Home Care
Roadmap Indicators
Data Standard

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## April 2004

Canadian Institute
for Health Information

Institut canadien
d'information sur la santé

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# CIHI Background Information

The Canadian Institute for Health Information (CIHI) is an independent, pan-Canadian, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality health information. CIHI's mandate, as established by Canada's health ministers, is to coordinate the development and maintenance of a common approach to health information for Canada. To this end, CIHI is responsible for providing accurate and timely information that is needed to establish sound health policies, manage the Canadian health system effectively and create public awareness of factors affecting good heath.

## Collaboration Is the Key

The Institute's mandate is based upon collaborative planning with key stakeholder groups, including all provincial, territorial and federal governments, national health care agencies and service providers.

## Governance Structure

CIHI is governed by a Board of Directors whose members strike a balance among the health stakeholders, sectors and regions of Canada.

## An Overview of CIHI's Core Functions

The Institute's core functions are to:

- identify health information needs and priorities
- conduct analysis and special studies and participate in/support health care system research
- support the development of national health indicators
- coordinate and promote the development and maintenance of national health information standards
- develop and manage health databases and registries
- fund and facilitate population health research and analysis, conduct policy analysis and develop policy options
- contribute to the development of population health information systems and infrastructure
- provide appropriate access to health data
- publish reports and disseminate health information
- coordinate and conduct education sessions and conferences (relevant to our core functions)

CIHI's mandate to provide accurate and timely health information is complemented by its pledge to respect personal privacy, to safeguard the confidentiality of information and to provide secure information systems. To ensure that health data entrusted to CIHI is protected, CIHI has established policies that address data integrity, system security, data access, data linkage, and data disclosure. Also, CIHI personnel sign a confidentiality agreement.

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- the individuals concerned provide consent, or
- laws require the disclosure.

# Introduction

The Home Care Roadmap Indicators Data Standard represents a standardized minimum reporting data set for generation of comparative region-level priority indicators for home care. These indicators were identified through four years of research and consultation conducted by the Canadian Institute for Health Information (CIHI). Further information on this process may be found on the CIHI Web Site at www.cihi.ca/homecare.

The data standard represents the *minimum* number of data elements required to populate indicators of access, outcomes and service utilization.

Given the rapid uptake of the RAI-HC© in Canada, the Roadmap Indicators Data Standard incorporates, with permission from inter*RAI*, data element definitions from the RAI-HC©, Canadian Version, October 2002,[1] wherever feasible.

Jurisdictions who elect to participate in health region-level reporting of Home Care Roadmap Indicators will submit data to the CIHI Home Care Reporting System (HCRS).

The HCRS will be a pan-Canadian, bilingual resource of standardized clinical, administrative and resource information about home care. The HCRS will accept data, in its prototype year (2005–2006), for five client groups (Data Element X2): Acute Home Care Clients, End-of-Life Clients, Rehabilitation Clients, Long-Term Supportive Care Clients and Maintenance Clients.

The HCRS is designed to adapt to the evolving home care sector. Additional modules will be developed in the future, as required, to support new clinical assessments and emerging priorities such as Community Mental Health.

Given the differences between client groups, the Roadmap Indicators Data Standard is customized to account for differences in information needs and the burden of data collection relative to the expected length of service. Each section of the data standard will indicate the client group(s) to which it applies.

Data submissions to HCRS may flow from provinces/territories or from regional organizations, such as Regional Health Authorities (RHAs), Community Care Access Centres (CCACs) or les centres locaux de services communautaires (CLSCs). Two reporting options for the HCRS will allow all provinces and territories to participate:

Option A: Populate the indicators directly through collection and submission of RAI-HC© and CIHI data elements

Option B: Populate the indicators through mapping from other clinical assessment tools (e.g. SMAF©) and collection of CIHI data elements

[1] Based upon the *RAI* Home Care which includes the MDS-HC and Client Assessment Protocols (CAPs). The RAI-HC is Copyright © inter*RAI* Corporation, 2001. Modified with permission for Canadian use under license to the Canadian Institute for Health Information. Canadianized items and their descriptions are Copyright © Canadian Institute for Health Information, 2002.

CIHI will support jurisdictions in planning for data collection and/or mapping and extraction from their current systems to facilitate comparative reporting.

Jurisdictions may also plan for phased implementation depending upon readiness on the front lines to implement standardized clinical assessment instruments to "feed" into the clinical indicators. Implementations of the RAI-HC© to date are focused on Long-Term Supportive and Maintenance clients. Inter*RAI* clinical assessment instruments are under development for Acute Home Care and End-of-Life clients and further consultation is required to identify a standard clinical assessment for Rehabilitation clients.

Jurisdictions electing to submit demographic and administrative elements for all clients, while phasing in their clinical assessment reporting for some client groups, will be able to report on comparable indicators of access and service utilization.

# interRAI Data Elements

## Section AA Identification Information

Client Group: All

### AA2 Case Record Number

*Intent*

To document any record identification number used at the home care agency.

*Process*

This number is originated at the home care agency.

*Coding*

Record the number beginning with the left-most box. Leave boxes blank if not filled with a number.

### AA3a Health Card Number

*Intent*

To record client's health (insurance) number as assigned by the Provincial/Territorial government.

*Definition*

The client's health (insurance) number as assigned by the provincial/territorial government of residence.

*Coding*

Record at assessment. Enter the client's health card number or "0" if unknown or "1" if not applicable.

### AA3b Province/Territory Issuing Health Card Number

*Intent*

To record Province/Territory that issued health (insurance) number.

*Definition*

The provincial/territorial government from which the health card number was issued.

*Coding*

Indicate province if health card number (item AA3a) is recorded.

**NL Newfoundland and Labrador**
**PE Prince Edward Island**
**NS Nova Scotia**
**NB New Brunswick**
**QC Quebec**
**ON Ontario**
**MB Manitoba**
**SK Saskatchewan**
**AB Alberta**
**BC British Columbia**
**NT Northwest Territories**
**YK Yukon Territory**
**NU Nunavut**
**-50 Not available/temporarily**
**-70 Asked Unknown**
**-90 Not applicable**

## AA4 Postal Code of Residence

*Definition*

The postal code assigned by Canada Post of the permanent dwelling in which the client lives.

*Coding*

Enter alphanumeric code. If the full postal code is not available, code the first three digits of the postal code (Forward Sortation Area). If the first three digits are not available, code one of the following:

**Z1Z1Z1 for homeless individuals**
**1 Asked, unknown**
**2 Not applicable**

# Section BB Personal Items

Client Group: All

*Intent*

These items capture basic demographic information of the client.

## BB1 Sex

*Coding*

**M Male**
**F Female**

## BB2a Birth Date

*Coding*

Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains a single digit, fill the first box with a "0". If birth is unknown or only partial birth date is known, enter an estimated year, month (between 1-12) and day (between 1–31).

**YYYY/MM/DD**

## BB2b Estimated Birth Date

*Intent*

To facilitate data quality when data in BB2a is an approximation of the actual birth date. Verification can be completed if BB2a data is not consistent on subsequent records and when all other client identifiers are consistent.

*Definition*

A flag to indicate that the client's birth date is estimated.

*Coding*

Is the birth date estimated?

**0 No, birth date is known**
**1 Yes, birth date is estimated**

## BB4 Marital Status

*Coding*

Choose the answer that describes the current marital status of the client. If in "Common Law" marriage, code 2.

**1 Never Married**
**2 Married**
**3 Widowed**
**4 Separated**
**5 Divorced**
**6 Other**

## BB5 Language

*Intent*

To record the distribution of languages that clients predominantly speak/understand. To identify clients likely to be underserved related to their inability to access services due to language/culture differences. This data informs health/social service planners to effectively target geographic areas/populations that need services. May also be used to plan/manage interpreter/translations services. (Adapted from Australian Institute of Health and Welfare—National Health Data Dictionary)

### BB5a Primary Language

*Definition*

The language the client primarily speaks or understands.

*Coding*

Enter "eng" for English and "fra" for French and for other languages refer to CIHI Home Care Roadmap Indicators Data Standard Addendum I: Language Codes. If there are multiple codes for a specific language, choose the first option in the list, e.g. German = deu.

**eng English**
**fra French**

# Section CC Referral Items

Client Group: All

*Intent*

The intent of this section is to identify circumstances surrounding the initial referral.

**Complete at intake only**.

## CC1 Date Case Opened/Reopened

*Process*

This date is when a referral was first received. If the home care agency did not receive a referral, enter the date when the client first became known to the agency as a person in need of an assessment.

*Coding*

Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains a single digit, fill the first box with a "0".

**YYYY/MM/DD**

## CC5 Where Lived at Time of Referral

*Intent*

Documentation of client's permanent living arrangement at time of referral.

*Definition*

1. **Private home with no home care services**—Any house or condominium in the community whether owned by the client or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled. Client receives no home care services.
   **Private apartment with no home care services**—Any apartment in the community whether owned by the client or another person. Client receives no home care services.
   **Home care services** refers to formal services provided through an agency. This does not include help received from family, friends, neighbours, etc.
2. **Private home with home care services**—Any house or condominium in the community whether owned by the client or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled. Client receives home care services.
   **Private apartment with home care services**—Any apartment in the community whether owned by the client or another person. Client receives home care services.
3. **Board and care/assisted living/group home**—A non-institutional community residential setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, home health, homemaker, personal care, meal service, transportation, etc.

4. **Residential care facility**—A licensed health facility may include but is not limited to long-term care facilities, nursing homes, homes for the aged that provide 24-hour skilled or intermediate nursing care.
5. **Other**

*Process*

Enter the client's permanent living arrangement at the time of referral. Note that if the client was in a hospital or staying at a temporary address until services are established, code for permanent prior living arrangements.

*Coding*

Record code that reflects most appropriate category.

**1 Private home/apartment with no home care**
**2 Private home/apartment with home care**
**3 Board and care/assisted living/group home**
**4 Residential care facility**
**5 Other**

## CC6 Who Lived With at Referral

*Coding*

Record the code that reflects who the client was living with at the time of referral. Note that this excludes any temporary arrangements in living made while the home care services were being set up.

**1 Lived alone**
**2 Lived with spouse only**
**3 Lived with spouse and other(s)**
**4 Lived with child (not spouse)**
**5 Lived with other(s) (not spouse or children)**
**6 Lived in a group setting with non-relative(s)**—A residential setting where the owner (not a relative of the client) offers room and board and minimum support for a fee.

# Section A Assessment Information

## A1 Assessment Reference Date

Client Group: All

*Intent*

Usually, assessments are completed based on information gathered at a single visit. Item A1 is the date of this visit. When an assessment carries over to a required second visit, this item still records the initial visit. Although the assessor may visit on different dates, the coding for all items for this assessment refers to the fixed initial visit date, thereby ensuring the commonality of the assessment period.

*Coding*

For the month and day of the assessment, enter two digits each. If the month or day contains a single digit, fill the first box with "0". Use four digits for the year.

**YYYY/MM/DD**

## A2 Reason for Assessment

Client Group: Long-Term Supportive Care and Maintenance

*Intent*

To document the reason for completing the assessment. Each assessment requires completion of the MDS-HC (Functional Assessment), review of triggered CAPs, and development or revision of a comprehensive care plan. At intake, this process should be completed within 14 days of the original referral.

*Definition*

1. **Initial assessment**—Assessment should be completed within 14 days of referral.
2. **Follow-up assessment**—This is the second assessment, and ensures that the care plan is correct and up to date. It should also identify instances where significant changes have occurred.
3. **Routine assessment at fixed intervals**—A comprehensive reassessment at specified intervals during the course of care (e.g. at the 12$^{th}$ month anniversary of the initial assessment).
4. **Review within 30-day period prior to discharge from the program**—Use this code whenever permanent program discharge is anticipated. This is a means of "closing" the clinical record at the point of discharge, laying the foundation for subsequent service initiatives.
5. **Review at return from hospital**—Purpose of review is to identify how the client's needs have changed.
6. **Change in status without a change in client group**—A comprehensive reassessment prompted by a "major change" that is not self-limited, that affects the client's health status, and that requires review or revision of the care plan to ensure that the appropriate care is given but does not result in a transfer to a different client group.

7. **Change in status with a change in client group**—A comprehensive reassessment prompted by a "major change" that is not self-limited, that affects the client's health status, and that requires review or revision of the care plan to ensure that appropriate care is given and results in a transfer to a different client group.
8. **Other**—Purpose can be quality assurance, clinical research, confirmation of current plan (not the second "follow-up" assessment), development of acuity scale, community needs assessments, etc.
9. **Inter-rater reliability assessment**—Assessments carried out to monitor quality of clinical assessments.

*Coding*

Enter the number corresponding to the reason for assessment.

# Section B Cognitive Patterns

Client Group: Long-Term Supportive Care and Maintenance

## B1 Memory/Recall Ability

*Intent*

To determine a client's ability to remember recent and past events.

*Process*

### B1a Short-Term Memory OK

Ask the client to describe a recent event that both of you have had the opportunity to remember (you should be able to validate that client's memory with your knowledge of such events). For persons with verbal communication deficits, non-verbal responses are acceptable. **If there is no positive indication of memory ability, code "1" Memory problem**.

*Coding*

Code for record of what was learned or known for each type of memory.

**0 Memory OK**
**1 Memory problem**

## B2 Cognitive Skills for Daily Decision Making

### B2a How Well Client Made Decisions About Organizing the Day

*Intent*

To record the client's actual performance in making everyday decisions about the tasks or activities of daily living. These items are especially important for further assessment and care planning in that they can alert the assessor to a mismatch between a client's abilities and his or her current level of performance, or the family may inadvertently be fostering the client's dependence.

*Process*

Consult client first, then a family member. Observations of the client can also be helpful. Review the events of each day. The inquiry should focus on whether the client is actively making these decisions, and not whether there is a belief that the client might be capable of doing so. Remember the intent of this item is to record what the client is doing (performance). When a family member takes decision-making responsibility away from the client regarding tasks of everyday living, or the client does not participate in decision-making, whatever his or her level of capability may be, the client should be considered to have impaired performance in decision-making.

*Coding*

Enter the single number that corresponds to the most correct response.

**0 Independent**—decisions are consistent, reasonable, safe (reflecting lifestyle, culture, values); the client organized daily routine and made decisions in a consistent, reasonable, and organized fashion.
**1 Modified Independence**—The client organized daily routine and made safe decisions in familiar situations, but experienced some difficulty in decision-making when faced with new tasks or situations.
**2 Minimally Impaired**—In specific situations, decisions become poor or unsafe and cues/supervision necessary at those times.
**3 Moderately Impaired**—The client's decisions were consistently poor or unsafe; the client required reminders, cues, and supervision in planning, organizing, and conducting daily routines at all times.
**4 Severely Impaired**—The client's decision-making was severely impaired; the client never (or rarely) made decisions.

### B2b Worsening of Decision Making as Compared to Status of 90 Days Ago (or Since Last Assessment if Less Than 90 Days)

*Intent*

Comparison of client's current decision-making to decision-making ability of 90 days ago.

*Coding*

**0 No**
**1 Yes**

# Section C Communication/Hearing Patterns

Client Group: Long-Term Supportive Care and Maintenance

## C2 Making Self Understood (Expression)

*Intent*

To document the client's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of work board or keyboard).

*Coding*

Enter the number corresponding to the most correct response.

**0** **Understood**—The client expresses ideas clearly, without difficulty.
**1** **Usually understood**—The client has difficulty finding the right words or finishing thoughts, resulting in delayed responses. If given time, little or no prompting required.
**2** **Often understood**—The client has difficulty finding words or finishing thoughts, prompting usually required.
**3** **Sometimes understood**—The client has limited ability, but is able to express concrete requests regarding at least basic needs (e.g. food, drink, sleep, toilet).
**4** **Rarely or never understood**—At best, understanding is limited to interpretation of highly individual, client-specific sounds or body language (e.g. indicated presence of pain or need to toilet).

# Section E Mood and Behaviour Patterns

Client Group: Long-Term Supportive Care and Maintenance

## E3 Behavioural Symptoms

*Intent*

To identify a) symptom frequency and b) the family's view of the alterability of the behavioural symptoms (in the last three days) that cause distress to the client, or are distressing or disruptive to others with whom the client lives. Such behaviours include those that are potentially harmful to the client or disruptive to others. This item is designed to pick up problem behaviours exhibited by the client at home.

In this item we ask the caregiver to tell us if a specified problem behaviour occurred or not. Then we also determine if this behaviour was able to be easily controlled or could be easily altered by actions of the family.

*Definition*

**a. Wandering**—Moved about with no discernible, rational purpose, seemingly oblivious to needs or safety. A wandering person may be oblivious to his or her physical or safety needs. Wandering behaviour should be differentiated from purposeful movement. Wandering may be by walking or by wheelchair. Do not include pacing as wandering behaviour. Pacing back and forth is not considered wandering.

**b. Verbally Abusive Behavioural Symptoms**—Others were threatened, screamed at or cursed at.

**c. Physically Abusive Behavioural Symptoms**—Others were hit, shoved, scratched, or sexually abused.

**d. Socially Inappropriate/Disruptive Behavioural Symptoms**—Includes disruptive sounds, excessive noise, screams, self-abusive acts, sexual behaviour or disrobing in public, smearing or throwing food or feces, rummaging through others' belongings, repetitive behaviours, rising early and causing distress to others.

**e. Resists Care**—Resists taking medications/injections, pushed caregiver during ADL assistance in eating or changes in position. This category does not include instances where client has made an informed choice not to follow a course of care. Signs of resistance may be verbal or physical. These behaviours are not necessarily positive or negative, but are intended to provide information about the person's responses to interventions and to prompt further investigation of causes for care planning purposes.

*Coding*

**Code "0"** if the described behavioural symptom was not exhibited in the last three days.

**Code "1"** if the behavioural symptom was present and the behavioural symptom was easily altered with current interventions.

**Code "2"** if the described behavioural symptom occurred with a degree of intensity that is not responsive to family's attempts to reduce the behavioural symptom through limit setting, diversion, adapting daily routines to the client's needs, environmental modification, activities programming, comfort measures, appropriate drug treatment, etc.

**0 Did not occur in last 3 days**
**1 Occurred, easily altered**
**2 Occurred, not easily altered**

# Section G Informal Support Services

Client Group: Long-Term Supportive Care and Maintenance

## G1A Primary Informal Helper/Caregiver

*Definition*

**Primary informal caregiver**—Primary caregiver may be a family member, friend or neighbour (but not a paid provider). It is not required that the caregiver actually live with the client, rather that he/she visits regularly, or would respond to needs that the client may have. This is the person who is most helpful to the client, who he/she could most rely upon.

### G1Ae Lives With Client

*Intent*

To assess the relationship between the client and the informal helper, and type of support they currently provide.

*Definition*

An informal helper is said to live with the client if the client and helper share the same space (house, apartment/flat). This does not include living in an adjacent or neighbouring apartment/flat/house.

*Coding*

**0 Yes, informal caregiver lives with client**
**1 No, informal caregiver does not live with client**
**2 No such helper (skip to Section H).**

### G1Af Relationship to Client

*Definition*

This refers to the nature of the relationship between the client and the informal helper. Consider the quality of the relationship, not simply as the relationship is defined by law or social customs.

*Coding*

Code with the category that best describes the relationship.

**0 Child or child-in-law (include partner's child, even if not married)**
**1 Spouse (include a partner, regardless of legal marital status)**
**2 Other relative**
**3 Friend/neighbour**

**Areas of Help**

*Definition*

**G1Ag Advice or Emotional Support**

Helper provides guidance or support. This advice or support may be task centered (e.g. balancing cheque book, tax advice, directions for dealing with a specific problem) or more loose (e.g. "being there" when needed, listening). Emotional support refers to time spent providing non-physical support around emotional issues such as loss, anxiety about the future, and change of body image. Advice and emotional support goes beyond simply being physically present.

**G1Ah IADL Care**

IADL areas include such activities as meal preparation, ordinary housework, managing finance or medications, phone use, shopping and transportation.

**G1Ai ADL Care**

ADL areas include such activities as bed mobility, transferring, locomotion in the home, dressing, eating, toilet use, personal hygiene and bathing.

*Coding*

Code for the areas the caregiver is providing help to the client.

**0 Yes**
**1 No**

**g. Advice or emotional support**
**h. IADL care**
**i. ADL care**

## G2 Caregiver Status

*Intent*

To assess the reserve of the informal caregiver support system.

*Definition*

**G2a A Caregiver Is Unable to Continue in Caring Activities**

The caregiver, client, or assessor believes that a caregiver(s) is not able to continue in caring activities. This can be for any reason, for example: lack of desire to continue, geographically inaccessible, other competing requirements (child care, work requirements), personal health issues.

**G2b Primary Caregiver Is Not Satisfied**

The primary caregiver is not satisfied with the support that others are currently providing in the care of the client.

### G2c Primary Caregiver Expresses Feelings of Distress

Primary caregiver expresses, by any means, that he/she is distressed, angry, depressed or in conflict because of caring for the client.

*Coding*

Check all that apply. If none of the categories apply, check "d" None of above.

**a A caregiver is unable to continue in caring activities.**
**b Primary caregiver is not satisfied.**
**c Primary caregiver expresses feelings of distress.**
**d None of above.**

# Section H Physical Functioning

## H1A Instrumental Activities of Daily Living (IADLs)— Self-Performance

Client Group: Long-Term Supportive Care and Maintenance

*Intent*

The intent of these items is to examine the areas of function that are most commonly associated with independent living.

*Process*

The client is questioned directly about his or her performance of normal activities around the home or in the community in the last 7 days. You may also talk to family members if they are available. You also should use your own observations as you are gathering information for other MDS-HC items.

*Definition*

### H1Aa Meal Preparation

How meals are prepared (e.g. planning meals, cooking, assembling ingredients, setting out food and utensils).

### H1Ab Ordinary Housework

How ordinary work around the house is performed (e.g. doing dishes, dusting, making bed, tidying up, laundry).

### H1Ac Managing Finances

How bills are paid, cheque book is balanced, household expenses are balanced.

### H1Ad Managing Medications

How medications are managed (e.g. remember to take medicines, open bottles, take correct dosage of pills, injections, ointments).

### H1Ae Phone Use

How telephone calls are made or received (with assistive devices such as large numbers on telephone, amplification as needed).

### H1Af Shopping

How shopping is performed for food and household items (e.g. selecting items, managing money).

### H1Ag Transportation

How the client travels by vehicle (e.g. gets to places beyond walking distance)—includes driving vehicle him/herself; traveling as a passenger in a car, bus or subway.

*Coding*

Code for the client's performance over the past 7 days.

**0 Independent—did on own**
**1 Some Help—client involved but received help from others some of the time**
**2 Full Help—client involved but received help from others all of the time**
**3 By Others—client totally dependent on others**
**8 Activity did not occur**

**a. Meal preparation**
**b. Ordinary housework**
**c. Managing finances**
**d. Managing medications**
**e. Phone use**
**f. Shopping**
**g. Transportation**

## H2 Activities of Daily Living (ADLs)—Self-Performance

Client Group: Long-Term Supportive Care and Maintenance

*Intent*

To record the client's self-care performance in activities of daily living (i.e. what the client actually did for himself or herself and/or how much help was required by family members or others) during the last three days, except for bathing—last seven days.

*Definition*

Measures what the client actually did (not what he or she might be capable of doing) within each ADL category over the last three days according to the performance-based scale.

### H2a Mobility in Bed

Including moving to/from lying position, turning from side to side, and positioning body while in bed.

### H2b Transfer

Including moving to and between surfaces—to/from bed, chair, wheelchair, standing position. [**Note:** excludes to and from bath/toilet].

### H2c Locomotion in Home

How client gets around in the home environment (excludes stairs). [**Note:** If in wheelchair, self-sufficiency once in chair.]

### H2d Locomotion Outside of Home

How client gets around outside of the home. [**Note:** If in wheelchair, self-sufficiency once in chair.]

### H2e Dressing Upper Body

How the client dresses and undresses **(street clothes and underwear)** above the waist. Includes prostheses, orthotics, fasteners, pullovers, etc.

### H2f Dressing Lower Body

How the client dresses and undresses **(street clothes and underwear)** from the waist down. Includes prostheses, orthotics (e.g. antiembolic stockings) belts, pants, skirt, shoes and fasteners.

### H2g Eating

Including taking in food by any method, including tube feedings.

### H2h Toilet Use

Including using the toilet room or commode, bedpan, urinal; transferring on/off toilet; cleaning self after toilet use (includes cleansing after incontinence episode); managing any special devices required (ostomy or catheter), and adjusting clothes.

### H2i Personal Hygiene

Including combing hair, brushing teeth, shaving, applying makeup, washing/drying face and hands, [EXCLUDES baths and showers].

### H2j Bathing

How the client takes full body bath/shower or sponge bath (EXCLUDES washing of back and hair). Includes how each part of the body is bathed: arms, upper and lower legs, chest abdomen, perineal area. **Code for the most dependent episode in the last 7 days.**

*Coding*

For each ADL category, code the appropriate response for the client's actual performance during the past three days.

**0** **Independent**—No help, setup, or oversight—OR—Help, setup, oversight provided only 1 or 2 times (with any task or subtask).
**1** **Setup Help only**—Article or device provided within reach of client 3 or more times.
**2** **Supervision**—Oversight, encouragement or cueing provided 3 or more times during period—OR—Supervision (1 or more times) plus physical assistance provided only 1 or 2 times during period (for a total of 3 or more episodes of help or supervision).
**3** **Limited Assistance**—Client highly involved in activity; received physical help in guided manoeuvring of limbs or other non-weight bearing assistance 3 or more times—OR—combination of non-weight bearing help with more help provided only 1 or 2 times during period (for a total of 3 or more episodes of physical help).
**4** **Extensive Assistance**—Client performed part of activity on own (50% or more of subtasks) BUT help of the following type(s) was provided 3 or more times:
- Weight bearing support
- Full performance by another of a task (some of time) or discrete subtask.

**5** **Maximal Assistance**—Client involved and completed less than 50% of subtasks on own, received weight bearing help—OR—full performance of certain subtasks 3 or more times. Includes two-person physical assist.
**6** **Total Dependence**—Full performance of the activity by another during the entire period.
**7** **Activity Did Not Occur**—During the last three days, the ADL activity was not performed by the client or others. In other words, the specific activity did not occur at all (regardless of ability).

**a. Mobility in Bed**
**b. Transfer**
**c. Locomotion in Home**
**d. Locomotion Outside of Home**
**e. Dressing Upper Body**
**f. Dressing Lower Body**
**g. Eating**
**h. Toilet Use**
**i. Personal Hygiene**
**j. Bathing**

## H3 ADL Decline

Client Group: Long-Term Supportive Care and Maintenance

*Intent*

To compare current ADL status to status of 90 days ago (or since last assessment if less than 90 days), is it now worse?

*Definition (from MDS-HC form)*

ADL status has become worse (i.e. now more impaired in self-performance) as compared to status 90 days ago (or since last assessment if less than 90 days).

*Coding*

Code for appropriate category.

**0 No**
**1 Yes**

# Section J Disease Diagnoses

Client Group: Long-Term Supportive Care and Maintenance

## J1 Diseases

*Intent*

To document the presence of diseases/infections that have a relationship to the client's current ADL status, cognitive status, mood or behaviour status, medical treatments, nursing monitoring or risk of death. Also code if reason for hospitalization in the last 90 days (or since last assessment if less than 90 days). In general, these are conditions that drive the current plan of care. Do not include conditions that have been resolved or no longer affect the client's functioning or care plan.

*Definition*

**Heart/Circulation**

**a. Cerebrovascular accident (Stroke)**—A vascular insult to the brain that may be caused by intracranial bleeding, cerebral thrombosis, infracting, embolus.
**b. Congestive heart failure**—Heart disease characterized by water retention often resulting in edema, signs and symptoms of breathlessness, and confusion.
**c. Coronary artery disease**—A condition in which one or more of the coronary arteries is narrowed by plaque or vascular spasms.
**d. Hypertension**—Persistently high arterial blood pressure.
**e. Irregularly irregular pulse**—Any abnormal cardiac rhythm (arrhythmia). For example, atrial fibrillation is characterized by rapid, randomized contractions of the atrial myocardium—which in turn causes an irregular pulse.
**f. Peripheral vascular disease**—Vascular disease of the lower extremities that can be of venous or arterial origin.

**Neurological**

**g. Alzheimer's**—A degenerative and progressive dementia that is diagnosed by ruling out other dementias and physiological reasons for the dementia.

**h. Dementia other than Alzheimer's disease**—Includes diagnoses of organic brain syndrome (OBS) or chronic brain syndrome (CBS), senility, senile dementia, multi-infarct dementia, and dementia related to neurologic diseases other than Alzheimer's (e.g. Picks, Creutzfeld-Jacob, Huntington's disease, etc.).

**i. Head trauma**—wound or injury to head, often caused by traffic or other accidents, that can cause language impediment, seizures, amnesia, functional impairments, and behavioural changes.

**j. Hemiplegia/hemiparesis**—paralysis of one side of the body.

**k. Multiple Sclerosis**—an inflammatory disease of the central nervous system in which infiltrating lymphocytes, predominantly T cells and macrophages degrade the myelin sheath of nerves.

**l. Parkinsonism**—Group of neurological conditions characterized by tremor, muscle rigidity, and abnormal mobility and difficulty swallowing.

**Musculo-skeletal**

**m. Arthritis**—Includes degenerative joint disease (DJD), osteoarthritis (OA), and rheumatoid arthritis (RA).

**n. Hip fracture**—Includes any hip fracture that occurred at any time that continues to have a relationship to current status, treatments, monitoring, etc. Hip fracture diagnoses also include femoral neck fractures, fractures of the trochanter, subcapital fractures.

**o. Other fracture (e.g. wrist, vertebral)**—Fracture of other than hip bone (e.g. wrist) due to any condition, e.g. falls, weakening of the bone, as a result of cancer, etc.

**p. Osteoporosis**—Reduction in bone mass, increasing risk of bone fractures.

**Senses**

**q. Cataract**—An opacity of the lens in one or both eyes that reduces visual acuity.

**r. Glaucoma**—Diseases to eye characterized by increased intraocular pressure, can lead to irreversible damage to optic nerve.

**Psychiatric/Mood**

**s. Any psychiatric diagnosis**—e.g. depression, anxiety disorder, schizophrenia, paranoia.

**Infections**

**t. HIV infection**—Check this item only if there is supporting documentation or the client (or surrogate decision-maker) informs you of the presence of a blood test positive for the Human Immunodeficiency Virus or if the person has a diagnosis of AIDS.

**u. Pneumonia**—An acute infection, inflammation of the lungs.

**v. Tuberculosis**—Includes only clients with active tuberculosis or those whose PPD test has converted to positive tuberculin status and are currently receiving drug treatment (e.g. isoniazid (INH), ethambutol, rifampin, cycloserine) for tuberculosis. It does not include those who have had tuberculosis in distant past.

**w. Urinary tract infection (in last 30 days)**—Includes chronic and acute symptomatic infection(s) in the last 30 days. Check this item only if the family states there is current supporting documentation and the client is being treated for a UTI.

**Other Diseases**

**x. Cancer**—(in past 5 years) not including skin cancer.

**y. Diabetes**—Any of several metabolic disorders marked by persistent thirst and excessive discharge of urine.

**z. Emphysema/COPD/Asthma**—Includes COPD (chronic obstructive pulmonary disease) or COLD (chronic obstructive lung disease), chronic restrictive lung diseases such as asbestosis, and chronic bronchitis.

**aa. Renal Failure**—Clinical condition that leads to derangement and insufficiency of renal excretory and regulatory function.

**ab. Thyroid Disease**—Three conditions are included under this category hyperthyroidism, hypothyroidism, and thyroid nodules.

**ac. None of the above**

*Coding*

Do not record any conditions that have been resolved, no longer affect the client's functioning or care plan, and are not being monitored.

**[BLANK] Disease not present**

**1 Disease is present, not subject to focused treatment or monitoring by a home care professional**

**2 Disease is present and is being monitored or treated by home care professional**

**If client has none of the diseases listed in J1, check J1ac (none of above).**

## J2 Other Current or More Detailed Diagnoses

*Process*

Enter other diseases that affect client's status, require treatments or symptom management. Also record more specific designations for general diseases listed under J1.

*Coding*

Up to four other or more detailed diseases can be captured. Diseases are to be coded to the appropriate ICD-10CA code from the CIHI pick list (see CIHI Home Care Roadmap Indicators Data Standard Addendum II: ICD-10-CA Codes)[2].

[2] The International Statistical Classification of Diseases and Related Health Problems, Tenth Revision, Canada (ICD-10-CA) 2001.

# Section K Health Conditions

Client Group: Long-Term Supportive Care and Maintenance

## K2 Problem Conditions Present on 2 or More Days

*Intent*

To record specific reoccurring problems or symptoms that affect or could affect the client's health or functional status, and to identify risk factors for illness, accident, and functional decline.

*Definition*

### K2e Vomiting

The forcible expulsion of the contents of the stomach through the mouth.

*Coding*

Check if present on 2 or more of the last three days.

## K3 Problem Conditions

*Intent*

To record specific problems or symptoms that affect or could affect the client's health or functional status, and to identify risk factors for illness, accident, and functional decline.

*Definition*

### K3d Edema

Excessive accumulation of fluid in tissues, either localized or systemic (generalized). Includes all types of edema (e.g. dependent, pulmonary, pitting).

### K3e Shortness of Breath

Difficulty breathing (dyspnea) occurring at rest, with activity, or in response to illness or anxiety.

*Coding*

Check if present at any time during the **last 3 days**.

## K4 Pain

*Intent*

To record the frequency and intensity of the signs and symptoms of pain. For care planning purposes this item can be used to identify indicators of pain as well as to monitor the client's response to pain management interventions.

*Definition*

### K4a Frequency With Which Client Complains or Shows Evidence of Pain

Client reported or was observed to have pain. Observable signs of pain include, but are not limited to guarding area of pain, withdrawal, grimacing, insomnia, agitation, anorexia, etc.

*Coding*

**0 No pain (score b-e as "0")**
**1 Less than daily**
**2 Daily—one period**
**3 Daily—Multiple periods (e.g. morning and evening)**

*Definition*

### K4b Intensity of Pain

The client's perception of intensity or severity of pain.

*Coding*

**0 No pain**
**1 Mild**
**2 Moderate**
**3 Severe**
**4 Times when pain is horrible or excruciating**

*Definition*

### K4c From Client's Point of View, Pain Intensely Disrupts Usual Activities

*Coding*

Client reports experiencing an intensity of pain such that he/she is either unable to continue doing usual activities, or his/her schedule needs to be adjusted.

**0 No**
**1 Yes**

### K4e From Client's Point of View, Medication Adequately Controls Pain

*Coding*

Client reports on the adequacy of pain control with current medication/treatment taken.

**0 Yes, or no pain**
**1 Medications do not adequately control pain**
**2 Pain present, medication not taken**

## K5 Falls Frequency

*Intent*

To determine the client's risk of future falls or injuries. Falls are a common cause of morbidity and mortality among elders. Clients who have sustained at least one fall or a near fall are at risk of future falls. Serious injury results from 6 to 10 percent of falls, with hip fractures accounting for approximately one-half of all serious injuries.

*Coding*

Code for number of times client fell in last 90 days (or since last assessment if less than 90 days). If none code "0", if more than 9 code "9".

## K8 Health Status Indicators

*Definition*

**K8e Less Than Six Months to Live**

The client or family has been told that in the best clinical judgement of the physician, the client has end-stage disease with approximately six or fewer months to live.

*Coding*

**0 No**
**1 Yes**

# Section L Nutritional/Hydration Status

Client Group: Long-Term Supportive Care and Maintenance

## L1 Weight

*Intent*

Marked unintended declines in weight can indicate failure to thrive, a symptom of a potentially serious medical problem, or poor nutritional intake due to physical, cognitive and social factors.

**L1a Weight Loss**

*Definition*

Unintended weight loss of 5% or more in last 30 days (or 10% or more in last 180 days).

*Coding*

**0 No**
**1 Yes**

# L2 Consumption

*Intent*

Regardless of the size of the meal, persons eating only one or fewer meals a day are unlikely to be deriving sufficient nutrition.

The question about number of meals is the introduction to a conversation about food intake. If the client eats three prepared meals (cold or warm) each day, the energy intake is probably satisfactory. If the client eats fewer meals, these meals have to be very well composed to give energy and enough nutrients. Fewer meals a day can indicate reduced appetite, mood distress, medication complications, alcohol abuse, or some other problem.

*Definition*

**In last 3 days, noticeable decrease** in the amount of food client usually eats or fluids usually consumes. Noticeable decrease is related to baseline consumption of foods and fluids. Consider the 24-hour period, not just during mealtime. The client may decrease on meals and opt for more frequent snacks. Any decrease in overall consumption should be considered noticeable.

## L2b Decrease in Usual Food/Fluid Intake

In **last 3 days**, noticeable decrease in the amount of food client usually eats or fluids usually consumes.

## L2c Insufficient Fluid

**Insufficient fluid**—did not consume all/almost all fluids during the last 3 days.

*Coding*

**0 No**
**1 Yes**

# CIHI Data Elements

## Demographic Information

Client Group: All

### X1 Unique Client Identifier

This element is under development. It will allow a client to be uniquely identified within a province or territory and will adhere to CIHI's principles and policies for the protection of personal health information. This data element may be derived at CIHI from personal identifiers submitted by jurisdictions.

## Client Group

Client Group: All

### X2 Client Group

*Definition*

The client group that the home care client is assigned to by the case manager/care coordinator that best reflects client need(s).

1. **Acute Home Care Client**—Client with acute health or post surgical condition(s) with clearly identified and predictable outcomes or expected recovery.
2. **End-of-Life Client**—Client with a health condition that is not responsive to curative treatment. The client and/or family has been informed by a physician that the client is expected to live less than six months.
3. **Rehabilitation Client**—Client with impairments (temporary or permanent), activity limitations and/or participation restrictions who has the potential for significant improvement in functional status and/or participation.
4. **Long-Term Supportive Care Client**—Client with ongoing multiple and/or complex health conditions, who may be unstable, medically fragile or considered by the case manager/care coordinator to be at risk for institutionalization.
5. **Maintenance Client**—Client with a stable chronic health condition or functional limitation who requires augmentation of personal resources for assistance with personal care, activities of daily living and/or instrumental activities of daily living.

*Coding*

Code only one.

**1 Acute Home Care Client**
**2 End-of-Life Client**
**3 Rehabilitation Client**
**4 Long-Term Supportive Care Client**
**5 Maintenance Client**

# Administrative and Resource Information

Client Group: All

## X3 Referral Source

*Definition*

The person or organization that referred the client to the home care program.

*Coding*

**1 Self**
**2 Family/Friend/Neighbour**
**3 Other home care program**
**4 Physician (includes GP/Family Medicine/Specialist)**
**5 Other health professional (includes Nurse, PT, OT, Social Worker)**
**6 Community service organization other than the home care program**
**7 Hospital (includes inpatient and ambulatory care service)**
**8 Residential care facility (includes long-term care facility, nursing home, special care home, home for the aged)**
**9 Assisted living setting (includes group home, retirement home, community care home, lodge, supporting housing, congregate living setting)**
**10 Other**
**99 Asked, Unknown**

## X4 Date of First Service (Excluding Comprehensive Assessment)

*Definition*

The calendar day (year, month, and day) of first contact between a home care service provider and the client for the purpose of delivering home care services.

Excludes contact for the purpose of completing a comprehensive assessment.

*Coding*

Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains a single digit, fill the first box with a "0".

If client receives other home care services on the same day as they receive their comprehensive assessment, the date of first service will be the same as the assessment reference date (data element A1).

**YYYY/MM/DD**

## X5 Date of Last Service

*Definition*

The calendar day (year, month, and day) on which the client received his/her last home health and/or home support service from a formal service provider prior to discharge from the home care program.

*Coding*

Fill in the boxes with the appropriate number. Do not leave any boxes blank. If the month or day contains a single digit, fill the first box with a "0".

**YYYY/MM/DD**

## X6 Service Delivery Setting(s)

*Definition*

The location(s) where the client receives health, and/or support services from the home care program.

1. **Private house, condominium, apartment**—refers to any house, condominium or apartment in the community whether owned by the client or another person. Also included in this category are retirement communities, and independent housing for the elderly or disabled.
2. **Boarding house (includes rented room)**—refers to community accommodation where meals may be provided.
3. **Assisted living setting**—refers to a non-institutional community setting that integrates a shared living environment with varying degrees of supportive services of the following types: supervision, housekeeping, personal care, meal service, transportation, social and recreational opportunities, etc. May have limited medical/nursing services available (includes group home, retirement home, community care home, lodge, supportive housing, congregate living setting).
4. **Residential care facility**—refers to a licensed health facility that provides 24-hour skilled or intermediate nursing care. 24 hour is defined as on-site and available to respond immediately, if required (includes long-term care facility, nursing home, special care home, home for the aged).
5. **Hospice**—refers to a home-like setting for persons of any age who are dying and require regular assessment of symptoms and ongoing changes in treatment and care plans, or who choose to die in a hospice environment.
6. **Ambulatory home care setting**—refers to community service sites where services are provided by the home care program or their contracted service provider agencies.
7. **Hospital**—refers to in-patient acute, continuing care, and rehabilitation services. (Includes auxiliary hospital).
8. **Shelter/public place**—refers to emergency housing and public locations. (Includes night shelter, hostel for the homeless, streets, parks and other public places).
9. **School**—refers to sites associated with all levels of education. (Includes elementary, intermediate and secondary schools, college and university).
10. **Other**

*Coding*

Code all that apply.

**1 Private house, apartment, condominium**
**2 Boarding house (includes rented room)**
**3 Assisted living setting**
**4 Residential care facility**
**5 Hospice**
**6 Ambulatory home care setting**
**7 Hospital**
**8 Shelter/public place**
**9 School**
**10 Other**

## X7 Face-to-Face Visits

*Definition*

The occasions during which home care services were provided face-to-face to a client. These services are documented by the service provider and are provided for longer than five minutes.

Includes client assessment and the provision of home health and home support services.

*Coding*

Enter the total number of face-to-face visits that were provided to the client since last submission. Enter by occupational group.

**a. Case Management**
**b. Nursing**
**c. Clinical Nutrition**
**d. Occupational Therapy**
**e. Physiotherapy**
**f. Social Work**
**g. Speech/Language Pathology**
**h. Home Support/Community Care Worker**
**i. Other**

## X8 Telephone Visits

*Definition*

The number of occasions, captured retrospectively, during which home care services were provided over the telephone to a home care client in lieu of a face-to-face visit. These services are documented by the service provider and are provided for longer than five minutes.

Includes client assessment and the provision of home health and home support services.

*Coding*

Enter the number of occasions that services were provided to clients over the telephone since last submission. Enter by service provider category.

**a. Case Management**
**b. Nursing**
**c. Clinical Nutrition**
**d. Occupational Therapy**
**e. Physiotherapy**
**f. Social Work**
**g. Speech/Language Pathology**
**h. Home Support/Community Care Worker**
**i. Other**

## X9 Service Hours

*Definition*

The hours, captured retrospectively, spent in the delivery of home care services to or on behalf of the home care client. Includes client assessments, provision of services aimed at health promotion, improving/maintaining health status, or minimizing the impact of deterioration on function and quality of life, consultation/communication with other service providers regarding the status and/or needs of the specific client, client/caregiver education, clinical documentation related to services provided.

Excludes travel time to and from the client's home.

*Coding*

Record the number of service hours provided since last submission. Report service hours by service provider category.

**a. Case Management**
**b. Nursing**
**c. Clinical Nutrition**
**d. Occupational Therapy**
**e. Physiotherapy**
**f. Social Work**
**g. Speech/Language Pathology**
**h. Home Support/Community Care Worker**
**i. Other**

## X10 Emergency Room Visits

*Definition*

The number of times, since last submission that the home care client visited a hospital-based emergency room.

*Coding*

Enter the number of hospital-based emergency room visits since last data submission.

# Discharge Information

Client Group: All

## X11 Service Goals Met at Discharge

*Definition*

An indication of whether the home care client's documented service goals have been met at discharge.

*Coding*

Have the expected service goals been met at discharge?

**0 No**
**1 Yes**

## X12 Reason for Discharge

*Definition*

The reason for the client's discharge from the home care program.

*Coding*

**1 Client no longer requires service**
**2 Client referred to other health service (go to X13)**
**3 Client no longer eligible for service (funding)**
**4 Client withdrew/terminated services**
**5 Client moved out of area**
**6 Client died**
**7 Agency unable to contact/reach client**
**8 Physical environment unsuitable for service delivery**
**9 Services terminated due to occupational health and safety reasons**
**10 Other**

# X13 Referred to Other Health Service

Client Group: All when X12 is coded 2

*Definition*

The health service setting that the client was referred to at time of discharge from the home care program.

*Coding*

**1 Hospital (includes in-patient acute, rehabilitation and continuing care services)**
**2 Residential care facility (includes long-term care facility, nursing home, homes for the aged)**
**3 Hospital-based ambulatory care service**
**4 Assisted living setting (includes group home, retirement home, community care home, lodge, supportive housing, congregate living setting)**
**5 Community-based health service/program**
**6 Other**


ten
years
dix
ans
taking health information further
à l'avant-garde de l'information sur la santé