Community Support Sector

Common Assessment Project

Software-generated CHA Reports
User Manual

Introduction

Capturing electronic information to do analysis and generate reports is a vital part of using interRAI Community Health Assessment (CHA) to enhance services to clients. Your HSP's completion of CHA assessments will provide you with useful reports to better understand clients accessing your services and ultimately help you deliver services where they are needed most.

This first series of reports offers ways to view and use information relevant to your organization and clients. For instance, the data your organization collects will generate reports that you can use to show the status of a client at their first assessment and compare that to their most recent assessments. This will demonstrate areas of need that are currently being met with existing services and those areas where additional resources may be required.

This manual describes the purpose, content and use of six reports that you can generate through your assessment software solution. The six reports include three assessor and three organizational reports.,.

A Community Support Services Common Assessment Project (CSS CAP) Working Group with CSS sector representation is finalizing a series of standardized reports that will be generated from the Integrated Assessment Record (IAR). In the meantime, we invite you to use this manual as a starting point to help you to get the most out of your interRAI CHA software solution-generated reports.

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General Information

This series of reports are generated by your software solution from the data you collect in the CHA assessments that your health service provider (HSP) completes. The reports are self-serve and available to assessors and authorized staff any time within the assessment software.

This set of reports is based on the CSS CAP report specifications common across all CSS HSPs participating in the CSS CAP implementation of the CHA. The design and intent of the reports was developed by a working group whose membership included the sector, LHIN and Ministry as well as researchers who developed the interRAI CHA tool.. Their feedback was vital in making sure the report elements and design aligns with each report objective.

These reports allow authorized users to view and analyze captured assessment information for clients or view reports at an aggregate level based on the report type. Organizations have the option to create additional reports to meet their needs to supplement these six reports defined by CSS CAP.

Assumptions

The reports generated by the assessment software should resemble the look and feel of the sample mock-up reports in this manual.

Report Details

Information about this Section

For each report in this manual, you will find the following information:

- Purpose
- Content
- Use
- Mock report with fictional data

Summary of Reports

Assessor Report #1: Client's CAPs and Outcomes	- Provides triggered CAPs and Outcome Measures and Scales for one client - Informal Support Status and Hospital/Physician utilization
Assessor Report #2: Client Progression Report	- Provides CAPs, Outcome Measures and Scales for one client over time - Always shows initial assessment as baseline - Informal Support Status and Hospital/Physician utilization
Assessor Report #3: Client Assessment Summary Report	- Provide a quick summary of a client - Provides information from Core CHA & Functional/MH Supplements - Provides Outcome Measures and Scales, description and scores - Informal Support Status and Hospital/Physician utilization
Organizational (HSP) Report #1: Clinical Report	- Understand acuity of an organization based on CAPs and Outcome Measures and Scales on a particular day of all current assessments of all active clients - Provides the client count for each CAP and Outcome Measures and Scales
Organizational (HSP) Report #2: Clinical Report	- Provides an overview of all active clients of the organization on their acuity at a point in time - Ability to download information for further analysis - Ability to run this report by Domains, Date Range or Monthly selection
Organizational (HSP) Report #3: Operational Report	- Understanding workload of assessors and status of completing assessments - Date range and/or monthly options

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Assessor Report #1: Client CAPs and Outcomes

Purpose:
To provide an overview of a client's health status and need based on triggered CAPS and Outcome Measures and Scales.

Content:
1) The basic demographics – i.e. Name, Date of Birth, HIN#, etc. – are displayed at the top of the report.
2) All triggered CAPs for an individual client along with the description of that CAP are displayed.
   – i.e. "Potential to improve", the (assessment) data elements that triggered the CAP along with the code and description of that code i.e. "limited assistance".
3) Actions Taken section which lists *possible* options. You *cannot* add or store data here; it is <u>intended</u> only as a prompt for options in addressing triggered CAPs.
4) Eight Key Outcome Measures and Scales are listed along with the score showing the severity level and subsequent description for each
5) Informal Helper Status from the Functional Supplement is shown.
6) The number of times of Hospital Use, Emergency Room Visit and Physician Visit are also listed.

Use:
Some suggested uses of this report are to:
o   Validate assessors assessment/intuition
o   Start the conversation to better understand the client's priorities around their needs and support requirements,
o   Inform care planning, and
o   Inform the reassessment time period

The Informal Helper status and Hospital Use, Emergency Room Visit and Physician Visit can be used to indicate if the informal caregivers are coping and/or need more support. Both of these items indicate if the client has appropriate supports in place.

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Mock Assessor Report #1: Client CAPs and Outcomes

First Name:	John	Primary Language:	English
Last Name	Doe	Marital Status:	Divorced
Healthcard Number:	1111-2222-3333 AB	Date Case Opened:	24-Dec-05
Case Record Number	23456	Last Assessment:	10-Apr-09
Birthdate:	11-Feb-40	Reason for Assessment:	3 - Return Assessment
Gender:	male	Current Assessment Date:	11-Aug-10
Residential Living Status:	1 - Private home/apartment	Current Assessor:	Eva Deer
Living Arrangement:	7 - with other relatives	Assessments completed:	CHA, FCT

CAPs	Code	Description	Actions Taken							
			Will be addressed in Service Plan	Previously addressed / No further intervention required	Client declined intervention	Addressed by another source	Deferred	Further investigation required / Reassessment needed	Other	Date
Instrumental ADL (IADL)	1	Potential to improve	☐	☐	☐	☐	☐	☐	Text field	10-Aug-10
Q: G1ab - Meal Preparation Difficulty	3	Limited Assistance	☐	☐	☐	☐	☐	☐	Text field	
Q: G1bb - Ordinary Housework Difficulty	3	Limited Assistance	☐	☐	☐	☐	☐	☐	Text field	
Q: G1gb - Shopping Difficulty	4	Extensive Assistance	☐	☐	☐	☐	☐	☐	Text field	
Q: G1hb - Transportation Difficulty	2	Supervision	☐	☐	☐	☐	☐	☐	Text field	
Q: G5 - Change in ADL Status as compared to 90 days ago	2	Declined	☐	☐	☐	☐	☐	☐	Text field	
Client's ability to perform these activities has declined compared to the last assessment										

Key Outcomes	Score	Description
Cognitive Performance Scale Scale: 0-6	2	Mild impairment
Depression Rating Scale Scale: 0- 14	2	Some symptoms of depression - intervention may be helpful
IADL Involvement Scale Scale: 0-21	14	Extensive Assistance required
Self- Reliance Index Scale Scale: 0 or 1	0	Self - Reliant
Pain Scale Scale: 0-3	1	Mild Pain - Pain less than daily
CHESS Scale: 0-5	1	Low level of medical complexity and instability
MAPLe Scale: 1-5	2	Mild
ADL Self −Performance Hierarchy Scale Scale: 0-6	3	Extensive assisstance required (I)

Informal Helper	Score	Description
Informal helper is unable to continue in caring activities	0	No
Primary informal helper expresses feelings of distress,anger and depression	1	Yes
Family or close friends report being overwhelmed by person's illness	0	No
Hospital Use, Emergency Room Use, Physician Visit	# of Times	
Inpatient acute hospital with overnight stay	0	
Physician visit	2	
Emergency Room Visit	4	

Assessor Report #2: Client Progression Report

Purpose:

To provide an overview of the change over time in a client's health status based on CAPS and Outcome Measures and Scales by comparing the three most recent assessments to the client's first assessment as the baseline.

Content:

1) The basic demographics -- i.e. Name, Date of Birth, HIN#, etc. – are displayed at the top of the report.

2) Triggered CAPs for the client from the initial assessment and the last three consecutive assessments are shown.

- This report always includes the first assessment as a baseline assessment.
- This report also shows the total number of CAPS triggered for each assessment.
- .CAPs that are not triggered are not shown

3) The change in status of CAPs for the two most recent assessments is shown.

3) Eight Key Outcome Measures and Scales are listed, showing the score for the three most recent assessments and the first assessment as a baseline assessment

4) Informal Helper Status & Hospital Use, Emergency Rooms Use, Physician visit

Use:

Some suggested uses of this report are to:

o   Determine if the current supports are effective or not by analyzing the change in status

o   Understand the historical perspective on change for this client since his/her first assessment showing overall stability, improvement or decline,

o   Start the conversation to see which areas the client would like support with or address/decline (prioritize),

o   Inform care planning

o   Inform reassessment time period

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The Informal Helper status and Hospital Use, Emergency Room Visit and Physician Visit can be used to indicate if the informal caregivers are coping and/or need more support. Both of these items indicate if the client has appropriate supports in place.

Mock Assessor Report #2: Client Progression Report

First Name:	John	Primary Language:	English
Last Name	Doe	Marital Status	Widow
Healthcard Number:	1111-2222-3333 AB	Date Case Opened:	24-Dec-05
Case Record Number	23456	Last Assessment:	10-Apr-09
Birthdate:	11-Feb-40	Reason for Assessment:	3 - Return Assessment
Gender:	male	Current Assessment Date:	11-Aug-10
Residential Living Status:	1 - Private home/apartment	Current Assessor:	Eva Deer
Living Arrangement:	7- with other relatives	Assessments completed:	CHA, FCT

CAPs	Change since Last Assessment	Assessment Assessor's Name Date: 10 Feb 2010	Assessment Assessor's Name Date: 20 Aug 2009	Assessment Assessor's Name Date: 10 Aug 2008	First Assessment Assessor's Name Date: 15 Aug 2006
Physical Activities Promotion (Activities)	No Change	1 = Triggered With Potential for Improvement	1 = Triggered With Potential for Improvement	0 = Not Triggered	0 = Not Triggered
Instrumental ADL (IADL)	No Change	1 = Triggered With Potential to Improve	1 = Triggered With Potential to Improve	1 = Triggered With Potential to Improve	0 = Not Triggered
Activities of Daily Living (ADL)	Improved	1 = Triggered To Facilitate Improvement	2 = Triggered To Prevent Decline	1 = Triggered To Facilitate Improvement	0 = Not Triggered
Home Environment Optimization (Enviromental)	Increased Need / Deteriorated	1 = Triggered	0 = Not Triggered	0 = Not Triggered	0 = Not Triggered

Key Outcomes				
Cognitive Performance Scale Scale: 0 - 6	0	0	0	0
Depression Rating Scale Scale: 0 - 14	2	2	2	2
IADL Involvement Scale Scale: 0 - 21	19	14	14	14
Self-Reliance Index Scale Scale: 0 or 1	1	1	1	1

Informal Helper	Score	Description
Informal helper is unable to continue in caring activities	0	No
Primary informal helper expresses feelings of distress,anger and depression	1	Yes
Family or close friends report being overwhelmed by person's illness	0	No

Hospital Use, Emergency Room Use, Physician Visit	# of Times
Inpatient acute hospital with overnight stay	0
Physician visit	2
Emergency Room Visit	4

Assessor Report #3: Client Assessment Summary Report

Purpose:

To provide a "summary" view of specific key data elements on a client's most recent assessment, including:

- o CHA core assessment
- o Functional and Mental Health supplements (if completed)
- o Outcome Measures and Scales

Content:

1) The basic demographics – i.e. Name, Date of Birth, HIN#, etc. – are displayed at the top of the report.

2) The respective coding responses from specific CHA domains of eight data elements of Core, six data elements of the Functional Supplement and one data element of the Mental Health Supplement.

3) It also shows the eight Key Outcome Measures and Scales scores and descriptions.

4) The Informal Helper Status from the Functional Supplement is shown.

5) This report also includes the number of times of Hospital Use, Emergency Rooms Use and Physician visits.

Use:

Some suggested uses of this Assessment Summary are to:

- o <u>Understand from a high level view </u>an individual client's physical, psychosocial, cognitive and informal support network. This aligns with the four broad areas discussed in CAPs training: Functional, Cognitive & Mental Health, Social and Clinical issues. This report provides a synopsis of key client assessment information to engage further client conversation.
- o Use as a communication tool with the client, family members or health providers in the clients circle of care
- o Have an overview of client prior to reassessment

The Informal Helper status and Hospital Use, Emergency Room Visit and Physician Visit can be used to indicate if the informal caregivers are coping and/or need more support. Both of these items indicate if the client has appropriate supports in place.

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Mock Assessor Report #3: Client Assessment Summary Report

First Name:	John		Primary Language:	English
Last Name	Doe		Marital Status:	Widow
Healthcard Number:	1111-2222-3333 AB		Date Case Opened:	24-Dec-05
Case Record Number	23456		Last Assessment:	10-Apr-09
Birthdate:	11-Feb-40		Reason for Assessment:	3 - Return Assessment
Gender:	male		Current Assessment Date:	11-Aug-10
Residential Living Status:	1 - Private home/apartment	Each section should be collapsable	Current Assessor:	Eva Deer
Living Arrangement:	7- with other relatives		Assessments completed:	CHA, FCT

Core CHA-Assessment			Results
Section C: Cognition			
	Cognitive skills for daily decision making		
1	Making decisions regarding tasks of daily life		0. Independent
Section D - Communication and Vision			
	Making self understood (expression)		
1	Expressing information content - both verbal and non-verbal		0. Understood
	Ability to understand others (comprehension)		
2	Understanding verbal information content (however, able, with hearing appliance normally used)	1.Usually understands	
	Hearing		
3	Ability to hear (with hearing applienace normally used)		0.Adequate
	Vision		
4	Ability to see in adequate light (with glasses or with other visual appliance normally used		1.Minimal Difficulty
Functional CHA-Assessment			
Section C - Mood and Behaviour			
			Core Assessment: Section E - Mood and Behaviour
	Behaviour symptoms		
2f	Resists care		0. Not Present
Mental Health CHA-Assessment			
Section E - Harm to Self and Others			
	Self injury		
1a	Most recent self-injurious attempts		0. Independent
	Violence		
4a	Intimidation of others or threatened violence		0. Independent

Key Outcomes and Measures		
ADL Self-Performance Hierarchy Scale	Independent	0
CHESS: Changes in Health, End-stage disease, signs and symptoms	Stable	0
PS: Pain Scale	No Pain	0
SRI: Self Reliance Index	Self Reliant	0
CPS: Cognitive Performance Scale	Intact	0
DRS: Depression Rating Scale	No symptoms of depression	0
IADL Involvement Scale	Independent	0
MAPLe Method of Assigning Priority Levels	Low	1

Informal Helper	Score	Description
Informal helper is unable to continue in caring activities	0	No
Primary informal helper expresses feelings of distress, anger and depression	1	Yes
Family or close friends report being overwhelmed by person's illness	0	No
Hospital Use, Emergency Room Use, Physician Visit	# of Times	
Inpatient acute hospital with overnight stay	0	
Physician visit	2	
Emergency Room Visit	4	

Organizational Report #1: Clinical Report

Purpose:
To understand the client acuity within an organization on a particular day or date range based on all current completed assessments for all active distinct clients by showing the client count for each:
- CAP
- Outcome Measure and Scale

Discharged clients are excluded. The report is based on the most recent assessment for each of the clients within the date range selected.

Content:
It is important to note that this report provides you with active distinct client counts, i.e. the number of active clients in your HSP at a point in time. Clients in your organization who are involved in more than one of your programs are only counted once.
Distinct client count and percentage of clients are shown by:
- Demographics (eg. gender, reason for assessment, age range, marital status, living arrangements, residential living status, referral source, languages)
- CAPs
- Outcome Measure & Scales
- Informal Helper Status and Hospital Use, Emergency Rooms Use, Physician visit

Note: Optional filters for program type, services, location and service admission (admitted vs. non-admitted) can be provided by HSP to be included as additional software requirements, exclusive of CSS CAP for organizational reports #1 and #2.

Use:
Some suggested uses of this Clinical Report are to:

- Gain an understanding of the acuity of clients within your organization based on CAPs, Outcome Measures and Scales at a point in time to see if the interventions are effective. This information can help identify the high risk client needs within your organization, statistical reporting, funding, staffing, gender needs, age, etc. For example: if your client population's age range is over a specific age, you can analyze how their needs, services,, social activities and interests change.
- Inform program planning
- Inform resource needs based on client acuity
- Prioritize support based on client need
- Support business cases

Mock Organizational Report #1: Clinical Report

Organizational CAP and Outcome Report							
Functional Performance CAPs							
	Physical Activities Promotion (Activities)	0 - Not Triggered		1 - Triggered with potential for improvement			
1		25	63%	15	37%		
2	Instrumental ADL (IADL)	20	50%	20	50%		
	Activities of Daily Living	0 - Not Triggered		1 - Triggered to facilitate improvement		2 - Triggered to prevent decline	
3		20	50%	18	45%	2	5%
4	Home Environment Optimization	0 - Not Triggered		1 - Triggered			
		#	%	#	%		
5	Institutional Risk (Risk)	0 - Not Triggered		1 - Triggered			
		#	%	#	%		

Total Number of Clients		40
Gender		
	#	%
Male	20	50%
Female	20	50%
Reason for Assessment		
	#	%
First Assessmnent	15	37%
Routine Assessment	5	12%
Return Assessment	8	20%
Significant Change in status reassessment	2	5%
Discharge covers last 3 days of service	3	8%
Discharge tracking only	5	13%
Other	2	5%

Scales and Outcomes	Range		
Cognitive Performance Scale (CPS)	0 - 6	# of Clients	% of Clients
Intact	0	#	%
Borderline intact	1	#	%
Mild impairment	2	#	%
Moderate impairment	3	#	%
Moderate Severe/impairment	4	#	%
Severe impairment	5	#	%
Very severe impairment	6	#	%

Organizational Report #2: Clinical Report

Purpose:
To provide an overview of the acuity of all active clients of the organization at a point in time. This report is based on all information in the assessment domains of the Core CHA, Functional and Mental Health (MH) supplements.

One can navigate to sections within the report and also download information for further analysis.

Discharged clients are excluded. The report is based on the most recent assessment for each of the clients within the date range selected.

Content:
This report shows the total number and percentage of distinct clients within the date range for:
- o   All demographic data elements
- o   All completed assessment data elements of:
    - o   CHA Core
    - o   CHA Functional Supplement when completed
    - o   CHA MH Supplement when completed

Use:
Some suggested uses of this Clinical Report are to:

- o   Gain an understanding of the acuity of clients within your organization based on assessment domains or by specific data elements or single response to a data element, in one domain i.e. Functional Status. This shows how many clients have needs by domain and the degree of assistance required which helps with:
    - o   Workload measures
    - o   Statistical reporting
    - o   Funding
    - o   Staffing

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Mock Organizational Report #2: Clinical report

Section C: Cognition		**0**-*Independent*		**1**-*Modified Independence*		**2**-*Minimally Impaired*		**3** -*Moderately Impaired*	
1	Cognitive Skills for Daily Decision Making	#	%	#	%	#	%	#	%
2	Memory/Recall Ability	**0** -*Yes Memory OK*		**1**- *Memory Problem*					
		#	%	#	%				
3	Change in Decision Making as Compared to 90 Days ago or less than 90 days ago	**0**- *Improved*		**1**- *No Change*		**2**-*Decline*		**8**- *Uncertain*	
		#	%	#	%	#	%	#	%
Section D: Communication and Vision		**0**-*Understood*		**1**- *Usually Understood*		**2**- *Often Understood*		**3**-*Sometimes Understood*	
1	Making Self Understood (Expression)	#	%	#	%	#	%	#	%
2	Ability to Understand Others (Comprehension)	**0**-*Understands*		**1**- *Usually Understands*		**2**- *Often Understands*		**3**-*Sometimes Understands*	
		#	%	#	%	#	%	#	%
3	Hearing	**0** -*Adequate*		**1**- *Minimal Difficulty*		**2**- *Moderate Difficulty*		**3**- *Severe Difficulty*	
		#	%	#	%	#	%	#	%
4	Vision	**0** -*Adequate*		**1**- *Minimal Difficulty*		**2**- *Moderate Difficulty*		**3**- *Severe Difficulty*	
		#	%	#	%	#	%	#	%
Section E: Mood Indicators of Possible Depressed, Anxious, or Sad Mood		**0**-*Not Present*		**1**-*Present but not exhibited in last 3 days*		**2**-*Exhibition on 1-2 of last 3 days*		**3**- *Exhibited daily in last 3 days*	
1a	Made Negative Statements	#	%	#	%	#	%	#	%
1b	Persistent Anger with self or others	#	%	#	%	#	%	#	%

Mock Organizational Report #2: Clinical Report (cont'd)

Functional Supplement									
Section B: Cognition		**0** - *Yes, Memory OK*		**1** - *Memory Problem*					
Memory/Recall Ability									
1a	Procedural Memory OK	#	%	#	%				
1b	Situational Memory OK								
Periodic Disordered Thinking/Awareness		**0** - *Behaviour not present*		**1** - *Behaviour present, consistent*		**2** - *Behaviour presen, appears*			
2a	Easily Distracted	#	%	#	%	#	%		
2b	Episodes of disorganizeds speech	#	%	#	%	#	%		
2c	Mental function varies over the course of the day	#	%	#	%	#	%		
3	Acute Change in Mental Status From Person's Usual Functioning		**0** - *No*		**1** - *Yes*				
Section C: Mood and Behaviour									
Indicators of Possible Depressed, Anxious,OR Sad Mood									
1a	Recurrent statements that somehting terrible is about to happen		**0** - *Not present*	**1** - *Present but not exhibited in last 3 days*		**2** - *Exhibited on 1-2 of last 3 days*		**3** - *Exhibited daily in last 3 days*	
1b	Expressions (including non-verbal) of a lack of pleasure in life (anhedonia)	#	%	#	%	#	%	#	%
Behaviour Symptoms		#	%	#	%	#	%	#	%
2a	Wandering	#	%	#	%	#	%	#	%
2b	Verbal Abuse	#	%	#	%	#	%	#	%
2c	Physical Abuse	#	%	#	%	#	%	#	%
2d	Socially inappropriate or disruptive behaviour	#	%	#	%	#	%	#	%
2e	Inappropriate public sexual behaviour or public disrobing	#	%	#	%	#	%	#	%
2f	Resists care	#	%	#	%	#	%	#	%

Mental Health Supplement		**0** - *None*		**1 - 1-3**		**2 - 4-5**		**3 - 6 or more**	
Section B: Mental Health Service History									
1: Number of lifetime psychiatric admission		#	%	#	%	#	%	#	%
2: Time since last contact with community mental health agency or professional in the past year		**0 - No contact in last year**		**1 - 31 days or more**		**2 - 30 days or less**			
		#	%	#	%	#	%		

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Organizational Report #3: Operational Report

Purpose:
To track the number of assessments and their status at organizational and assessor levels.

Content:
This report shows the total nunber of assessments within each assessment status type – overdue based on business rule, in progress, due in the next 30 days, cancelled and completed -- by assessor and Core and Supplements.

Use:
Some suggested uses of this Operational Report are to:

- o   Audit status of assessments
- o   Analyze business process

Mock Organizational Report #3

Organization (HSP) Report #3: Operational Report

						Functional Supplement			Mental Health Supplement		
Number of Assessments	Overdue based on business rule	In Progress	Due in the next 30 days	Cancelled	Completed	Triggered & Completed	Not Triggered & Completed	Triggered & Not Completed	Triggered & Completed	Not Triggered & Completed	Triggered & Not Completed
Assessor Name											
Assessor Name											
Assessor Name											
Assessor Name											
Assessor Name									.		
Assessor Name											
Totals											

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Conclusion

The effort that your organization makes to collect and use CHA information can offer great benefits to your clients, staff and organization.

We hope this manual is useful in helping you to understand these reports and to gain the valuable insight from the data provided by the interRAI CHA.

If you have questions or comments, please contact us via the Support Centre.

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