

VIRTUAL LEARNING SERIES

PERSON- AND FAMILY-CENTRED CARE: InterRAI

A decision support tool to ensure that patients and their carers are at the centre of the planning and delivery of care

WELCOME

JUNE 18, 2019
12:00PM ET

About the Canadian Home Care Association's Virtual Learning Series

The aim of the virtual learning series is to improve the capabilities of individuals and organizations across the home and community care sector.

Today's webinar may be heard through your computer or a dial-in audio connection.

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Features of this webinar

- To ensure you will have the best experience, please close other programs on your computer.
- Use the “Questions and Comments” Chat Pod to the left of the presentation to ask questions or post comments throughout the webinar.
Please tell us who your questions should be directed at.
Questions will be answered at the end.
- A link for the protected recording will be emailed to participants, with a copy of the slides next week.
- Access our Virtual Learning Series calendar via the Calendar Pod to see upcoming events and register directly as they become available.

Harmonized Principles for Home Care

PERSON- AND FAMILY-CENTRED *Care*

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

ACCESSIBLE *Care*

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

EVIDENCE-INFORMED *Care*

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

SUSTAINABLE *Care*

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

ACCOUNTABLE *Care*

Patient, provider and system outcomes are managed, met and reported.

INTEGRATED *Care*

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

Harmonized Principles for Home Care

ACCOUNTABLE

Care

Patient, provider and system outcomes are managed, met and reported.

FUNDAMENTAL ELEMENTS

- Use performance metrics and clinical outcomes to inform planning and delivery.
- Report service delivery and outcome metrics in a user-friendly way.

SPECIFIC CONSIDERATIONS FOR POLICY PLANNERS AND HOME CARE PROVIDERS

- How are effective **performance indicators** for home care developed and used?
- What elements need to be considered for **effective reporting** of home care performance and outcomes?

Harmonized Principles for Home Care

EVIDENCE-INFORMED

Care

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

FUNDAMENTAL ELEMENTS

- Collection and application of research evidence, provider expertise and individual (patient and caregiver) experience.
- Understanding and use of standardized tools and methodology for data collection and analysis.

SPECIFIC CONSIDERATIONS FOR WHEN CREATING POLICIES AND PROGRAMS

- How are **clinicians being supported** to make evidence-informed decisions? At the frontline, in the development of care pathways and new programs.
- What strategies are effective in measuring **patient and caregiver experience**? Are these strategies being used? How is this informing clinical practice, program design and policy development?

Harmonized Principles for Home Care

PERSON- AND FAMILY-CENTRED *Care*

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

FUNDAMENTAL ELEMENTS

- Understanding and acknowledgement of individuals' (patients) and caregivers' unique strengths and application of ways to engage them both as 'partners in care'.
- Respecting and addressing the emotional, physical, mental, environmental and cultural needs of individuals (patients) and their caregivers.

SPECIFIC CONSIDERATIONS TO ENSURE PATIENT AND FAMILY-CENTRED CARE IS CORE TO HOME AND COMMUNITY CARE SERVICES:

- What **home-based assessment tools and protocols** are being used to determine the needs and strengths of patients and their caregivers?
- What **conversation strategies and tools** can effectively support patient and caregiver involvement in shared decision-making?



VIRTUAL LEARNING SERIES



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From Principle to Practice: Unleashing the Power of interRAI

John P. Hirdes, PhD FCAHS¹

Margaret Saari, RN PhD^{1, 2}

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2- SE Research Centre



Agenda

- interRAI in Canada
- Need for a system perspective
- Scientific basis for interRAI systems
- Decision support functions of interRAI systems
- Clinical applications → Dr. Margaret Saari



interRAI Countries

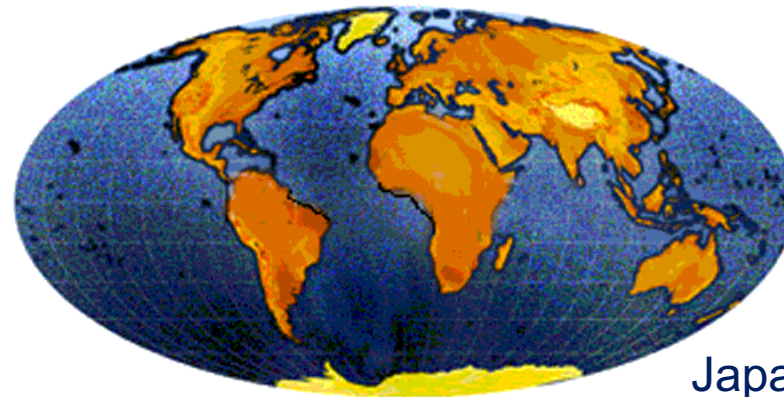
North America

Canada
US

Europe

Iceland, Norway, Sweden, Denmark, Finland,
Netherlands, France, Germany, Switzerland,
UK, Italy, Spain, Czech Republic, Poland,
Estonia, Belgium, Lithuania, Ireland
Portugal, Austria, Russia

**Central/
South America**
Brazil, Chile
Peru



South Asia, Middle East & Africa

India, Israel, Lebanon, Qatar
South Africa, Rwanda

Pacific Rim

Japan, China, Taiwan,
Hong Kong, South Korea,
Australia, New Zealand
Singapore



Why do we need to think at the system level?

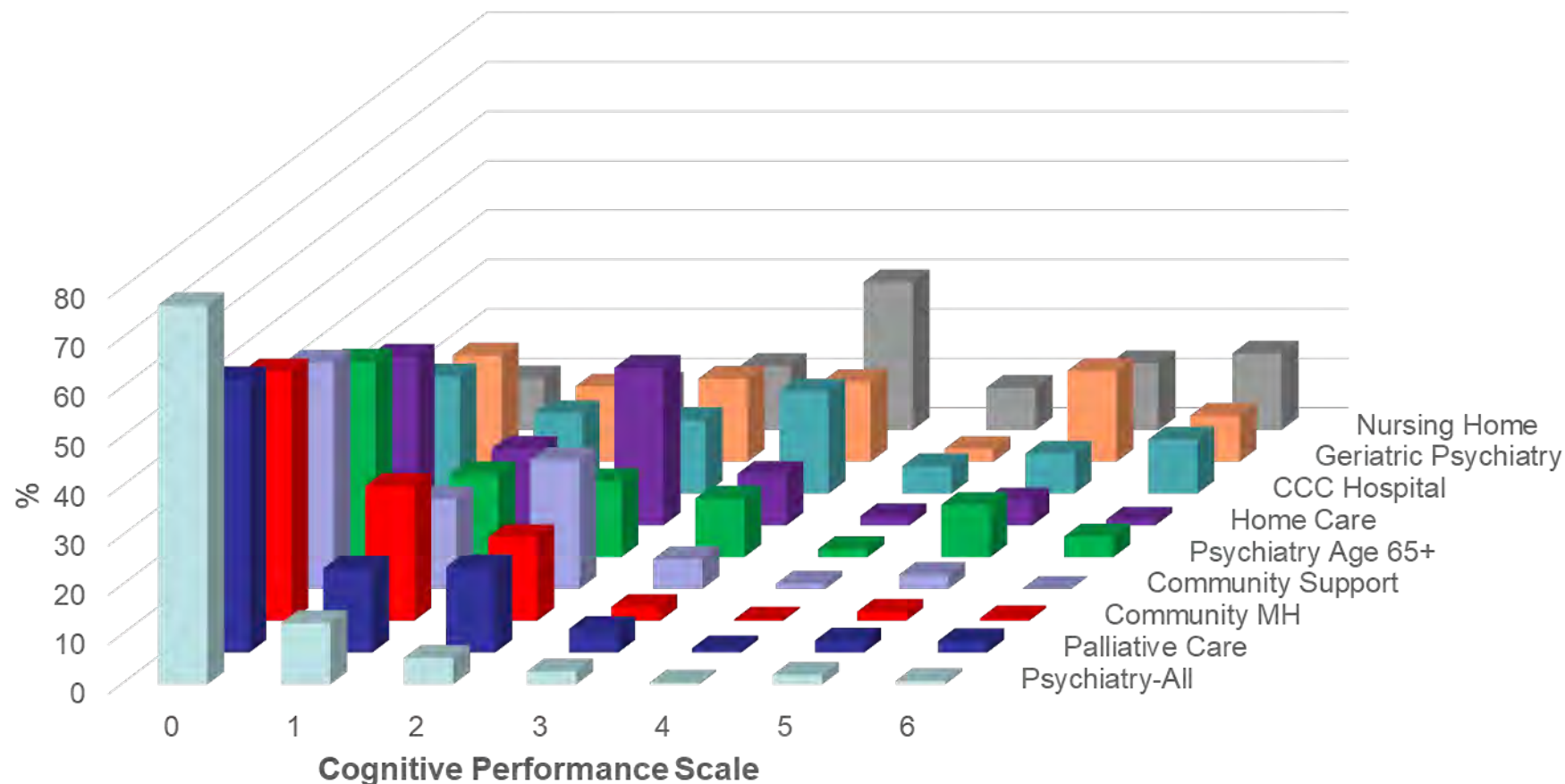
- People with comparable needs receive services in different sectors of health care system
 - Especially true for persons with complex needs
 - Elderly
 - Persons with mental illness
 - End of life care
- System-level implication:
 - May be able to fine-tune who gets what services where
- Person-level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



The interRAI Family of Instruments

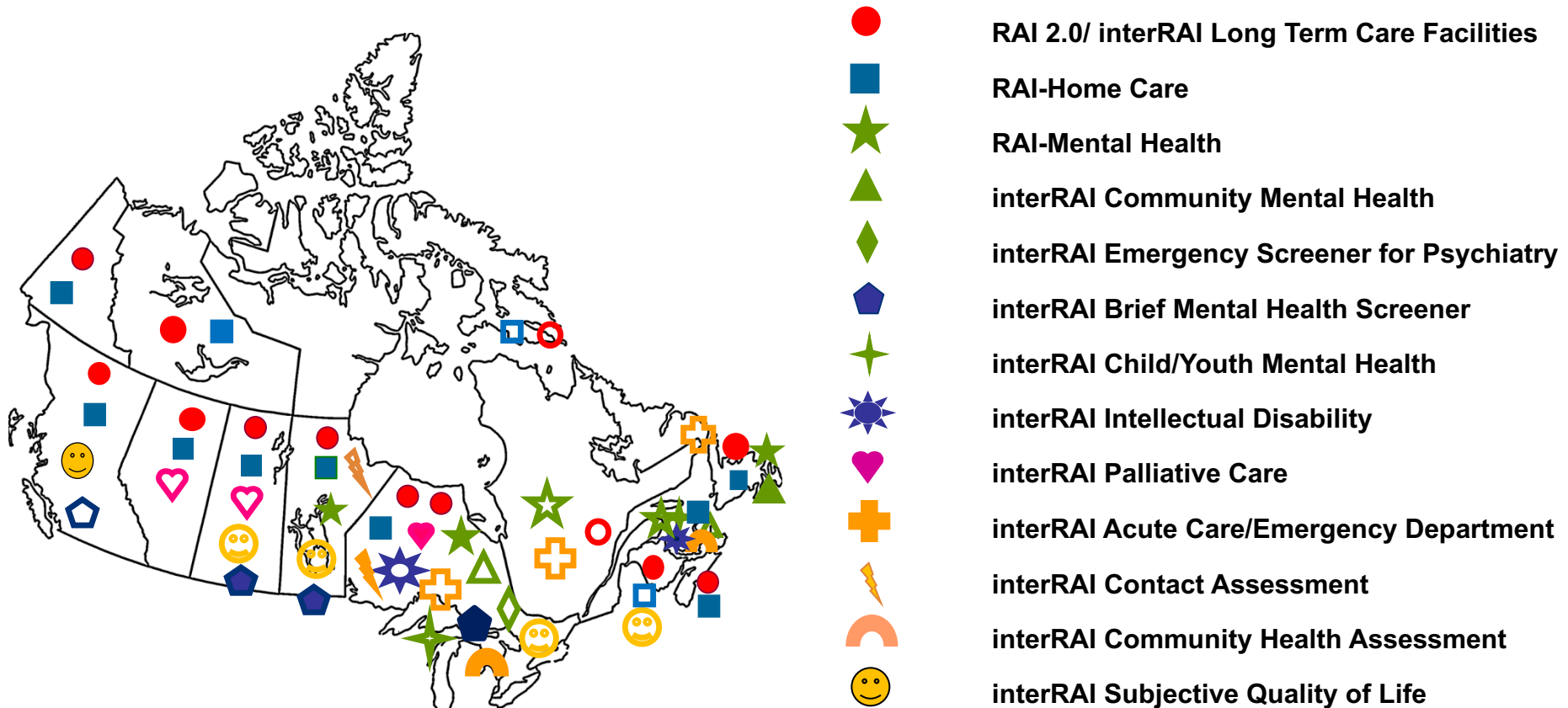
- **Mental Health**
 - Inpatient
 - Community
 - Emergency Screener
 - Forensic Supplement
 - Addictions Supplement
 - Correctional Facilities
 - Brief Mental Health Screener
 - Child & Youth Suite
- **Intellectual Disability**
- **Nursing Homes**
- **Home Care**
 - + Contact Assessment
 - + Adult and pediatric
- **Community Health Assessment**
 - Functional supplement
 - MH supplement
 - Deafblind supplement
 - AL supplement
- **Acute Care**
 - + ED Screener
- **Post-Acute Care-Rehabilitation**
- **Palliative Care**
- **Primary Care**
 - + Clinician version
 - + Self-report
- **Community Rehabilitation**
- **Carer Needs**
- **Subjective Quality of Life**
 - Long term care
 - Home and community care
 - Mental Health
 - Adult
 - Child/Youth

Distribution of Cognitive Performance Across Care Settings





Use of interRAI Instruments in Canada



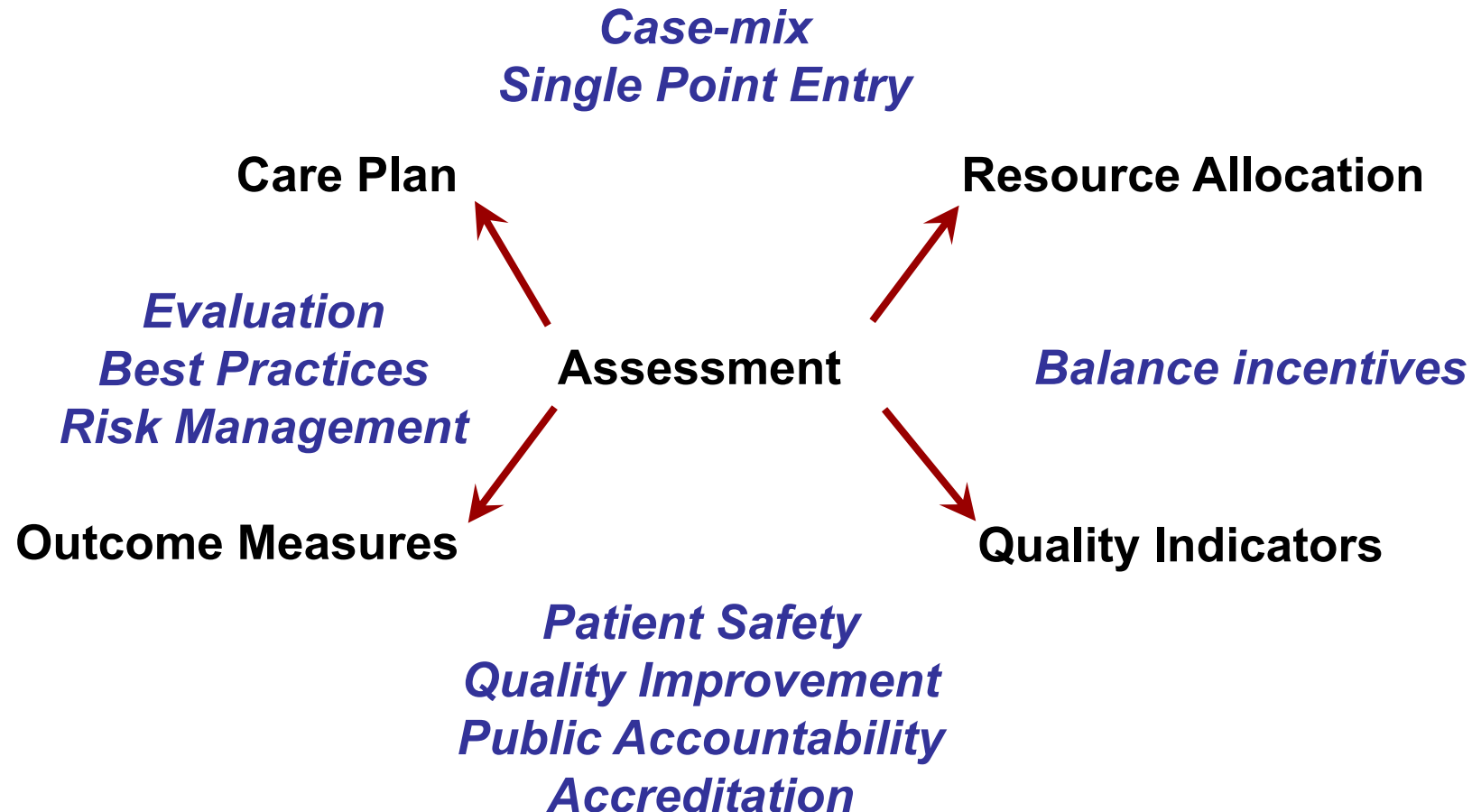
Solid symbols refer to implementations that have been mandated by government
Hollow symbols refer to research, pilot studies, or implementation planning underway

13.5 million+ assessments on 3.5 million+ individuals



Applications of interRAI's Assessment Instruments:

One assessment ... multiple applications





Developing interRAI Assessments

- Key design considerations
 - System vs standalone sector
 - Multidimensional
 - demographics, service use, function, medical conditions, psychosocial, environment, treatments & interventions, support systems
 - Multiple applications for multiple audiences
 - Minimum data sets → triggers for detailed clinical follow-up
 - Cross-national and cross-cultural applicability



Key design features of interRAI systems

- Use multiple sources of information + clinical judgement
- Detailed item descriptions on form
- Minimization of missing data
 - Avoid “don’t know”; “No” means no confirmatory evidence
- Inclusion and exclusion criteria
- Observational time frame
 - Standard look back=3 days; some are 7, 30, 90 days)
- Illustrative examples
- Detailed instructions in coding manual
 - Definition, intent, coding process, case examples

System level inter-rater reliability

12-country study

Independent assessors

Demonstrated high reliability within
AND between health settings

BMC Health Services Research



Research article

Open Access

Reliability of the interRAI suite of assessment instruments: a 12-country study of an integrated health information system

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Abstract

Background: A multi-domain suite of instruments has been developed by the interRAI research collaborative to support assessment and care planning in mental health, aged care and disability services. Each assessment instrument comprises items common to other instruments and specialized items exclusive to that instrument. This study examined the reliability of the items from five instruments supporting home care, long term care, mental health, palliative care and post-acute care.

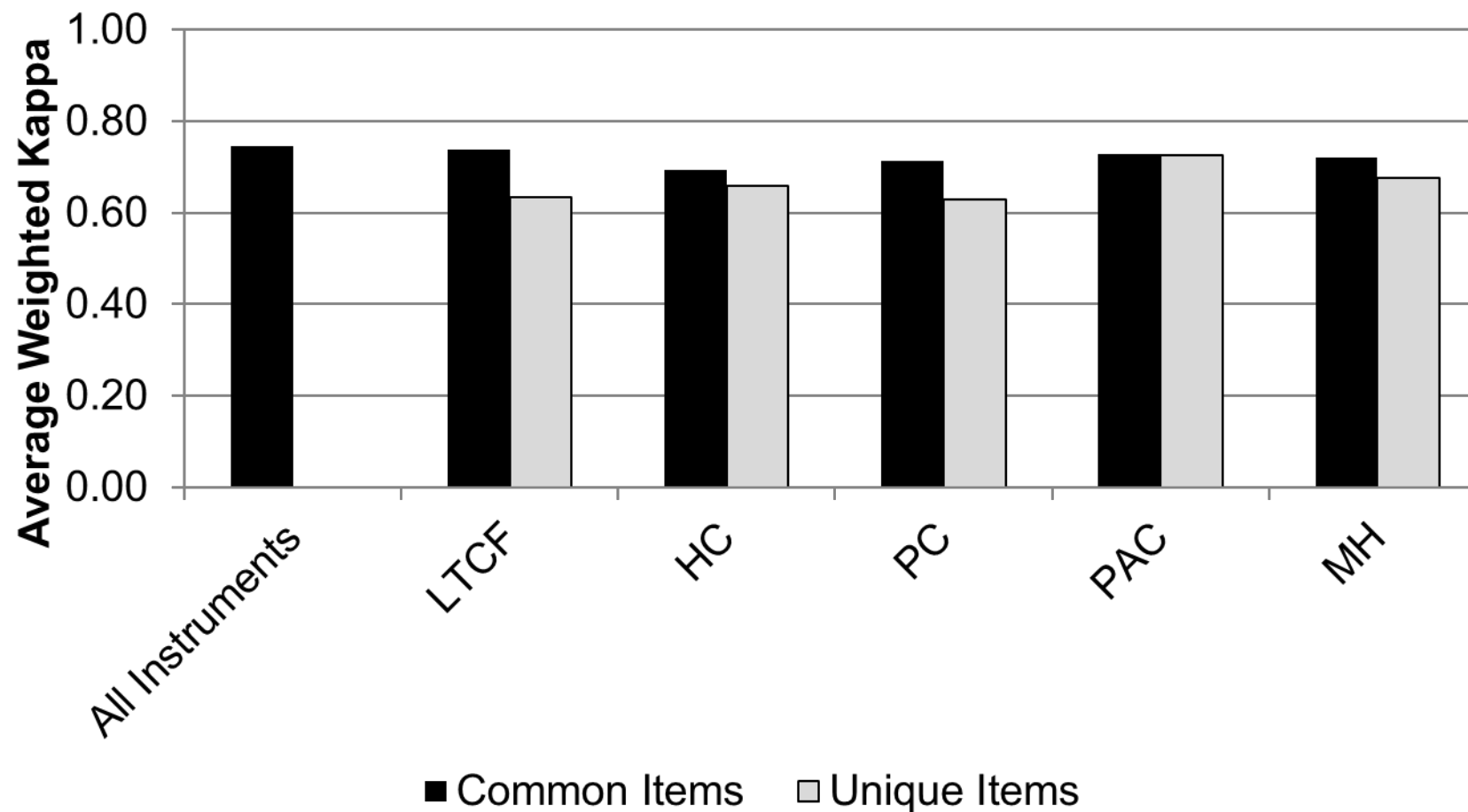
Methods: Paired assessments on 783 individuals across 12 nations were completed within 72 hours of each other by trained assessors who were blinded to the others' assessment. Reliability was tested using weighted kappa coefficients.

Results: The overall kappa mean value for 161 items which are common to 2 or more instruments was 0.75. The kappa mean value for specialized items varied among instruments from 0.63 to 0.73. Over 60% of items scored greater than 0.70.

Conclusion: The vast majority of items exceeded standard cut-offs for acceptable reliability, with only modest variation among instruments. The overall performance of these instruments showed that the interRAI suite has substantial reliability according to conventional cut-offs for interpreting the kappa statistic. The results indicate that interRAI items retain reliability when used across care settings, paving the way for cross domain application of the instruments as part of an integrated health information system.



Average weighted kappa value by interRAI instrument and type of item





Data quality in RAI-HC and interRAI CHA

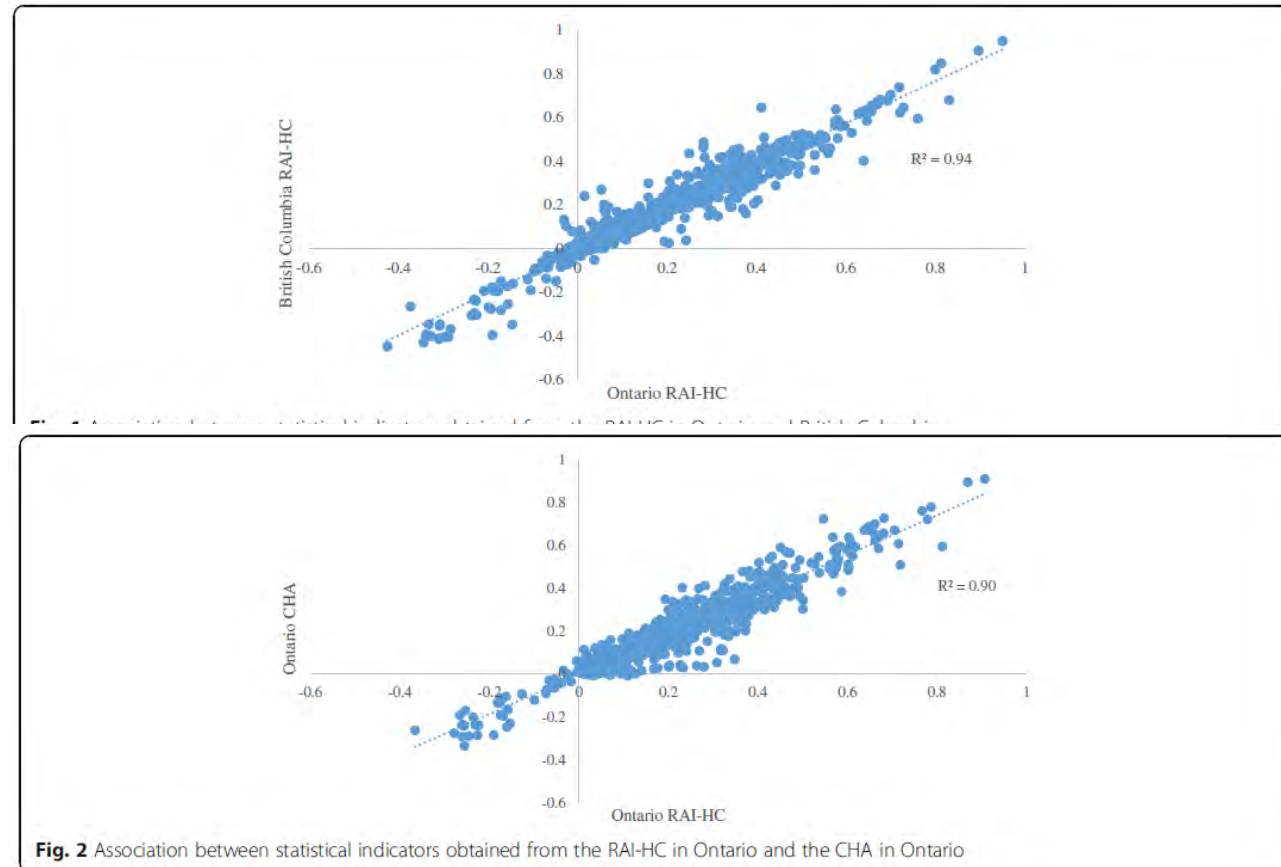
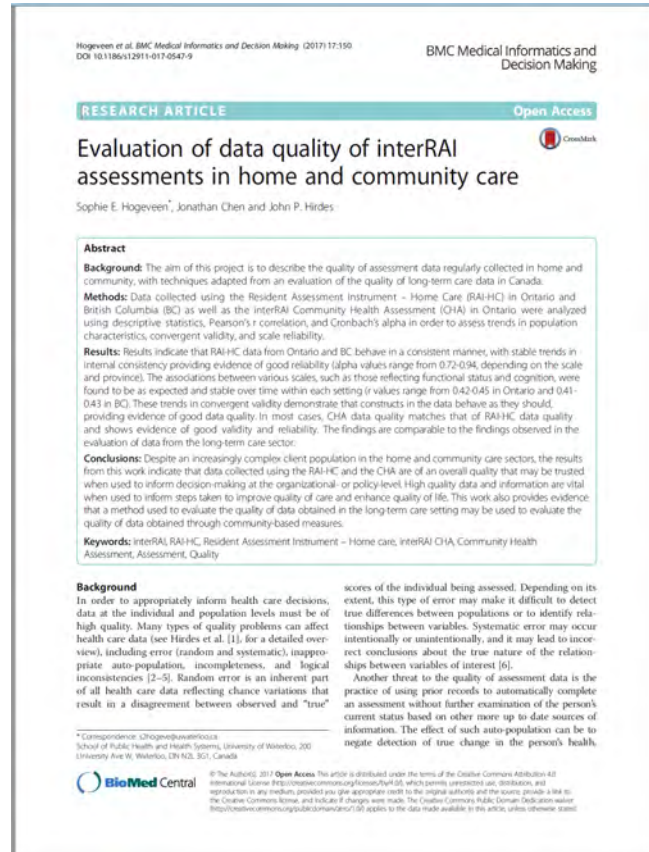


Fig. 2 Association between statistical indicators obtained from the RAI-HC in Ontario and the CHA in Ontario



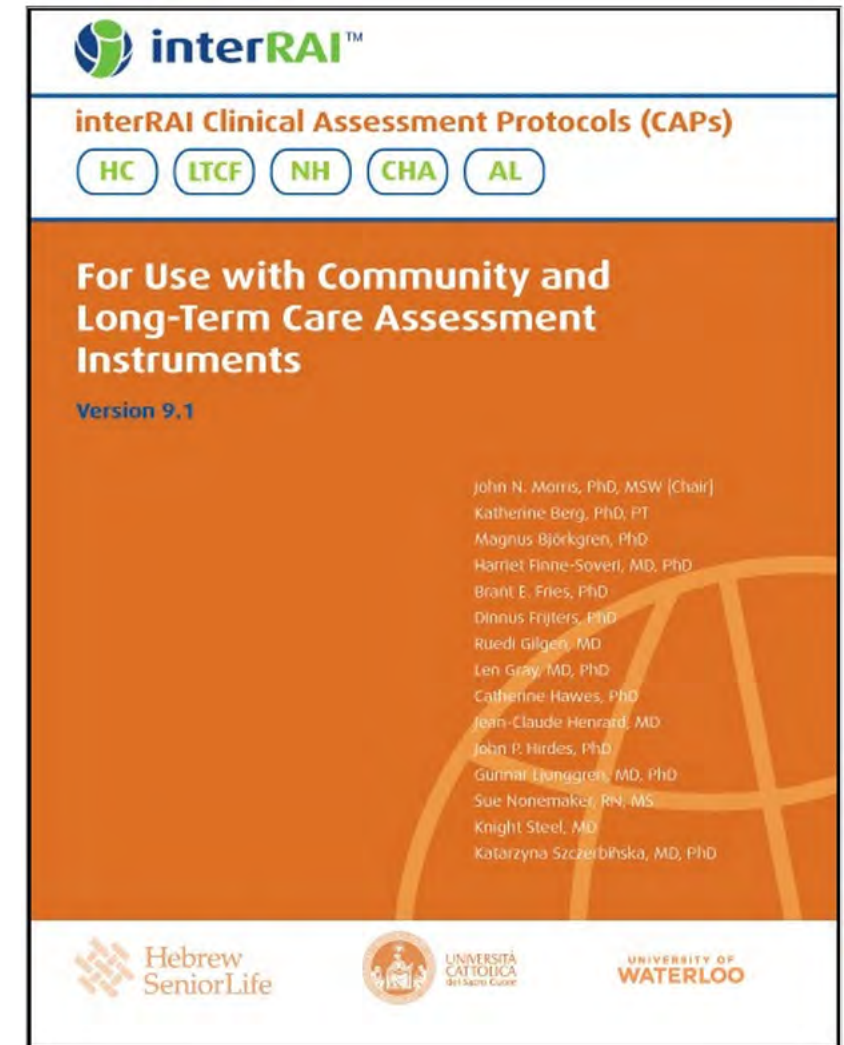
interRAI Clinical Assessment Protocols (CAPs)

Clinical tools to identify

- Need
- Risk of adverse change/event
- Potential for improvement

Compatibility

- Legacy instruments
- New suite





interRAI CAPs: The Research Effort

- International consultation
 - Feedback through interRAI Fellows and collaborating agencies
 - International experts participate in CAP revision
 - Extensive review by interRAI ISD Committee
- Literature reviews and examination of best practices
 - Examination of new research on CAP topics
 - Search of English language and non-English language BPGs
 - Aimed to find international consensus on clinical approach
- Extensive analysis of interRAI data holdings
 - **Millions** of longitudinal home care and nursing home assessments

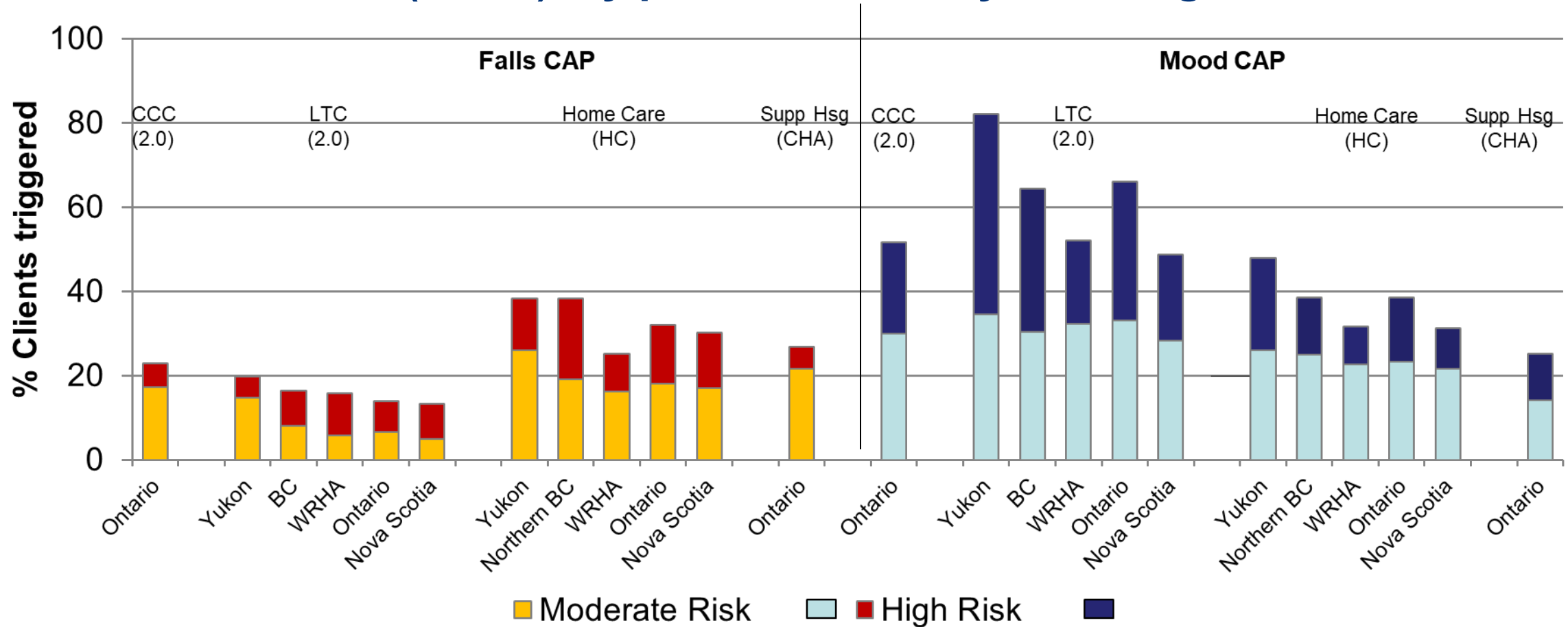


interRAI CAPs for Nursing Homes, Home & Community Care

- **Functional Performance**
 - Physical activities promotion
 - Instrumental activities of daily living
 - Home environment
 - Institutional risk
 - Physical restraints
- **Cognition/Mental Health**
 - Cognitive loss
 - Delirium
 - Communication
 - Mood
 - Behaviour
 - Abusive relationships
- **Clinical Issues**
 - Falls
 - Pain
 - Pressure Ulcer
 - Cardiorespiratory conditions
 - Undernutrition
 - Dehydration
 - Feeding tube
 - Prevention
 - Appropriate medications
 - Tobacco & alcohol use
 - Urinary incontinence
 - Bowel conditions
- **Social Life**
 - Activities
 - Informal support
 - Social relationships



Triggering rates for two multi-level interRAI Clinical Assessment Protocols (CAPs), by province/territory & setting



Three Dependent Variables

- Time to LTC admission
- Caregiver distress
- Better off elsewhere

...but also relates to informal care
time and costs

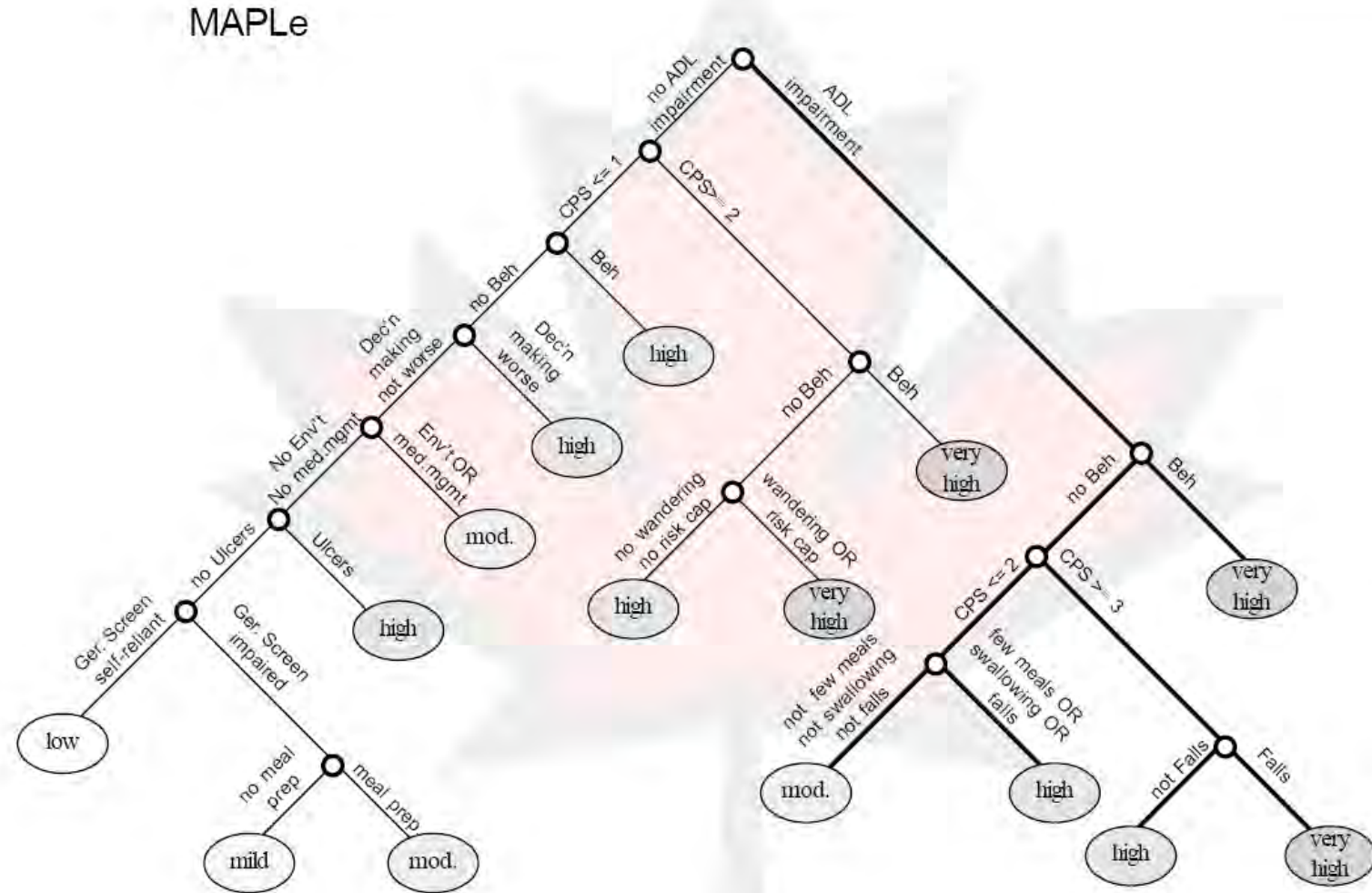
Analytic approach

Decision tree for one outcome

Logistic regression for all outcomes

- Refine as needed

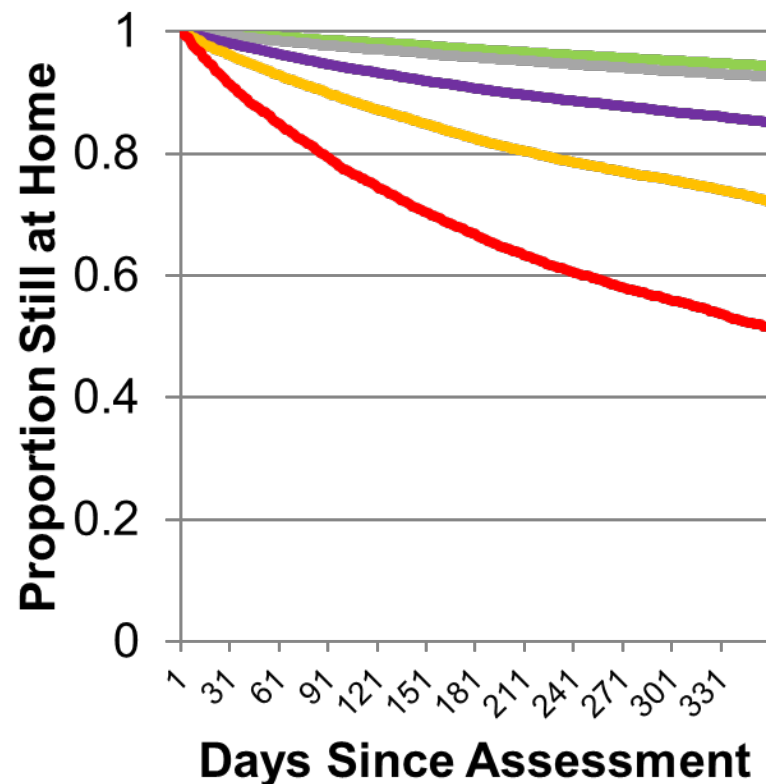
Cross-national validation



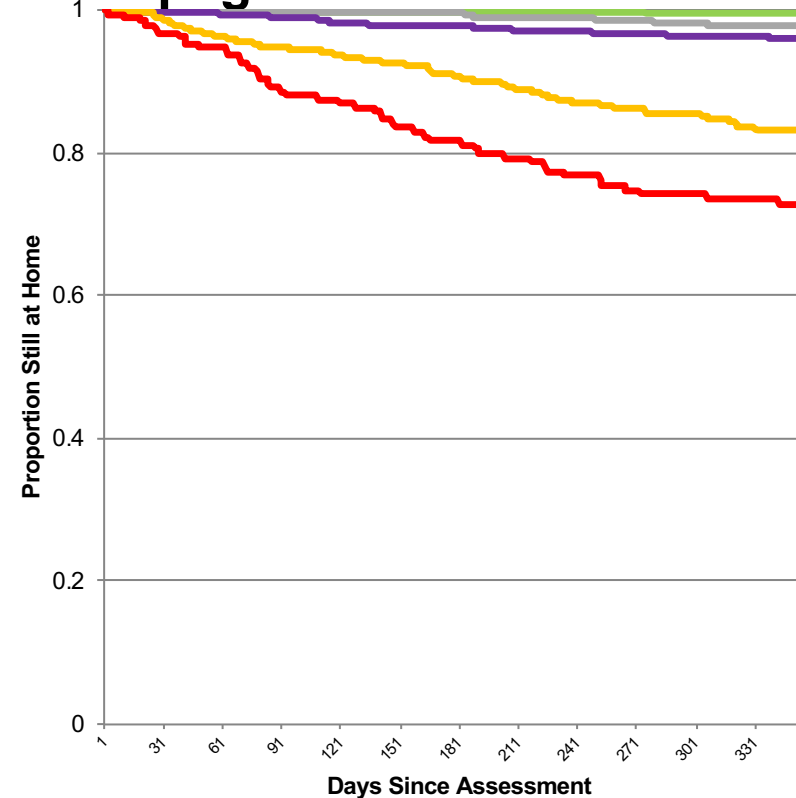


Nursing Home Placement Among Home Care Clients by MAPLe Level, Ontario & Winnipeg Regional Health Authority

Ontario



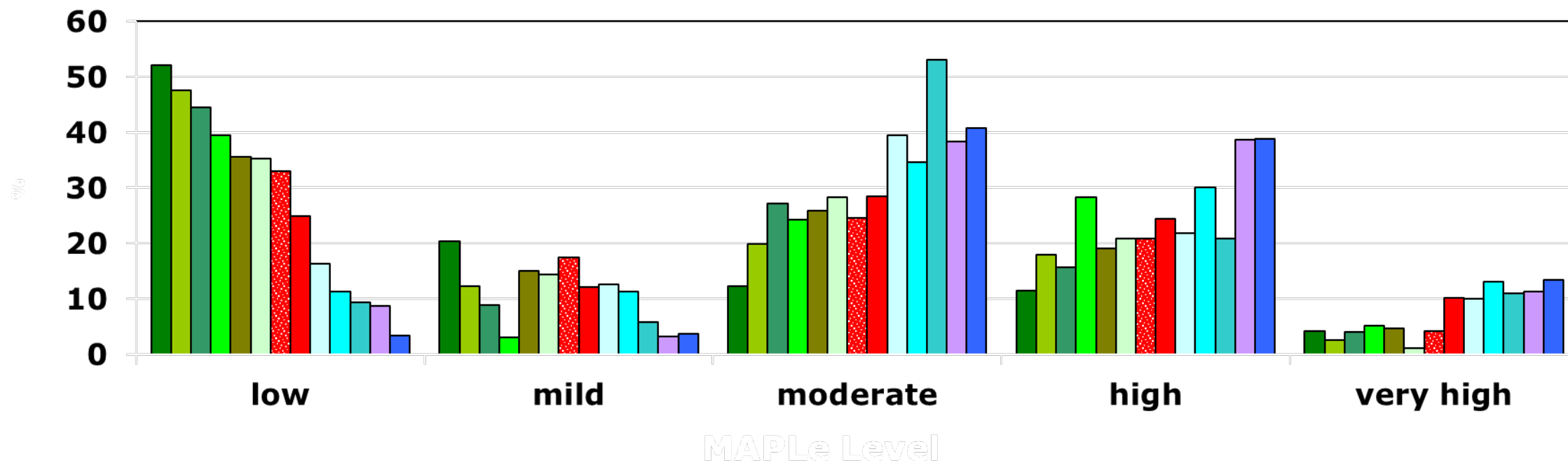
Winnipeg



Low Mild Moderate High Very High

International Differences in Access to Home Care:

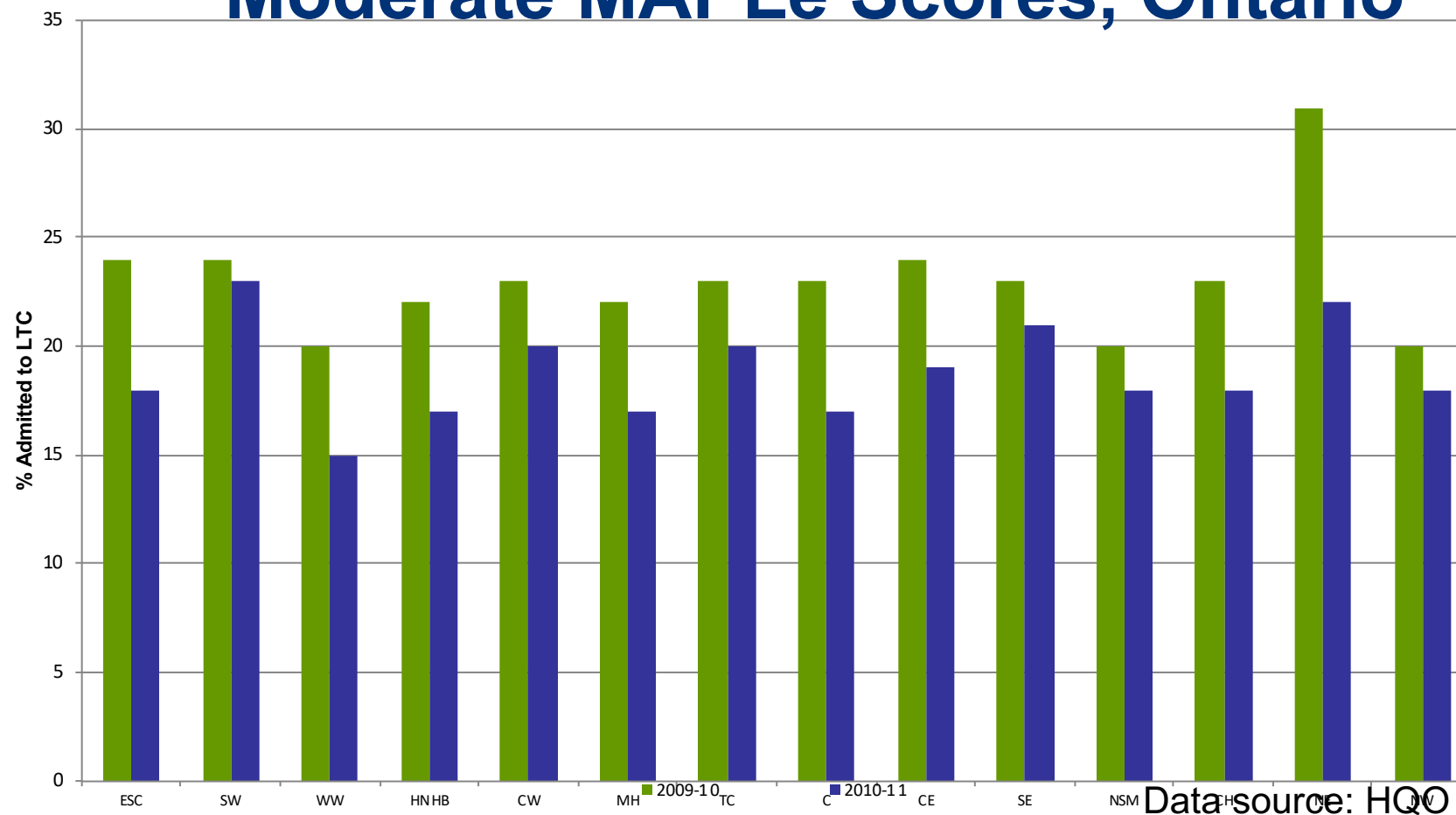
Distribution of MAPLe Levels by Country



 Sweden	 Denmark	 Iceland	 Netherlands	 Norway	 Finland	 Winnipeg
 Ontario	 UK	 Germany	 Czech Rep	 France	 Italy	

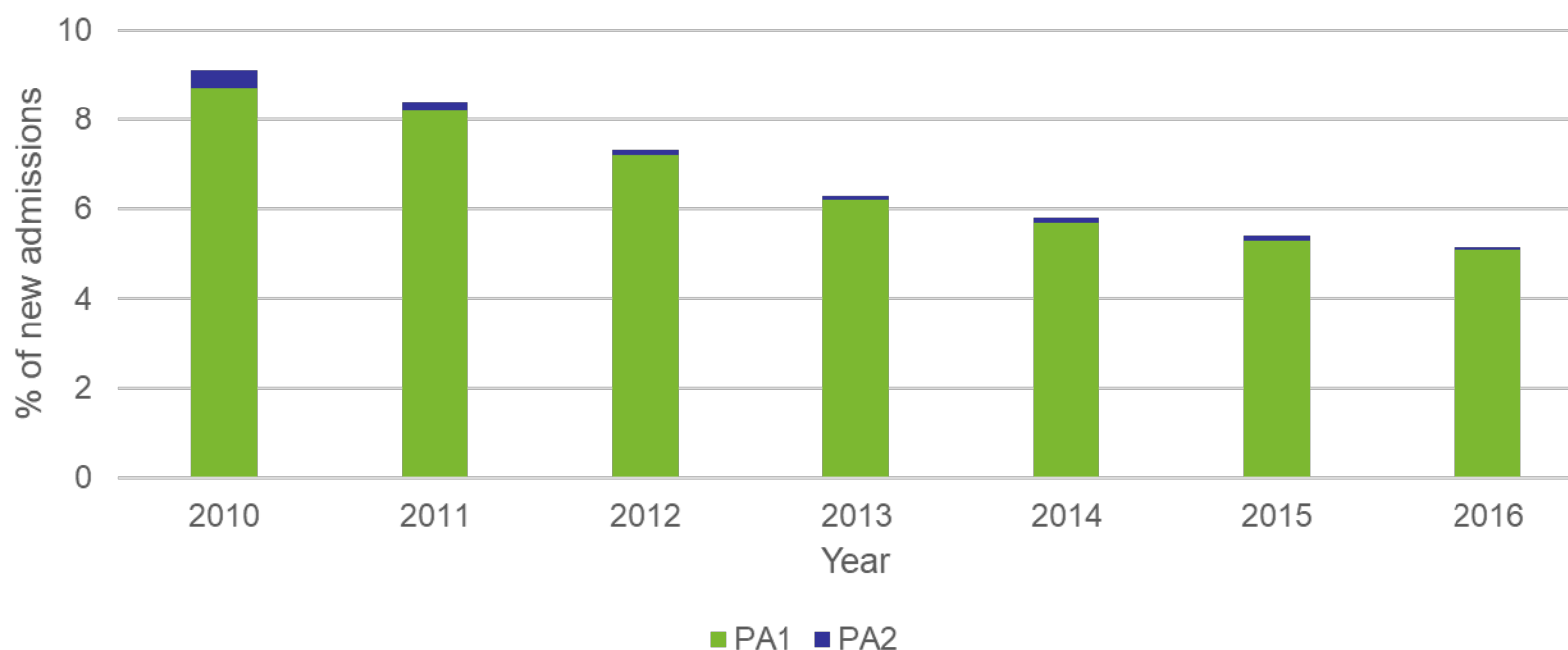


LTC Admissions Among Persons with Low-Moderate MAPLe Scores, Ontario



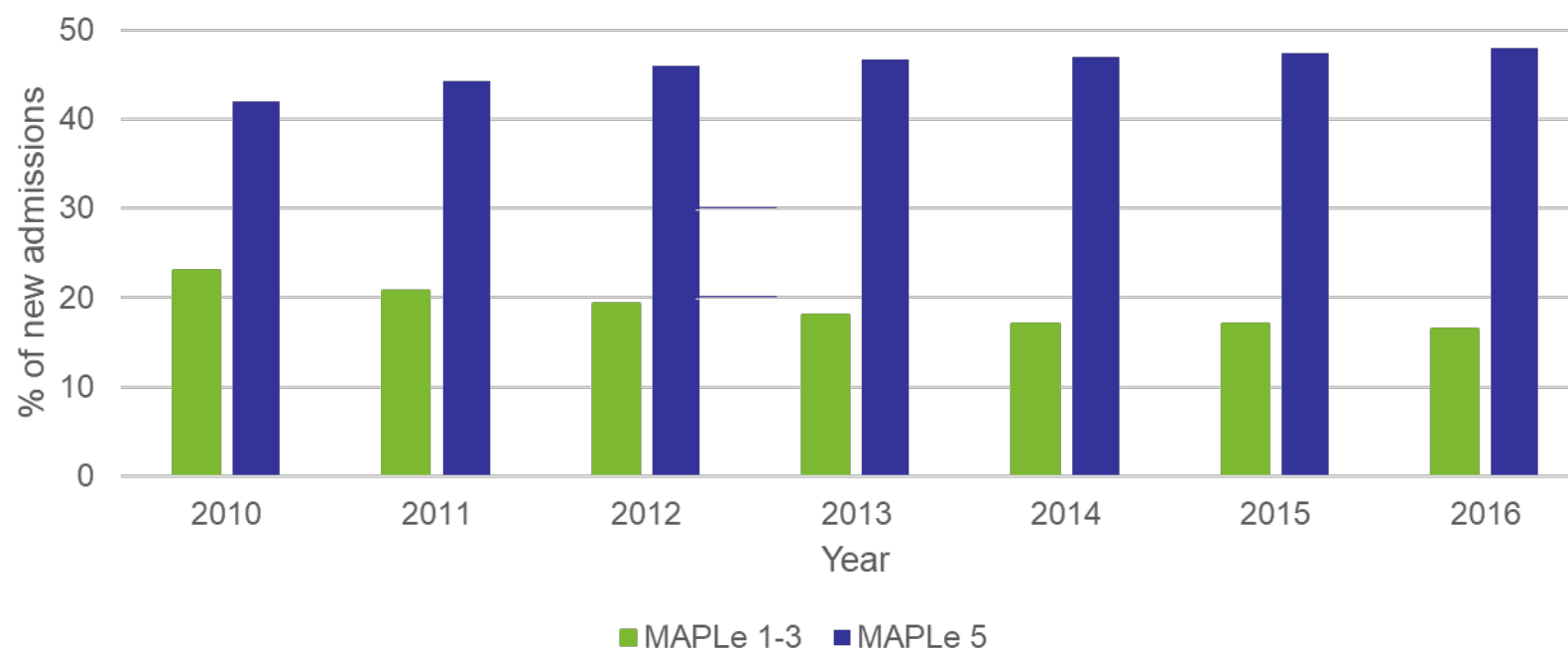
Percentage of new admissions to Long Term Care with low resource intensity based on RUG-III, by year and setting, Ontario

(note: PA1 and PA2 are the two lowest intensity RUG-III case mix groups)



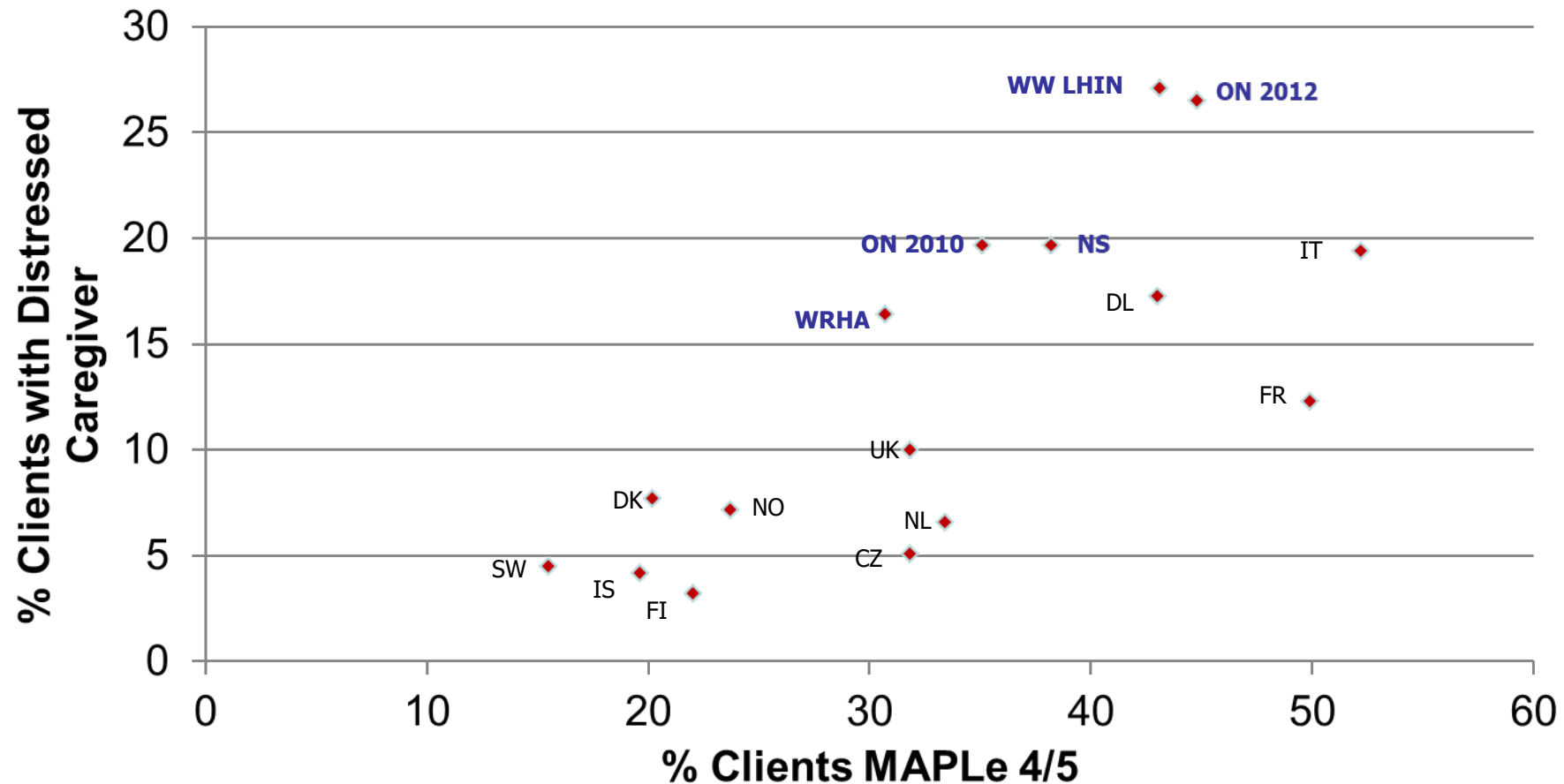


MAPLe levels of new admissions to Long Term Care, by year and setting, Ontario





Rates of caregiver distress by percentage of elderly home care clients at MAPLe level 4/5, by country





Unleashing the Power of interRAI

Application of the interRAI suite of
tools to support person-centred
home and community-based care

Margaret Saari RN, PhD

June 18th, 2018



Presentation Outline

- Rethinking home care
- Assessment practices in home care
- Opportunities for improvement
- SE Health as a Learning Health System
- Early lessons learned

Rethinking Home Care




Focus on the CHCA Principles

- **Person and family-centred**
 - assessment of the needs and strengths of patients and caregivers
 - shared decision-making
- **Accountable**
 - tracking and reporting on common performance indicators.
- **Evidence-informed**
 - supports clinicians to use their expertise, patient experience and best available research in practice and care decisions
- **Integrated**
 - enables seamless transitions across home care, primary care, acute care and long-term care.

Assessment Practices in Home care

- Geriatric Assessment Practices (G-CAP) Survey
 - On-line self-report tool examining assessment methods, attitudes toward assessment, interdisciplinary collaboration and perceptions of the interRAI tools
 - Survey completed by nurses, PTs and OTs from 12 different frontline home care agencies in Ontario
 - N=305

Assessment Practices in Home care

- Geriatric Assessment Practices (G-CAP) Survey
 - Frontline home care providers in Ontario reported:
 -  • Rarely sharing or receiving data within or outside their discipline.
 -  • Using observation and interview skills far more than standardized assessment tools when creating care plans.
 -  • Knowing about interRAI tools but few used the outputs of the tools to plan and provide care

Opportunities for improvement

- Provide frontline home care staff with **access to standardized assessment data** and **training** on how to utilize tools to guide care planning and delivery
- Improve information-sharing and communication between frontline home care staff to develop more **integrated home care teams**
- Develop better **operational integration** between interRAI data and frontline provider observations / targeted assessments

SE Health as a Learning Organization

“Doing organization”



“Learning organization”

To support this transition, SE Health has chosen to leverage the interRAI suite of tools to:

- Re-orient from a transactional, task-based medical model to a holistic, person and family-centred model
- Focus on how symptoms / clinical issues impact clients' cognitive, functional and social functioning regardless of the cause
- Support shared-decision making, direct clinical care as well as organizational operations

SE Health as a Learning Organization

Hillcrest Reactivation Centre – Understanding who we are serving



Assessment of the needs and strengths of patients and caregivers

- interRAI CHA
- interRAI Caregiver Needs Assessment

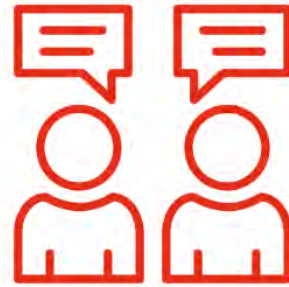
Data to inform:

- Improved understanding of client profile
- HHR needs within the site
- Caregiver programming

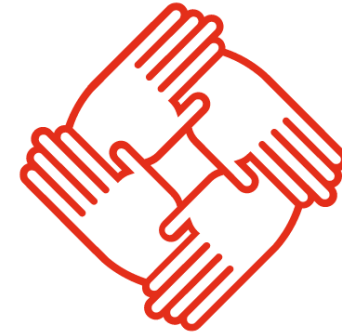
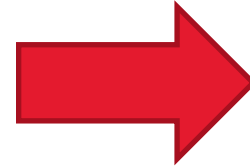
Full implementation of interRAI tools supports shared decision making



Measure of
strengths &
needs



Discussion of
preferences



Co-creation of client
centered care plan

SE Health as a Learning Organization

Hillcrest Reactivation Centre – Co-creating care

Co-designing interdisciplinary care planning process

- Interdisciplinary care team
- Site leadership
- Clients and caregivers

Early feedback

- Traditional referral process does not provide accurate picture of client needs at transition
- Clients and caregivers want:
 - providers to have holistic understanding of their needs
 - to have informed discussions about care and what to expect along their journey
 - time to consider options and make plans



SE Health as a Learning Organization

Southlake@Home – Embedding assessments into clinical care



Embedded into community-based transitional care model with frontline, primary nurses completing assessments

Early lessons learned:

- This is not “business as usual”
- Need to consider and plan for:
 - Integration into clinical workflow
 - Training and support plan for assessments
 - Software selection
- Asynchronous interdisciplinary care planning can be complex and requires additional considerations and training

SE Health as a Learning Organization

Connecting front-line data to organizational decision-making

- Day-to-day operations
- Quality monitoring – standardized key performance indicators
- Finance



Early lessons learned

- Focus on clinical use first and foremost
 - Highlight how tools support will clinical decision-making and require strong interview skills, therapeutic interaction with clients and clinical expertise
 - Emphasize how frontline clinical data is valued to support decision-making and operations at the organizational level
- Develop strong change management plan including how to train, support and sustain use in practice
- Build organization wide understanding of the tools
 - Highlight potential applications and implications on various departments' operations



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VIRTUAL LEARNING SERIES

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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