Are our Clients in Northern Health in the Right Place at the Right Time? The Example of Residential Care

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Current Research Project

Caring for older adults in their preferred location of care: An evidence based intervention study to support safe transition from long-term care back to rural and remote northern communities

northern health
the northern way of caring

Agenda

1. Background to the Project
2. Selection Criteria for Residential Care
3. Current Picture of Residential Care Clients in Northern Health
   - Client Profiles at time of admission from the community

Background

"Quality Of Life (QOL) of older adults may be improved when the person is able to live and be supported in their ***preferred setting of care"***[1]

CIHR's Institute of Aging–

- Community based care can have:
  - Reduce physical symptoms and psychological distress
  - Improve wellbeing, independence, and access to formal care providers
  - Reduce health care expenditures

But…

What happens when older adults are in the wrong place???

[1]Canadian Institute for Health Research-Institute of Aging. (2014) IA Strategic research priorities 2013-2018. Retrieved from: http://www.cihr-irsc.gc.ca/e/46837.html

Background

- Assumptions
  - Anecdotal evidence in northern BC up to half of LTCF residents do not exhibit clinical need for the level of care provided by LTCF
    - Community based "alternative setting of care" (ASC)
    - What is the resident's preferred setting of care??
    - Lack of process and precedents for discharge to the community
  - LTCF resident discharge to an ASC will free up occupied beds and thereby may relieve waitlist demands for LTCFs.

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    - Lack of process and precedents for discharge to the community
  - LTCF resident discharge to an ASC will free up occupied beds and thereby may relieve waitlist demands for LTCFs.
- **Data already exists** to start to create the evidence base
  - Need to mobilize this knowledge in to action

Background

- Literature from the US
  - Short stay LTCF residents (<90 days)
  - Relationship to Medicare funding system and discharge
- Canadian research
  - LTCF to hospital and emergency departments (OPTIC study)
  - Lack of generalizability to rural, remote, or northern communities
  - Focus is often to divert persons before entry to LTC

Current Research Project

Objectives:

A. Create a comprehensive evidence based profile of LTCF residents eligible for discharge in NH;
B. Develop, implement, and evaluate a pilot supporting resident discharge back to community settings; and
C. Inform health care decision making processes and policy in NH to develop discharge protocols for LTCFs

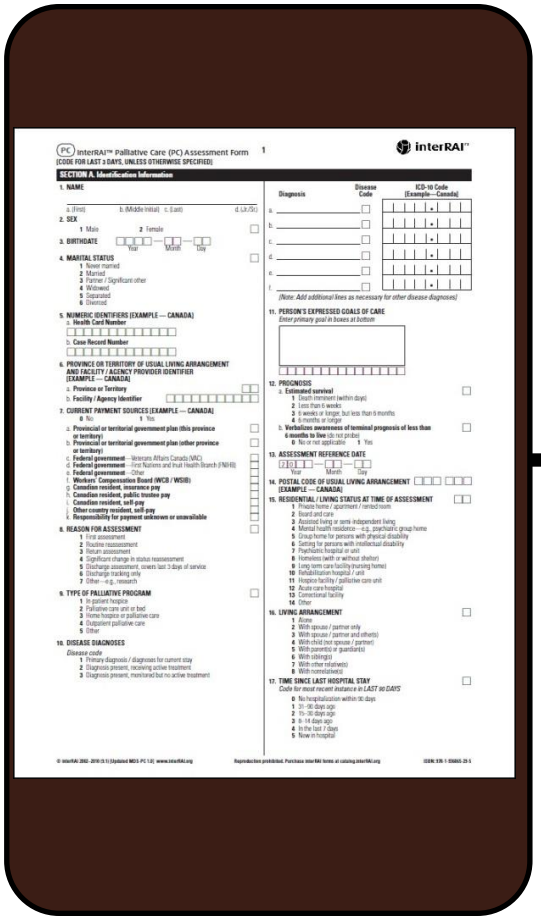
interRAI

- Who
  - International, not-for-profit network of ~60 researchers and health/social service professionals
- What?
  - Comprehensive assessment of strengths, preferences, and needs for vulnerable populations
- How?
  - Multinational collaborative research to develop, implement and evaluate instruments and their related applications

The interRAI Suite of Assessment Instruments

- Home Care (**MDS-HC**)
  - Contact Assessment
- Complex Continuing Care, Long Term Care (**MDS 2.0**)
- Acute Care
  - ED Screener
- Mental Health
  - Inpatient
  - Community
  - Emergency Screener
  - Plug-in Modules
- Intellectual Disability
- Palliative Care
- Post-Acute Care-Rehabilitation
- Community Health Assessment
  - Functional supplement
  - Assisted Living supplement
  - MH supplement
  - Deaf blind supplement

Using interRAI Assessment Instruments



Care Planning

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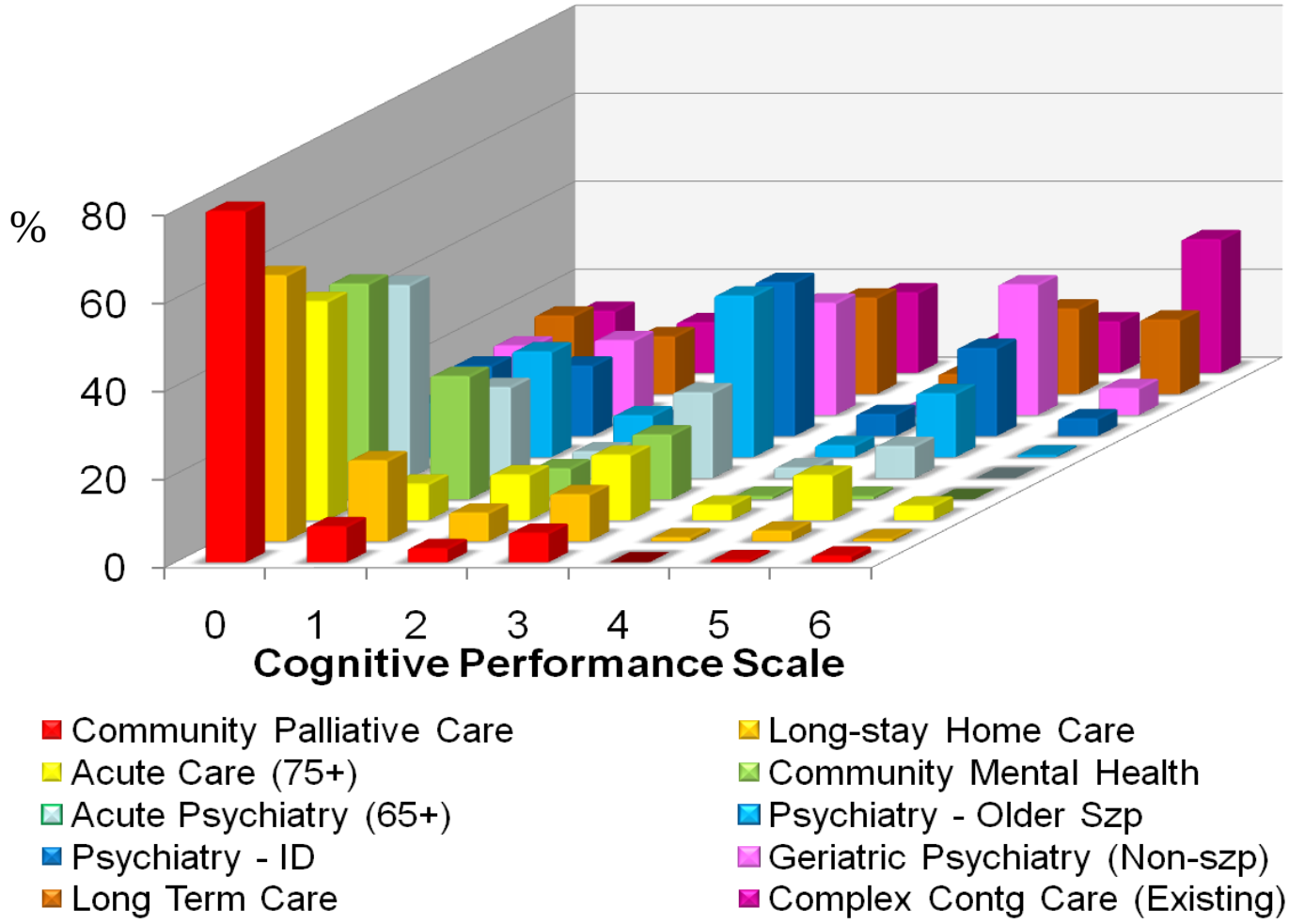
Clinical Assessment Protocols

Outcomes

Quality indicators

Case-mix

Can Inform Systems Level Decisions: Are People in the Right Place?



What should be the "shape" of the health care system?

Distribution of the Cognitive Performance Scale in Various Care Settings

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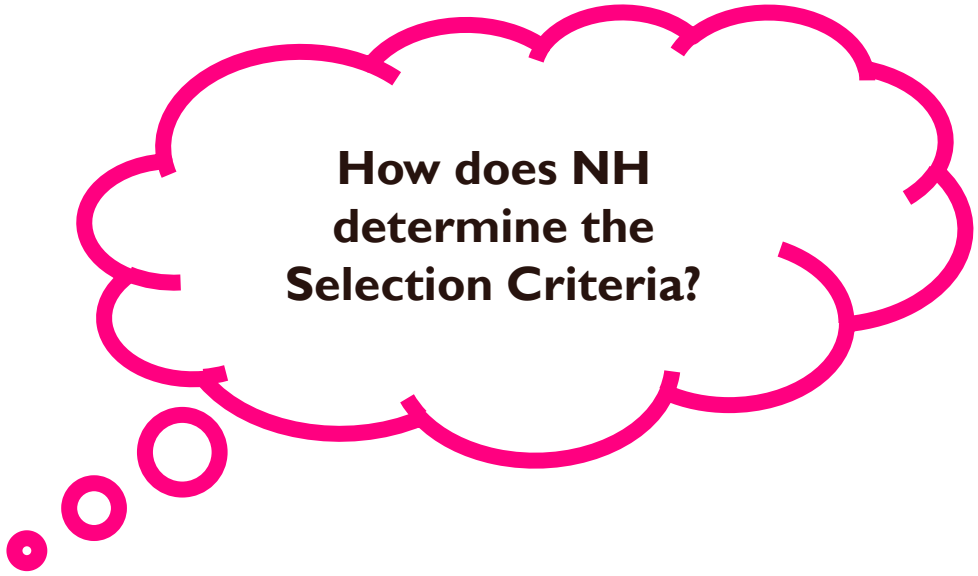

Background on Selection Criteria in Northern Health

- Request from case managers
  - Needed an objective way to determine appropriate admission candidate
  - Based on clinical need
- Focus team (content experts) included case managers, RAI team & managers
- April -October 2010 majority of work completed
- May 2013 – New policy implemented

Purpose of Refining Decision Support Tool

- Identify:
  - "Right" person (population) for residential care
  - Services/care options (innovations) needed to support people to remain in the community
- Ensure consistency across Northern Health
- Enhancing community capacity

How Does Someone in Residential Care Look?

- Late stages of life span
- Frail
  - Significant functional losses
  - Significant cognitive losses
- Need 24 hour professional care
- Difficult behaviours
- Unable to be supported in the community

Client Criteria

Based on Ministry definitions (MoH 6.C. p.1)

- Severe continuous behavioural problems
- Moderate to severe cognitively impaired
- Physically dependent with medical needs that require professional nursing care
- Clinically complex that require professional nursing care/monitoring/specialized skilled care)

Clinical Profile

Assessment	RAI-Home Care 2014	Reference Date

Outcome Scales

ADL Long Form (0-28)	25
ADL Short Form (0-16)	13
ADL Self Performance Scale (0-6)	5
IADL Difficulty Scale (0-6)	6
IADL Involvement Scale (0-21)	21
Cognitive Performance Scale (0-6)	4
Depression Rating Scale (0-14)	3
CHESS (0-5)	2
Pain Scale (0-3)	2
MAPLE Score (1-5)	5
Self Reliance Algorithm	Level 2 - Not Self Reliant
Informal Care Available	No
Pressure Ulcer Risk (0-8)	4

Key Variables in Eligibility Criteria

- **Method for Assessing Priority Level (MAPLe)** indicates⇑ risk:
  - for caregiver burnout,
  - premature admission to residential care,
  - inappropriate admission to acute care
- **ADL Hierarchy** – disablement process
- **ADL Long Form** – how much help needed (dressing, toileting, eating, transfers, locomotion, bed mobility, hygiene)
- **Cognitive Performance Scale (CPS)** - Cognitive Losses
- Behaviour Symptoms

Decision Support Tool

Primary Criteria	All appropriate community based resources have been tried and exhausted.					
Supporting Criteria	There are five combinations of criteria that support placement. Work across the row.					
HCC policy description	**RAI-HC description**					
	MAPLe	**CPS**	**ADL long form**	**ADL hierarchy**	**Mood & Behaviour Patterns**	**Specific diagnosis**
Moderate to severe cognitively impaired	4 or 5	Greater than or equal to 3	Greater than or equal to 9	Greater than or equal to 3	Not applicable	Not applicable
Physical dependent with medical needs that require professional nursing Needs a planned program to retain or improve functional ability	4 or 5	Not applicable	Greater than or equal to 9	Greater than or equal to 3	Not applicable	
	3 Only if other criteria present	Not applicable	Greater than or equal to 14	Greater than or equal to 3	Not applicable	MS, ALS
Clinical complex – multiple disabilities and/or complex medical conditions	4 or 5	Not applicable	Not applicable	Greater than or equal to 3	Not applicable	
Continuous severe behavioural problems	4 or 5	Not applicable	Not applicable	Not applicable	Any two of the following: E3a = 2 Wandering E3b = 2 verbally abusive E3c = 2 physically abusive E3d = 2 socially inappropriate E3e = 2 resists care E4 = 1 changes	

Decision Support Tool Exception Dementia Alternative Services

Primary Criteria	All appropriate community based resources have been tried and exhausted.		
MAPLe	**CPS**	**ADL Long Form**	**ADL Hierarchy**
4	Greater than or equal to 3	Less than or equal to 9	0,1,2
5	Greater than or equal to 3	Less than or equal to 9	0,1,2

- To prioritize this group consider:
  - Safety risks due to no informal care provider
  - Safety risks due to informal care provider expresses distress

Thank you very much
Questions or Comments?

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