interRAI New Zealand – Future Direction 2018-2021

What is interRAI?

interRAI is a suite of clinical assessment tools used in over 30 countries. In New Zealand we use interRAI as the primary assessment instrument in aged residential care and home and community services for older people.

A consortium of international experts develop interRAI assessment instruments following evidence based best practice guidelines.

Assessment information automatically goes to a data warehouse, and population data is available and can be used for service development, planning and research.

interRAI in New Zealand

New Zealand is the first country in the world to introduce the standardised use of interRAI assessment tools nationwide. This quality, consistent approach to assessment and care planning provides a solid platform to further enhance the services delivered in our communities.

The primary purpose of interRAI assessment is to accurately determine the characteristics of a person in order to fully understand their needs, ranging from clinical to social support and prepare a care plan. The information provided by interRAI assessment supports the decisions made by a healthcare professional.

Each assessment has items specific to the assessment, for example, palliative items for the Palliative Care assessment instrument, as well as a set of core items that are shared across assessments.

A person's responses to the assessment and the outcome measures produced may be tracked over time and across a continuum of care.

The interRAI suite consists of over 20 assessment instruments covering different areas of healthcare, for more about available assessments see www.interrai.org

Assessments currently used in New Zealand

Name of assessment	Description
interRAI Contact Assessment (CA)	A basic screening assessment that provides clinical information to support decision making about the need and urgency for a comprehensive assessment, support and specialised rehabilitation services. It is used for continuing evaluation of those with non-complex needs living in the community at home.
interRAI Community Health Assessment (CHA)	The Community Health assessment and its accompanying supplements is a modular approach to comprehensive clinical assessment. Everyone is assessed using the core assessment, then only those older adults with specific problem areas receive one or more of the additional assessments: • Functional Supplement: Mental Health • Deaf-Blind and • Assisted Living. The Community Health assessments together with the functional supplement are the same as the Home Care assessment.
interRAI Home Care Assessment (HC)	A comprehensive clinical assessment that informs and guides the planning of care and services in community-based settings. It focuses on the person's functioning and quality of life and helps support clinical decision-making when considering aged residential care.
interRAI Palliative Care Assessment (PC)	A comprehensive assessment of the strengths, preferences and needs of community-based older adults where a palliative care focus is required.
interRAI Long Term Care Facilities Assessment (LTCF)	A comprehensive assessment for evaluating the needs, strengths and preferences of those in aged residential care. The assessment enables a health care provider to assess key issues that will help with individualised care planning.

The benefits of interRAI

interRAI tools are internationally validated and share a common language; that is, they refer to the same clinical concepts in the same way across different tools. Using common measures enables clinicians and providers in different care settings to improve continuity of care and to integrate the care and supports needed for each individual.

The interRAI software displays information for clinical decision making and care planning. It highlights opportunities for improvement for the person and potential areas of decline and focuses on the creation of individualised care plans, which can lead to improved health outcomes.

The assessment software allows for the information captured to be collected once and used many times. The single national software platform means assessments can take place at the individual's current point of care and move with them to different care settings.

The data from each assessment may be aggregated to provide a range of outputs such as clinical decision support tools, case-mix classification systems, quality improvement and benchmarking, monitoring measures, and screening algorithms to target priority groups or identify groups that are at relative risk of adverse outcomes.

interRAI New Zealand Governance Board

The Director-General of Health appointed the interRAI NZ Governance Board (the Board) to support the vision for interRAI in New Zealand. The Board is a governance board under the authority given to it by the Ministry of Health under the licence with interRAI international.

The primary purpose of the Board

'The Governance Board members have been appointed by the Director-General of Health to provide leadership and oversight to interRAI New Zealand (interRAI NZ) to ensure the continuous improvement of health outcomes for New Zealanders as they age, and the effectiveness and efficiency of our health system by guiding and leading the use of interRAI instruments and the dissemination and use of interRAI information.

The Governance Board is a governance group with the authority to give direction and provide strategic governance for interRAI from a clinical, operational, and consumer perspective. The interRAI Governance Board will take strategic direction from the New Zealand Health Strategy and the Health of Older Persons Strategy.

New Zealand Health Strategy – Future Direction

The New Zealand Health Strategy was refreshed and published in April 2016. This is the first refresh of the New Zealand Health Strategy since 2000, it sets the direction for development during the next 10 years.

The strategy has five interconnected strategic themes as shown below:

interRAI is a key tool to be used in working towards the vision for health in New Zealand and supporting implementation across the five strategic themes.

interRAI NZ – Future Direction

The interRAI NZ – Future Direction is a three year rolling strategic plan updated in June each year. The Future Direction is based on the five strategic themes of the refreshed New Zealand Health Strategy and how interRAI can support the implementation of the strategy.

This three year plan is supported by the following key documents:

- MoU and Outcome Agreement with the MoH – Providing a national interRAI Service
- interRAI Services Business Plan 2018/19

The interRAI NZ – Future Direction 2018 - 2021 is described below in a one page format.

All New Zealanders live well, stay well, get well in a system that is people powered, provides services closer to home, is designed for value and high performance and works as one team in a smart system – New Zealand Health Strategy 2016

People Powered	Closer to Home	Value and High Performance	One Team	Smart System
Making New Zealanders 'health smart' Enabling individuals to make choices Understanding people's needs and preferences Supporting people to navigate the system	Providing care closer to where people live Integrating and making better connections Promoting wellness and preventing long term conditions Investing in health and wellbeing early	Striving for equitable outcomes Measuring performance well Building a culture of performance and quality improvement Using investment approaches to address complex health issues	Operating as a team in a high trust system Using our workforce in the most effective way Strengthening the roles of family, whanau and communities Collaborating with researchers	Taking advantage of new and emerging technologies Having data and smart systems that improve evidence based decisions Reliable, accurate information available at point of care Using standardised technology that allows changes easily and efficiently

To continuously improve health outcomes for New Zealanders as they age and the effectiveness and efficiency of our health system by guiding and leading the use of interRAI instruments and the dissemination and use of interRAI information

BETTER ASSESSMENT, BETTER CARE, BETTER OUTCOMES

12 months • actionable information from interRAI data will facilitate better understanding of people's needs • healthcare providers receive active assistance to understand and make decisions using interRAI data • a refreshed interRAI Maori strategy is in place	• strategic partnerships to support the provision of integrated health services maintained • increased capability and capacity for health professionals to target service delivery • interRAI information is available to a wider group of clinicians	• interRAI data is valued by a range of stakeholders • Phase 2 national interRAI quality indicators project is complete • interRAI data integrity mechanisms are enhanced • interRAI is providing effective value for money	• interRAI training is flexible, responsive, accessible • relationships with research organisations are maintained • stakeholder input continues to be valued in the development of interRAI • professionals across the social sector are aware of the use of interRAI as a comprehensive clinical assessment	• interRAI information is used to inform national policy • interRAI is seen as an effective, smart system to support co-ordination and communication between health professionals • the benefit of linking interRAI data with other data sets is evident
24 months • assessment practice for older people meets best practice standards • interRAI data will be used to determine What works for older people? and Why? • interRAI data is used for reporting on equity	• interRAI information is available to Primary Care clinicians • interRAI is interoperable with a range of systems across the wider social sector	• interRAI quality indicators inform and add value to older peoples services • an evidence based approach to service development using interRAI data is embedded • collaboration across health organisations maximises the value of interRAI	• interRAI data and tools are used wherever available to inform research activity • interRAI data and discussion forums to integrate information into quality improvement work are readily available to home support and residential care providers	• interRAI software is more responsive, has greater functionality and an improved 'look and feel' • interRAI tools support shared learning and promote knowledge and innovation to deliver better outcomes • healthcare providers receive support to use other modules in the interRAI software
36 months • further exploration of the Self-Reported Quality of Life tool underway • consumers are able to access summary interRAI information via a patient portal	• exploration of the interRAI Care Giver assessment underway	• interRAI data used to test scenarios and develop micro simulations for the future • interRAI is viewed as the optimum tool for delivering increased value	• professionals across the social sector use interRAI to assist their decision making	• exploration of the relationship between the national health record and interRAI underway