

“Measuring Up”

Improving Health Systems Performance in OECD Countries



Measuring the quality of long-term care in institutional and community settings

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Health
Canada

Santé
Canada

Canada

What is long-term care?

- Variety of ongoing health and social services
- For individuals needing assistance on a continuing basis because of physical or mental disability
- Services provided in an institution, the home, or community
- Includes both informal and formal services

(Institute of Medicine, 1986)



Why is LTC difficult?

- Difficult to draw line between public and private responsibility
- Services require a mix of health and social services
- Governments are already burdened by pension and health care programs
 - reluctant to start a new entitlement program



Why should governments take on responsibility for LTC?

- Increasing demand for formal services:
 - Ageing society, decline in family support available
- Distortions and fiscal strains in health, social and housing programs
- Unfair allocation of limited LTC formal services
- Need for an equitable and efficient publicly funded LTC program



How to ensure equitable access

- Need to establish equitable and affordable entitlement standards for publicly funded LTC services
 - Fairness in access: First criterion of quality
 - An assessment instrument for evaluating need
 - Reliability essential: Amount of resources may depend on how the patient is evaluated in one key assessment item
 - Explicit guidelines or algorithm for allocating services
 - Training staff to appropriately use the instrument
 - Formal mechanisms for monitoring program
- Policy makers must decide on levels of entitlement, researchers can provide evidence-based options



Measuring quality of LTC services

- “Tender loving care”
 - As close to that given by family members
- Standards set by the service industry
 - Friendliness of staff, clean room
- Traditional standards of quality
 - Staffing levels in institutional settings
 - Professional qualifications of staff
- Professional standards of quality
 - Slowing rates of decline, improving quality of life

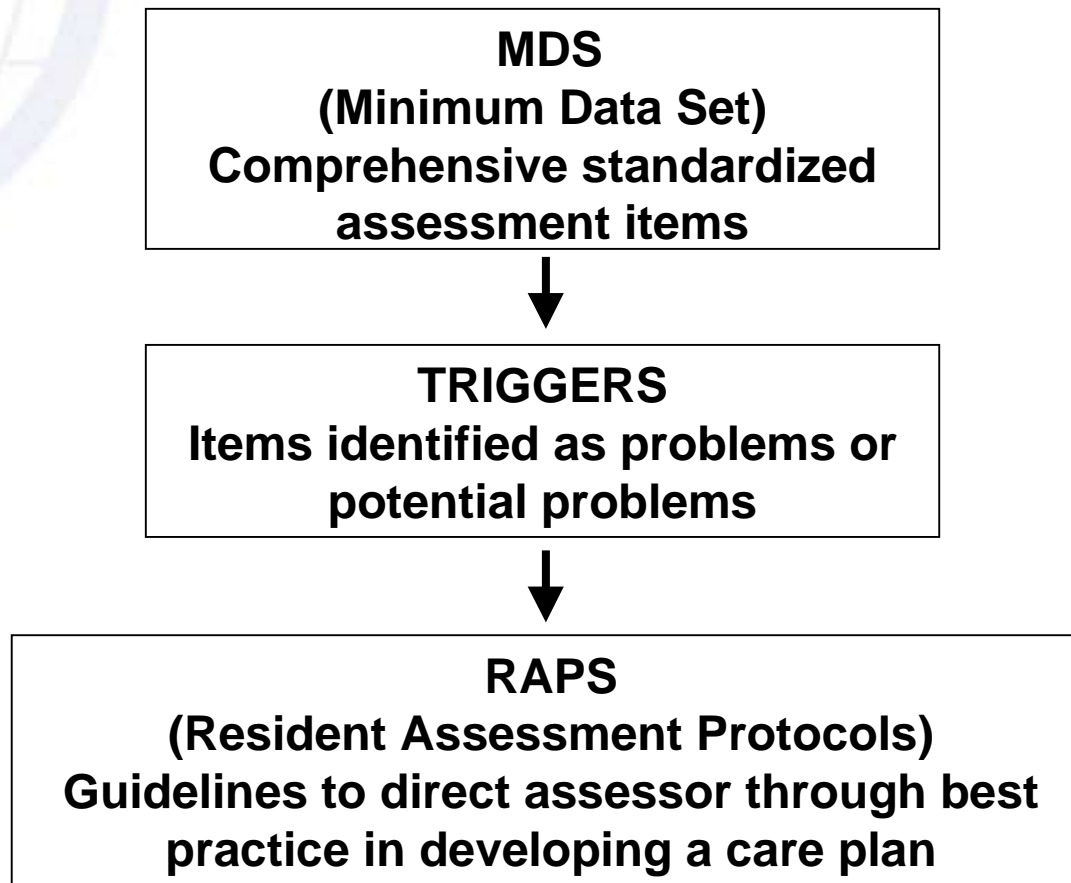


The development of the RAI

- Need for a uniform, comprehensive resident assessment system
- For care planning of residents, and monitoring of quality by the government
- RAI (Resident Assessment Instrument) implemented in United States in 1991 and required for virtually all nursing homes
- Also mandated in Iceland, two provinces of Canada
- Translated and validated in over 21 countries



Structure of the RAI system



Resident Assessment Protocols

- Delirium
- Visual Function
- ADL Functional/Rehabilitation
- Psychosocial Well-being
- Behaviour Problems
- Falls
- Feeding Tubes
- Dental Care
- Psychotropic Drug Use
- Cognitive Loss/Dementia
- Communication
- Urinary Continence/Catheter
- Mood State
- Activities
- Nutritional Status
- Dehydration/Fluid Maintenance
- Pressure Ulcers
- Physical restraints



interRAI

- What is it?
 - international group of 40+ researchers and clinicians (mainly MDs and PhDs)
 - registered as not-for-profit corporation
 - owns international rights to RAI/MDS instruments
- What does it do?
 - Conducts multinational collaborative research to develop, implement and evaluate the RAI/MDS instruments and their related applications



interRAI Countries



Nordic Countries

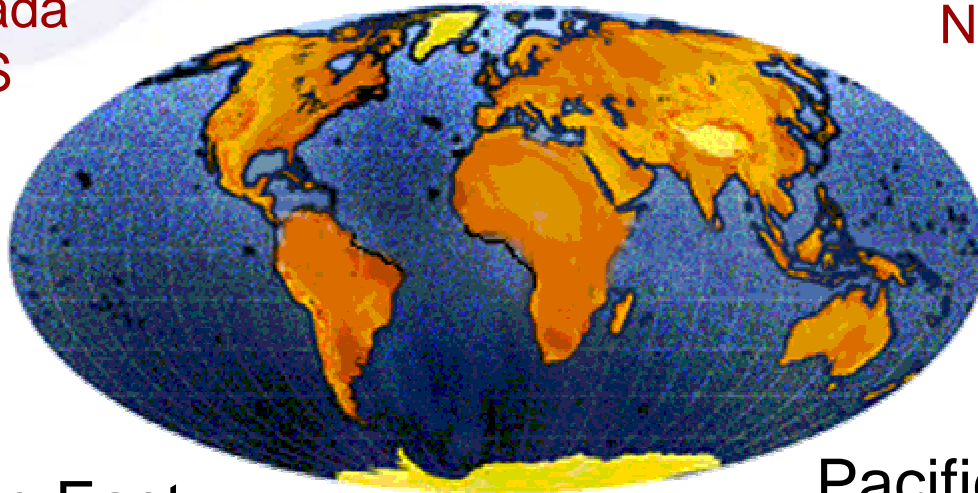
Iceland, Norway, Sweden, Denmark, Finland

North America

Canada
US

Europe

Netherlands, Germany,
Switzerland,
France, UK
Italy, Spain,
Czech Republic,
Estonia*



Middle East

Israel

Pacific Rim

Japan, South Korea, Taiwan, Hong Kong,
Australia, New Zealand*

* Blue indicates countries with projects underway in collaboration with interRAI Fellows

The development of the RAI-HC

- Developed by *interRAI* in 1996 (updated 1999)
 - Tested in multiple countries before completion
- Broader in scope compared with institutional care
 - Role of informal support, elder abuse
 - IADL (Instrumental ADL: preparing meals etc.)
 - Adherence to care, environmental factors
- Assessment form shorter in length
- More reliance on second level 30 CAPs



The use of the RAI-HC

- CAPs provide opportunities for cross-training and self-education
 - Those providing services in the community are alone
 - Greater need to cover both health and social services
- MDS and MDS-HC share core assessment items
 - Possible to track individuals between the two
- RAI-HC translated and validated in over 10 countries
 - Implemented in 9 US states
 - 5 Canadian provinces expected to implement
 - Most widely used assessment instrument in Japan
 - EU 5th Framework study in 11 EU countries



Quality Indicators based on MDS data

- Indicators to evaluate care based on:
 - Process of care
 - Polypharmacy, restraint use, indwelling catheters
 - Outcome of care
 - New fractures, increase in cognitive impairment
- 24 Quality Indicators calculated from the MDS data of each facility
 - No need to collect new data for evaluating quality
- Quality indicators' rates compared among facilities
 - Strengths and weaknesses of each facility made clear



Examples of MDS Quality Indicators

- **Outcome QIs**
 - Prevalence of falls
 - Prevalence of problem behavior toward others
 - Incidence of cognitive impairment
- **Process QIs**
 - Use of 9+ scheduled medications
 - Prevalence of daily physical restraints
 - Prevalence of indwelling catheters
- **Combined QIs**
 - Prevalence of occasional/frequent bladder/bowel incontinence with no toileting plan
 - Insulin-dependent diabetes with no foot care
- **Other QIs**
 - Prevalence of tube feeding
 - Prevalence of little or no activity

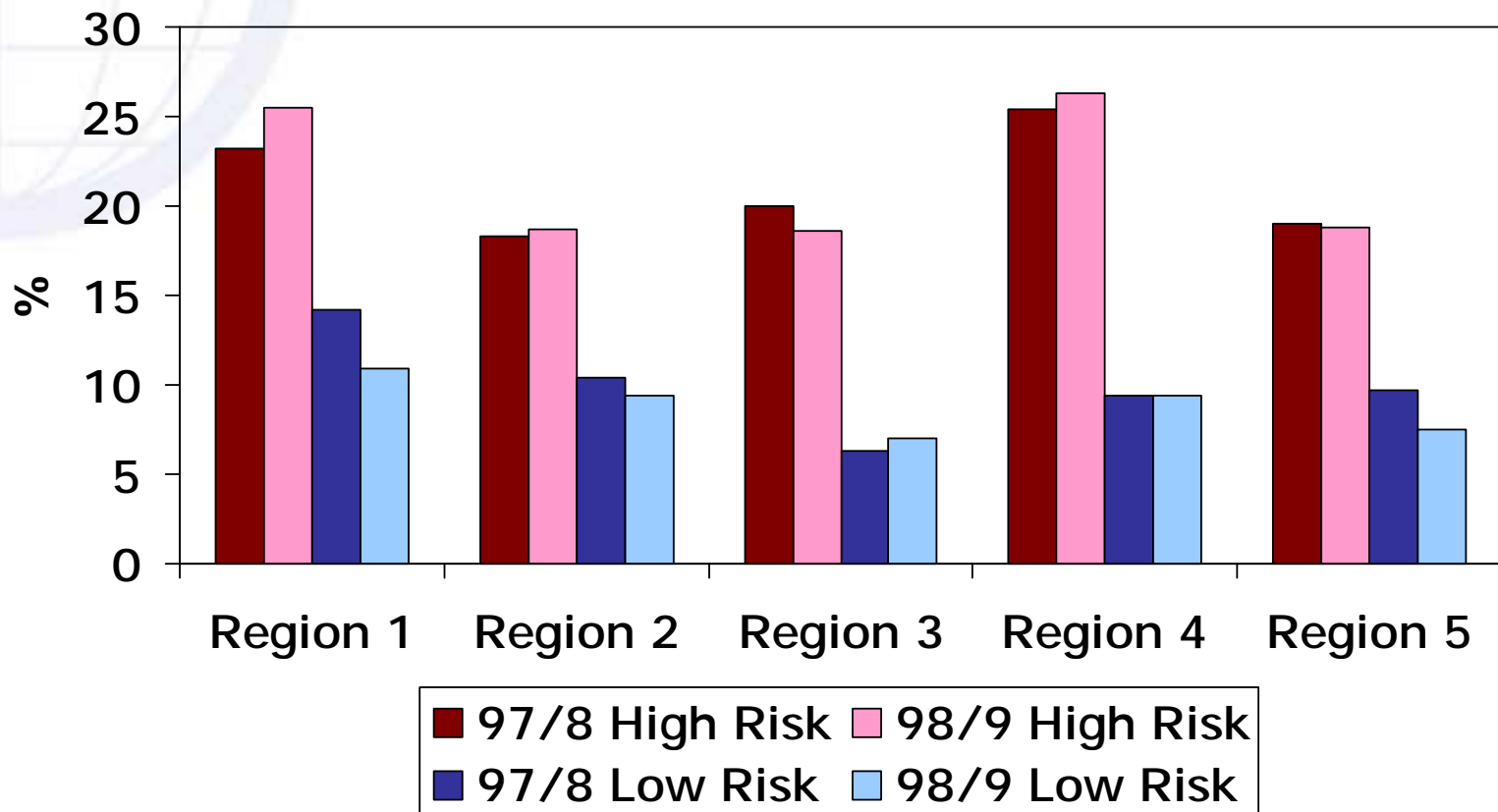


Conditions that must be met for measuring quality in LTC

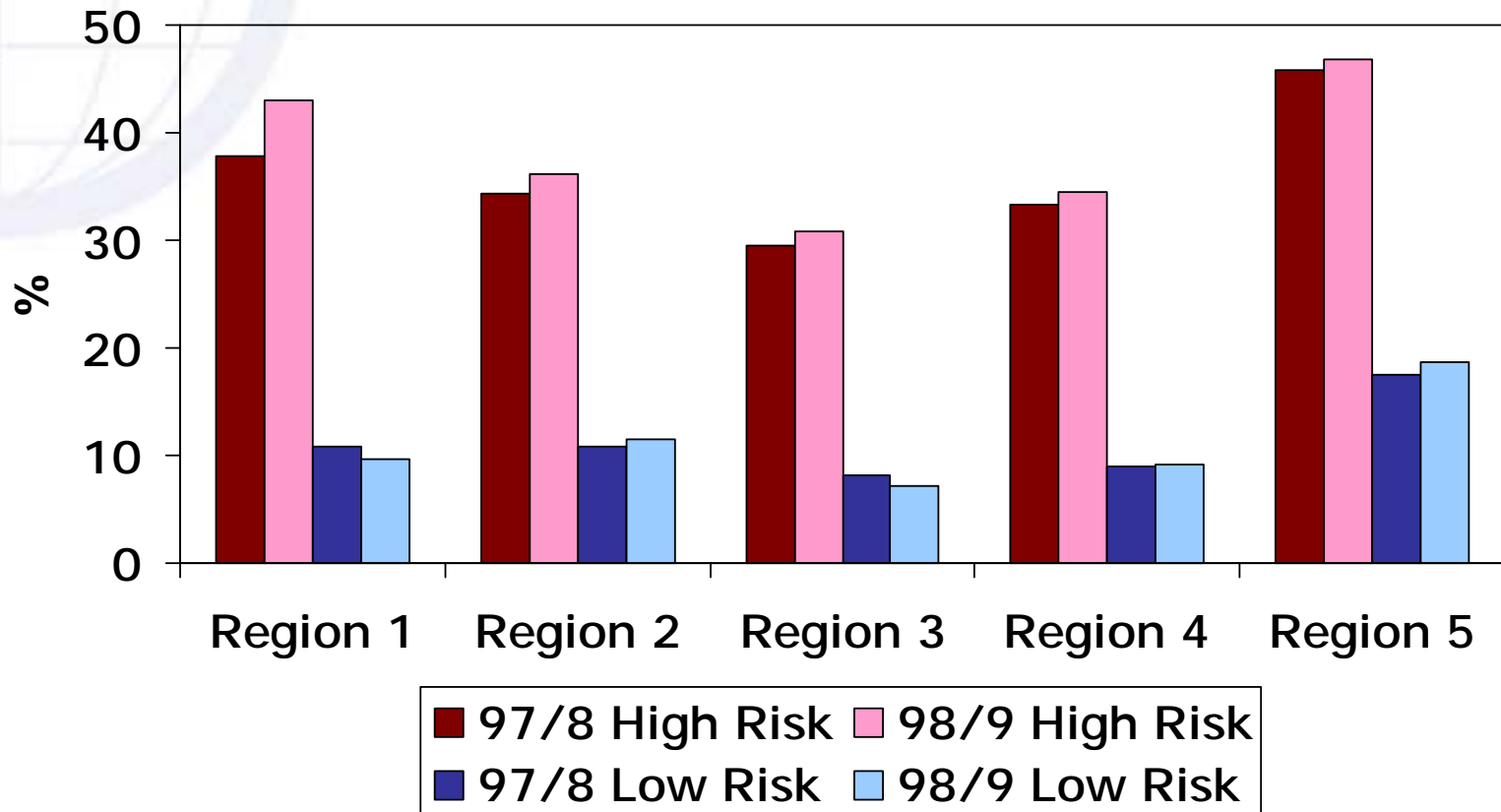


- Reliable and valid standardized assessment instruments
 - RAI and RAI-HC have been tested in many countries
 - Designed for clinical and administrative use
- Methodology for interpreting data
 - New Quality Indicators provide benchmarks
- Databases of the assessment information
 - More efficient if also used for payment purposes
 - Possible to track individuals across sectors
- Training of clinicians and administrative staff

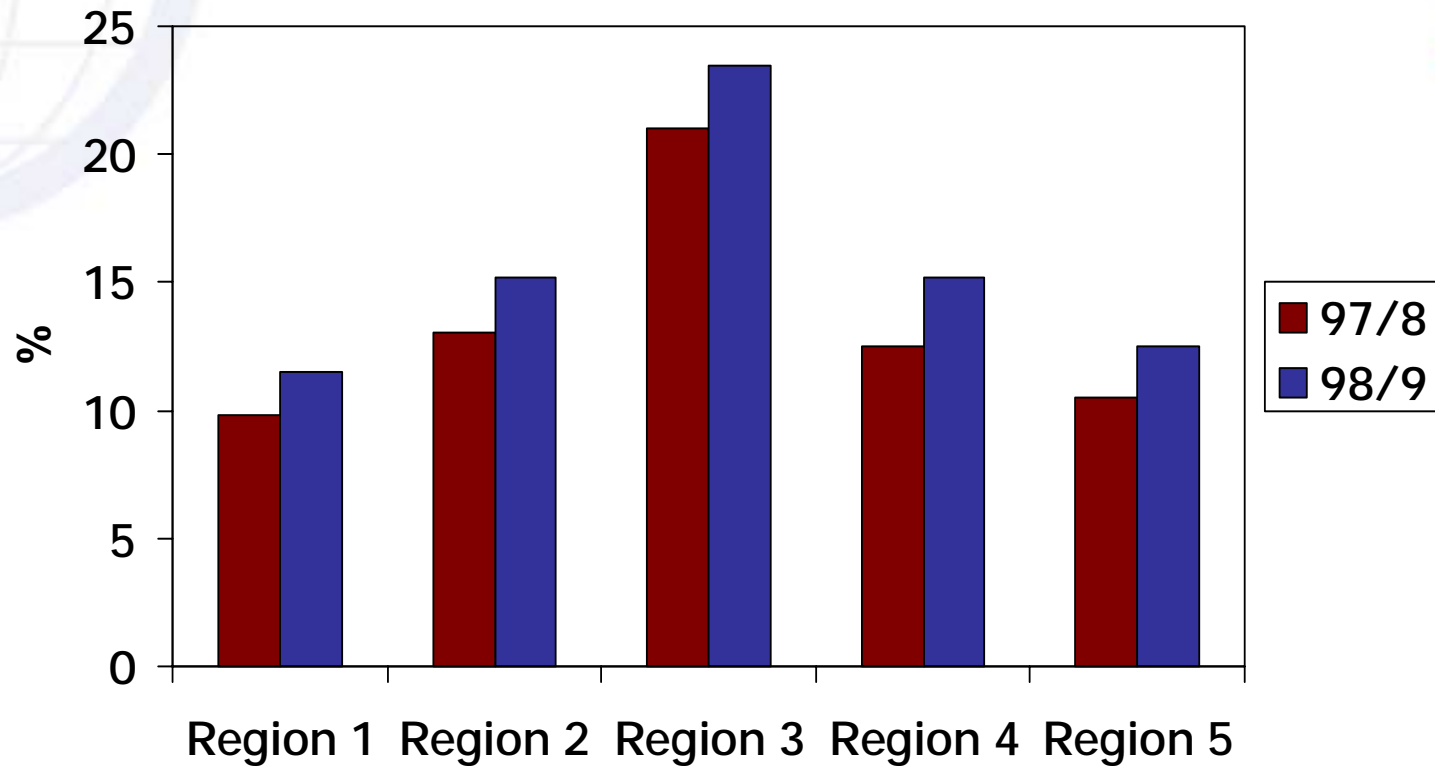
Prevalence of Stage 1-4 Pressure Ulcers by Risk Status, Ontario, 1998-9



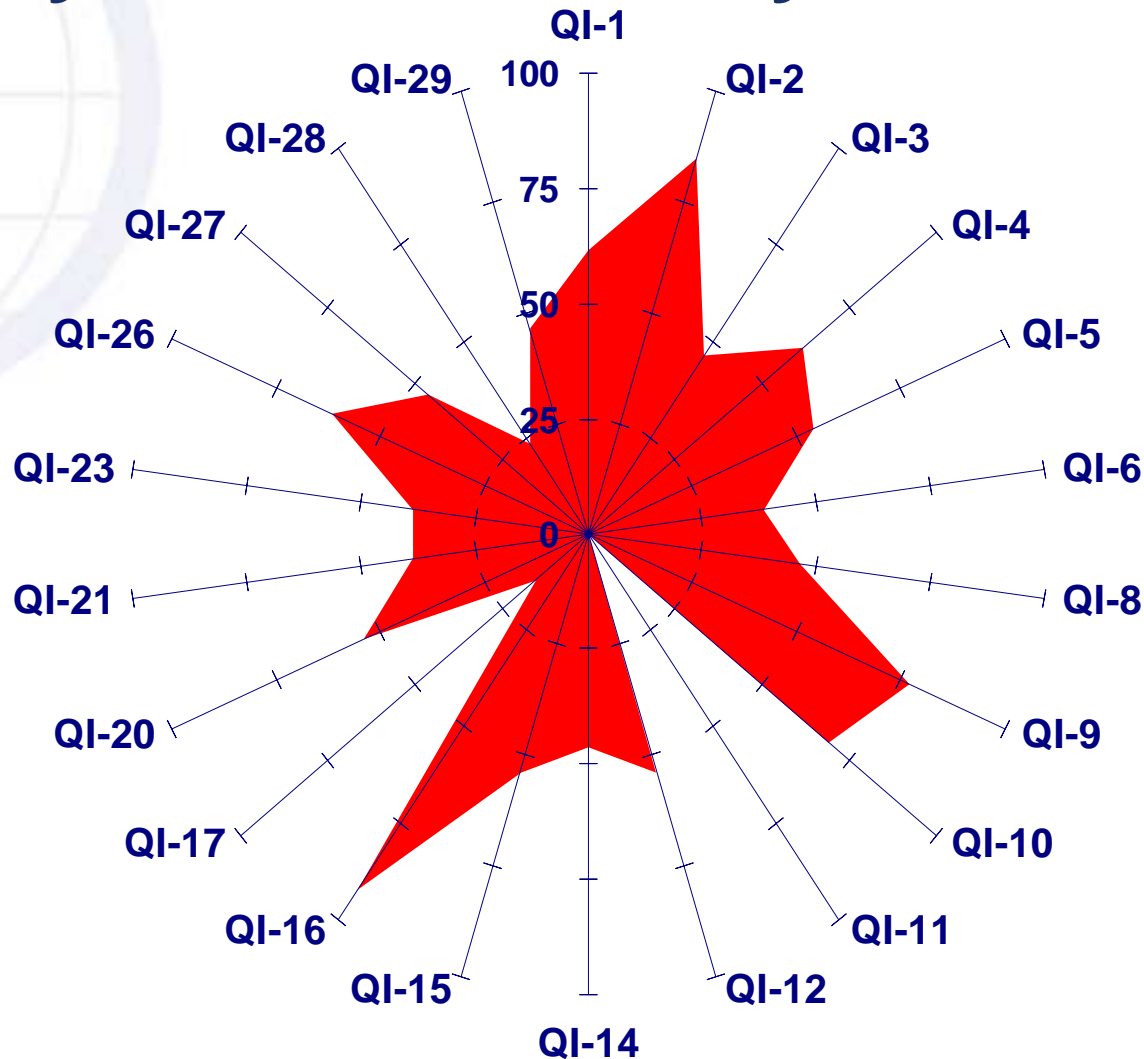
Prevalence of Antipsychotic Use in Absence of Psychotic Conditions by Risk Status, Ontario, 1998-9



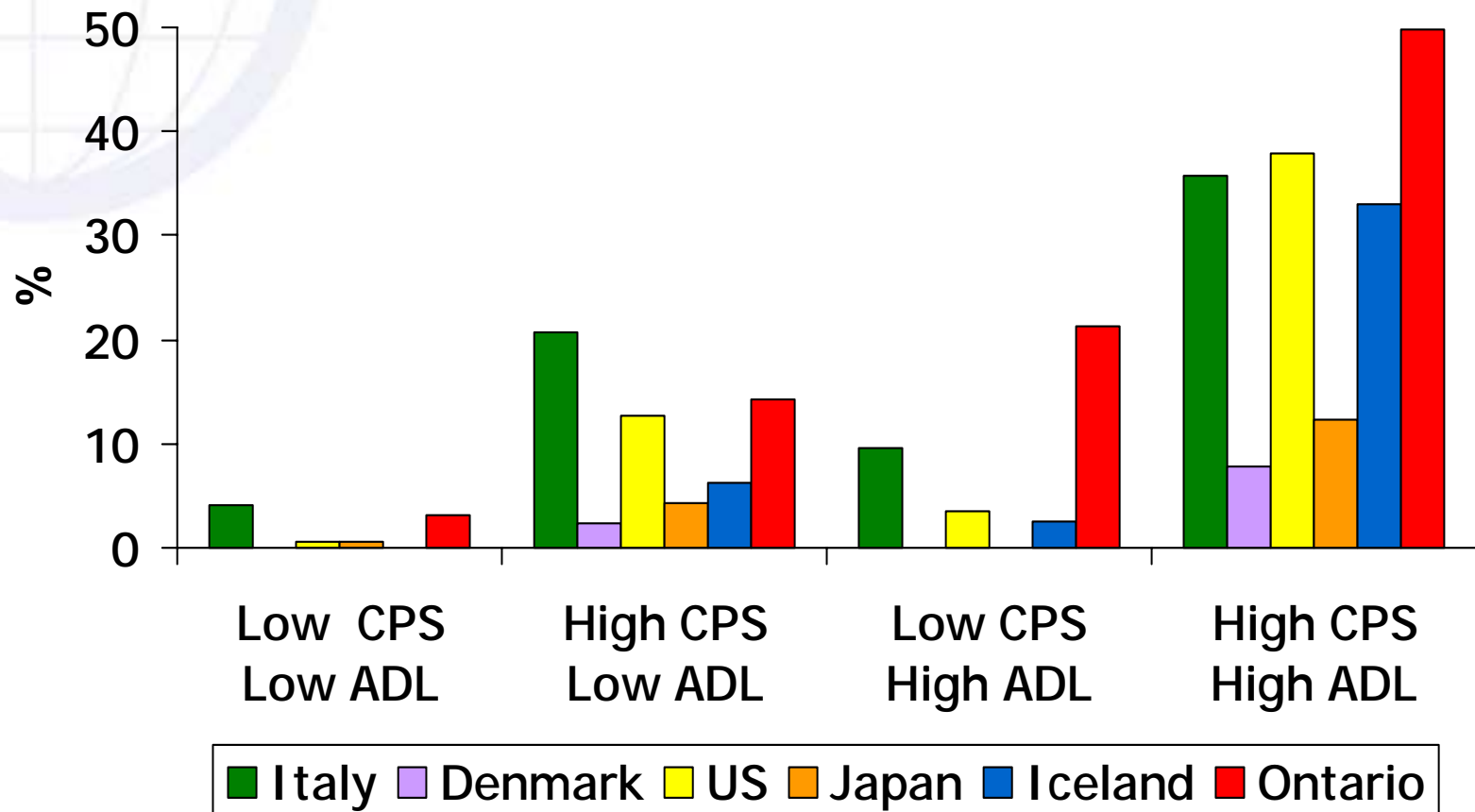
Prevalence of Tube Feeding by OHA Region, FY 97/98 & 98/99



Radar Plot of Percentile Ranks by Quality Indicator, Facility C, 1995



Prevalence of Daily Restraint Use by Cognitive Impairment and Disability



interRAI's Prevalence-based Home Care Quality Indicators

- **Nutrition**
 - Inadequate Meals
 - Weight Loss
 - Dehydration
- **Medication**
 - No medication review
- **Physical function**
 - No Assistive Device Among Clients with Difficulty in Locomotion
 - ADL/Rehabilitation Potential & No Therapies
- **Psychosocial function**
 - Social Isolation w/ Distress
 - Delirium
 - Negative mood
- **Pain**
 - Disruptive/Intense Pain
 - Unmanaged Pain
- **Safety/Environment**
 - Falls
 - Any injuries
 - Neglect/Abuse
- **Other**
 - Not Receiving Influenza Vaccination
 - Hospitalization

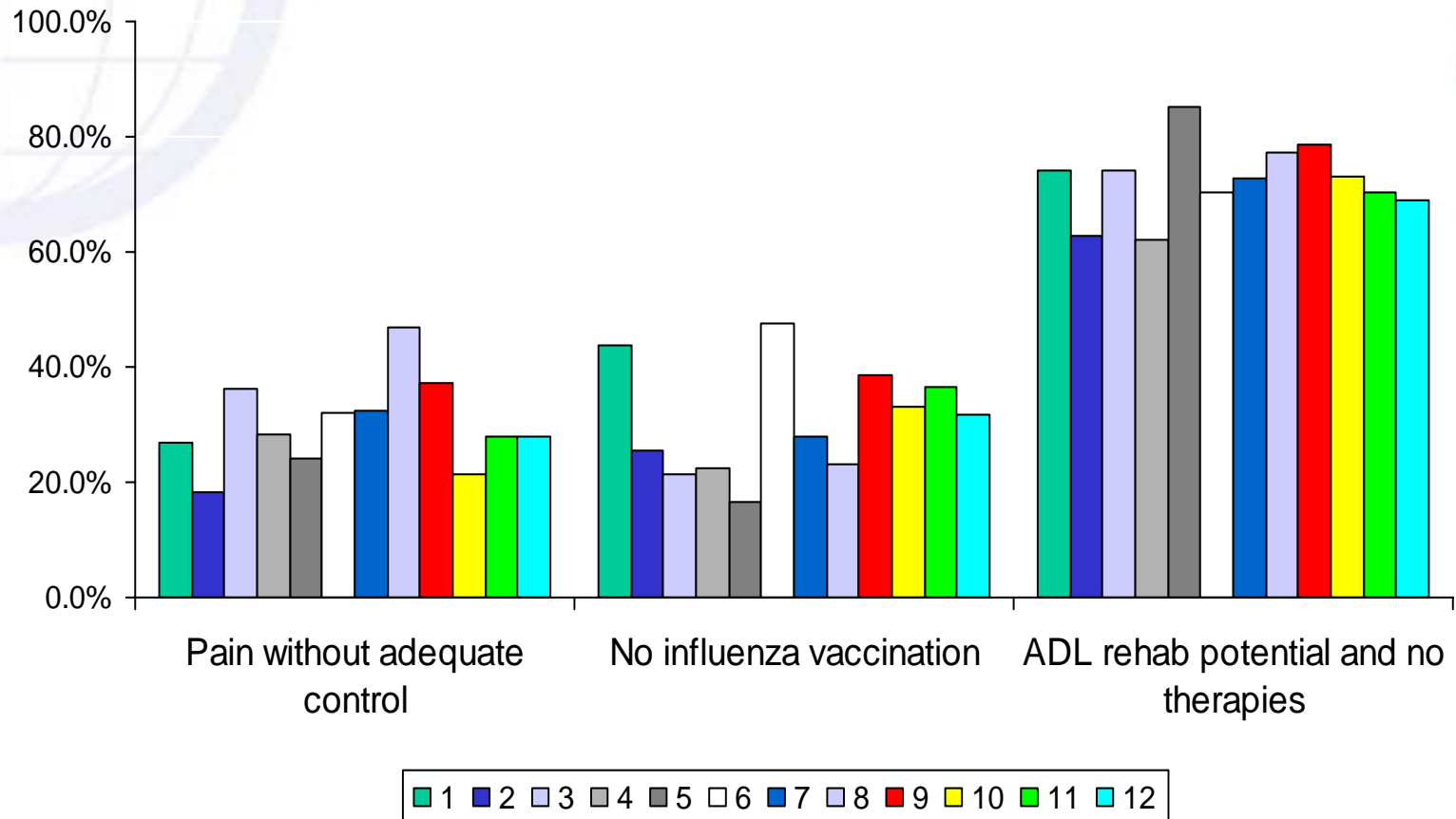


interRAI's Incidence-based Home Care Quality Indicators

- Incontinence
 - Failure to improve/
incidence of bladder
continence
- Ulcers
 - Failure to improve/
incidence of skin ulcers
- Physical function
 - Failure to improve/
incidence of decline on
ADL long form
 - Failure to improve/
incidence of impaired
locomotion in the home
- Psychosocial function
 - Failure to improve/
incidence of cognitive
decline
 - Failure to improve/
incidence of difficulty
in communication



Prevalence HCQIs by CCAC, Ontario (n=2963)



The RAI Family of Instruments

- Chronic care/nursing homes
 - RAI 2.0
- Home Care
 - RAI-HC2
- Mental Health
 - RAI-MH2
- Assisted Living
 - RAI-AL
- Acute Care
 - RAI-AC
- Post-Acute Care-Rehabilitation
 - RAI-PAC
- Palliative Care
 - RAI-PC
- interRAI Screener



Where can I get more information?

- www.interrai.org
- Canadian Journal on Aging, Special *interRAI* Issue, December 2000
- Age and Ageing, Special *interRAI* Issue, September 1997

