



NATIONAL INSTITUTE FOR HEALTH AND WELFARE

Quality of care in institutional-, and home care during 2001-2009, in Finland

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National Institute of Health and Welfare (THL)

1. Grounded in 1st January 2009,
2. Maintains social and health registers for Finland through legislation (including RAI)
3. 1300-1600 employees
4. Under the Ministry of Social Welfare and Health
5. Independent research activities



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Contents

- RAI-benchmarking project launched in 2000
- Impact of benchmarking (?)
- Long/term care for older persons
- Summary
- Conclusions



"I've got it, too, Omar... a strange feeling like we've just been going in circles."



RAI

- Originates from the US (Resident Assessment Instrument)
- Copyright interRAI™, not-for profit research organisation
- Structure
 - Questionnaire
 - Manual
 - Guidelines
- Aim always is to improve care planning

MINIMUM DATA SET (MDS) – VERSION 2.0
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

Resident: _____ Numeric Identifier: _____

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME: a. (First) _____ b. (Middle initial) _____ c. (Last) _____ d. (Suffix) _____

2. ROOM NUMBER: _____

3. ASSESSMENT REFERENCE DATE: a. Last day of MDS observation period: _____
b. Original (O) or corrected copy of form (after number of correction): _____

4a. DATE OF RESIDENCY: Date of residency from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days): _____

5. MARITAL STATUS: 1. Never married 2. Widowed 3. Divorced 4. Separated 5. Deceased

6. MEDICAL RECORD NO.: _____

7. CURRENT RESIDENT SOURCE FOR THIS STAY: (Using Office to indicate; check all that apply in last 30 days)
Medicare per diem: _____ VA per diem: _____
Medicare ancillary per diem: _____ Medicaid resident liability or Medicare copayment: _____
Private insurance per diem (including copayment): _____
Other per diem: _____

8. REASONS FOR ASSESSMENT: (Mark—(N/A) if a discharge or reentry assessment; only a limited subset of MDS items are to be completed)
a. Primary reason for assessment:
1. Annual assessment (required by day 14) _____
2. Admission assessment (required by day 14) _____
3. Significant change in status assessment _____
4. Significant transition of prior full assessment _____
5. Quarterly review assessment _____
6. Discharge—medium not anticipated _____
7. Discharge—medium anticipated _____
8. Discharged prior to completing initial assessment _____
9. Significant correction of prior quarterly assessment _____
10. None of above _____
b. Special review for use with supplemental assessment (open to Case Mix demonstration states or other states where required):
1. 30 day assessment _____
2. 60 day assessment _____
3. 90 day assessment _____
4. Quarterly assessment using full MDS form _____
5. Medication/health assessment _____
6. Other skills required assessment _____
7. Medicare of-cycle (RUG) change assessment _____

9. RESPONSIBILITY LEGAL GUARDIAN: (Check all that apply)
Legal guardian: _____ Duration power of attorney/health care proxy: _____
Durable power of attorney: _____ Family member responsible: _____
Durable power of attorney/health care proxy: _____ Patient responsible for self: _____
None of above: _____

10. ADVANCED DIRECTIVES: (Check all that apply)
Living will: _____ Feeding restrictions: _____
Do not resuscitate: _____ Medication restrictions: _____
Do not transplant: _____ Other treatment restrictions: _____
Organ donation: _____
Autopsy request: _____ None of above: _____

SECTION B. COGNITIVE PATTERNS

1. COMATOSE: (Check all that apply)
a. Resident requires direct, observable stimulation to become alert: _____
b. No: _____ (If yes, skip to Section G)

2. MEMORY: (Check all that apply)
a. Short-term memory OK—remembers to recall after 5 minutes: _____
b. Memory OK: _____ 1. Memory problem: _____
c. Long-term memory OK—remembers to recall long past: _____
d. Memory OK: _____ 1. Memory problem: _____

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING: (Mark hearing appliance, if used)
1. HEARS ADEQUATELY—normal talk, TV phone _____
2. HEARS IN SPECIAL SITUATIONS ONLY—speaker has to adjust tone, quality or speed clearly _____
3. HEARLY MARGINAL—hears some of what is said _____
4. DOES NOT HEAR AT ALL _____

2. COMMUNICATION TECHNIQUES: (Check all that apply)
Hearing aid, present and used regularly: _____
Hearing aid, present and not used regularly: _____
Other hearing comm. technique used (e.g., to hearing): _____
None of above: _____

3. MODES OF EXPRESSION: (Check all that apply)
Speech: _____
Sign/gestures/signals: _____
Writing messages to express or clarify needs: _____
Communication board: _____
Apostroph sign language or Braille: _____
Other: _____
None of above: _____

4. MEANS OF SELF UNDERSTOOD: (Check all that apply)
1. UNDERSTOOD _____
2. USUALLY UNDERSTOOD—difficulty finding words or phrasing: _____
3. SOMETIMES UNDERSTOOD—ability is limited to making concrete requests: _____
4. USUALLY UNUNDERSTOOD _____

5. SPEECH CLARITY: (Check all that apply in last 7 days)
1. CLEAR SPEECH—distinct, intelligible words: _____
2. UNCLEAR SPEECH—mumbled, mumbled words: _____
3. NO SPEECH—absence of spoken words: _____

6. ABILITY TO UNDERSTAND OTHERS: (Check all that apply)
1. UNDERSTANDS _____
2. USUALLY UNDERSTANDS—may miss some part/inform of message: _____
3. SOMETIMES UNDERSTANDS—responds adequately to simple, direct communication: _____
4. RARELY/NEVER UNDERSTANDS _____

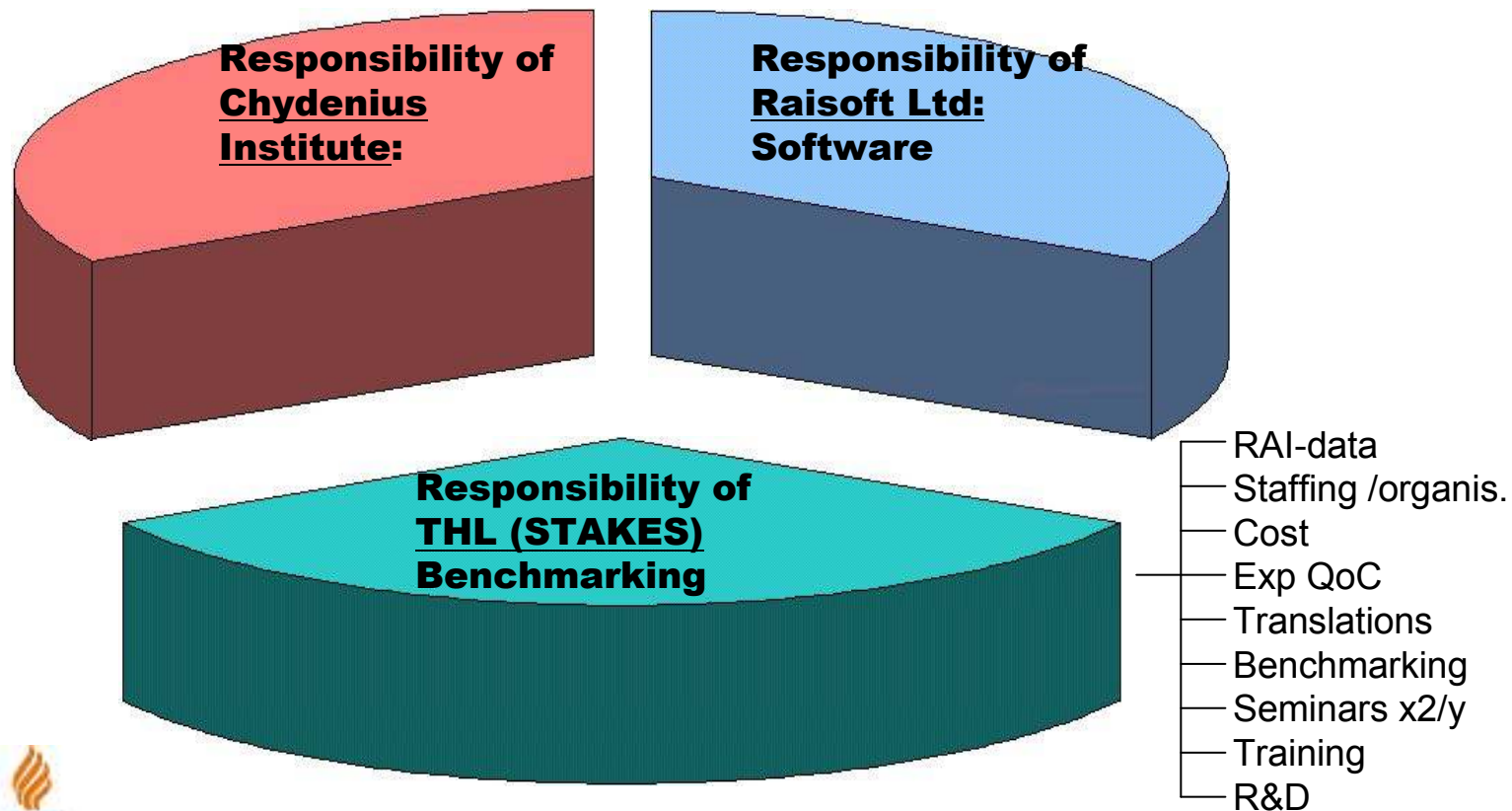
7. CHANGE IN COMMUNICATION/HEARING: (Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago or since last assessment if less than 90 days)
1. No change _____ 2. Improved _____ 3. Deteriorated _____

When box blank, must enter number or letter When letter in box, check if condition applies

MDS 2.0 (01/05/04)

The RAI-benchmarking concept – Finland

Slide (modified): Magnus Björkgren



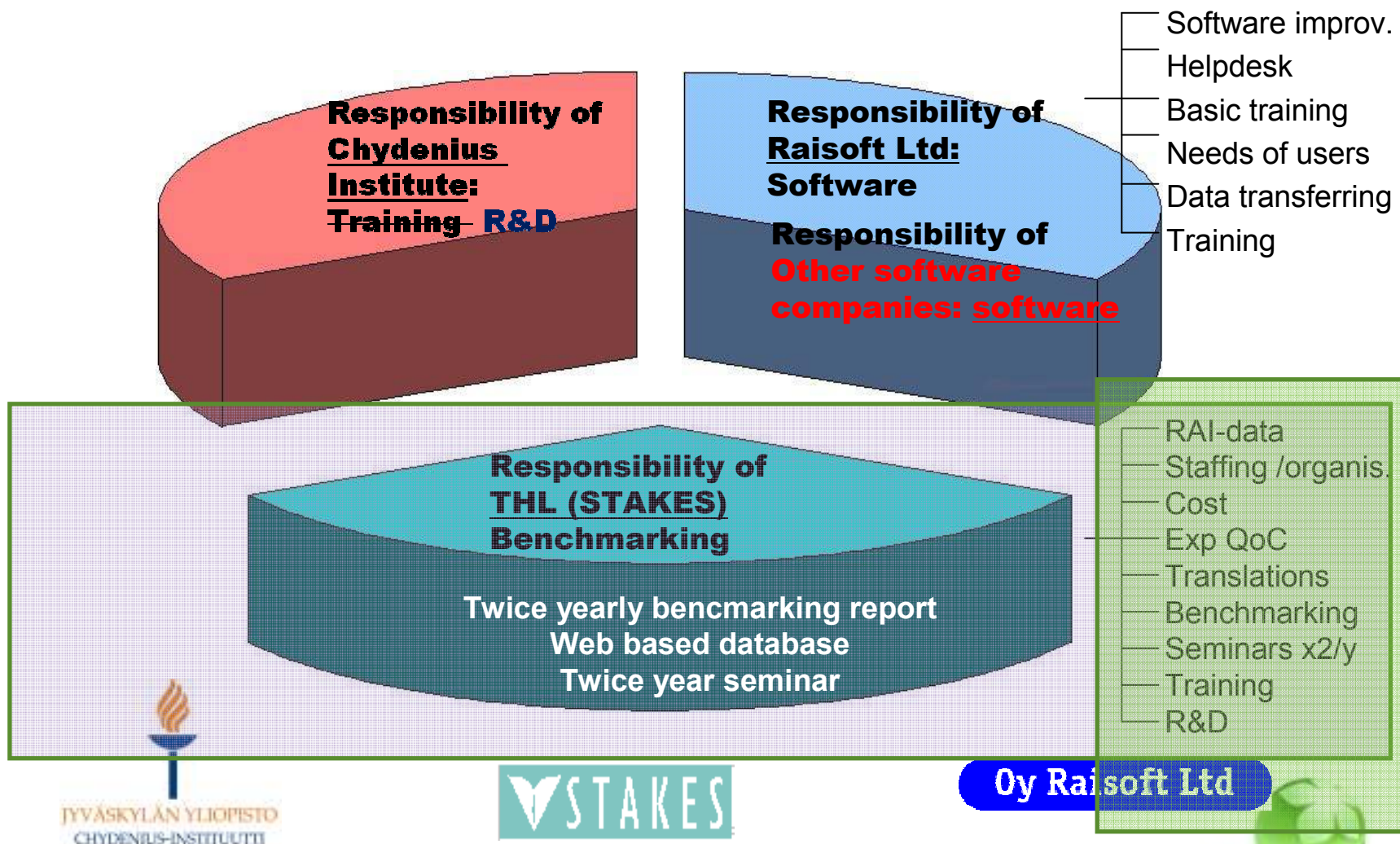
Oy Raisoft Ltd



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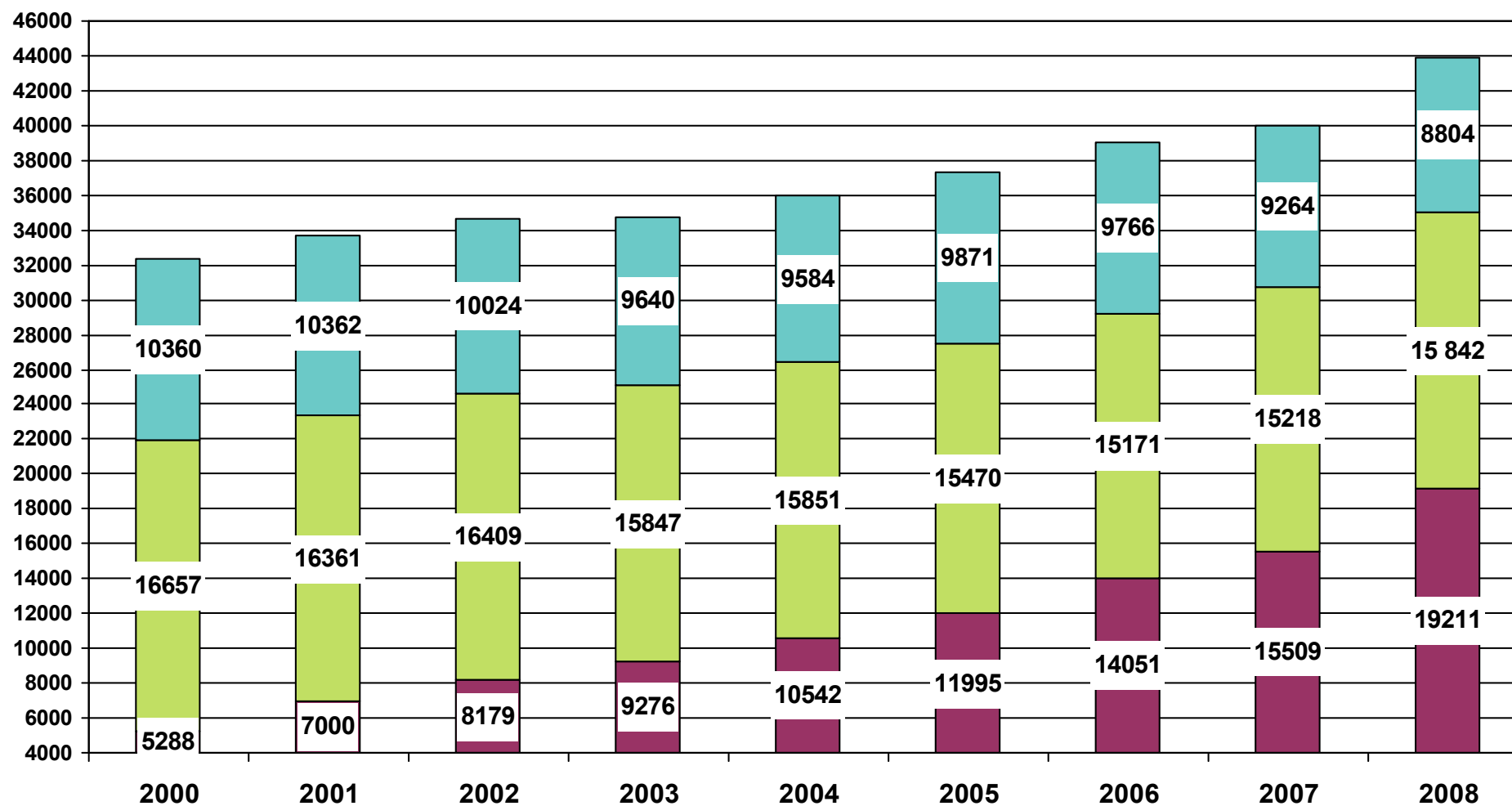
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Individuals (n) in 24/7 care, during 2000-2008 (Source: THL)



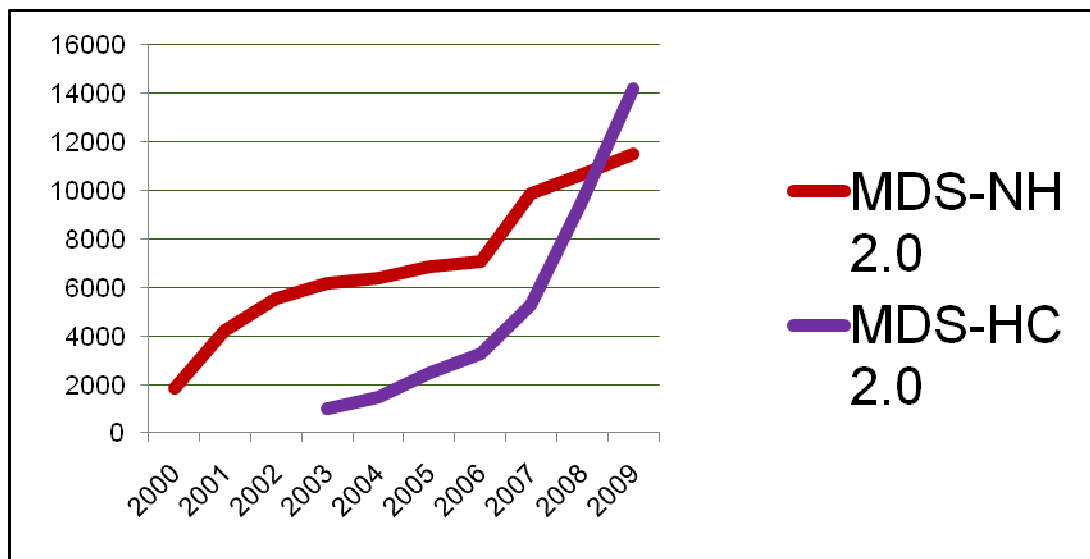
■ Terveyskeskusten 75 vuotta täyttäneet pitkäaikaisasiakkaat 31.12.

■ Vanhainkotien 75 vuotta täyttäneet pitkäaikaisasiakkaat 31.12.

■ Ikääntyneiden tehostetun palveluasumisen 75 vuotta täyttäneet pitkäaikaisasiakkaat 31.12.

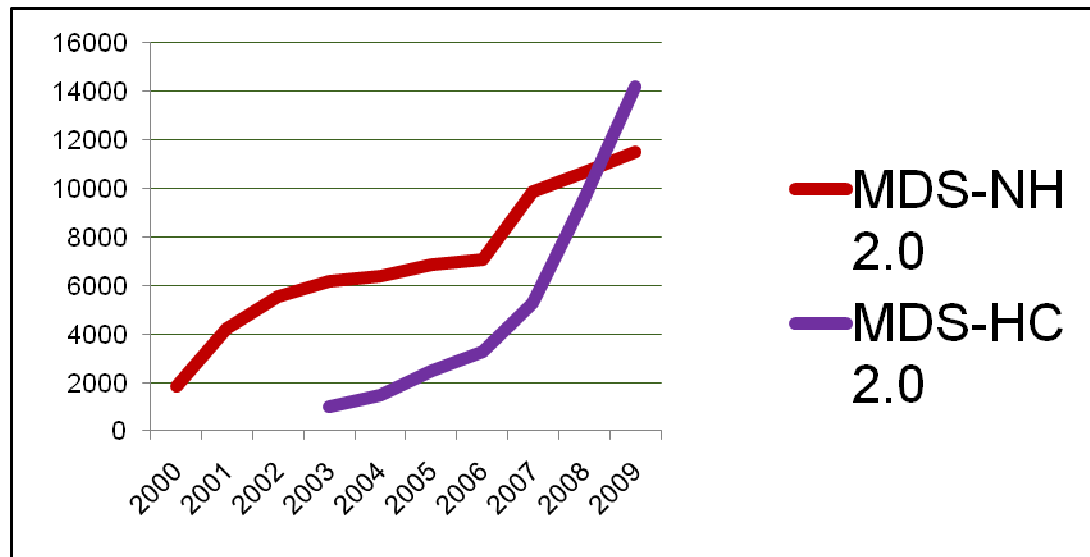
interRAI instruments in Finland

	MDS2,0	MDS HC	interRAI MH	interRAI CMH	interRAI AC	interRAI LTCF	interRAI ID	interRAI CA
2000	1826							
2001	4235							
2002	5530							
2003	6164	991						
2004	6384	1485						
2005	6864	2491						
2006	7093	3245						
2007	9856	5302						
2008	10677	9524	525	56				
2009	11477	14207	2000	100	500	600	50	510



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From the assessment to the impact QI:s for long-term care

1. University of Wisconsin (CHSRA) Quality Indicators were chosen in 1999/2000 QIs (total 26; 5 with risk adjustment, 4 measuring incidence 22 measuring prevalence)
2. Q-metrics
3. Mega QI's
 - The current official interRAI quality indicators focusing on transitions: What happens to the individual during the care episode

Zimmerman DR, Karon SL.
Developing and Testing of Nursing Home Quality Indicators.
Health Care Financing Review 1995;16:107-28.

Hirdes Fries BE, Morris JN, Ikegami N, Zimmerman D, Dalby DM,
Aliaga P, Hammer S, Jones R,
Home care quality indicators (HCQIs) based on the MDS-HC.
Gerontologist 2004; 44(5): 665-679.

Quality Domains

- Accidents
- Behavioral & Emotional Patterns
- Clinical Management
- Cognitive Functioning
- Elimination & Incontinence
- Infection Control
- Nutrition & Eating
- Physical Functioning
- Psychotropic Drug Use
- Quality of Life
- Skin Care

Source: www.CHSRA.wisc.edu/



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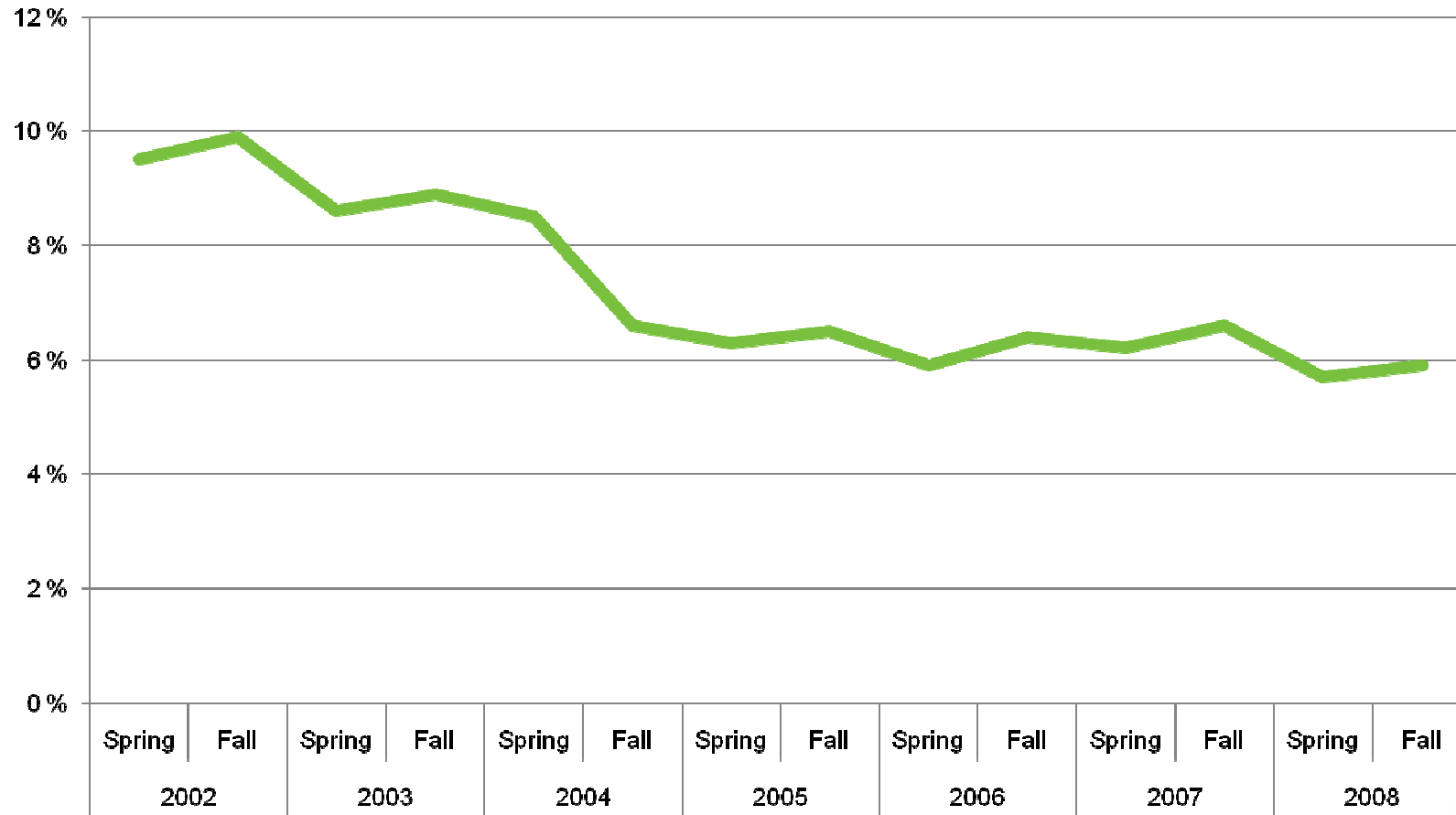
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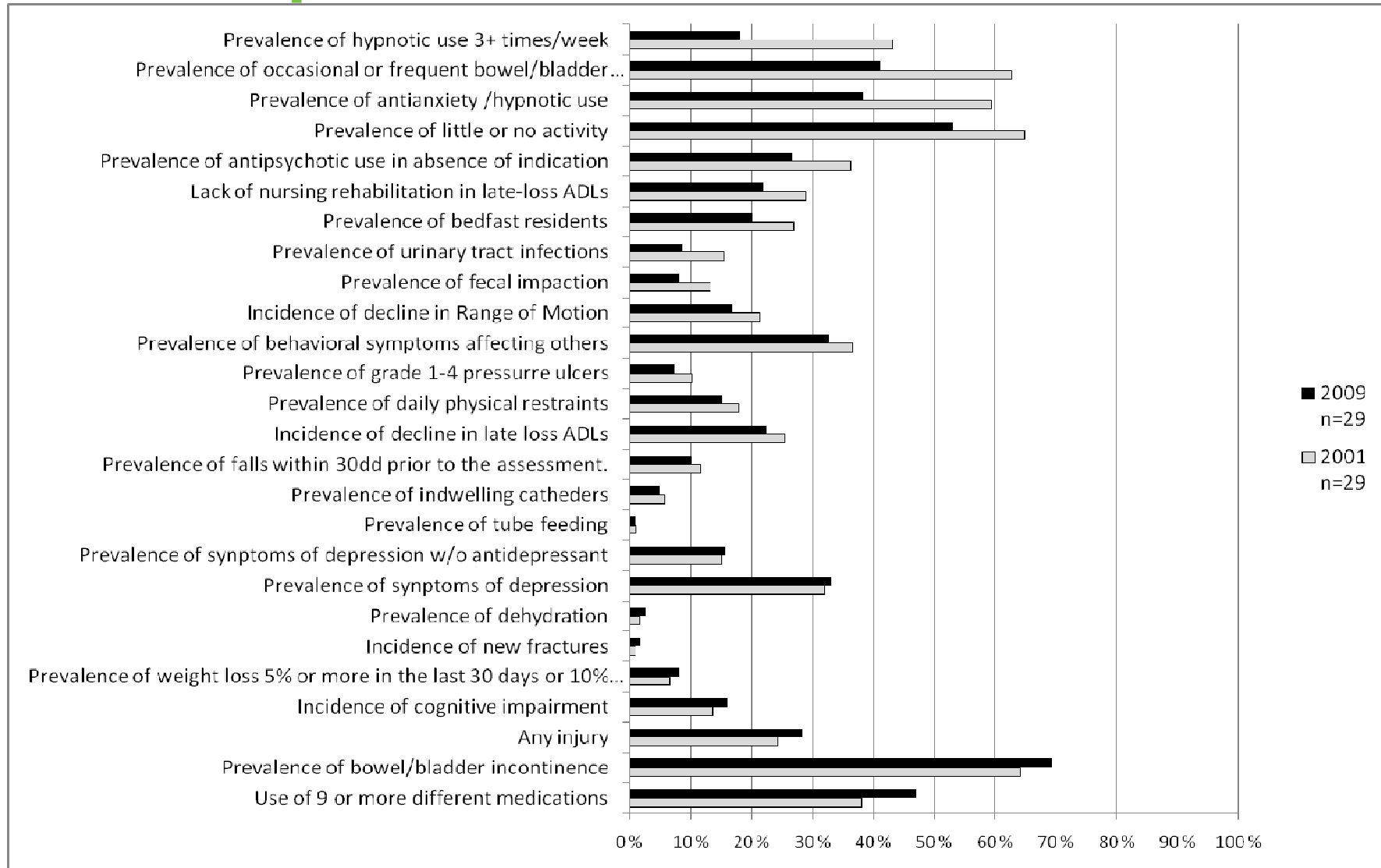
Light care residents in institutions 2002-2009



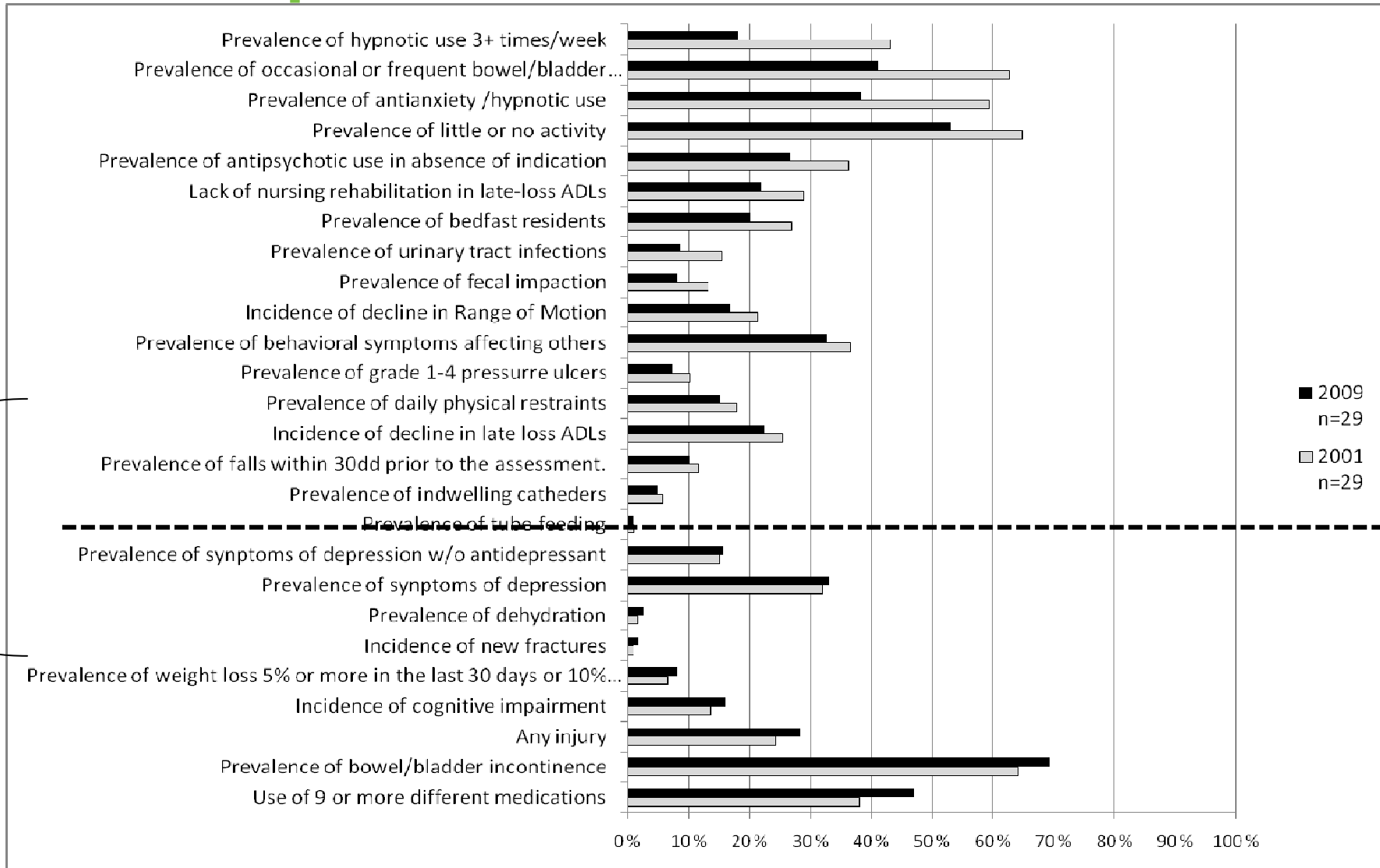
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Nine-year performance measure follow-up of 29 facilities








Nine-year performance measure follow-up of 29 facilities



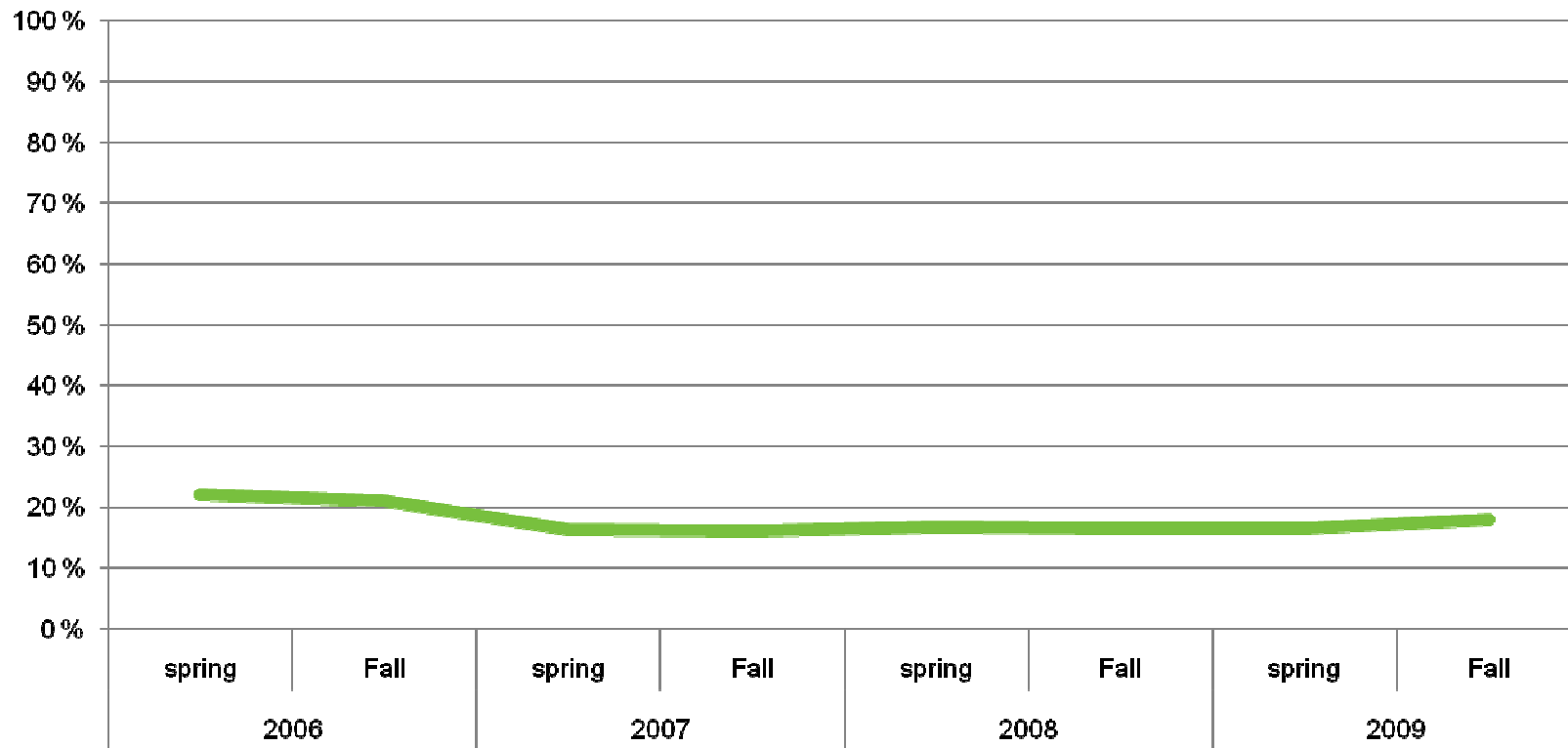
		2001 n=29	2008 (all) CCH & LTCF n=95	2008 CCH & LTCFs included in 2001 n=29
Deteriorated	Use of 9 or more different medications	34,9	41,4	41,8
2% or more	Incidence of cognitive impairment	11,1	15,2	14,9
	Prevalence of bowel/bladder incontinence	68,2	72	71,2
No change	Any injury	25,5	26,4	25
(+/-2%)	Prevalence of falls within 30dd prior to the assessment.	9,9	8,7	8,6
	Incidence of new fractures	0,8	1,1	1
	Prevalence of symptoms of depression	34	32,2	31,9
	Prevalence of symptoms of depression w/o antidepressant	14,9	15,9	15,6
	Prevalence of indwelling catheters	5,6	4,7	5,4
	Prevalence of weight loss 5% or more in the last 30 days or 10% or more in the last 6 months	7	7,3	7,8
	Prevalence of tube feeding	0,8	1,3	1,2
	Prevalence of dehydration	1,7	2	1,9
	Incidence of decline in late loss ADLs	23	24,4	23,3
	Incidence of decline in Range of Motion	17,22	17,9	16,8
	Prevalence of grade 1-4 pressure ulcers	9,8	8	8,8
Improved	Prevalence of behavioral symptoms affecting others	39,8	34,2	34,4
2-9%	Prevalence of occasional or frequent bowel/bladder incontinence w/o toileting plan	64,9	49,5	49
	Prevalence of fecal impaction	14,3	9,2	8,8
	Prevalence of urinary tract infections	14,3	8,8	8,7
	Prevalence of bedfast residents	29,5	24,6	25,8
	Lack of nursing rehabilitation in late-loss ADLs	28,4	28,8	22,3
	Prevalence of antipsychotic use in absence of indication	35,6	27,1	27,2
	Prevalence of daily physical restraints	20,3	16,7	16
Improved	Prevalence of antianxiety /hypnotic use	58,4	38,7	38
10 %or more	Prevalence of hypnotic use 3+ times/week	40,8	18,9	18
	Prevalence of little or no activity	65,5	56,4	52,1

		2001 n=29	2008 (all) CCH & LTCF n=95	2008 CCH & LTCFs included in 2001 n=29	
Deteriorated 2% or more	Use of 9 or more different medications	34,9	41,4	41,8	
	Incidence of cognitive impairment	11,1	15,2	14,9	
	Prevalence of bowel/bladder incontinence	68,2	72	71,2	
No change (+/-2%)	Any injury	25,5	26,4	25	
	Prevalence of falls within 30dd prior to the assessment.	9,9	8,7	8,6	
	Incidence of new fractures	0,8	1,1	1	
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	Improved 2-9%	Prevalence of behavioral symptoms affecting others	39,8	34,2	34,4
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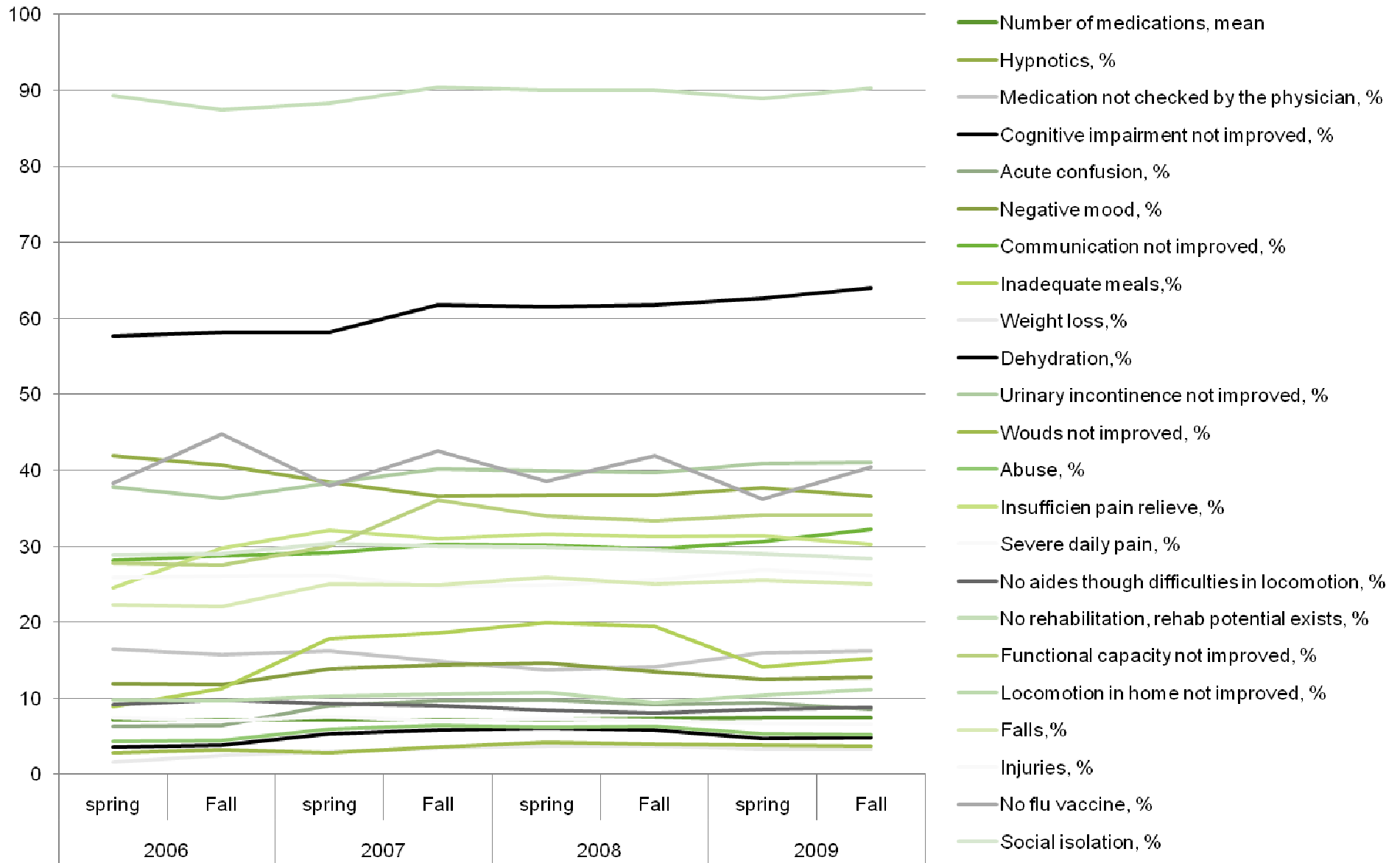
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Light care residents in home care 2006-2009

Lightcare, %



Home care Qis 2006-2010



Quality-efficiency ladder, in the care for older persons, in Finland


<p><u>Chronic care hospitals</u></p> <ul style="list-style-type: none"> • Functional capacity: ADL=4,4 • Cognition: CPS=4,0 (MMSE 7) • Mood: DRS=1,9 • Behaviour: BEH=1,9 • Staffing ratio: 0.69 carers/person
<p><u>Nursing home</u></p> <ul style="list-style-type: none"> • Functional capacity: ADL=3,6 • Cognition: CPS= 3,5 (MMSE 21) • Mood: DRS= 2,4 • Behaviour: BEH= 2,2 • Staffing ratio: 0.66 carers/person
<p><u>Assisted living (sheltered housing) - night time help is available</u></p> <ul style="list-style-type: none"> • Functional capacity: ADL=2,6 • Cognition: CPS=3,2 (MMSE 14) • Mood: DRS=2,2 • Behaviour: BEH=2,1 • Staffing ratio: 0.57 carers/person
<p><u>Assisted living (sheltered housing) -no night time help available</u></p> <ul style="list-style-type: none"> • Functional capacity: ADL=1,25 • Cognition: CPS=1,9 (MMSE 19) • Mood: DRS=1,4 • Behaviour: BEH=1,3 • Staffing ratio: 0.36 carers/person
<p><u>Integrated home care (social+health)</u></p> <ul style="list-style-type: none"> • Functional capacity: ADL=0,68 Scale 0-6, 0=independent, 6=totally dependent • Cognition: CPS=1,3 (MMSE 21) Scale 0-6, 0=normal, 6=very severe dementia • Mood: DRS=1,4 Scale 0-14, 0-2=normal, 3+=depression • Behaviour: BEH=0,6 Scale 0-5, 0=none, 5=all measured problems • Staffing ratio: 0.17 carers/person

- Long-term care for older persons, in Finland, is delivered either at home, in sheltered housings, residential homes (nursing homes), or health centre inpatient wards (chronic care hospitals).
- In 2008, more than 10 % of those 75 years of age or older received 24-hour care elsewhere than in their original homes and 6% lived in institutions



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Summary

- The long-term care sector is under construction
- Burden of care has slightly increased in the units and in home-care
- Incontinence and pain need special attention
- Reducing restraints in the institutions is a further issue
- Improvement in institutions seen in
 - nutritional procedures and outcomes
 - fall prevention
 - pressure ulcers
 - psychotropic medications
 - nursing procedures such as rehabilitative care
 - possibilities for social life have increased slightly
- Further analyses are needed to unveil the nature of these changes
- Trends of improvement are not as visible in home care WHY?



Conclusions-2

- We are on the right way, in Finland, but not there yet
- Home care needs special attention
- Quality of care and cost of it are not always contradictory
- Use of standardized data gathering and documenting instruments, such as RAI, is a useful method of gathering comparable information from different care providers in the elderly care sector
- Benchmarking pays off with strong leaders and clear targets



In real life there are no simple solutions

