

Assess & Restore Guideline

October 2014

Ministry of Health
and Long-Term Care

Ministère de la Santé et
des Soins de longue durée



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1. GUIDELINE STATEMENT

This Assess & Restore (A&R) Guideline defines the elements of an A&R approach to care and sets out the Ministry's expectations of Local Health Integration Networks (LHINs) and Health Service Providers (HSPs) with respect to the planning, establishment, delivery, monitoring, and evaluation of A&R initiatives.¹

This Guideline is intended to improve access to 'A&R interventions', which are individualized bundles of short-term rehabilitative and other restorative care services that are:

- delivered by integrated teams that include regulated health professionals with expertise in geriatrics; and
- directed at increasing strength, mobility, and functional ability.²

A&R interventions are targeted to frail seniors and other persons³ who:

- have experienced a recent loss of functional ability following a medical event or decline in health;
- are at high risk for imminent hospitalization or admission into a long-stay Long-Term Care (LTC) home bed as a result of that functional loss ('high-risk'); and
- have the potential to regain that functional loss so that they are no longer at high risk ('restorative potential').⁴

A&R is one component of a larger, cross-continuum, integrated model of care for frail seniors. It is recognized that Assess and Restore interventions may be provided across the care continuum. In particular, this Guideline is intended to improve access to '*facility-based*' A&R interventions, which are A&R interventions targeted to frail, high-risk seniors and others with restorative potential who require a level of care that is only available in a hospital bed or LTC home Convalescent Care Program (CCP) bed setting.

Implementation of this Guideline is intended to:

- extend the functional independence of community-dwelling frail seniors and other persons for as long as possible;
- reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors and other persons; and

¹ This Guideline does not address the roles and responsibilities of persons requiring care, their unpaid caregivers, and their families. The Ministry nonetheless recognizes that these persons all make crucial contributions to seniors' independence.

² Functional ability is the ability to perform one or more essential Activities of Daily Living (ADLs) such as walking, toileting or bathing.

³ Frail seniors are older persons who are vulnerable for developing increased dependency and/or mortality when they are challenged by a health stressor (Source: Adapted from Heckman et al. "Addressing health care needs for frail seniors in Canada: the role of interRAI instruments," *CGS Journal of CME* 3, no. 1, 2013). See section 4 for a more detailed description of the targeted persons.

⁴ Adapted from Rehabilitative Care Alliance, 2013.

- facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors and other persons.

A&R is *not* intended:

- for persons who experience a loss of function that is either minor or not amenable to recovery through a time-limited course of therapeutic interventions (i.e. those who do not have restorative potential);
- to replace the care pathways developed under a Quality Based Procedure (e.g. for persons who receive a hip or knee replacement or experience a hip fracture or stroke);⁵ or
- to provide continuing, preventative, or maintenance care.

Figure 1: A&R targets a small subset of seniors and other persons, in order to help them recover their functional abilities and remain independent in the community for as long as possible.⁶



A&R targets a small subset of the senior population. Few seniors are frail, and few of these people are high-risk. High-risk seniors are distinguishable in that they have begun to experience serious functional decline and are reaching a stage where that decline threatens to become precipitous and permanent. Frail high-risk seniors typically have complex psychosocial needs, multiple chronic conditions, and a history of frequent and heavy use of primary, home and community care, or hospital resources. A diagnosis of "failure to thrive" or "debility" is also common. Functional loss is a concern for all frail seniors, but the concern is heightened when the loss is severe and there is a likelihood that without timely intervention the loss would become permanent. For frail seniors, severe functional loss, if it becomes permanent, typically means a significantly greater risk of hospitalization or admission to a long-stay LTC home bed.

⁵ A component of Health System Funding Reform, Quality-Based Procedures (QBPs) are specific groups of patient services for which health care providers are reimbursed according to the types and quantities of patients they treat, using evidence-informed rates that are associated with the quality of care delivered. Quality-Based Procedures set payment rates for each health care provider contributing to the patient's care journey. Clinical handbooks have been developed to support clinicians' transition to QBPs.

⁶ See section 4 for a more detailed description of the persons targeted by A&R.

An A&R approach to care encompasses a range of programs and settings and is multidisciplinary and cross-sectoral in design and nature. A&R is not a provincial program; it is not a bed designation or another term for ‘rehabilitation services’ or convalescent care. A&R interventions are delivered within and across a range of programs and bed designations.⁷

2. GUIDELINE SCOPE

This Guideline sets out:

- the elements of an A&R approach to care;
- the criteria for identifying seniors and other persons for whom facility-based A&R interventions are appropriate;
- the three types of facility-based A&R interventions;
- the shared and individual roles and responsibilities of primary care providers, Community Care Access Centres (CCACs), approved agencies, including Community Support Service (CSS) agencies, hospitals, and LTC homes with respect to A&R; and
- accountability and performance measurement expectations with respect to A&R.

3. ELEMENTS OF AN A&R APPROACH TO CARE

The five elements of an A&R approach to care are:

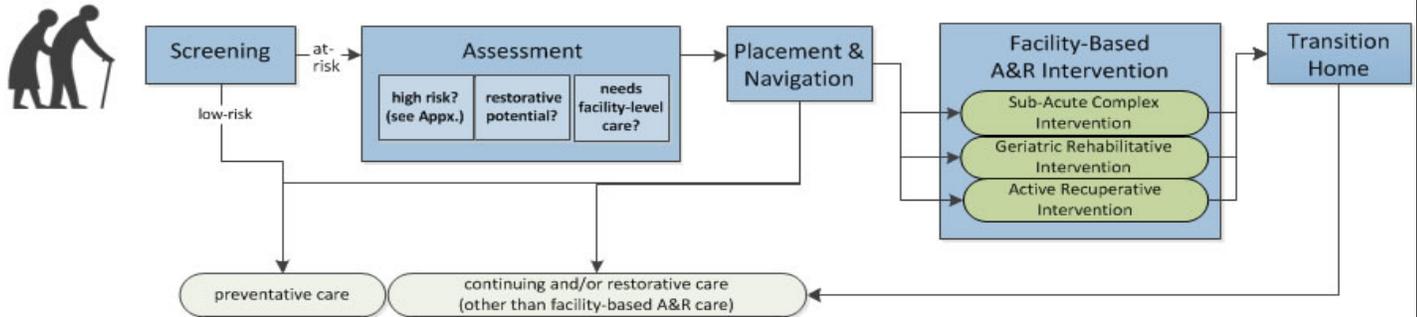
- **Screening:** active use of standardized screening tools in the community and in hospitals to identify seniors and other persons who have begun to experience or are at risk of functional impairments that could lead to hospitalization or a loss of independence (‘at-risk seniors and other persons)
- **Assessment:** prompt assessments of at-risk seniors and other persons by qualified persons using standardized assessment instruments to inform determinations of appropriateness for facility-based A&R;
- **Navigation & Placement:** efficient navigation of assessed seniors and other persons to the most-appropriate provider(s), setting(s), and type(s) of intervention(s);
- **Facility-Based A&R Intervention:** evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices;

⁷ For example, A&R interventions may be delivered in CCP beds, but a person need not be within the target population for A&R to meet the eligibility criteria for admission to a CCP bed. At any given time, only a subset of persons in CCP beds might be within the target population for A&R. The eligibility criteria for the CCP are set out in the regulations under the *Long-Term Care Homes Act, 2007* and are broader than the targeting criteria for A&R described in this Guideline. CCP beds cannot be designated as A&R beds or otherwise reserved or prioritized for persons within the A&R target population.

Similarly, A&R interventions may be delivered in rehabilitation or CCC beds in hospital, but only a subset of persons eligible for admission to rehab and CCC beds under the admission criteria defined in the *Public Hospitals Act* will fall within the target population for A&R. In contrast with LTC homes with CCP beds, however, hospitals can choose to prioritize access to a portion of their rehabilitation or CCC beds for the benefit of persons within the A&R target population. Any such decision should be made in consultation with the LHIN and with consideration for the overall needs of the local community, region, and province.

- **Transition Home:** integration and linkages with primary and community care providers and caregivers to ensure gains made are retained.

Figure 2: The five elements of an A&R approach to care



The patient journey under an A&R approach to care begins with risk **screening** for loss of independence related to functional impairment. Seniors and other persons identified as low-risk should be directed to preventative programs and services in the community (e.g. exercise and falls prevention classes) to help them maintain and improve their strength and functional abilities.

Seniors and other persons identified as being ‘at-risk’ for loss of independence should be referred for **assessment** of their risk level, restorative potential, and need for facility-based (vs. in-home and/or ambulatory) rehabilitative and other restorative care.⁸

Assessed seniors and other persons should then be referred for **navigation and placement** to the most-appropriate provider(s), setting(s), and types(s) of intervention(s). (See Table 1 next page).

⁸ Not all at-risk seniors and other persons are high-risk. At-risk seniors and other persons are those who have been identified as potentially high-risk by an untrained person using a simple screening tool. A determination of whether a person is at high risk for hospitalization or admission into a LTC home long-stay bed must be made by a trained hospital or CCAC staff person, and the determination must be informed by the results of one or more assessments performed by a qualified person using a standardized assessment instrument. Only CCACs may determine eligibility for LTC home admission.

Table 1: Navigation and placement decisions should be informed by A&R (and other) assessments.

Assessment			Navigation and Placement
High Risk for Hospital or LTCH?	Restorative Potential?	Needs Facility-Based Intervention?	Appropriate Services/Provider Type
Yes	Yes	Yes	→ Facility-based A&R intervention
‘No’ for any of the above questions			→ Other types of preventative/continuing/restorative care, e.g. via: <ul style="list-style-type: none"> • Hospital (rehab or CCC bed) (non-A&R intervention) • LTC home – short-stay bed (CCP bed - non-A&R intervention, respite care program bed) • Geriatric Day Hospital program • Geriatric outreach care • Clinic-based care • Assisted Living Services for High Risk Seniors • Home Care • Community Support Services • LTC home (long-stay bed)

Persons assessed as being at high risk, having restorative potential, and requiring facility-based interventions should be guided to and placed with a program that includes **facility-based A&R interventions** that are:

- provided through interprofessional teams whose members have expertise in geriatric care⁹, such as:
 - o geriatric and psychiatry specialists,
 - o physiotherapists, occupational therapists, speech language pathologists, rehabilitation nurses, and therapy assistants,
 - o a range of medical, nursing, pharmacy, dietary and psychiatric professionals, and
 - o other team assistants;
- designed to include unpaid caregivers in the care process through discussions about goals, plans, and key treatment decisions;¹⁰ and
- delivered under a dedicated, coordinated, and integrated model of care¹¹ that includes protocols and/or monitoring for services such as:
 - o physiotherapy, occupational therapy, and speech language pathology services delivered directly by a regulated health professional (RHP) or a person acting under the direct supervision of an RHP;¹²

⁹ The degree of care providers’ expertise in geriatrics and of a patient’s access to a dedicated, coordinated, and integrated inter-professional team may vary according to the type of programs providing A&R care to which the person is admitted.

¹⁰ Providers must, of course, comply with applicable requirements, including the *Health Care Consent Act, 1996* and the *Personal Health Information Protection Act, 2004*.

¹¹ Hospitals should also refer to the Senior Friendly Hospital Strategy and Framework.

- o wound care and preventative wound care;
- o continence care;
- o medications reconciliation and management;
- o pain management;
- o diet/nutrition/hydration management;
- o case management;
- o psychosocial/behavioural support; and
- o caregiver support.¹³

LHINs should work with hospitals and CCACs to ensure that persons who do not meet the target criteria for A&R (e.g. are not at high risk for hospitalization or admission into a long-stay LTC bed or lack restorative potential, as these terms are defined under this Guideline), but who could nonetheless benefit from rehabilitative care, are provided appropriate support to enable their access to the most appropriate provider(s), setting(s), and types(s) of intervention(s).

To ensure continuity of care and maintain the functional independence of any person following the completion of a course of A&R interventions, sending facilities, CCACs, and other HSPs should coordinate safe **transition home** by ensuring accountable processes are in place for primary, home and community-based care coordination.¹⁴ These processes should encompass:

- the collaborative process of assessment, planning, facilitation and identification of options and services with the person’s family and/or unpaid caregiver to meet an individual's home and community care needs;
- the deliberate organization of client care activities to facilitate the appropriate delivery of home and community care; and
- the organizing of interventions and scheduling of personnel and other resources, including access to primary care services, needed to carry out all required home and community care activities to meet the needs of the person.

¹² For the purposes of this Guideline, the term ‘direct supervision’ should be interpreted broadly and with reference to the ordinary meanings of the words and any guidance and direction on types or forms of supervision issued by the relevant RHP College. For example, the College of Audiologists and Speech-Language Pathologists of Ontario has defined indirect and direct supervision, with the latter defined as referring to on-site, in-view observation and guidance by the supervising RHP while an assigned activity is performed by an assistant (CASLPO, Position Statement: Use of Supportive Personnel, 1997). This Guideline does not purport to define when direct care or supervision is appropriate, or the types, forms, necessary elements or other features of supervision. The use of the term in this Guideline is intended only to indicate that the frailty of the A&R target population in general suggests that in an A&R intervention, professional standards defined by the individual Colleges will likely require relatively active oversight of any rehabilitation services provided by a therapy assistant or other person acting under RHP supervision.

¹³ Caregiver support includes teaching caregivers how to assist in or supervise care after discharge, and providing information to caregivers on respite, transport, and delivery services that could be accessed in the community after discharge.

¹⁴ Health Quality Ontario provides guidance on care transitions in [“Adopting a Common Approach to Transitional Care Planning: Helping Health Links Improve Transitions and Coordination of Care”](#) (Toronto: Government of Ontario, 2014)

4. TARGET CRITERIA FOR A&R INTERVENTIONS

A&R interventions should be targeted to persons who have been:

- assessed by qualified persons using standardized, evidence-based assessment tools; and
- determined, based on those assessments, to have met the following criteria:
 - have experienced a recent loss of functional ability related to a medical condition or life event;
 - are at high risk for imminent admission into a long-stay Long-Term Care (LTC) home bed (see Appendix A) or hospitalization (see Appendix B), as a result of that functional loss (are 'high-risk'); and
 - have the potential to regain that functional ability through participation in individualized bundles of short-term rehabilitative and other restorative care services so that they are no longer at high risk (i.e. have 'restorative potential')

Facility-based A&R interventions should be targeted to persons who meet the above criteria and also require, in order to be safe and/or to realize their restorative potential, an intensity and frequency of services) that is not available, or could not be delivered cost-effectively, on an in-home and/or ambulatory basis (i.e. the person 'requires a facility-based intervention').

5. TYPES OF FACILITY-BASED A&R INTERVENTIONS

There are three types of facility-based A&R interventions. The descriptions of each type of facility-based A&R intervention provided in this Guideline are intended to help LHINs, hospitals, and CCACs define service expectations and help hospitals and CCACs navigate and place targeted seniors and other persons with appropriate providers of A&R interventions.

Each type of facility-based A&R intervention is distinguished by:

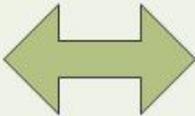
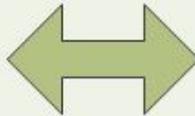
- the target sub-population for that type of intervention, as defined by the relative need for active medical management¹⁵ and need for rehabilitative care delivered by professionals with expertise in geriatrics (see Table 2);
- the type, duration and frequency of services available; and
- the facility settings in which that type of intervention would typically be provided.

¹⁵ Persons requiring active medical management have one or more of the following characteristics:

- acute medical issues are incompletely addressed, but the person is well enough to participate in an A&R intervention;
- major acute care diagnostic tests and treatments are complete, although some minor or supporting results may be pending;
- medication needs have not been fully determined;
- major health needs have been identified, although a clear diagnoses of minor issues and co-morbidities may not be established;
- a definitive treatment plan that addresses non-critical care needs has not been established.

The Ministry recognizes that a physician or other clinician will ultimately determine whether a patient's needs for active medical management preclude A&R interventions.

Table 2: Characteristics of targeted seniors and other persons for the 3 types of facility-based A&R interventions

Patient Characteristics	Type 1: Sub-Acute Complex Intervention	Type 2: Geriatric Rehabilitative Intervention	Type 3: Active Recuperative Intervention
Need for Active Medical Management			
Need for Intensive Rehab Services	Least		Most
			Least

5.1 Type 1: Sub-Acute Complex Interventions

5.1.1 Target Subpopulation

This type of A&R intervention is for persons who require at least a moderate degree of active medical management (i.e. who may or may not be medically stable)¹⁶ and, as a consequence, may possess a relatively low level of physical or cognitive ability to participate in rehabilitative care activities.

These persons may be transitioning from acute medical treatment or surgery, require treatment for acute exacerbation of one or more chronic medical conditions, or a brief stabilization period to resolve medical issues, e.g. delirium or other symptoms related to poly-pharmacy.

These persons require a degree of active medical management that makes it unsafe or impractical to receive A&R interventions on an in-home or ambulatory basis.

5.1.2 Intervention Types and Frequencies

Targeted seniors and other persons who require Type I A&R intervention should be referred to HSPs that can provide the following services:

- Daily scheduled physician services
- On-call physician and on-site nursing services available 24/7
- Routine and regular daily scheduled nursing care

¹⁶ A person is medically stable when: there is a clear diagnosis; co-morbidities have been established; there are no undetermined medical issues (e.g. excessive shortness of breath, falls, congestive heart failure); vital signs are stable; medication needs have been determined and there is an established plan of care (GTA Rehab Network, Inpatient/LTLC Referral Guidelines, 2009)

- Skilled, technology-based care not available at home or in long-term care homes
- Some daily rehabilitative therapy focused on restoration, adaptive skill acquisition, and mobilization, delivered or supervised by an RHP
- Services delivered by professionals with expertise in geriatrics that are optimally delivered in a hospital setting

5.1.3 Facility Settings

Type 1 A&R interventions may be provided in settings where team-based medical (physician and nursing) and rehabilitative (physiotherapy, occupational therapy, and speech language pathology therapy) services are provided, and there is an ability to respond rapidly and effectively to unpredictable fluctuations in medical status.

Type 1 A&R interventions may be provided in acute, rehabilitation, or CCC beds in hospital as long as the appropriate services are made available to the patients in those beds. For example, rehabilitation and CCC beds may be used as sites for the provision of Type 1 A&R interventions as long as appropriate physician, diagnostic, and other medical services are available as required for the safe and effective care of patients within this target subpopulation. Where provided in acute care beds, appropriate rehabilitative care services should be available to the patients in those beds.

Because of the extent of active medical management and care delivered by professionals with expertise in geriatrics required, this type of intervention would, in most cases, not be appropriately delivered in an LTC home.

5.2 Type 2: Geriatric Rehabilitative Interventions

5.2.1 Target Subpopulation

This type of A&R intervention is for persons who require less active medical management than patients in Type 1 interventions (though more than in Type 3) and currently possess, or demonstrate the potential to possess, the necessary stamina, cognitive capacity, and endurance required to participate in daily, intensive, goal-directed rehabilitative therapy with medical oversight.

5.2.2 Intervention Types and Frequencies

Targeted seniors and other persons who require Type 2 A&R interventions should be referred to HSPs that can provide the following services:

- On-call physician and on-site nursing services available 24/7
- Some daily scheduled nursing care with a dominant rehabilitative focus
- Intense daily rehabilitative therapy delivered or supervised by an RHP

5.2.3 Facility Settings

Type 2 A&R interventions may be provided in a setting that has the resources to provide ongoing medical and nursing support with 24/7 access to on-call physician and intensive rehabilitative care services delivered by RHPs.

Type 2 A&R interventions may be provided in acute, rehabilitation, or CCC beds in hospital as long as the appropriate services are made available to the patients in those beds. For example, in small, rural and northern communities, this type of A&R intervention could be appropriately delivered in acute care beds if Rehab or CCC beds are not available. Where provided in acute care beds, appropriate rehabilitative care services should be made available to the patients in those beds.

Due to the intensity of team-based rehabilitative care required, this type of intervention would, in most cases, not typically be delivered in an LTC home.

5.3 Type 3: Active Recuperative Interventions

5.3.1 Target Subpopulation

Type 3 A&R interventions are for persons who require less active medical management than patients admitted to Types 1 and 2 A&R interventions. It is acknowledged that facilities providing Type 3 A&R interventions (e.g. LTC homes with CCP beds, and hospitals) may, depending on the availability of the required resources at the facility, provide care on occasion to persons who require a relatively moderate level of active medical management. Targeted individuals receiving Type 3 A&R interventions are expected to at least be capable of active participation in time-limited, low-intensity restorative care, but may lack the physical or cognitive capacity to participate in a rigorous rehabilitative care regimen.

5.3.2 Intervention Types and Frequencies

Targeted seniors or other persons who require Type 3 A&R interventions should be referred to HSPs that can provide the following services:

- On-site nursing services available 24/7
- Some daily scheduled nursing care
- A significant amount of daily or near-daily activation, mobilization, strengthening, and other low-intensity rehabilitative activities delivered or supervised by an RHP
- Other services as required under the LTCHA and O. Reg. 79/10 if care is being delivered in a CCP bed.

5.3.3 Facility Settings

Type 3 A&R interventions may be provided in a setting that has the resources to provide medical oversight and rehabilitative care services.

Type 3 A&R interventions may be provided in CCC beds in hospital and CCP beds in LTC homes, but could be provided in acute or rehabilitation beds. For example, in small, rural and northern communities with no or a limited number of CCC beds or CCP beds, this type of intervention could be appropriately delivered in acute care beds.

6. TRANSITION INDICATORS

Transition from a course of facility-based A&R interventions¹⁷ is generally indicated when the care team determines that:

- The person is medically stable and his or her ability to perform ADLs and IADLs has improved to a level that enables a transition home, with or without support;
- The person's medical stability or ability to participate in rehabilitative care has deteriorated and another type of A&R intervention is more appropriate; or
- The person no longer has the potential to reverse their recent functional loss enough to return home safely or the patient's progress has plateaued.

These transition indicators do not supersede the discharge criteria for CCP set out in the regulations under the LTCHA or the discharge criteria for hospital beds set out in the regulations under the *Public Hospitals Act*. A person can only be discharged from a LTC home or hospital in accordance with those regulations.

7. SERVICE DELIVERY ROLES AND RESPONSIBILITIES

7.1 Screening (early risk identification)

- LHINs should support their HSPs to cooperatively implement a provincial set of standardized, validated, and reliable screening tools for identifying at-risk seniors and other persons in accordance with this Guideline.
 - These tools should be simple to use and implemented across various settings in the community to provide early screening of seniors and other persons who have begun to experience or are at risk of functional impairments.

¹⁷ Note that this section refers to transition from a course of facility-based A&R interventions (i.e. the completion of a phase of care comprising A&R interventions), not discharge from a hospital or LTC home. A person may be transitioned from a course of A&R interventions and yet continue to receive care outside the scope of A&R as an admitted hospital patient or as an LTC home short-stay or long-stay resident. Discharge from a hospital or LTC home must be in accordance with the relevant legislation and regulations.

- Each LHIN should support its HSPs to ensure that these tools are made available to primary care physicians, CCACs, hospitals, approved agencies, including Community Support Service (CSS) agencies, and unpaid caregivers and community-dwelling seniors in the LHIN.
- LHINs should support their HSPs to ensure that information about where to refer seniors and other persons identified as at-risk is made available to persons responsible for acting on screening results.
- Primary care physicians, CCACs, and hospitals should promptly refer at-risk seniors and other persons to the appropriate agency or person for standardized assessments to inform a determination of whether a referral to an HSP offering facility-based A&R interventions is appropriate.
 - At-risk seniors and other persons identified in a primary care setting or an in-home setting should be referred for assessments by the CCAC or other qualified assessor approved by the LHIN.
 - At-risk seniors and other persons identified in an emergency department or other hospital setting should be referred for assessments to a designated, qualified on-site hospital staff person or CCAC staff person, as established between the hospital and CCAC and with the agreement of the LHIN.

7.2 Assessment

- LHINs should support their HSPs to cooperatively identify the standardized, validated, and reliable assessment instruments, tools and protocols to be used by hospitals and CCACs to inform determinations of whether a person is appropriate for facility-based A&R interventions under section 4 of this Guideline.
- Each LHIN should support its HSPs to ensure that these assessment instruments, tools, and protocols are made available to hospitals, the CCAC, and other qualified assessors in the LHIN.
- Hospitals, CCACs, and other qualified assessors approved by the LHIN should use standardized and validated instruments and applications in making their assessments of whether a person is at high risk and has restorative potential under this Guideline.
- CCACs should assess the restorative potential of persons being considered for admission to a long-stay bed in an LTC home.
- Mild to moderate symptoms of cognitive impairment, depression, or delirium and the presence of multiple chronic conditions or medical complexity should not be used as exclusion criteria in decisions about whether an at-risk senior or other person has restorative potential.
- Hospitals, CCACs, or other qualified assessors approved by the LHIN should conduct their own assessments, as required by LHIN or Ministry policies/directives or professional standards. To avoid duplication of work, however, they should also consult and, where appropriate, use the results from recent assessments conducted by regulated health professionals with geriatric training, including primary care physicians with geriatric training, geriatricians, and Geriatric Emergency Nurses.

- A CCAC, hospital, or other qualified assessor approved by the LHIN that receives a referral of an at-risk senior or other person for an A&R assessment should promptly:
 - conduct the assessment;
 - determine whether a facility-based A&R intervention is appropriate, and if so, which type of facility-based A&R intervention is appropriate; and
 - take the appropriate actions to begin the navigation and placement process and facilitate timely access to appropriate interventions.

7.3 Navigation & Placement

- LHINs should work with CCACs and hospitals to develop provincial, operational-level admission criteria and service descriptions for hospital programs providing facility-based A&R interventions.
- LHINs should work with CCACs and hospitals offering facility-based A&R interventions to establish shared protocols for managing the placement of persons, including targeted seniors and other persons, into rehabilitation and CCC beds from emergency departments, other hospitals, and the community.
- LHINs should work with CCACs and hospitals offering facility-based A&R interventions to promote acceptance by hospitals with rehabilitation and CCC beds of direct referrals from the community and the admission of targeted seniors and other persons with stable but complex medical needs to rehabilitation beds.
- LHINs should work with hospitals to develop patient prioritization processes that do not arbitrarily disadvantage people based on their current location or referral source (e.g. in the community, another hospital, another hospital network, an acute bed, or an emergency department).
- In making placement decisions, hospitals and CCACs must comply with applicable legislative requirements. Hospitals should (and CCACs must, in relationship to CCP beds) take into consideration the person's condition, circumstances and preferences, including the person's preferences in relation to the proximity of the program to the person's family, home and community and support networks and requirements for the person's consent.¹⁸
- In making prioritization decisions in relation to beds where A&R interventions can be provided, hospitals should take into account the best available evidence of the relative value of a focused period of facility-based interventions (vs. care in a home, community, or ambulatory care setting) for improving the functional independence of patients with care needs.
- Hospitals, CCACs, and other care coordinators approved by the LHIN should ensure that referrals to facility-based A&R interventions are made with due consideration for minimizing the impact of relocations on the person, including with respect to the person's anticipated need to access different types of A&R interventions as their needs change.

¹⁸ CCACs must make decisions relating to eligibility, authorization, and prioritization for admission to CCP beds where A&R interventions can be provided in accordance with the requirements under the LTCHA and its regulations.

- Persons who choose not to participate in the A&R referral process should, upon request, be referred to other types of services and provided with assistance in arranging alternative care and/or services as appropriate in the circumstances.

7.4 A&R Interventions (Facility-Based)

- LHINs should determine the optimal resource mix and capacity requirements for delivering A&R within their boundaries, with the goal of providing the most appropriate interventions in the most cost-effective manner possible.
- LHINs should seek to ensure that the use of hospital and LTC home resources to provide facility-based A&R interventions is planned and coordinated across settings and providers to minimize transfers and promote continuity of care.
- LHINs should support their HSPs to cooperatively develop further provincial standards and best practices for planning, delivering, and evaluating care for hospitals and LTC homes providing facility-based A&R interventions.¹⁹
- LTC homes providing facility-based A&R interventions must comply with the requirements of the LTCHA and its regulations with respect to assessments, plans of care, and provision of services.
- LTC homes and hospitals providing facility-based A&R interventions must comply with the requirements of their Service Accountability Agreements with respect to assessments, plans of care, and provision of services.
 - LTC homes providing facility-based A&R interventions must use the RAI-MDS 2.0 assessment tool for all CCP residents, including persons identified as being within the target population for A&R.
 - Hospitals providing facility-based A&R interventions must use the FIM and RAI-MDS 2.0 and assessment tools for all patients in rehabilitation and CCC beds, respectively, including patients identified as within the target population for A&R.
- LTC homes and hospitals must use the required assessment tools and should use appropriate assessment tools and methods in determining on an ongoing basis whether a person receiving care is currently within the target population for A&R. Hospitals and LTC homes should seek to ensure that an assessment of clinical and functional status and care needs is performed at least upon admission and immediately prior to discharge for all persons within the target population for A&R interventions.
- Hospitals and LTC homes should seek to ensure that care planning for all persons within the target population for A&R interventions is:
 - based on standardized, valid, and reliable assessment tools;

¹⁹ Each LTC home providing facility-based A&R interventions must comply with requirements for assessment tools and care plans applicable to the CCP, including all requirements under the LTCHA and its regulations and under the LTC home's Service Accountability Agreement with its LHIN. Specifically, LTC homes must use the RAI-MDS 2.0 assessment tool to develop or revise plans of care, but under this Guideline should consider the concurrent use of additional assessments tools to supplement the RAI-MDS for the purpose of assessing care requirements and developing plans of care.

- o made with consideration of the person’s Health Link Coordinated Care Plan or home and community-based care coordination plan, if there is one;
 - o consistent with evidence-based practice and any applicable provincially defined best practices for relevant Quality Based Procedures; and
 - o informed by the best available evidence.
- Hospitals and LTC homes²⁰ should seek to ensure that care plans for all persons within the target population for A&R interventions are based on interdisciplinary assessments that address, at a minimum, the following elements:
 - o cognitive impairment
 - o nutrition status
 - o pain management
 - o polypharmacy
 - o self-care ability in managing ADLs and IADLs
 - o mobility
 - o risk for falls
 - o risk for fractures
 - o depression
 - o incontinence
- Hospitals and LTC homes²¹ should ensure that care plans for all persons within the target population for A&R interventions set out at minimum:
 - o the person’s care goals;
 - o the type, frequency, and duration of services that will be provided; and
 - o clear direction to staff and others who provide direct care to the person.
- Hospitals and LTC homes²² should seek to ensure that for all persons within the target population for A&R interventions, care teams regularly review the person’s progress against his or her care plan at least:
 - o daily for persons receiving type 1 (sub-acute complex) A&R interventions;
 - o twice weekly for persons receiving type 2 (geriatric rehabilitative) A&R interventions; and
 - o weekly for persons receiving type 3 (active recuperative) A&R interventions.

7.5 Transition Home

- LHINs should support their HSPs to ensure that robust processes are in place for anticipating the post-discharge needs of persons to be discharged from programs providing facility-based A&R interventions.

²⁰ Hospitals should follow the guidelines in the Senior Friendly Hospital Strategy and Framework. LTC home operators must comply with all care planning requirements under the LTCHA.

²¹ LTC home operators must comply with all care planning requirements under the LTCHA.

²² LTC home operators must comply with all care planning requirements under the LTCHA.

- As part of a patient-centred model of care, hospitals and LTCHs should engage the person who has been provided an A&R intervention, his or her family and/or unpaid caregiver, or, where the person is incapable of participating, his or her substitute decision-maker to develop an individualized transition plan.
- Hospitals and LTC homes should share the health information of the person to be discharged from programs providing facility-based A&R interventions with other providers in the person's circle of care, unless the hospital or LTC home is aware that the person has withheld or withdrawn their consent to this sharing, to promote continuity of care and reduce duplication of assessments.
- CCACs should ensure that as soon as reasonably possible prior to a person's discharge from a program providing facility-based A&R interventions, he or she is assessed for eligibility for services to be delivered under an integrative, shared care coordination model which incorporates:
 - the collaborative process of assessment, planning, facilitation and identification of options and services with the person's family and/or unpaid caregiver to meet an individual's home and community care needs (including with the person's primary care provider and Health Link team, if there is one);
 - the deliberate organization of client care activities to facilitate the appropriate delivery of home and community care; and
 - the organizing of interventions and scheduling of personnel and other resources, including access to primary care and/or community support services, needed to carry out all required home and community care activities to meet the needs of the person.

8. ALIGNMENT WITH OTHER POLICIES AND INITIATIVES

8.1 Transitional Care Program

This Guideline updates the Transitional Care Program (TCP) Framework (August, 2010).

In particular, this Guideline updates the Framework with respect to hospital-based restorative-type TCP programs, including by further defining the TCP Framework requirement that TCP beds in a hospital setting have:

... specific criteria for admission, a length of stay target, a clear plan of care with specific goals, and a discharge plan with home as the primary discharge site where feasible. These beds must support the achievement and maintenance of optimal levels of functioning and independence as primary outcomes that must be measured and reported.

Hospitals providing facility-based A&R interventions may utilize beds funded under the TCP Framework, but patients admitted to those beds must have a discharge goal of home.

Beds in LTC Homes, retirement homes, and hospitals that are licensed or approved under the LTCHA

and funded under the TCP Framework as community-based Interim LTC beds are not appropriate settings for delivery of facility-based A&R interventions. These beds are not intended as settings for the delivery of restorative care with a discharge goal of home.

LHINs that wish to use beds in LTC Homes and retirement homes as settings for delivery of facility-based A&R interventions should work with interested LTC Homes and retirement homes to ensure compliance with licensing and site suitability requirements. Applications may be submitted to the Ministry of Health and Long-Term Care for the licensing or approval of these beds as CCP beds under the LTCHA.²³

8.2 Senior Friendly Hospital (SFH) Strategy and Framework

This Guideline builds on the Senior Friendly Hospital Strategy and Framework by standardizing and prioritizing specialized interventions for frail seniors to minimize adverse outcomes and health complications often associated with hospitalization.

Hospitals delivering facility-based A&R interventions are expected to have in place, or be working towards implementing, the key domains of the Framework with respect to processes of care, emotional and behavioural environment, ethics in clinical care and research, organizational support, and physical environment. The implementation of the SFH Strategy and Framework is a critical enabler for Assess and Restore as these Framework elements form the foundation upon which the enhanced, specialized A&R interventions described in this Guideline are delivered.

Implementation of this Guideline by hospitals is expected to positively impact their performance on SFH Indicators including:

- Percentage of patients (65 and older) receiving delirium screening using a validated tool upon admission to hospital
- Incidence of delirium in patients (65 and older) acquired over the course of hospital admission
- Percentage of hospitalized patients (65 and older) receiving assessment of ADL function with a validated tool at both admission and discharge
- Percentage of patients (65 and older) with no decline in ADL function from hospital admission to hospital discharge as measured by a validated tool

8.3 Community Health Links (HLs)

Health Link success depends upon ready access to community and facility-based resources that address the needs of the patient population in real time and, in particular, to services and interventions that can reverse premature functional loss. An A&R approach to care is an enabler of HLs by providing

²³ The exemptions for alternative settings listed in s. 318 of Ontario Regulation 79/10 of the LTCHA apply to beds in retirement homes that are licensed as short-stay beds under the LTCHA but only if the retirement home in question has no long-stay program LTC beds.

options within an individualized care plan for a complex patient to connect that patient immediately with facility-based A&R interventions as required. This Guideline further provides a standardized platform for the provision of these facility-based A&R interventions to Health Links patients.

This Guideline also seeks to ensure that complex patients whose care needs have been managed within the primary care and community sector can continue living in the community even after they experience a reversible functional loss that puts them at high risk for needing imminent admission into a long-stay LTC home bed. As a result, this Guideline strengthens the capacity of the primary care and community sector to enhance patient outcomes.

An A&R approach to care is one strategy for achieving progress on metrics measured under Health Links including:

- coordinated care plans for all complex patients
- reducing the number of avoidable ED visits for patients with conditions best managed elsewhere
- reducing unnecessary admissions to hospitals
- ensuring primary care follow-up within seven days of discharge from an acute care setting
- enhancing the health system experience for patients with the greatest health care needs
- reducing the average cost of delivering health services to patients without compromising the quality of care

8.4 Convalescent Care Program

This Guideline must be implemented in a manner that is consistent with the requirements under the LTCHA and its regulations as well as the policies that apply to the CCP, including the Policy for the Operation of Short-Stay Beds (POSSB). In particular, the requirements for Short-Stay Programs (SSPs) and the Convalescent Care SSP described in the POSSB apply.

Beds operated under the Interim Bed SSP described in the POSSB are not appropriate settings for delivery of facility-based A&R interventions. The intent of the Interim Bed SSP is to provide “a safe and suitable care setting for LTC home applicants to live as a temporary measure while they wait for a long-stay bed”. A&R interventions are intended to be used as care settings for the delivery of restorative care services to enable a person to return home, avoiding the need for a long-stay LTC Home bed.

8.5 Policy Guideline for CCAC and CSS Collaborative Home and Community-Based Care Coordination, April 2014

This A&R Guideline should be implemented in concert with the policies that apply to home and community-based care services. In particular, providers of facility-based A&R interventions and CCACs should implement the A&R Guideline section on transitions home in accordance with the Policy Guideline for CCAC and CSS Collaborative Home and Community-Based Care Coordination.

By enhancing CSS capacity to support individuals who are relatively independent, and thereby improving the capacity of CCACs to focus on clients with complex and post-acute needs, this shared care approach builds on an integrated model of care for frail seniors and other persons in the community setting. Successful implementation of the Policy Guideline for CCAC and CSS Collaborative Home and Community-Based Care Coordination will enable the CCACs to fulfill the roles and responsibilities assigned to them under the A&R Guideline.

9. ACCOUNTABILITY AND PERFORMANCE MEASUREMENT

9.1 Accountability

- In accordance with its Ministry-LHIN Performance Agreement, each LHIN should ensure that delivery of facility-based A&R interventions by its HSPs is in accordance with this Guideline.

9.2 Performance Measurement

- LHINs should seek to cooperatively identify a provincial set of performance indicators for an A&R approach to care and the delivery of facility-based A&R interventions.
- The provincial set of performance indicators should build on data reported by Health Links organizations and by hospitals implementing the Senior Friendly Hospitals initiative. These indicators should include:
 - measures derived from financial information;
 - system measures including wait times, admission and readmission rates; and
 - outcome measures, including comparisons of clinical/functional outcomes and independence before admission and after discharge.
- Until a provincial set of performance indicators is established, LHINs should seek to collect information on service volumes and discharge destinations for persons referred to programs providing facility-based A&R interventions.

10. PROTECTIONS AND SAFEGUARDS

- This Guideline does not affect any person's rights under the LTCHA to apply for placement into an LTC Home long-stay bed. No person is obligated to participate in a facility-based A&R intervention as a condition of applying for, or being determined to be eligible for, admission into a long-stay bed in an LTC home.
- A determination by a CCAC that a person is eligible for admission into a long-stay LTC Home bed does not exclude that person from being determined appropriate for admission into a hospital program offering facility-based A&R interventions.

11. APPENDIX A

A person is at high risk for imminent admission into a long-stay LTC home bed if they fit one of the following three profiles. (Source: Assisted Living for High Risk Seniors Policy)

Profile #1

- has an unpaid caregiver (whether or not the caregiver lives with the person) who is able to provide the support the applicant requires (e.g. provide direction to other providers and manage challenging behaviours and hazards in the home), and
- has two or more of the following characteristics:
 - needs assistance with dressing, toileting, transfer, locomotion, or hygiene
 - wanders, is verbally or physically abusive, acts in a socially inappropriate manner, or resists care
 - has difficulty with memory, decision-making, or making themselves understood
 - has a history of falls
 - has difficulty managing medications
 - has difficulty with meal preparation
 - has pressure/stasis ulcers
 - has difficulty swallowing
 - is not functioning safely in their current environment

Profile #2

- does not have an unpaid caregiver able to provide the required support
- has two or more of the following characteristics:
 - cognitively intact or borderline intact
 - no or limited difficulty with short term memory
 - no or limited difficulty with cognitive skills for daily decision making
 - no or limited difficulty making oneself understood
- has difficulty eating, and
- has two or more of the following characteristics:
 - needs assistance with meals preparation
 - needs assistance with ordinary housework
 - needs assistance with using the phone.

Profile #3

- does not have an unpaid caregiver able to provide the required support,
- has two or more of the following characteristics:
 - mild to moderate cognitive impairment
 - mild to moderate difficulty with short term memory
 - mild to moderate difficulty with cognitive skills for daily decisions making
 - mild to moderate difficulty making oneself understood
 - mild to moderate difficulty eating
 - is occasionally incontinent.²⁴

²⁴ 'Occasionally' means less often than daily for bladder incontinence and no more than once a week for bowel incontinence.

12. APPENDIX B

A person is most at-risk of future hospitalization, according to the Hospital Admission Risk Prediction (HARP) tool²⁵, if they score:

1. On the simple model algorithm, based on the following variables:
 - the person's age,
 - the location where the person was discharged to,
 - the number of acute admissions in the past six months,
 - the number of emergency department visits in the past six months; and
 - the presence of the six top conditions, ranked by prevalence and predictive strength.

	90 th percentile
Near-term (30-day) risk	Score 16, out of maximum score of 41
Longer-term (15-month) risk	Score 7, out of maximum score of 15

Or

2. On the complex model algorithm, based on the factors included in the simple model, plus the following variables:
 - Resource Intensity Level,
 - whether there was an admission through the emergency department,
 - the Charlson index,
 - select interventions during hospital encounter,
 - length of stay; and
 - the presence of the eighteen top conditions, with the highest odds ratios.

	90 th percentile
Near-term (30-day) risk	Score 18, out of maximum score of 44
Longer-term (15-month) risk	Score 30, out of maximum score of 59

²⁵ The HARP tool was designed in partnership by Health Quality Ontario (HQO), the Canadian Institute of Health Information (CIHI), and other experts to identify an individual patient's near and longer-term risk of future hospitalization. The simple model accounts for five factors, while the complex model accounts for 10 factors. The complex model performs slightly better, but the simple model is a strong substitute for care settings without access to hospital data sources. (Source: www.hqontario.ca)

