Using the RAI-HC in Hospital Settings

Background

interRAI developed the Resident Assessment Instrument—Home Care (RAI-HC)© to assess clients in home and community settings. Some jurisdictions across Canada also use the RAI-HC to assess clients in hospital settings to inform discharge-planning decisions, particularly for placement in residential care facilities. As certain sections were difficult to code for clients in hospital settings, Canadian stakeholders, the Canadian Institute for Health Information (CIHI) and interRAI identified the need for coding standards related to the use of the RAI-HC in hospital settings.

CIHI solicited input from Canadian jurisdictions and, with interRAI, completed a review of the intent and guidelines for each section, including their impact on the outcomes. The Coding Standards for RAI-HC in Hospital Settings were developed and later published in 2008.

Two Data Elements Added to RAI-HC

To distinguish between clients assessed in hospital settings and those assessed in home and community settings, two new data elements were added:

- X70 (Location of Assessment)
- X71 (Facility Admission Date)

Technical Specifications

The specifications for submitting RAI-HC data to CIHI's Home Care Reporting System (HCRS) have been modified to take into account the coding standards for assessing clients in hospital settings (which include the two new data elements and allow certain data elements to be optional in certain conditions). The specifications are provided to HCRS software vendors that are licensed with CIHI as part of the annual HCRS specifications release.

Using the Coding Standards

As of April 1, 2009, HCRS has been accepting RAI-HC data collected in hospital settings.

For all clients assessed in home, community and hospital settings, clinicians will use the RAI-HC coding standards available in the *RAI–Home Care (RAI-HC) User's Manual, Canadian Version, September 2010*. In addition, for those sections that are difficult to code when assessing clients in hospital settings, clinicians may refer to the Coding Standards for RAI-HC in Hospital Settings text boxes found in the manual. These coding standards can also be used when assessing clients in other types of facilities, such as residential care homes (for convalescent care), hospices, homeless shelters, correctional facilities and ambulatory care settings.

Questions?

Please use the eQuery application available at www.cihi.ca to search for answers to frequently asked questions and/or to submit questions about the RAI-HC or HCRS.

Two Data Elements Added to RAI-HC

Element	Description	Coding Standards for RAI-HC in Hospital Settings	Software Change
X70	Location of Assessment	The location where the assessment takes place	✓
X71	Facility Admission Date	The date the client was most recently admitted to a hospital setting	✓

Information is optional (may be left blank)
Software change required ✓

- G3 (Extent of Informal Help)
- H1a–gA (IADL Self-Performance)
- P1a–e and P1i (Formal Care)
- P3 (Management of Equipment in Last 3 Days)
- P5 (Treatment Goals)
- Q3 (Medical Oversight)

If in hospital[i] 90 days or MORE,
information is optional (may be left blank)
Software change is required ✓

- CC4 (Time Since Last Hospital Stay)
- CC5 (Where Lived at Time of Referral)
- CC6 (Who Lived With at Referral)
- CC8 (Residential History)
- F3a (Length of Time Client Is Alone During the Day)
- G1g–i (Areas of Help)
- G1j–l (If Needed, Willingness to Increase Help)
- O1 (Home Environment)
- Q4 (Compliance/Adherence With Medications)

Coding standard clarified
(no software change required)

Refer to the *RAI–Home Care (RAI-HC) User's Manual, Canadian Version, September 2010* for coding standards

- AA4 (Postal Code of Residence)
- G1a–d (Name of Primary and Secondary Helpers)
- G1e (Lives With Client)
- G1f (Relationship to Client)
- G2 (Caregiver Status)
- H4 (Primary Modes of Locomotion)
- J1 (Disease Diagnoses)
- K6b (Limits Going Outdoors Due to Fear of Falling)
- O2a (Client Lives With Other Persons)
- O2b (Client or Primary Caregiver Feels Client Would Be Better Off in Another Living Environment)
- P4 (Visits—In Last 90 Days or Since Last Assessment)
- P7 (Trade Offs)

Apply *RAI-HC Manual* guidelines regardless of the location in which the client is assessed or service is provided (for example, hospital setting)

- BB7a (Legal Guardian/Substitute Decision-Maker)
- BB7b (Advanced Medical Directives)
- B2a (Cognitive Skills for Daily Decision-Making)
- E1 (Indicators of Depression, Anxiety and Sad Mood)
- E3 (Behavioural Symptoms)
- F2 (Change in Social Activities)
- F3b (Client Says or Indicates Feels Lonely)
- H1a–gB (IADL Difficulty)
- H2a–j (ADL Self-Performance)
- K1a–e (Preventive Health—Past 2 Years)
- P1f (Physical Therapy)
- P1g (Occupational Therapy)
- P1h (Speech Therapy)
- P1j (Social Worker)
- P2 (Special Treatments, Therapies, Programs)
- Q5 (List of All Medications)

i. When referring to hospital (code 2), it also implies residential care facility (code 3) and other settings (code 4) per new data element Location of Assessment (X70).

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