bladder Incontinence – Ranges from *continent with catheter* to *incontinent*	• Managing Medications - Ranges from *set up help to total dependence* with medication management
Examples	Patient is independent with decision making and independent to set-up help for the following ADLs: bathing, personal hygiene, locomotion and dressing lower body. Patient may require assistance with some IADLs particularly for housework, meal preparation and telephone use. Patient may have bladder incontinence or difficulty with medication management.		
CCM Population	***Primary* Community Independence/ *Secondary* Chronic**		
Care Planning Options to Consider	• System Navigation • Home Care services • Community Support Service Agency • Private Pay Services • Supportive Housing • Social programs • Group Exercise/Fall Risk classes		
Goals of Care	• Prevent decline/ maintain/ promote independence of ADLs and mobility • Prevent decline/maintain/promote independence of IADLs (including medication management, meal preparation and evaluation of mood on functional status)		

interRAI HC Hospital Addendum

- Hospital Addendum – Version 9.1 developed as a Canadian Standard (CIHI, interRAI and HSSOntario)

- Uses capacity scales instead of performance scales to calculate outcomes, including RUGs III

- Hospital tool in AcuteNet will support that items to be left blank will not be displayed
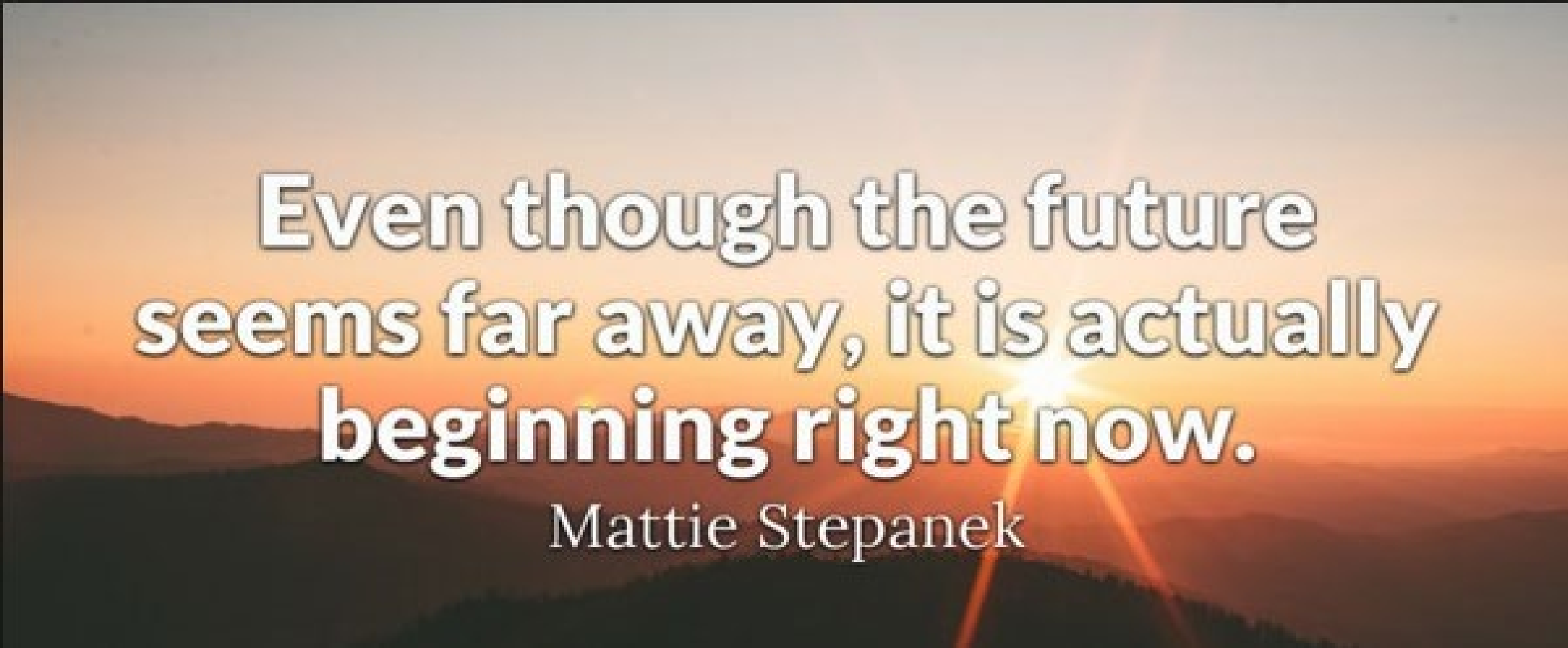
Making the outputs accessible

- Integration of assessment software with electronic health record

- Support use of the algorithm and scale outputs by driving function in the electronic health record

Local Implementation

Leadership Endorsement and Provincial Support + Support from PMO + Dynamic Project Team + Robust Work Plan = interRAI HC

Where do we go from here?

Even though the future seems far away, it is actually beginning right now.

Mattie Stepanek