Supporting Entry to Residential Care and Level of Care Decisions Utilising interRAI Data

Alex Colliss

Lead Practitioner

Hutt Valley Service Coordination Centre

Care Coordination

Connecting Care in the Community

Clare Ferrick

Lead Practitioner interRAI / Community Coordinator

FOCUS Wairarapa

WAIRARAPA DHB FOCUS Nga Kaupapa Hauā

interRAI

"Not designed to find people that need residential care….Designed to find what needs to be done to avoid the need for residential care"

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

Can interRAI support….

1. Eligibility to residential care

2. Level of care (Rest home or Hospital)

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

What we know….

interRAI allows us to compare using the same assessment information

Great start!

Care Coordination

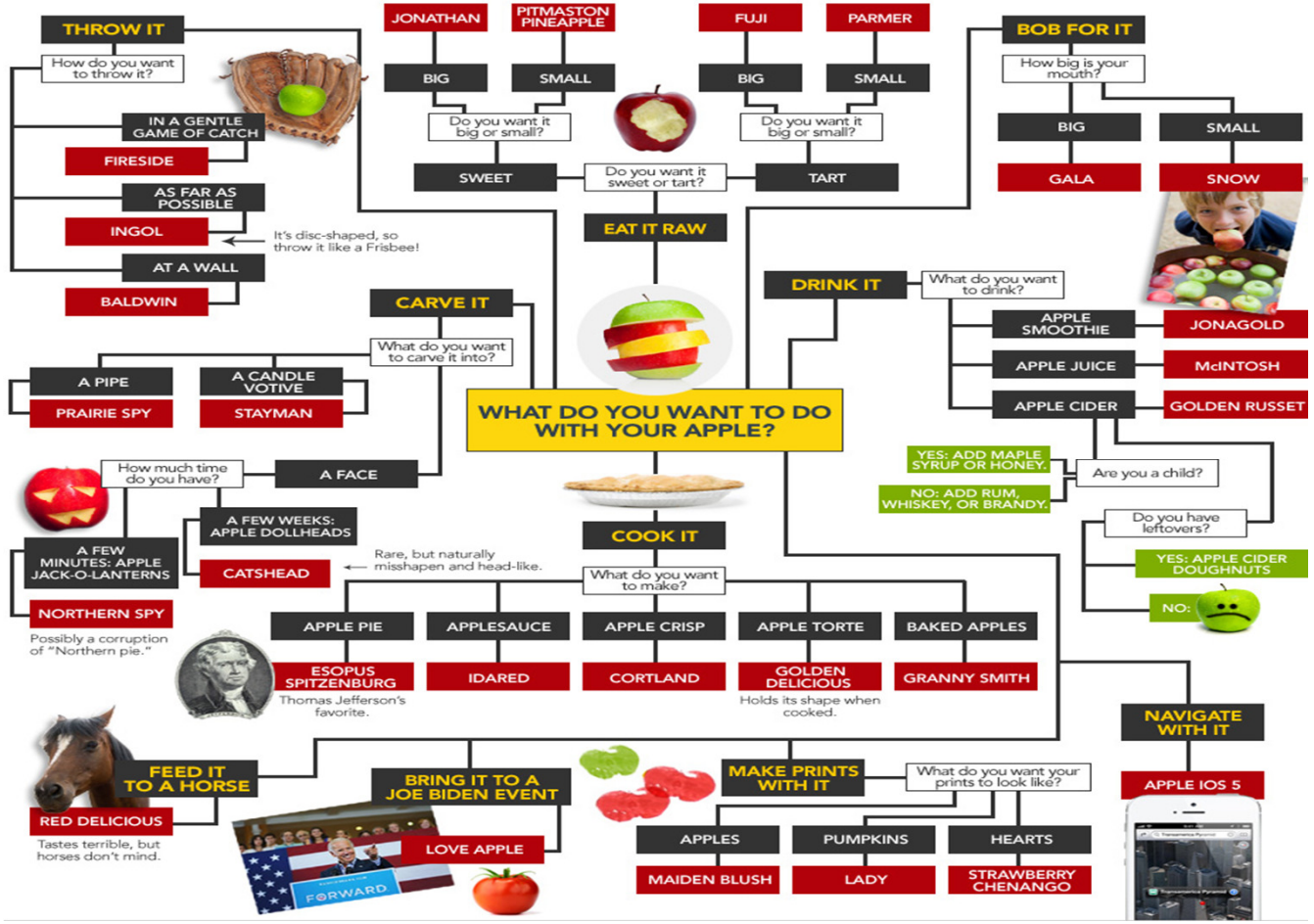
WAIRARAPA DHB FOCUS Nga Kaupapa Hauā

We Don't Do Different Things, We Do Things Differently

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

And this is how it looks….



Care Coordination

WAIRARAPA DHB FOCUS
Nga Kaupapa Hauā

What we did

NASC workshop with “real” situations to identify drivers for residential care support

- Workshop 1 – Hutt Valley and Wairarapa DHB NASCs
- Workshop 2 – 6 Central Region DHB NASCs

Results

- Cognition
- Mobility
- High levels of Personal Care
  (dressing and undressing)
- Clinical components of care/support

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

Unable to be supported at home = threshold for residential care

Driver	Threshold	Reason
Cognition	Oversight for constant safety	Unable to plan routine supports around
Mobility	Support of a person to mobilise or transfer	Unable to plan routine supports around
ADL support	Support needed cannot be provided at home. E.g. overnight support	Potential resource balance including cost
Clinically complex	Complexity unable to be met in community	Unable to plan routine supports or care unavailable in community

Care Coordination

WAIRARAPA DHB FOCUS Nga Kaupapa Hauā

What we all agreed to do

- Collect data on clients as they are assessed by the 6DHBs
- Sample = 100+

- Look for “matches” in data/outcome scores when similar combination of “drivers” are in play

  (example - if cognition is the “driver” what information from the interRAI assessment supports this)

Care Coordination

WAIRARAPA DHB FOCUS Nga Kaupapa Hauā

Outcome of data from 5 DHBs

Driver (Triggers)	High Support needs (Rest home level)	Very High Support Needs (Hospital level)
Cognition	CPS = 3+ (2+ if other triggers) CQ1 = 2+ (insufficient alone)	CPS =4+ CQ1 =3+ (Insufficient alone)
ADL Support/Mobility	ADL Long = 5+ G2 c-j = 2+ (any 1 or more)	ADL Long =15+ G2 c-j =5+
Significant vulnerability and safety issues	No specific interRAI score	No specific interRAI score
Clinically complex including behaviour and other issues	MAPLe = 3+ (insufficient alone)	MAPLe =4+ (insufficient alone)

Care Coordination

WAIRARAPA DHB FOCUS Nga Kaupapa Hauā

What we did next

Test the same assumptions and thresholds over a “full population” (including clients living in the community) ensuring:

That a person currently able to be supported at home remains identified as being able to be supported at home

That a person currently needing residential support remains identified as needing residential support

Sample = FOCUS 110 clients ranging from low to very high needs

Outcome

5 False positives*

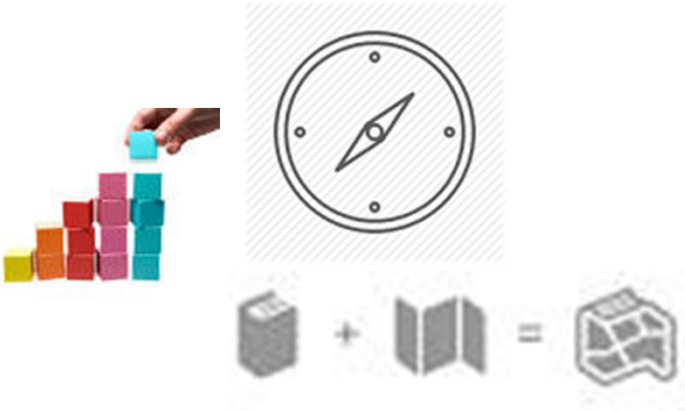
0 False negatives

*Further investigation concluded 5 false positives were related to coding errors

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

The Guide



- Builds on current work by 6 Central Region DHBs
- Supports decision making
- User friendly
- Provides consistent method for determining access to residential care
- Able to be integrated into local systems

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

IMPORTANT: Guide not a rule!

Care Coordination

WAIRARAPA DHB
FOCUS
Nga Kaupapa Hauā

So what did we find?

Three months of data from Hutt Valley DHB interRAI Home Care assessments

February 2015 – April 2015 (n=152)

Check in at 1 month and 3 months after assessment to see whether client remained at the same level of care or if there had been any changes

Care Coordination

WAIRARAPA DHB FOCUS Nga Kaupapa Hauā