Canadian Home Care Association
canadienne de soins et services à domicile

Advancing Excellence in Home Care

KNOWLEDGE NETWORK
Building Capacity... Improving Performance

VIRTUAL LEARNING SERIES

Unleashing the Power of InterRAI
INTEGRATED CARE

October 22 , 2019

HARMONIZED PRINCIPLES FOR HOME CARE

Patient- and Family-Centred Care

Patients and their carers are at the centre of the planning and delivery of care.

- Foster autonomy and self-sufficiency.
- Integrate safety practices into all patient care and service delivery.
- Respect and address psychosocial, physical and cultural needs.
- Acknowledge patients and carers' unique strengths and engage them as partners in care.

Accessible Care

Patients and their carers have equitable and consistent access to appropriate care.

- Provide care that is responsive and consistent among providers and across jurisdictions
- Promote patients' and carers' understanding of care needs and options, and consequences of decisions and actions.
- Customize care to the unique needs of patients and their families to ensure appropriate care.

Accountable Care

Patients, providers and system outcomes are managed, met and reported.

- Focus on increasing capacity and improving performance.
- Ensure transparency through user-friendly reporting on service delivery information and outcomes.
- Use performance metrics and outcomes to inform planning and delivery.
- Foster adaptive leadership and governance to facilitate change and collaboration.

Evidence-Informed Care

Patients receive care that is informed by clinical expertise, patient values and best available research evidence.

- Collect and apply research evidence, provider expertise and patient experience.
- Use standardized tools and supports to strengthen the quality of services and programs delivered.
- Create a culture of innovation and ingenuity.

Integrated Care

Patients' needs are met through coordinated clinical and service-level planning and delivery involving multiple providers and organizations.

- Build strong foundational partnerships between home care and primary care.
- Optimize system resources and seamless navigation through care coordination.
- Facilitate joint planning, decision-making and open communication
- Engage health and social care sectors with a focus on continuity for the client .

Sustainable Care

Patients whose needs can reasonably be met in the home will receive the services and support to do so.

- Use current and future population needs in strategic policy and system planning.
- Modernize delivery through the exploration and testing of new funding and service models.
- Plan and manage health human resources in anticipation of changing supply and future demand.
- Develop strategic procurement approaches to evaluate and adopt innovation and new technology.

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Presenters:

PROFESSOR JOHN HIRDES
School of Public Health and Health Systems, University of Waterloo

CHERYL BEACH
Executive Director, Home Support Transition project , Fraser Health BC

LESLIE ECKEL
Knowledge Exchange Associate at interRAI Canada.

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School of Public Health and Health Systems

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INTEGRATED CARE:
How does interRAI facilitate integrated care across providers and settings?

John P. Hirdes, PhD FCAHS

Professor

School of Public Health and Health Systems

University of Waterloo

Why do we need to think at the system level?

- People with comparable needs receive services in different sectors of the health care system
  - Especially true for persons with complex needs
    - Elderly
    - Persons with mental illness
    - End of life care
  - System-level implication:
    - May be able to fine-tune who gets what services where
  - Person-level implication:
    - Must deal with multiple providers
    - Continuity of care important

System Level Questions of Interest

- Transitions across settings
  - Who moves from one setting to another?
  - Why do they make the transition?
  - What are the consequences of the transition?
- Needs in different care settings
  - What are the characteristics of service recipients in different settings?
  - What is the quality of care for comparable needs in different settings?
  - What needs are managed “in place” and which require outside expertise?

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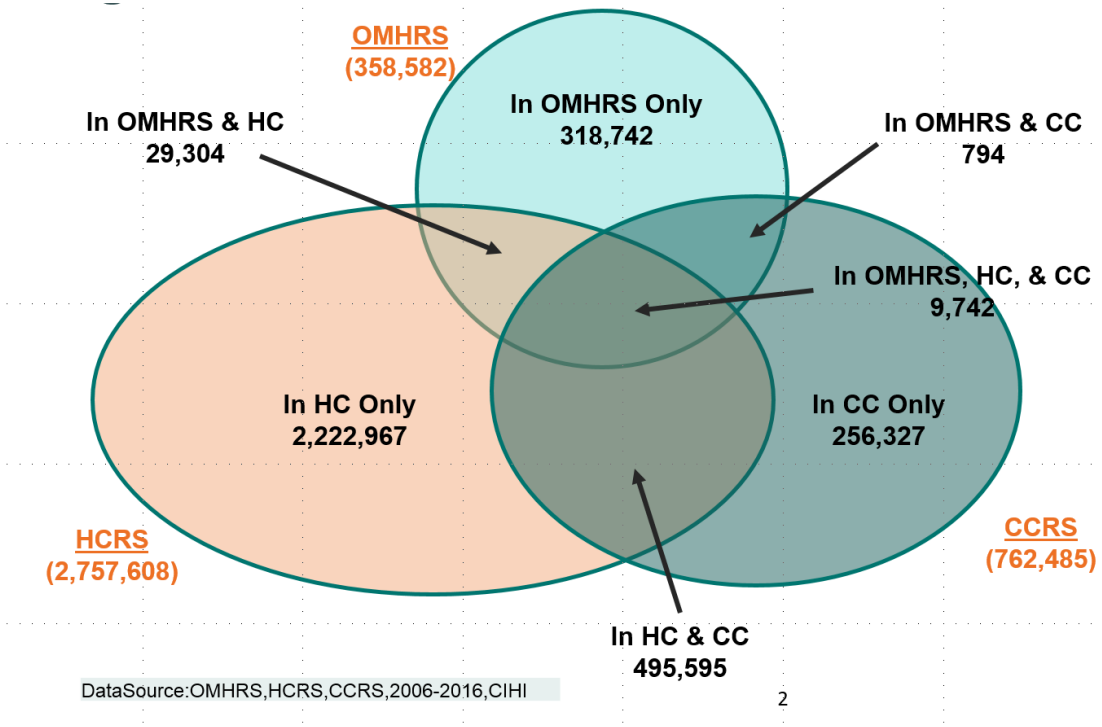
What Makes interRAI Instruments an Integrated System?

- Common language
  - consistent terminology across instruments
- Common theoretical/conceptual basis
  - triggers for care plans
- Common clinical emphasis
  - functional assessment rather than diagnosis
- Common data collection methods
  - professional assessment skills + clinical judgment of best information source
- Common core elements
  - some domains in all instruments (e.g., depression, cognition)
- Common care planning protocols
  - for sectors serving similar populations

Individuals in CIHI Reporting Systems for interRAI Instruments



Setting	Individual
OMHRS Only	318,742
HC Only	2,222,967
CC Only	256,327
OMHRS & HC	29,304
OMHRS & CC	794
HC & CC	495,595
OMHRS, HC, & CC	9,742
Total Unique Individuals	3,333,471

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Why are previous interRAI assessments relevant to the current assessment?

- Wrong answers
  - "I don't need to do the assessment again"
    - Only if you are certainly that clinically meaningful change has NOT occurred
  - "I can use it to automatically complete the one I am doing now"
    - Auto-population is a ***bad*** idea
- Right answers
  - "Repeat assessments show me outcomes of care and possible future trajectory of change"
  - "Longitudinal view gives a richer clinical understanding of the person's current situation"
    - True even if assessment done in a different sector

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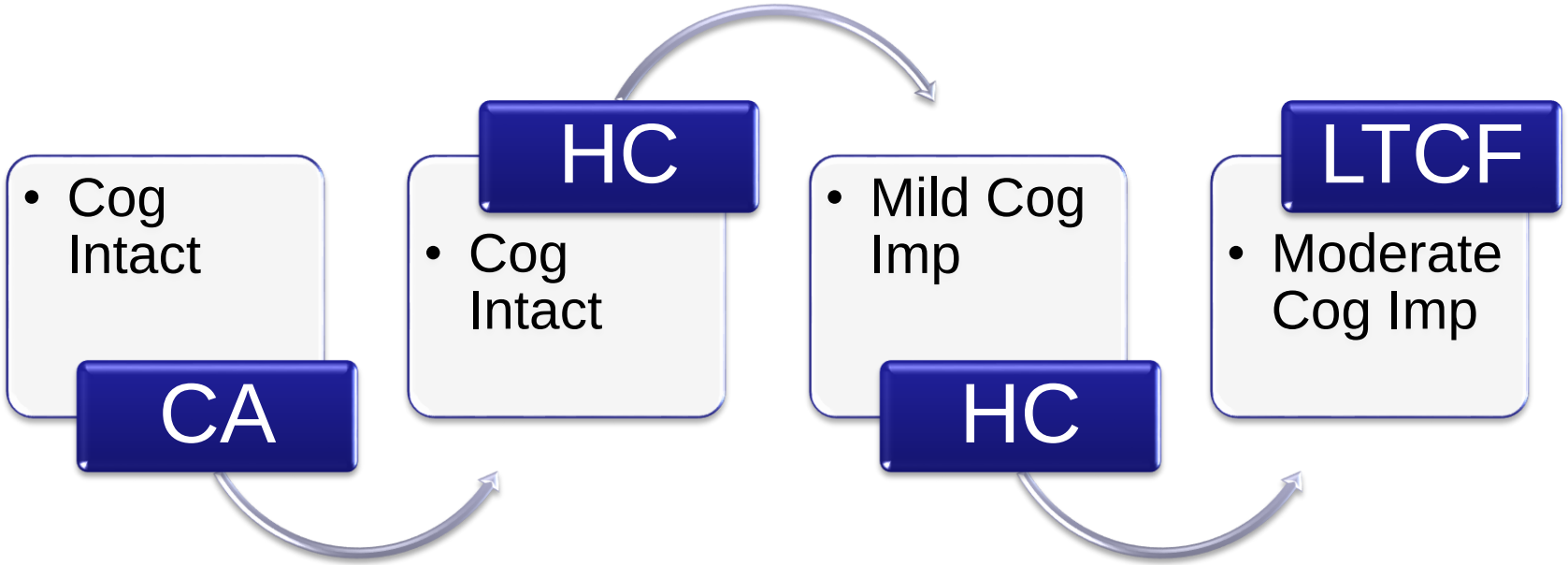
Tracking Cognition Longitudinally with Linked interRAI Assessments



Twitter: @interRAI_Hirdes

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Moving from Home Care to Nursing Home

- Consider LAST RAI-HC assessment compared with FIRST RAI 2.0 assessment
  - What can we learn about changes with LTC admission?
  - How can home care and LTC homes collaborate to manage risk related to the transition?
- Sample of 17,949 Ontario HC assessments linked to first RAI 2.0 assessments

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What predicts decline in cognition with the transfer to LTC home?

- Consider 4 assets among home care clients
  - Absence of open conflict with family and friends
  - Client believes s/he capable of improved function
  - Caregivers believe capable of improved function
  - Rated as having good prospects of recovery

- Consider also presence of a dementia diagnosis

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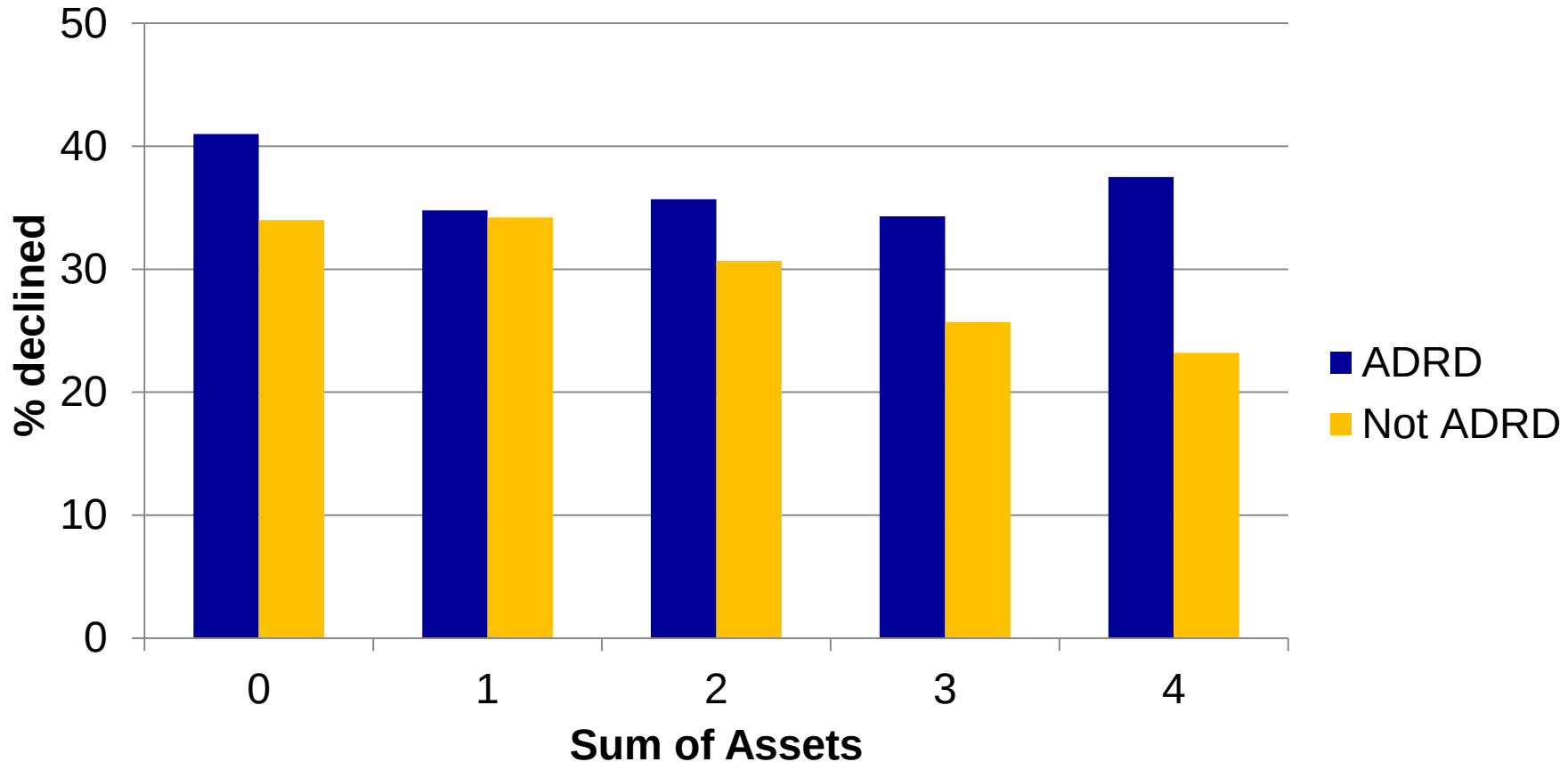
Relationship between sum of "assets" in home care and cognitive decline in LTC home, by dementia diagnosis



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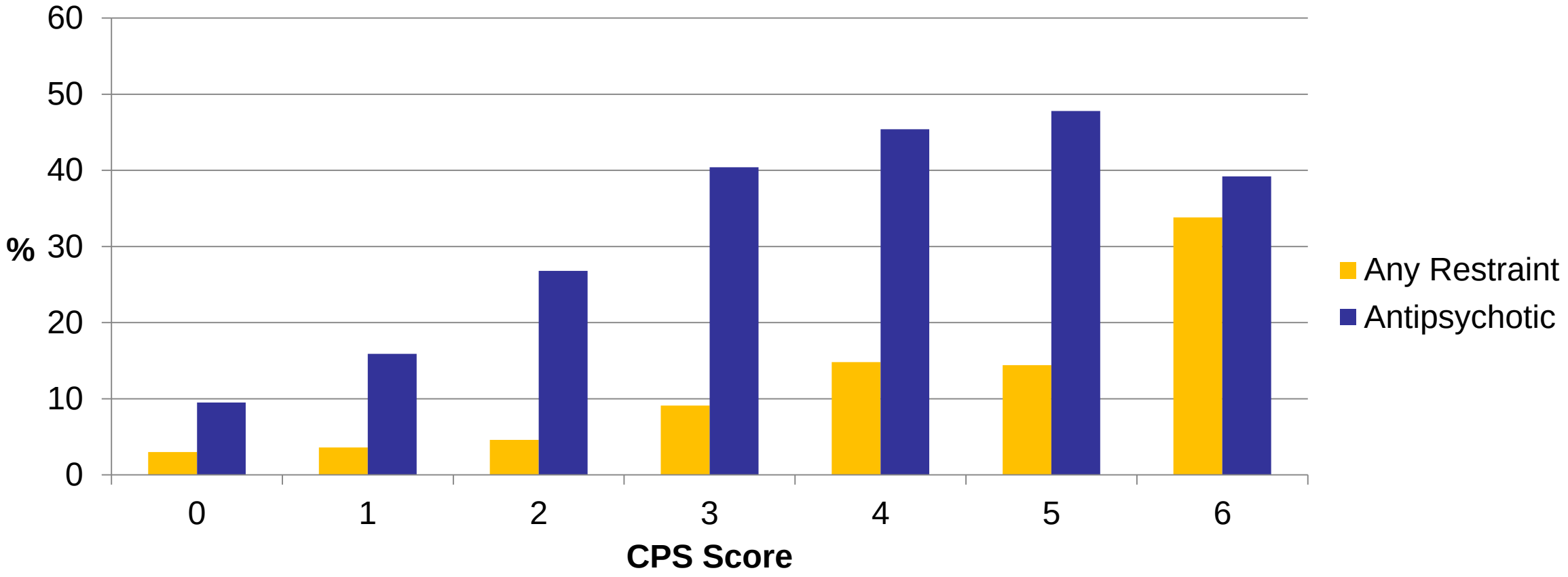
Use of Restraints and Antipsychotics in Nursing Home by CPS Score When Person in Home Care



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Implications?

- What does this mean for home care case managers placing a client into LTC home?
- Whose responsibility is quality of care after admission?
- Can HC and NH staff collaborate to improve quality of transitions?

Thank you!

Questions/comments?

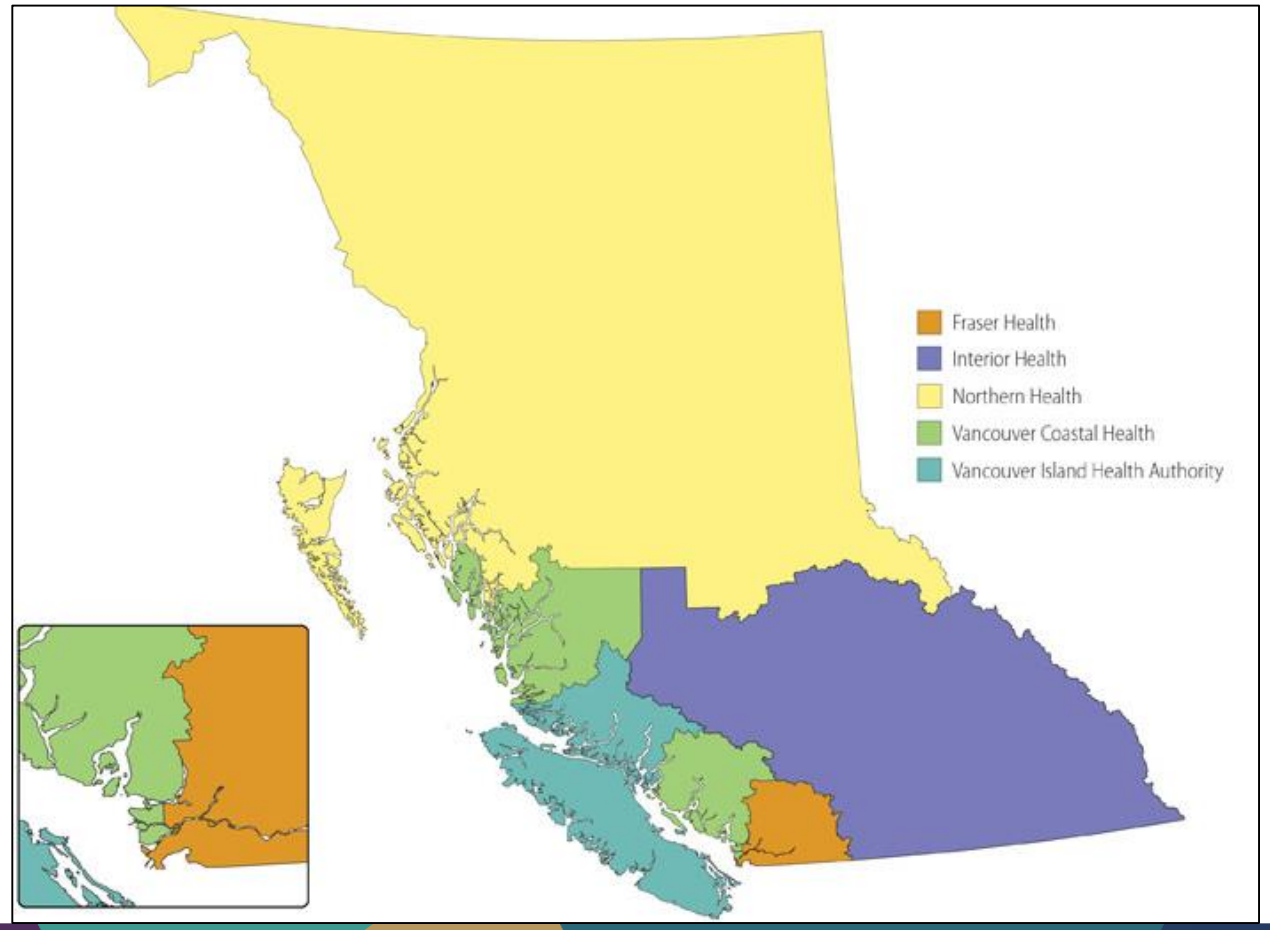
Enhancing Collaborative Team-based Care using the RAI-HC Assessment

Cheryl Beach
Sept 2019

Outline

- Background
- Some uses of RAI-HC in Fraser Health
- New Integrated Team-based Model and RAI-HC
- Lessons Learned
- Questions

British Columbia: 5 Regional Health Authorities + Provincial Health Services Authority (PHSA)

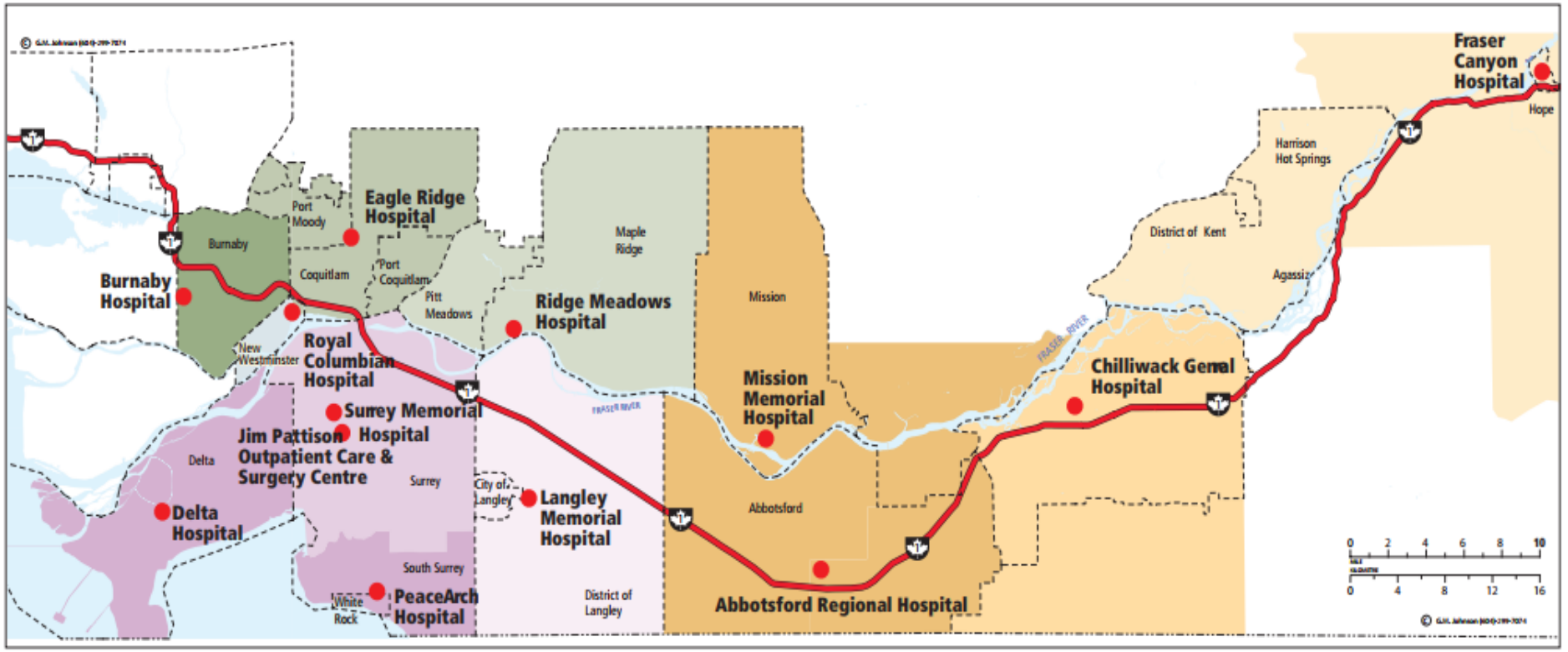


PHSA oversees delivery of provincial programs and highly specialized health-care services. Includes resource-intensive services, such as heart surgery, transplants and cancer treatment, which cannot be delivered in every community.

fraserhealth

Better health. Best in health care.

Delivers health care services to more that 1.8 million people living in communities stretching from Burnaby to White Rock to Hope. Culturally and geographically diverse communities, including ~ 38,000 First Nations people.

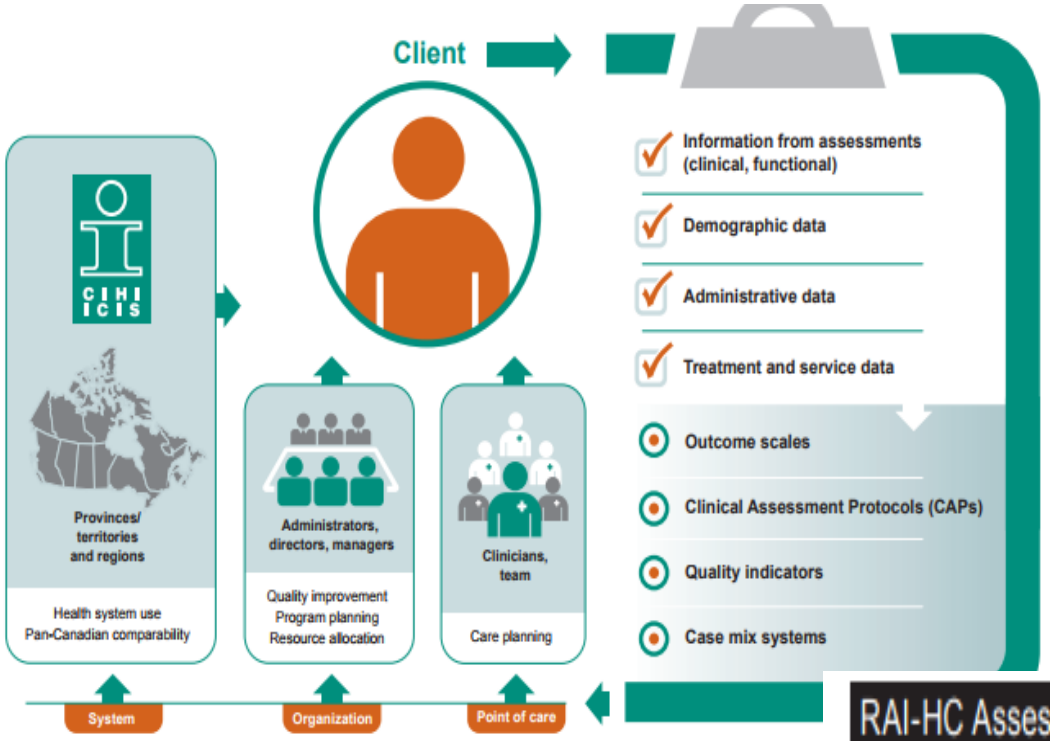


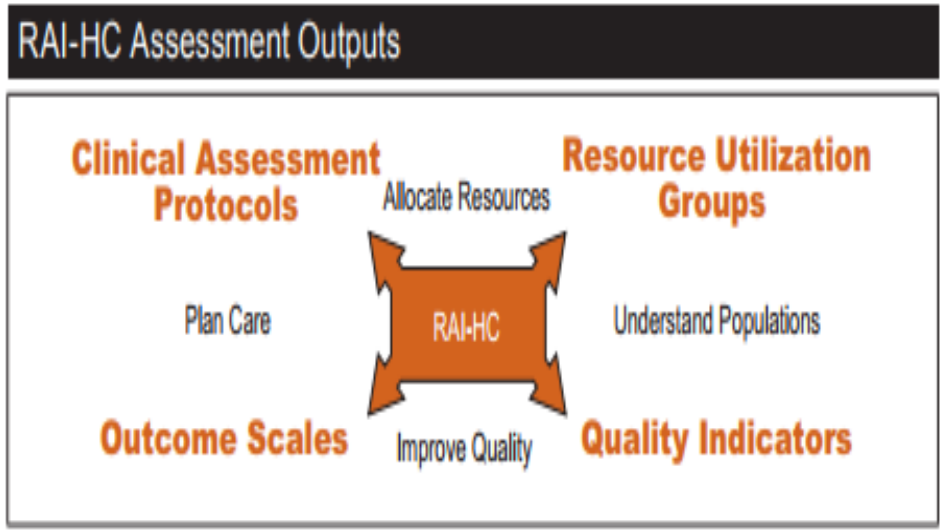
Fraser Health: *Respect, Caring and Trust*

Inter-RAI Assessments

- interRAI is an international collaborative to improve the quality of life of vulnerable persons through a seamless comprehensive assessment system.
- Suite of assessment instruments used world wide
- BC: uses RAI-Home Care and RAI 2.0 (long term care) assessments

RAI Outputs



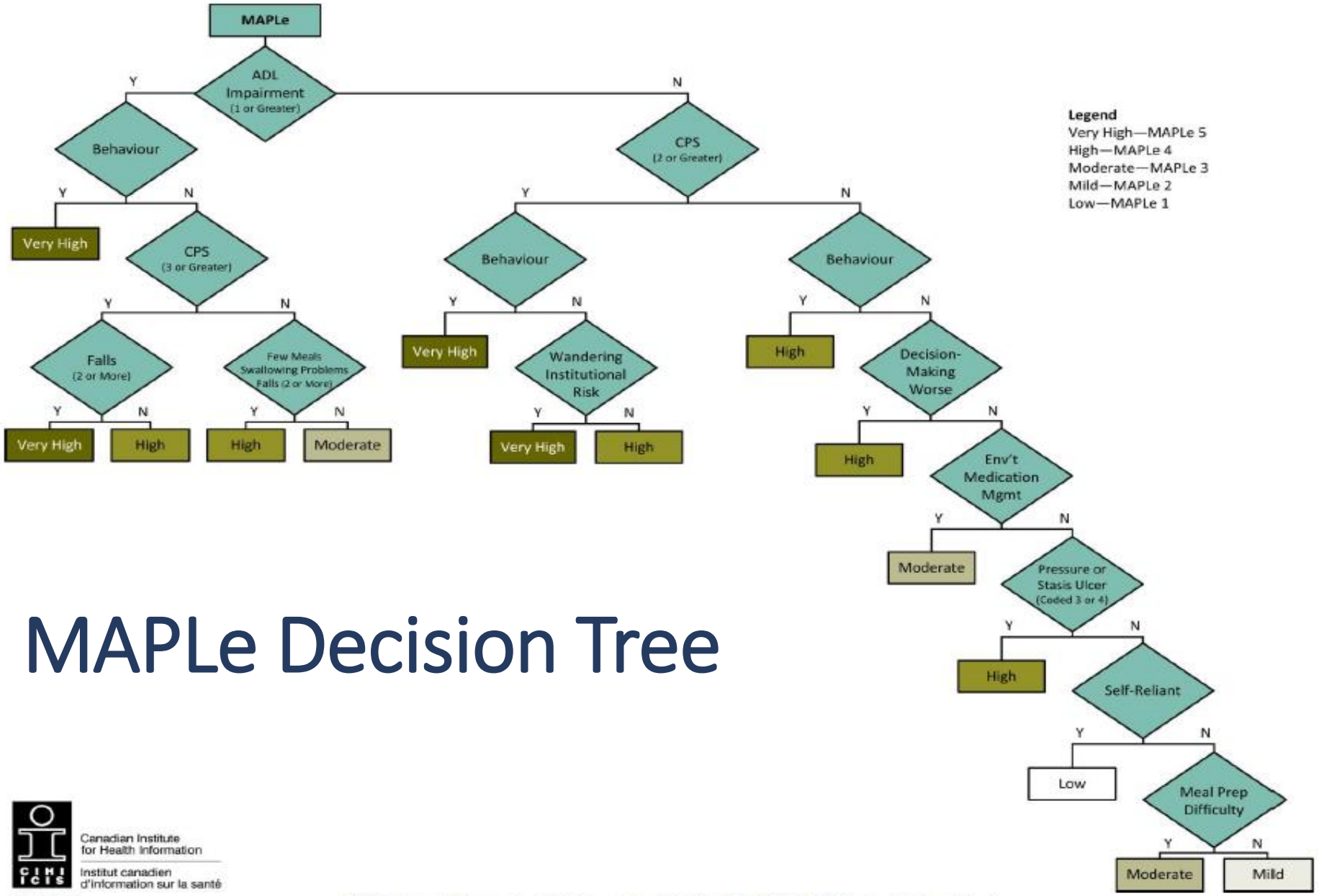


https://www.cihi.ca/sites/default/files/document/hcrs-rai-hc-overview-infosheet-2017-en.pdf

RAI-HC Outcome Scales

Depression Rating Scale (DRS)
Changes in Health, End Stage Disease and Signs and Symptoms
Pain Scale
Activities of Daily Living (ADL): • Long Form • Self-Performance Hierarchy • Short Form
Instrumental Activities of Daily Living (IADL): • Involvement (Performance) • Difficulty
Pressure Ulcer Risk Score (PURS)
Cognitive Performance Scale (CPS)
Detection of Indicators and Vulnerabilities for Emergency Room Trips (DIVERT)
Methods in Assigning Priority Levels (MAPLe)

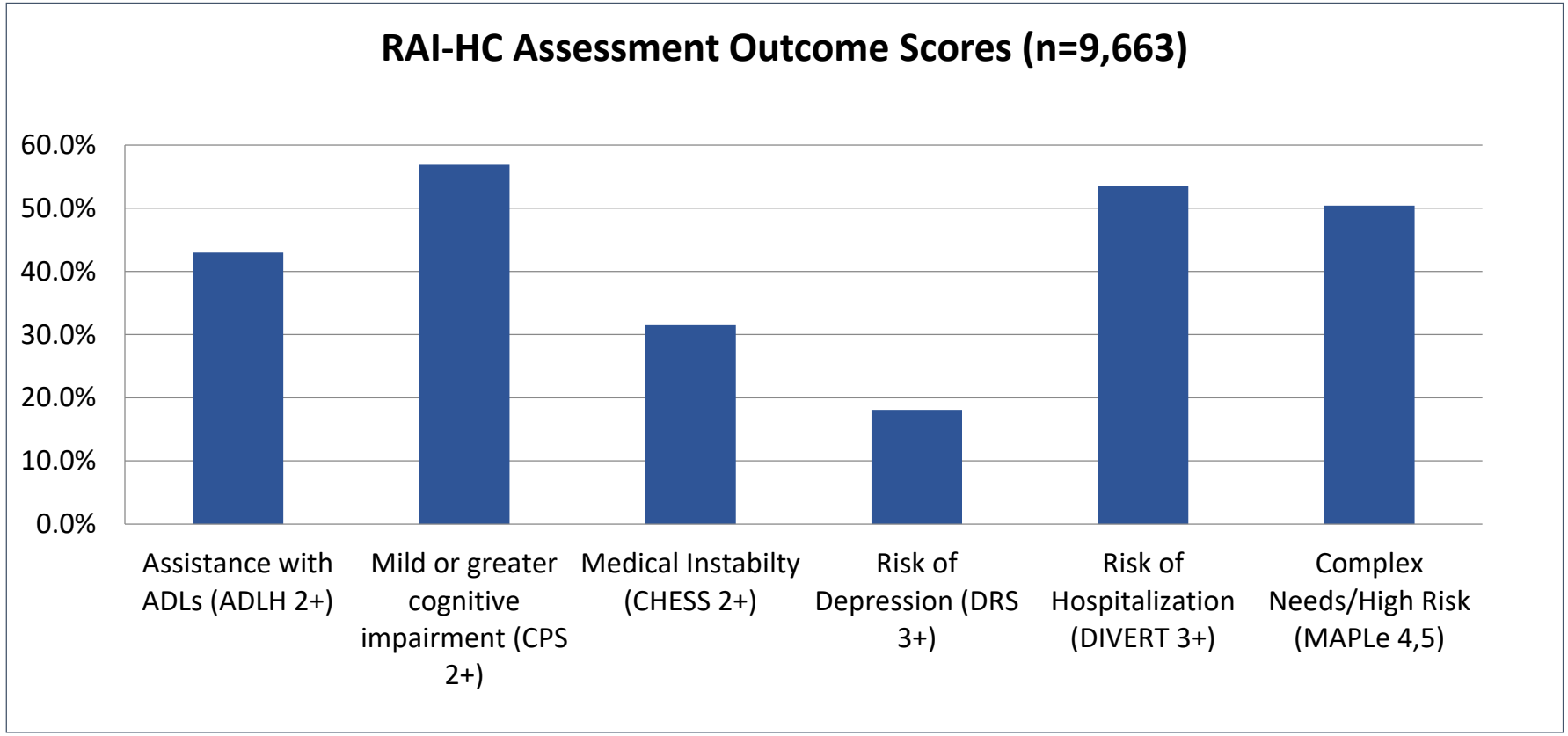
MAPLe Decision Tree



Canadian Institute for Health Information
Institut canadien d'information sur la santé

CIHI 2013

RAI-HC Client Profile in Fraser Health

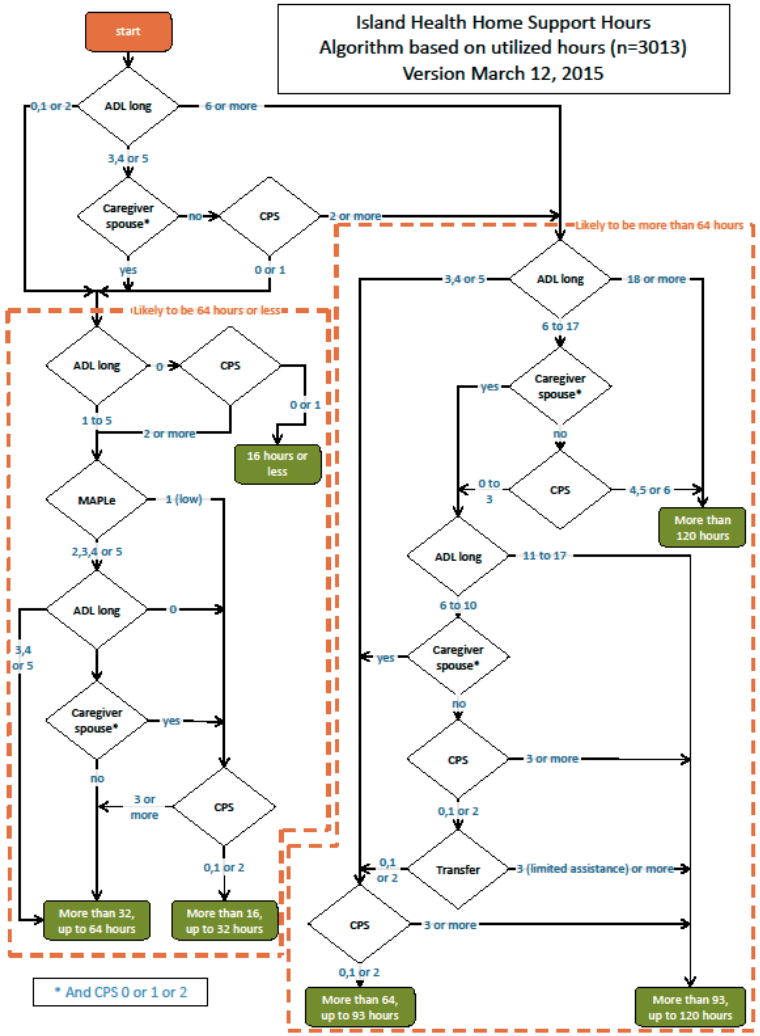


RAI-HC: Clinical Decision Making and Team-based Care

Allocation of Home Support hours

Key drivers from RAI-HC client assessment:

- activities of daily living, spouse as caregiver, cognitive performance and MAPLe
- Provide consistency, common language and promote conversations across care providers regarding client need.



Created by: Jeff Poss & Cheryl Beach

Funded Assisted Living: Future Directions

Used RAI-HC assessment data to:

- Profile clients in Assisted Living and Home Care (e.g. what clients are using Assisted Living)
- Measure effectiveness (e.g. use of emergency department and hospital admissions)
- Update suitability criteria for admission

Assisted Living: Comparison of Care Outcomes

637 clients in AL and 637 matched clients in community

- Average age = 83
- 75% female
- STM problems = 53%
- Incontinent = 32%
- ADL Hierarchy >1 = 28%

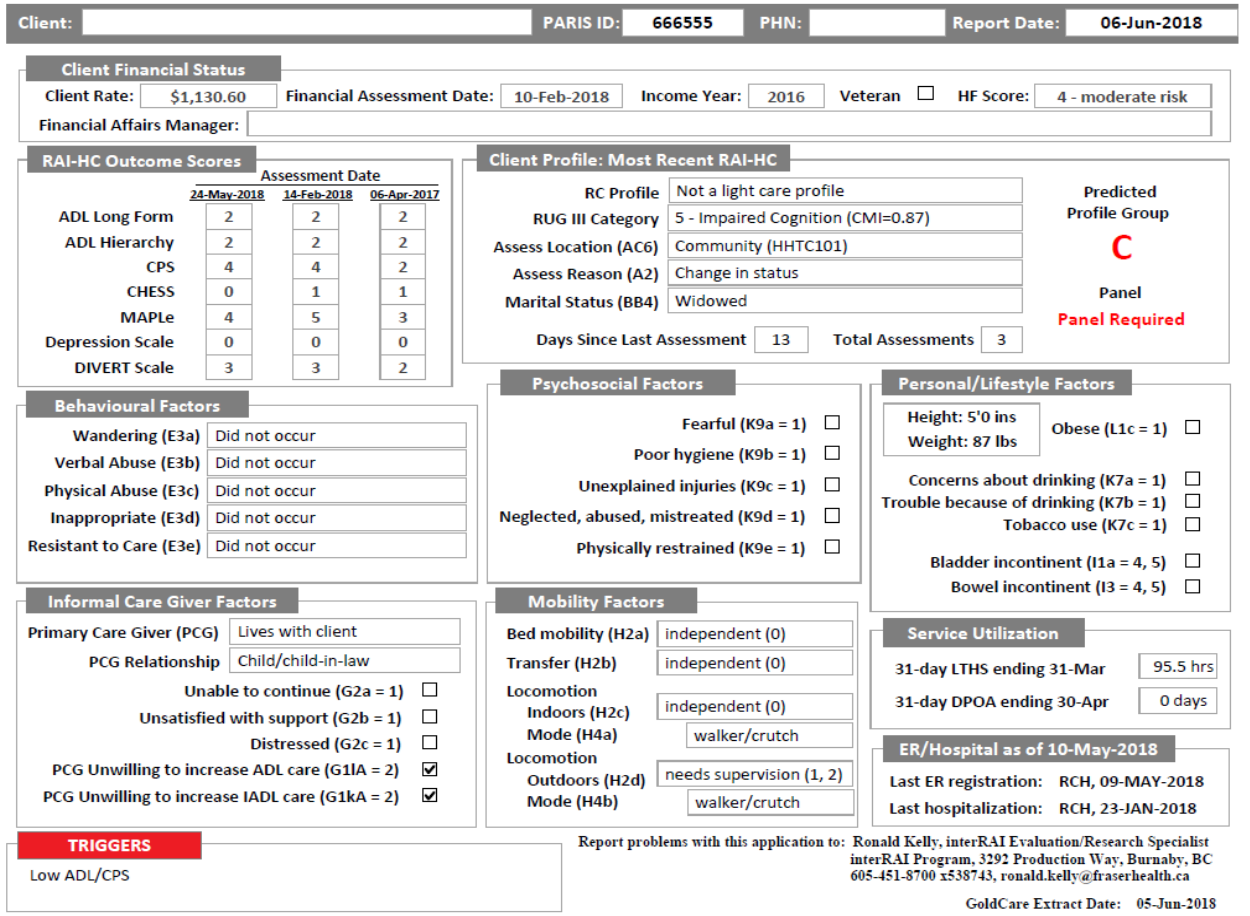
	Diabetes	CHF	COPD	Dementia	Psychiatric dx	Meds 9+	Maple 4,5	CHESS >2
AL	29	18	**22**	**18**	**30**	**59**	44	7
CM	30	16	**18**	**23**	**10**	**46**	42	9

	Admission in past 90 days	Emergency visit in past 90 days
AL	**16**	**30**
CM	**25**	**39**

Access to Long Term Care

- Multipurpose report based upon the RAI-HC assessment to reduce duplication and build communication between Home Care, Access and Long Term Care
  - Eligibility/Suitability Criteria
  - Clients who require special services – e.g. behaviours, medically complex
  - Lifestyle or Psychosocial factors (e.g. smoking or abuse/neglect)
  - Equipment needs
  - Population profile
  - Decision-making re: Collaborative Review Panel

Example of Report



Client: | PARIS ID: 666555 | PHN: | Report Date: 06-Jun-2018

Client Financial Status

Client Rate: $1,130.60 | Financial Assessment Date: 10-Feb-2018 | Income Year: 2016 | Veteran ☐ | HF Score: 4 - moderate risk

Financial Affairs Manager:

RAI-HC Outcome Scores

	Assessment Date 24-May-2018	14-Feb-2018	06-Apr-2017
ADL Long Form	2	2	2
ADL Hierarchy	2	2	2
CPS	4	4	2
CHESS	0	1	1
MAPLe	4	5	3
Depression Scale	0	0	0
DIVERT Scale	3	3	2

Client Profile: Most Recent RAI-HC

RC Profile: Not a light care profile
RUG III Category: 5 - Impaired Cognition (CMI=0.87)
Assess Location (AC6): Community (HHTC101)
Assess Reason (A2): Change in status
Marital Status (BB4): Widowed
Days Since Last Assessment: 13 | Total Assessments: 3

Predicted Profile Group: C
Panel: Panel Required

Behavioural Factors

Wandering (E3a): Did not occur
Verbal Abuse (E3b): Did not occur
Physical Abuse (E3c): Did not occur
Inappropriate (E3d): Did not occur
Resistant to Care (E3e): Did not occur

Psychosocial Factors

Fearful (K9a = 1) ☐
Poor hygiene (K9b = 1) ☐
Unexplained injuries (K9c = 1) ☐
Neglected, abused, mistreated (K9d = 1) ☐
Physically restrained (K9e = 1) ☐

Personal/Lifestyle Factors

Height: 5'0 ins
Weight: 87 lbs
Obese (L1c = 1) ☐
Concerns about drinking (K7a = 1) ☐
Trouble because of drinking (K7b = 1) ☐
Tobacco use (K7c = 1) ☐
Bladder incontinent (I1a = 4, 5) ☐
Bowel incontinent (I3 = 4, 5) ☐

Informal Care Giver Factors

Primary Care Giver (PCG): Lives with client
PCG Relationship: Child/child-in-law
Unable to continue (G2a = 1) ☐
Unsatisfied with support (G2b = 1) ☐
Distressed (G2c = 1) ☐
PCG Unwilling to increase ADL care (G1lA = 2) ☑
PCG Unwilling to increase IADL care (G1kA = 2) ☑

Mobility Factors

Bed mobility (H2a): independent (0)
Transfer (H2b): independent (0)
Locomotion Indoors (H2c): independent (0)
Mode (H4a): walker/crutch
Locomotion Outdoors (H2d): needs supervision (1, 2)
Mode (H4b): walker/crutch

Service Utilization

31-day LTHS ending 31-Mar: 95.5 hrs
31-day DPOA ending 30-Apr: 0 days

ER/Hospital as of 10-May-2018

Last ER registration: RCH, 09-MAY-2018
Last hospitalization: RCH, 23-JAN-2018

TRIGGERS

Low ADL/CPS

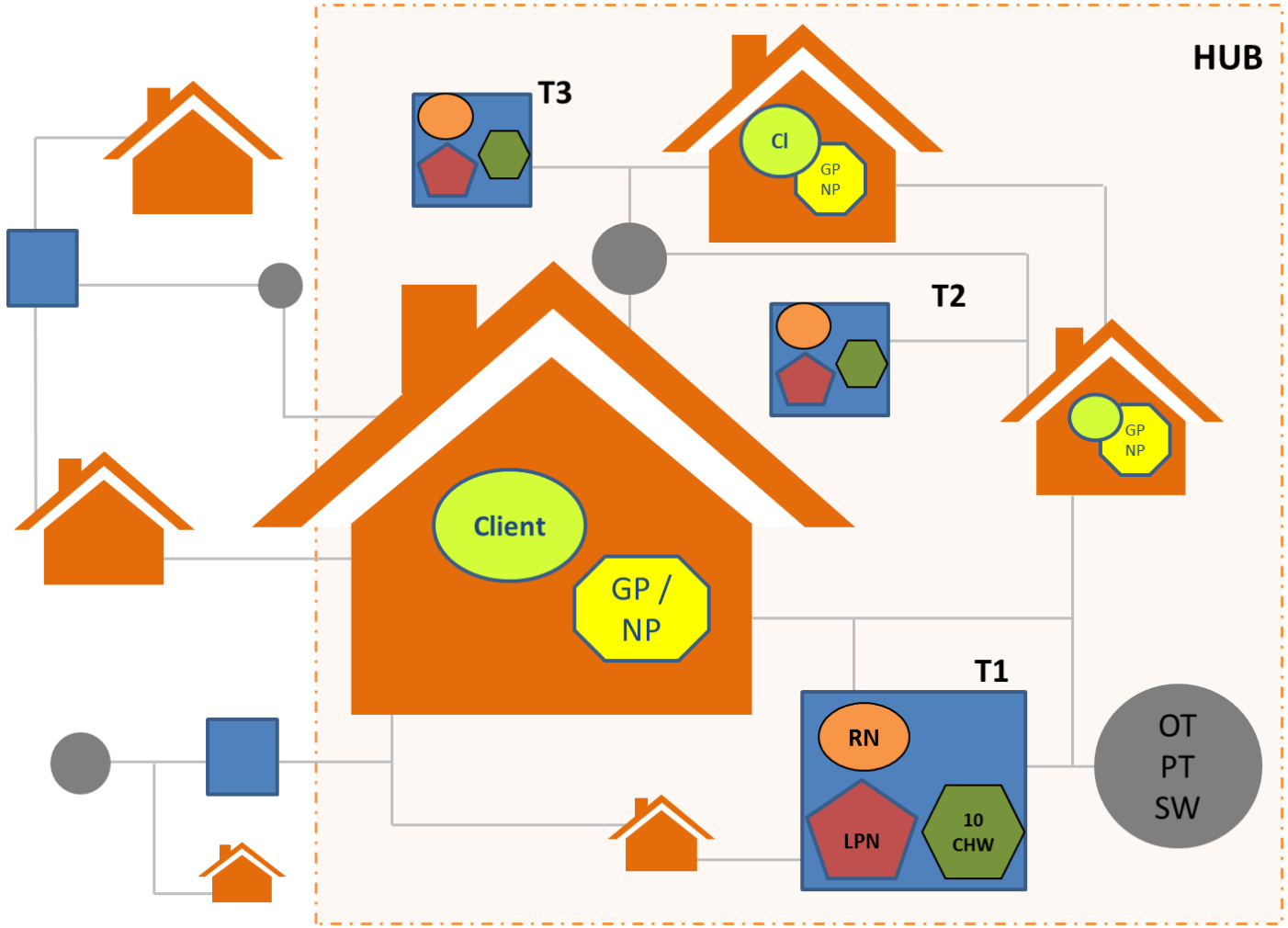
Report problems with this application to: Ronald Kelly, interRAI Evaluation/Research Specialist interRAI Program, 3292 Production Way, Burnaby, BC 605-451-8700 x538743, ronald.kelly@fraserhealth.ca

GoldCare Extract Date: 05-Jun-2018

Chronic Disease Management & Emergency Use - DIVERT

- Education to Home Care Professionals
- Identify clients at risk
- Make referrals to Home Health Monitoring for clients with COPD
- Develop Client Care Plan to promote self-management
- Collaborate with Physician

New Directions in Integrated Team-based Care: Chilliwack Model



Where does the RAI fit in Team-based Care?

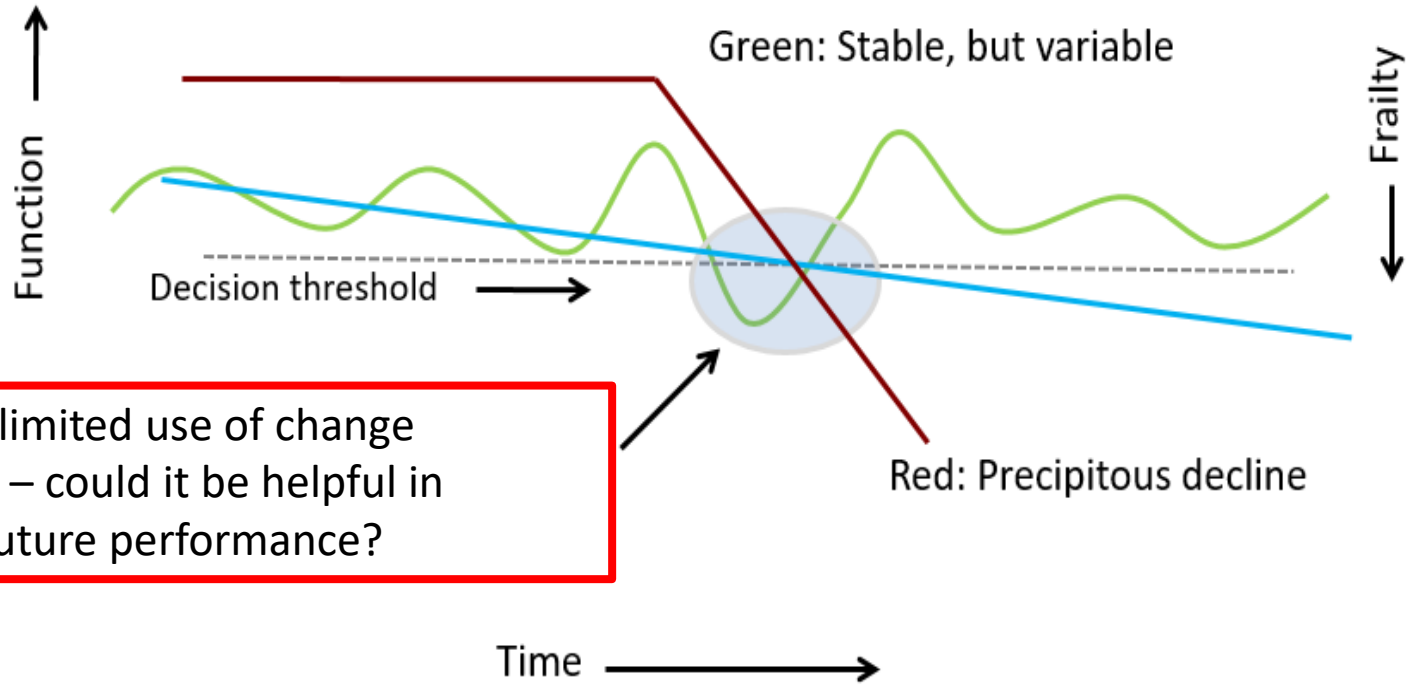
- Common language and building communication/team care planning to best meet the needs of the client

- Complex Rounds: Interdisciplinary (Nursing, Rehab, Social Work, Home Support) and Physician

Team-based Assessment and Care Planning discussions: some lessons learned

- Build Trust
- Share information and understanding on RAI outcomes and coding
- Be open to others
- Assessment is a ‘snapshot’ in time

Clinical Decision Making: Central Importance of Change



Decision point limited use of change information – could it be helpful in predicting future performance?

Change and the RAI-HC

		Odds Ratio
	Age	1.021
	Gender	1.043
	Dementia	2.066
IADL	Level	1.263
	Change	**1.416**
CPS	Level	1.074
	Change	**1.121**
CHESS	Level	1.060
	Change	**1.192**
ADL	Level	0.774
	Change	**1.148**

MacDonald, S. et al.
CFN grant

Summary

- Assess Once, Use Many…..
- Reduce duplications
- Create a common language and understanding of the assessment tool
- Use RAI-HC Assessment information to guide collaborative team-based decision-making for complex, frail seniors in the community

Question and answer session

Webinar participants – please post questions for our speakers in the ‘Questions and Comments’ chat pod to the left of the presentation.

Please tell us who your question should be directed to.

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