ASSESS & RESTORE SHARED PROVINCIAL INDICATORS AND TECHNICAL SPECIFICATIONS

January 2018

BACKGROUND

To evaluate the impact of Assess and Restore (A&R) funding, the Ministry of Health and Long Term Care (Ministry) has identified a number of system-level indicators and project indicators. In Ministry reporting, A&R-funded projects are required to identify at least one relevant system indicator, and report on one or more project indicators. The Ministry mandated indicators included in the 2017/18 reporting templates are the same as those identified for the 2014/15 - 2016/17 funding period. These indicators include:

System Indicators

1) % of unplanned readmission to hospital within 30 days of discharge from hospital
2) % of unplanned, less-urgent ED visit within the first 30 days of discharge from hospital
3) % of primary care follow-up visit within 7 days of discharge from hospital
4) % of LTC placements where home care client could have stayed home / in the community
5) Annual ALC Rate

Project Indicators

6) # incremental attendances/visits
7) # frail seniors served
8) Quality of Life (QoL) measure
9) # clinicians trained
10) % patients designated ALC within two days of acute care admission d/c to rehabilitative care bed
11) % admissions to rehabilitative care beds that were directly admitted from community/ED
12) % patients directly admitted to bedded rehab, from the community, who were discharged home
13) Other (please describe)

In addition to reporting Ministry mandated deliverables, during the 2015/16 -2016/17 funding period, LHINs and pan-LHIN cluster groups identified additional project indicators, which more accurately capture the local impact of targeted A&R initiatives. More than 40 individual A&R projects were undertaken during the 2014/15 – 2016/17 funding period; each reporting on a different set of more than 25 possible indicators. This variability in reporting has made it difficult to demonstrate the collective provincial impact of A&R funding and the collaborative pan-LHIN efforts to implement an A&R approach to care in Ontario.

PROPOSED SHARED PROVINCIAL INDICATORS

The Rehabilitative Care Alliance (RCA) is proposing a more concise set of shared provincial indicators, which align with the Ministry mandated indicators as well as the stated objectives of the A&R Guideline (*Improve Outcomes; Extend Functional Independence; Best Practice Adoption*). The standardized indicator sets, detailed below, will allow LHINs to demonstrate progress towards implementing the A&R Guideline and demonstrate the collective provincial impact of A&R funding, while satisfying the Ministry reporting requirements.

Proposed indicator sets, by project type/sector, with technical specifications, are outlined below:

Proposed Provincial A&R Indicator	Indicator within MOH Report Template	Primary Care Initiatives	Home & Community Care Initiatives	Emergency Department Initiatives	Bedded Care Initiatives
1. Volume of patients/caregivers served	✓	✓	✓	✓	✓
2. % admissions to rehabilitative care beds that were directly admitted from community/ED	✓				
3. % of unplanned readmission to hospital within 30 days of discharge from hospital	✓				✓
4. % of unplanned, less-urgent ED visit within the first 30 days of discharge	✓			✓	
5. ALC Rate for A&R Patients	✓				✓
6. Improved Function (ADLs)			✓		✓
7. Rate of Discharge Home vs Baseline or other Comparator					✓
8. Referral rate for community-dwelling frails seniors screened at-risk for loss of independence		✓		✓	

TECHNICAL SPECIFICATIONS

The following technical specifications will support standardized measurement and reporting of the shared provincial indicators. The specifications include indicator definitions, relevance to and alignment with the objectives of the A&R Guideline, information on calculation of the indicator, and additional reference information.

TECHNICAL SPECIFICATIONS

INDICATOR 1: Number of patients served

Indicator Description	Indicator Name	Number of patients served
	Indicator Description	This indicator should provide the total number of unique older adults who received the A&R restorative initiative.[i]
	Relevance	Provides a measure of the volume served. A higher number is preferred.
Calculation	**Calculation**	Number of older adults, ≥ 65 years*, who received risk-screening and restorative intervention[i] through the A&R initiative, during the reporting period (unique patients)
	Exclusion/Inclusion Criteria	Include: • Older adults, ≥ 65 years*, who received A&R restorative intervention[i] Exclude: • Patients served within A&R initiative organization/ program who did not receive A&R intervention
	Data Sources**	Program database (i.e., DAD NACRS, NRS, CCRS) or customized data base specific to A&R patients (identified through a special project field in health record)
Additional Information	**References**	Older adults who require A&R restorative intervention[i] may be identified through risk-screening. Examples of risk-screening tools: • The interRAI ED Screener/Preliminary Screener[ii] uses the Assessment Urgency Algorithm to quickly stratify older adults by level of risk for loss of independence. • Clinical Frailty Scale[iii]: Revised 2008.2. K. Rockwood et al. CMAJ 2005; 173:489-495. • ISAR – Identification of Seniors at Risk tool; McCusker et al, 1999[iv]
	Alignment with Objectives of A&R Guideline	**BEST PRACTICE ADOPTION:** "facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors"

[i] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

[ii] The InterRAI ED Screener/Preliminary Screener: http://www.healthscape.ca/Pages/resources-06052014-mhealthinterraiapp.aspx

[iii] Canadian Study on Health & Aging, Revised 2008. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495. Available at: http://geriatricresearch.medicine.dal.ca/pdf/Clinical%20Faily%20Scale.pdf

[iv] McCusker, Jane, et al. (1999) Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool." *Journal of the American Geriatrics Society* 47.10:1229-1237.

INDICATOR 2: % admissions to rehabilitative care beds that were directly admitted from community/ED

Indicator Description	**Indicator Name**	**% admissions to rehabilitative care beds that were directly admitted from community/ED**
	Indicator Description	This indicator should be interpreted as the % proportion of older adults, ≥ 65 years*, admitted directly from community or emergency department (ED) to inpatient restorative intervention[v]
	Relevance	Provides a measure of the proportion of older adults who accessed inpatient restorative intervention[v] directly from the community/ED; avoiding an unnecessary acute-care admission. A higher % is preferred, within the context of baseline data illustrating potential benefit of direct admissions to rehab
Calculation	**Calculation (Define the Numerator)**	Number of older adults, ≥ 65 years*, admitted directly to inpatient A&R restorative intervention[v] from community/ED.
	Exclusion/Inclusion Criteria	Exclude: • Patients admitted to inpatient restorative care from acute care
Denominator	**Calculation (define the denominator)**	All older adults, ≥ 65 years*, admitted to inpatient restorative intervention[v] (including admission from home, acute care, long term care or other hospital/facility setting)
	Exclusion/Inclusion Criteria	Exclude: • Patients < 65 years
	Data Sources**	DAD: *Institution Form* NRS: *Referral Source* NACRS: *Admit by ambulance*
Additional Information	**Reference information**	Hospitalization poses significant risk to frail older adults, in terms of functional decline and adverse health-outcomes. Preventing avoidable hospitalizations through proactive access to multidisciplinary restorative intervention[v] can improve outcomes and independence and reduce frailty[vi],[vii],[viii]
	Alignment with Objectives of A&R Guideline	**EXTEND FUNCTIONAL INDEPENDENCE:** "extend the functional independence of community-dwelling frail seniors and other persons for as long as possible"

[v] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

[vi] Brown, Cynthia J., et al. "Comparison of posthospitalization function and community mobility in hospital mobility program and usual care patients: a randomized clinical trial." JAMA internal medicine 176.7 (2016): 921-927

[vii] Cameron, Ian D., et al. "A multifactorial interdisciplinary intervention reduces frailty in older people: randomized trial." BMC medicine 11.1 (2013): 65.

[viii] Beswick, Andrew D., et al. "Complex interventions to improve physical function and maintain independent living in elderly people: a systematic review and meta-analysis." The Lancet 371.9614 (2008): 725-735.

INDICATOR 3: % of unplanned readmissions to hospital within 30 days of discharge

Indicator Description	**Indicator Name**	% of unplanned readmission to hospital within 30 days of discharge
	Indicator Description	This indicator should be interpreted as the % proportion of older adults who experienced an unplanned readmission to hospital within 30 days following discharge from a facility-based (bedded) restorative intervention.[ix]
	Relevance	Provides a measure of how effective the A&R intervention was in preventing avoidable hospital readmissions, compared to an evidence-based rate of hospital readmission risk for frail/high-risk older adults. A lower number is preferred.
Calculation	**Calculation (Define the Numerator)**	Number of older adults, ≥65 years*, who received facility-based restorative intervention[ix] who were admitted to hospital in the 30 days following discharge (all diagnostic categories)
	Exclusion/Inclusion Criteria	Include: • Readmission date within 30 days of the index case discharge, for all diagnostic categories; • DAD field "admission category" is urgent (non-elective readmission) Exclude: • Planned/elective readmission • Readmission case is coded as an acute transfer by the receiving hospital
Denominator	**Calculation (Define the denominator)**	Total number of discharges for older adults, ≥65 years*, who received the facility-based A&R restorative intervention
	Exclusion/Inclusion Criteria	Include: • Patients ≥65 years* who received A&R restorative intervention Exclude: • Patients discharged from A&R initiative program/ organization who did not receive the A&R restorative intervention[ix]
	Data Sources**	Intellihealth DAD: *Unplanned Return to Intervention Location; Admission Category*
Additional Information	**References**	Evidence based comparator: Risk of hospital readmission for high-risk/frail older adults: • Research indicates that up to 31% of moderately to severely frail older adults experience readmission or death in the 30 days following discharge. [x]
	Alignment with Objectives of A&R Guideline	**IMPROVE OUTCOMES:** "reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors"

[ix] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

[x] Kahlon, S. et al. (2015) Association between frailty and 30-day outcomes after discharge from hospital CMAJ 10.1503

Indicator 4: % of unplanned, less-urgent ED visits within the first 30 days of discharge

Indicator Description	**Indicator Name**	% of unplanned, less-urgent ED visits within the first 30 days of discharge from hospital
	Indicator Description	This indicator should be interpreted as the % of older adults receiving A&R restorative interventions[xi] who have an unplanned, less urgent, ED visit within the first 30 days of discharge
	Relevance	Provides a measure of how effective the A&R restorative intervention[xi] was in preventing avoidable ED visits, compared to an evidence-based rate[xii] of ED visit risk for frail/high-risk older adults.
Calculation	**Calculation (Define the Numerator)**	Number of patients who had an ED visit assessed at Canadian Triage and Acuity Scale levels 4 or 5 (but who were not admitted to hospital) in the first 30 days after discharge from the A&R restorative intervention.[xi]
	Exclusion/Inclusion Criteria	Include: • Older adults, ≥65 years*, who received the A&R restorative intervention[xi], who have an ED Registration Date within 30 days of discharge • Low acuity: CTAS Level = 4, 5. Exclude: • Patients who did not receive the A&R restorative intervention[xi] • Planned/scheduled attendances to ED • Mid to High acuity; CTAS Level =1,2,3
Denominator	**Calculation (Define the denominator)**	Total number of older adults discharged from the facility-based A&R intervention
	Exclusion/Inclusion Criteria	Include: • All older adults, ≥65 years*, discharged from the A&R restorative intervention[xi] Exclude: • Patients who did not receive the A&R restorative intervention[xi]
	Data Sources**	Intellihealth; DAD; HCD; NACRS
Additional Information	**References**	This indicator is a Home Care QIP priority indicator for 2018/19. More information on this indicator can be accessed through HQO: • http://indicatorlibrary.hqontario.ca/Indicator/Detailed/Unplanned-emergency-department-visits-QIP/EN Evidence based comparator for Risk of ED visit for high-risk older adults: • Research indicates up to 32.7% of moderate-severely frail older adults experience ED visits in the 30 days following discharge. [xii]
	Alignment with Objectives of A&R Guideline	**IMPROVE OUTCOMES:** "reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors"

[xi] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

[xii] Research indicates that up to 32.7% of moderately to severely frail older adults experience ED visits in the 30 days following discharge. *Kahlon, S. et al. (2015) Association between frailty and 30-day outcomes after discharge from hospital CMAJ 10.1503*

Indicator 5: ALC Rate for Assess & Restore Patients

Indicator Description	**Indicator Name**	ALC Rate for Assess & Restore Patients
	Indicator Description	This indicator describes the ALC rate for patients receiving A&R restorative intervention[xiii]
	Relevance	This measure can be interpreted as the impact the A&R initiative has on ALC rate. Impact can be demonstrated through comparison to a baseline ALC rate, or to an ALC rate on a similar unit/program.
Calculation	**Calculation (Define the numerator)**	Total ALC days for patients receiving A&R restorative intervention[xiii], in reporting period
	Exclusion/Exclusion Criteria	Include: • ALC days for older adults, ≥65 years*, who received the A&R restorative intervention[xii] Exclude: • ALC cases discontinued due to 'Data Entry Error' • ALC cases identified by the facility for exclusion • ALC days for patients < 65 years
	Calculation (Define the denominator)	Total patient days for patients receiving A&R restorative intervention[xiii], in reporting period
	Exclusion/Exclusion Criteria	Include: • All patient days for older adults, ≥65 years*, receiving A&R restorative intervention[xiii] Exclude: • Patient days contributed by patients in the emergency department • Patient days for patients < 65 years
	Data Sources**	BCS WTIS
Additional Information		• Ontario ALC Patient Definition: (http://www.health.gov.on.ca/en/pro/programs/waittimes/edrs/alc_definition.aspx)
	Alignment with Objectives of A&R Guideline	**IMPROVE OUTCOMES:** "reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors"

[xiii] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

Indicator 6: Improved Function (ADLs)

Indicator Description	**Indicator Name**	Average functional change
	Indicator Description	This indicator measures average functional change, expressed as a %, achieved by patients who received A&R restorative intervention[xiv], as measured by a standardized, validated measure of function [e.g., Barthel Index(BI) or Functional Independence Measure (FIM®)]
	Relevance	This indicator should be interpreted as the average functional improvement experienced by older adults who receive the A&R restorative intervention[xiv]. A higher % improvement is preferred.
Calculation		Average function change = [(average post) – (average pre)] / (average pre)
	Calculation (Define the Numerator)	Average functional change (post – pre) of patient function from admission to discharge for patients discharged from A&R restorative intervention[xiv] during the reporting period.
	Exclusion/Inclusion Criteria	Include: • Scores for older adults, ≥65 years*, who received A&R intervention[xiv] • Scores for patients discharged alive Exclude: • Missing admission or discharge function score • Deceased patients • Scores for patients who did not receive A&R restorative intervention[xiv]
	Calculation (Define the denominator)	Average pre-intervention function score
	Exclusion/Inclusion Criteria	Include: • Older adults, ≥65 years*, who received A&R restorative intervention[xiv] • Discharged alive Exclude: • Missing admission or discharge function score • Deceased patients • Patents who did not receive A&R intervention
	Data Sources**	NRS Customized database including admission and discharge function score
Additional Information	**Resources and References**	NRS and FIM, additional information: https://www.cihi.ca/en/national-rehabilitation-reporting-system-metadata The Barthel Index[xv] and supporting information is displayed with permission of the author at the www.StrokEngine.ca website hosted at McGill University: https://www.strokengine.ca/family/bi_family/
	Alignment with Objectives of A&R Guideline	**IMRPOVE OUTCOMES:** "reduce caregiver burden by improving psychosocial and health outcomes for community-dwelling frail seniors"

[xiv] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

[xv] Mahoney, F. I., & Barthel, D. W. (1965). Functional evaluation: the Barthel Index: a simple index of independence useful in scoring improvement in the rehabilitation of the chronically ill. *Maryland state medical journal*.

Indicator 7: Rate of Discharge Home

The impact of A&R initiatives on ***rate of discharge home*** may be best demonstrated through three different comparators: *Baseline Rate; Pre-Initiative Rate,* or *Similar Case Mix Group*. A&R initiatives may choose to report on 7A, 7B, ***or*** 7C, depending on the comparator most relevant to the program/initiative.

7A – Rate of Discharge Home for inpatient A&R patients - **Compared to a Baseline Rate*

Indicator Description	**Indicator Name**	Rate of Discharge Home
	Indicator Description	The indicator should be interpreted as the percentage of older adults receiving care through the A&R-funded initiative, who are discharged home to their baseline living environment
	Relevance	Provides a measure of how effective the A&R intervention was in facilitating discharge home to baseline living environment. A higher number is preferred. Impact of the initiative is demonstrated through comparison to baseline rates of discharge home for older adults, in same unit/program.
Calculation	**Calculation (Define the Numerator)**	Number of older adults receiving care through the A&R-funded initiative, who are discharged home to their baseline living environment (disposition = home; retirement home)
	Exclusion/Inclusion Criteria	Include: • Patients, ≥65 years*, who are discharged to baseline living environments including: patient residence, retirement home, family residence Exclude: • Patients admitted from LTC • Patients discharged to Long Term Care, or other bedded-level of care • Patients treated within the A&R initiative program/unit who did not receive A&R intervention (geriatric assessment & restorative care)
	Calculation (Define the denominator)	Total number of discharges from A&R initiative/program for older adults who received restorative care through the A&R-funded initiative (all dispositions)
	Exclusion/Inclusion Criteria	Include: • Patients ≥65 years* who received A&R intervention • Discharged alive • All discharge destinations Exclude: • Patients admitted from Long Term Care • Patients treated within the A&R initiative program/unit who did not receive A&R intervention (geriatric assessment & restorative care)
	Data Sources**	NRS: *Post-Discharge Living setting* DAD: *Disposition*
Additional Information	**Comparator**	Baseline rate of discharge home: % of patients, ≥65 years*, discharged home, in same unit/program, prior to A&R initiative (as per technical specifications detailed above)
	Alignment with Objectives of A&R Guideline	**EXTEND FUNCTIONAL INDEPENDENCE:** "extend the functional independence of community-dwelling frail seniors and other persons for as long as possible"

7B – Rate of Discharge Home for inpatient A&R patients ** Compared to similar case mix group patients*

Indicator Description	**Indicator Name**	Rate of Discharge Home
	Indicator Description	The indicator should be interpreted as the percentage of older adults receiving care through the A&R-funded initiative, who are discharged home to their baseline living environment
	Relevance	Provides a measure of how effective the A&R intervention was in facilitating discharge home to baseline living environment. A higher number is preferred. Impact of the initiative is demonstrated through comparison to similar case mix group patients.[xvi]
Calculation	**Calculation (Define the Numerator)**	Number of inpatient A&R patients who are discharged home to their baseline living environment (disposition = home; retirement home)
	Exclusion/Inclusion Criteria	Include: • Patients, ≥65 years*, discharged to baseline living environments: patient residence, Retirement Home, family residence Exclude: • Patients admitted from Long Term Care • Patients discharged to Long Term Care, or other bedded-level of care • Patients discharged from program of A&R initiative who did not receive A&R intervention (geriatric assessment & restorative care)
	Calculation (Define the denominator)	Total number of discharges from A&R initiative/program for older adults who received restorative care through the A&R-funded initiative (all dispositions)
	Exclusion/Inclusion Criteria	Include: • Patients ≥65 years* who received A&R intervention • Discharged alive; All discharge destinations Exclude: • Patients admitted from Long Term Care • Patients treated within the A&R initiative program/unit who did not receive A&R intervention
	Data Sources**	NRS: *Post-Discharge Living setting* DAD: *Disposition*
Additional Information	**Comparator**	% of patients (as per above specifications) discharged home, among a similar case mix group[xvii] • Rehab Patient Group Methodology: https://www.cihi.ca/sites/default/files/document/info_rpg_method_costweight_en.pdf • Acute Inpatient Case Mix Group+ Methodology: https://www.cihi.ca/en/cmg
	Alignment with Objectives of A&R Guideline	**EXTEND FUNCTIONAL INDEPENDENCE:** "extend the functional independence of community-dwelling frail seniors and other persons for as long as possible"

[xvi] The Case Mix Groups methodology is designed to aggregate patients with similar clinical and resource-utilization characteristics.

[xvii] A comparable case mix group may be unique for each A&R initiative, depending on type of program and interventions; diagnostic categories of patients, average age and complexity of patients and average number of comorbidities.

7C – Rate of Discharge Home for A&R patients admitted directly from community to inpatient rehab– **Compared to patients admitted to rehab from acute care*

Indicator Description	**Indicator Name**	Rate of Discharge Home – For Patients admitted directly from Community to Inpatient Rehab
	Indicator Description	The indicator should be interpreted as the percentage of older adults receiving care through the A&R-funded initiative, who are discharged home to their baseline living environment
	Relevance	Provides a measure of how effective the A&R intervention is in facilitating discharge home to baseline living environment. A higher number is preferred. Impact of the initiative is demonstrated through comparison to the discharge home rate for patients admitted to rehab from hospital (not directly admitted to rehab from community/ED).
Calculation	**Calculation (Define the Numerator)**	Number of older adults receiving care, through the A&R-funded initiative, who are discharged home to their baseline living environment (disposition = home; retirement home)
	Exclusion/Inclusion Criteria	Include: • Patients, ≥65 years*, admitted direct from community to inpatient rehab, who are discharged to baseline living environments including: patient residence, Retirement Home, family residence Exclude: • Patients admitted from Long Term Care • Patients discharged to Long Term Care, or other bedded-level of care • Patients treated within the A&R initiative program/unit who did not receive A&R intervention (geriatric assessment & restorative care)
	Calculation (Define the denominator)	Total number of discharges (all dispositions) from A&R initiative/program for older adults, ≥65 years*, who received restorative intervention through the A&R-funded initiative
	Exclusion/Inclusion Criteria	Include: • Patients, ≥65 years*, directly admission from community to inpatient rehab, who received A&R intervention • Discharged alive • All discharge destinations Exclude: • Patients treated within the A&R initiative program/unit who did not receive A&R intervention (geriatric assessment & restorative care) • Patients admitted from Long Term Care
	Data Sources**	NRS: *Post-Discharge Living setting* DAD: *Disposition*
Additional Information	**Comparator**	Rate of discharge home (% proportion) for patients, ≥65 years*, in same program, who were admitted to rehab from hospital/acute care (not admitted from directly from community/ED to inpatient rehab)
	Alignment with Objectives of A&R Guideline	**EXTEND FUNCTIONAL INDEPENDENCE:** "extend the functional independence of community-dwelling frail seniors and other persons for as long as possible"

Indicator 8: Referral rate for community-dwelling frail seniors screened at risk for loss of independence

Indicator Description	**Indicator Name**	Referral rate for community-dwelling frail seniors screened *at-risk*[xviii]
	Indicator Description	This indicator should be interpreted as % proportion of *at-risk*[xix] [xviii] **o**lder adults who were referred for restorative intervention[xx]
	Relevance	Provides a measure of how effective the A&R initiative is at facilitating access to best practice care (restorative intervention[xx]) for *at-risk* [xviii] older adults. A higher % proportion is preferred.
Calculation	**Calculation (Define the Numerator)**	Number of community-dwelling *at-risk*[xviii] older adults referred for further restorative intervention[xx], through the A&R initiative
	Exclusion/Inclusion Criteria	Include: • Patients, ≥65 years*, who are identified as *at-risk*[xviii] through a validated screening tool or documented clinical assessment, who are referred for restorative intervention[xxxx] Exclude: • Older adults served within A&R initiative organization/program who declined/did not receive proactive risk screening
	Calculation (Define the denominator)	Total number of patients who are identified as *at*-risk[xviii]
	Exclusion/Inclusion Criteria	Include: • Patients ≥65 years* identified as *at-risk*[xviii] through a validated screening tool or documented clinical assessment Exclude: • Older adults served within pilot initiative organization/program who declined/did not receive proactive risk screening • Older adults screened as low-risk
	Data Sources**	DAD: *Institution To; Disposition;* NACRS: *Visit Disposition* Customized data base specific to A&R patients (identified through a special project field in health record)
Additional Information	**Screening Tools**	The interRAI ED Screener/Preliminary Screener uses the Assessment Urgency Algorithm to quickly stratify older adults by level of risk for loss of independence.[xxi] Clinical Frailty Scale: Frailty stratification can help with planning interventions and predicting the need for institutional care.[xxii] ISAR – Identification of Seniors at Risk tool; McCusker et al, 1999[xxiii]
	Alignment with Objectives of A&R Guideline	**BEST PRACTICE ADOPTION:** "facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors"

[xviii] The MOHLTC A&R Guideline defines *at-risk* older adults having begun to experience serious functional decline and are reaching a stage where that decline threatens to become precipitous and permanent http://www.health.gov.on.ca/en/pro/programs/assessrestore/docs/ar_guideline.pdf

[xix] The MOHLTC A&R Guideline defines *at-risk* older adults having begun to experience serious functional decline and are reaching a stage where that decline threatens to become precipitous and permanent http://www.health.gov.on.ca/en/pro/programs/assessrestore/docs/ar_guideline.pdf

[xx] Evidence-based delivery of assessments, treatments, and therapies in accordance with leading practices (MOHLTC. 2014. Assess & Restore Guideline)

[xxi] The InterRAI ED Screener/Preliminary Screener: http://www.healthscape.ca/Pages/resources-06052014-mhealthinterraiapp.aspx

[xxii] Canadian Study on Health & Aging, Revised 2008. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005; 173:489-495. Available at: http://geriatricresearch.medicine.dal.ca/pdf/Clinical%20Faily%20Scale.pdf

[xxiii] McCusker, Jane, et al. (1999) Detection of older people at increased risk of adverse health outcomes after an emergency visit: the ISAR screening tool." *Journal of the American Geriatrics Society* 47.10:1229-1237.

***** The Ministry of Health and Long Term Care defines older adults as "Ontarians 65 and older with valid health card number as of the start of the fiscal period" for the purposes of A&R funding.

****Data Sources:**

- **DAD:** Discharge Abstract Database
- **HCD**: Home Care Database
- **NACRS**: National Ambulatory Care Reporting System
- **NRS**: National Rehabilitation Reporting System
- **BCS**: Bed Census Summary
- **WTIS**: Wait Time Information System
- **Intellihealth**: IntelliHealth is a knowledge repository that contains clinical and administrative data collected from various sectors of the Ontario healthcare system. Intellihealth enables users to create queries and run reports through easy web-based access to high quality, well organized, integrated data.