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
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.

Local: 647-260-3077
North American Toll-free: 1-855-392-2520
Access Code: 5418737 #
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

<table>
<thead>
<tr>
<th><strong>PERSON- AND FAMILY-CENTRED Care</strong></th>
<th><strong>ACCESSIBLE Care</strong></th>
<th><strong>EVIDENCE-INFORMED Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients and their carers are at the centre of the planning and delivery of care.</td>
<td>Patients and their carers have equitable and consistent access to appropriate care.</td>
<td>Patients receive care that is informed by clinical expertise, personal values and best available research evidence.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>SUSTAINABLE Care</strong></th>
<th><strong>ACCOUNTABLE Care</strong></th>
<th><strong>INTEGRATED Care</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients whose needs can reasonably be met in the home will receive the services and support to do so.</td>
<td>Patient, provider and system outcomes are managed, met and reported.</td>
<td>Patients’ needs are met through coordinated clinical and service-level planning and delivery involving multiple health and social care providers and organizations.</td>
</tr>
</tbody>
</table>
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?
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?
VIRTUAL LEARNING SERIES

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

Dr. John Hirdes
Professor, School of Public Health and Health Systems
University of Waterloo
Senior Canadian Fellow and Board Member
InterRAI

Dr. Margaret Saari
Postdoctoral Fellow
University of Waterloo and SE Research Centre
Applied Health Services Researcher
SE Health

Leslie Eckel
Knowledge Exchange Associate
University of Waterloo and InterRAI Canada
From Principle to Practice: Unleashing the Power of interRAI

John P. Hirdes, PhD FCAHS¹
Margaret Saari, RN PhD¹, ²

1- School of Public Health and Health Systems, University of Waterloo
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

Central/South America
Brazil, Chile
Peru

South Asia, Middle East & Africa
India, Israel, Lebanon, Qatar
South Africa, Rwanda

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

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

- **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

- **Intellectual Disability**

- **Nursing Homes**

- **Home 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

- RAI 2.0/ interRAI Long Term Care Facilities
- RAI-Home Care
- RAI-Mental Health
- interRAI Community Mental Health
- interRAI Emergency Screener for Psychiatry
- interRAI Brief Mental Health Screener
- interRAI Child/Youth Mental Health
- interRAI Intellectual Disability
- interRAI Palliative Care
- interRAI Acute Care/Emergency Department
- interRAI Contact Assessment
- interRAI Community Health Assessment
- interRAI Subjective Quality of Life

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

Twitter: @interrai_Hirdes

www.interrai.org
Applications of interRAI’s Assessment Instruments:
One assessment … multiple applications

Case-mix
Single Point Entry

Care Plan
Outcome Measures
Evaluation
Best Practices
Risk Management
Assessment

Resource Allocation
Balance incentives

Quality Indicators

Patient Safety
Quality Improvement
Public Accountability
Accreditation

Twitter: @interrai_Hirdes
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
Average weighted kappa value by interRAI instrument and type of item
Data quality in RAI-HC and interRAI CHA
**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

For Falls CAP:
- CCC (2.0): [Graph showing percentage]
- LTC (2.0): [Graph showing percentage]
- Home Care (HC): [Graph showing percentage]
- Supp Hsg (CHA): [Graph showing percentage]

For Mood CAP:
- CCC (2.0): [Graph showing percentage]
- LTC (2.0): [Graph showing percentage]
- Home Care (HC): [Graph showing percentage]
- Supp Hsg (CHA): [Graph showing percentage]
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

Days Since Assessment

Proportion Still at Home

Days Since Assessment

Proportion Still at Home

Winnipeg

Low  Mild  Moderate  High  Very High
International Differences in Access to Home Care:
Distribution of MAPLe Levels by Country

MAPLe Level

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

Twitter: @interrai_Hirdes
www.interrai.org
LTC Admissions Among Persons with Low-Moderate MAPLe Scores, Ontario

Data source: HQO
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
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.

Dr. John Hirdes
@interraiHirdes
Hirdes@waterloo.ca

Dr. Margaret Saari
@trifectaRN
@SEHCRResearch
margaretsaari@sehc.com

Leslie Eckel
Eckel@waterloo.ca