interRAI in Home Support

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Background

- July 2009 Enhanced Home Support Contract
- Objectives:

1. Streamlined Access for service users to all aspects of older persons health services ensuring a ‘right place, right time’ experience
2. A delivery model for Home Based Support Services (HBSS) which is strengths based and promotes independence utilising formal goal setting when appropriate
3. Flexible packages of funding to better meet the needs of clients wishing to remain at home with support
4. A comprehensive suite of assessment tools for use across all aspects of the sector.

Key Features

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- Traditional NASC function replaced
- Complex clients assessed and managed by DHB Specialist Team
- Non complex clients assessed and managed by HBSS Providers
- Restorative and strengths based
- Discharge model
- Health professional assessment and coordination
- Bulk funding moving on to Case Mix methodology
- Alliance Based Contracting Environment

interRAI MDS HC

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The MDS-HC:

- is the assessment component of the RAI-HC system;
- was designed for home care agencies;

The following are characteristics of the MDS-HC:

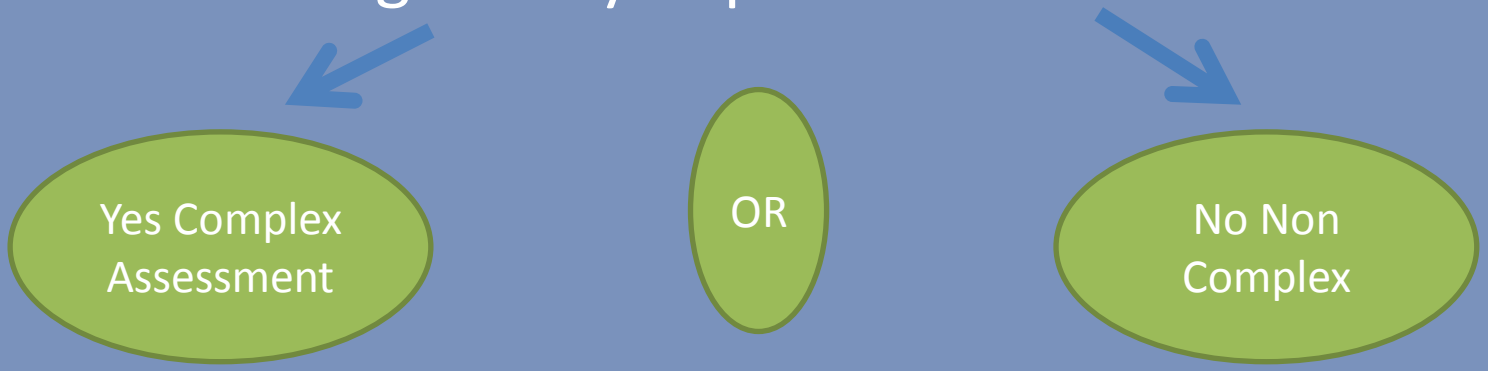
- standardized;
- clinically relevant domains;
- requires in-home interview / observation;
- uses information from both client and primary caregiver;
- allows for use of other health care documentation;
- uses both available information and clinical judgment to rate client status; with other RAI instruments,
- forms an integrated health information system.

interRAI Contact Assessment

- The interRAI Contact Assessment (interRAI CA) Screener was created to provide information to support the home care intake process.
- Three main goals guided its development:
  - to support decision making;
  - to record basic clinical information on persons who would *not* be receiving any additional comprehensive assessment at a later stage; and
- The interRAI CA is not intended to be a care planning instrument like the interRAI HC, but it does provide some important clinical information needed at the onset of home care service provision.

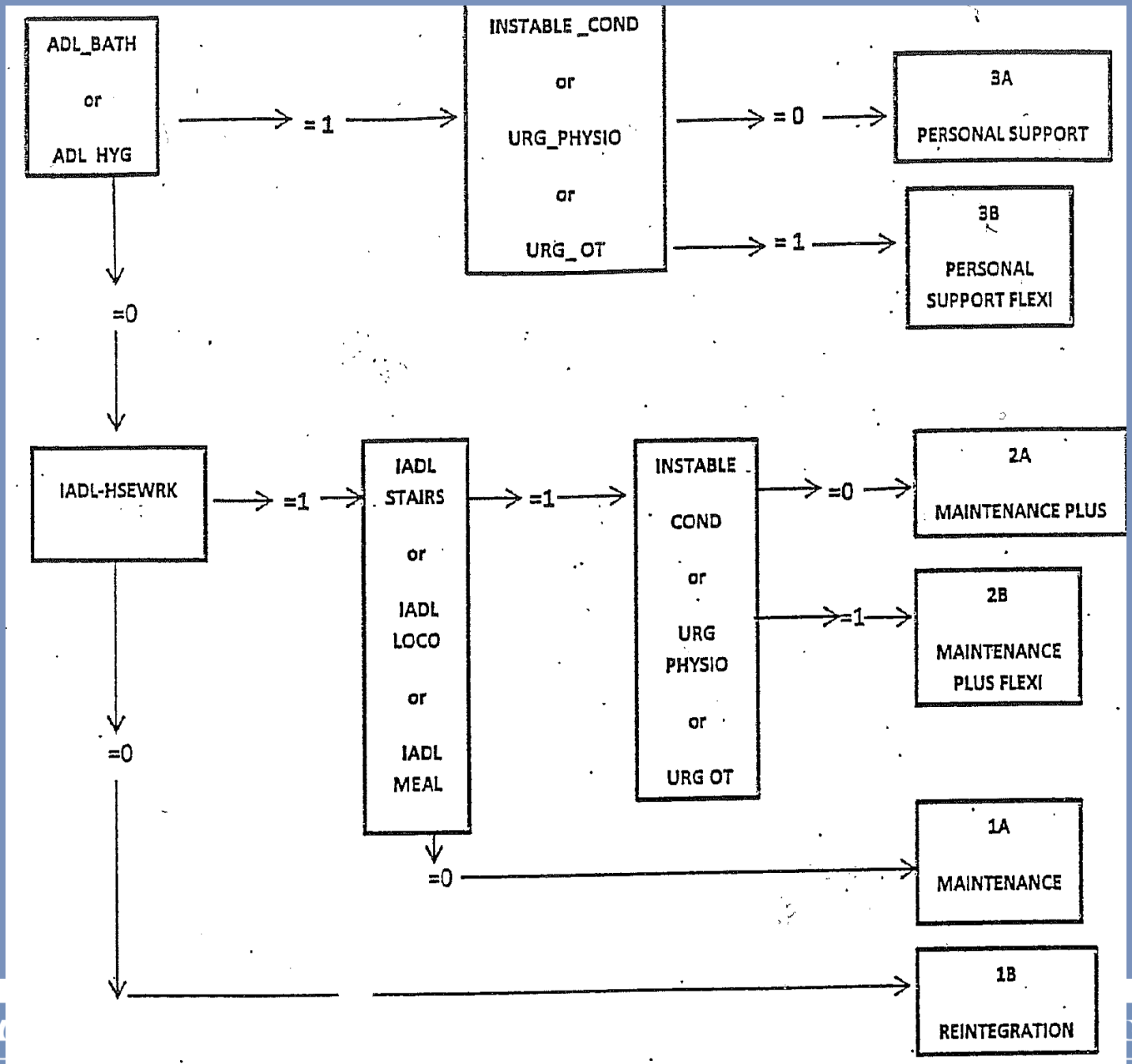
Triage

Has the client presented to ED in the past month?
Does the client require assistance with washing and dressing bottom half?
Does the client require medication management?
Does the client have brittle support systems in place /suspected abuse, neglect?
Is the client cognitively impaired?



Case Mix

A case mix approach provides a predefined level of funding for specific health related conditions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IADL STAIRS
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IADL LOCO
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IADL MEAL
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URG PHYSIO
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2A
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MAINTENANCE PLUS FLEXI
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MAINTENANCE
1B
REINTEGRATION

Case Mix – Complex

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Cognitive Impairment		Brittle Social Support				MDS-HC Questions					
C1(B2a)	C5(B2b)	F3(F2)	P2a(G2d)	P2b(G2d)	P2c(G2d)	G1a(H1aA)	G1d(H1dA)	G2c(H2e)	G2d(H2f)	G2a(H2j)	H1(I2a & I2b)
Cognitive skills - current status (0,1,2,3,4,5)	Cognitive skills - decline =2	Change in social activities (0,1,2)	Informal helper unable to continue (0=No, 1= Yes)	Informal helper stress (0=No, 1=Yes)	Family stress (0=No, 1=Yes)	IADL Meal (0,1,2,3,4,5,6, 8)	IADL Medication Management (0,1,2,3,4,5,6, 8)	ADL Upper Body Dressing (0,1,2,3,4,5,6,8)	ADL Lower Body Dressing (0,1,2,3,4,5,6,8)	ADL Bathing (0,1,2,3,4,5,6,8)	Incontinence (0,1,2,3,4,5,8)

Outcomes – Client Numbers

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Year	Quarter	Client Numbers
2012/13	1	3776
	2	3764
	3	3850
	4	3820
2013/14	1	3792
	2	3777
	3	3806

Outcomes - Northern Region Stats

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- Home Based interRAI Assessments for quarter ending 31/12/2014

	ADHB	OTHER NORTHERN DHB'S
Number Long Term Clients with interRAI assessment anytime prior	95.3%	44.6%
Number Long Term Clients with interRAI assessment within 12 months	81.9%	38.1%

- Note – assessment may be a Contact or MDS HC

Client Outcomes

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For the last six months

Clients discharged to Independence	11.9%
Clients discharged to natural supports	8.9%
Clients with decrease in needs level	15%
Clients readmitted after discharge	0%

Client Outcomes

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- Avoids duplication of assessments
- No waiting list for assessments or services
- Fair process- clients aware it is a standardised assessment
- Safety- case management not dependent on receiving services
- Focus on independence- move to lower levels or discharge
- Promotes use of natural supports & community reintegration
- Responsiveness and flexibility

Coordinator Outcomes

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- Competence and training
- Ease of use
- Consistency and confidence using a standardised tool
- Promotes credibility & respect of Coordinators Health Professional status with other health professionals
- Supported by National audit processes
- Understanding of client groupings to manage packages for the individual

Limitations/Challenges

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- Momentum – as a user and accessing data
- Need the right technology
- Snapshot in time
- Assessments completed in hospital
- Process to review casemix

Example

Complex client :

- Referred following L CVA ; R hemiparesis severe oral dysphasia. Husband suspected to have dementia (not diagnosed at time of referral).
- Triage
- InterRAI triggers
- Casemix on discharge

Clients goal on Discharge:

- S wishes to settle back into a home routine following hospital and stroke by next review (achieved)

Example

Interventions on discharge to home:

- Med's blister packed
- Bath board/bath mat
- Referral to continence nurse
- Referral for diagnosis of husband
- PC's daily (0.75 mins)
- Evening daily 0.5 mins to support with sequencing for meal prep
- HH (90 mins/week)

Example

Ad Hoc Review:
Triggered by Support Worker
Triage
Change in level

Clients goal revised:

- S aims to be able to manage her morning hygiene safely and independently by next review (achieved)
- Client is managing a lot of PC herself and now supported x3 weekly.
- Evening visits discontinued
- Husband has had formal diagnosis of cognitive impairment and is under Gerontology services.

Example

At six months:

- Change in level
- Decision Making Tree
- Managing own PC”s independently
- HH Only in situ .

Latest client goal:

S aims to return to look after her vege patch & flower garden by next review