This document provides a high level description of the Assess and Restore initiatives that were completed in each LHIN with 2015/16 Assess and Restore funding. This summary was developed as a repository of information about the initiatives in order to support knowledge translation.

**Summary of Key Messages and Lessons Learned**

- Proactively identifying at-risk older adults and providing timely access to restorative services across the care continuum is crucial to avoiding a decline in function and potential permanent loss of independence.
- Primary care has been identified as an important participant in providing a proactive Assess and Restore approach to care, and in managing the complexity of frail older adults in the community.
- Building staff competency and expertise in geriatrics is an essential component to the success and capacity of A&R initiatives. More education is necessary for community partners in order to understand the impact of geriatric syndromes on functional decline, and the benefits of a comprehensive geriatric assessment and treatment in the prevention of functional decline. Knowledge exchange opportunities have been imperative in learning from the success and challenges of other organizations.
- Implementation of Assess and Restore approaches to care across the province has highlighted the inconsistency of specialized geriatric services resources in various communities. Successful implementation must focus on leveraging regionally available resources. Although access to a comprehensive geriatric assessment in order to accurately assess the needs of the patients has been helpful, use of a Nurse Practitioner with gerontological expertise has been highly successful.
- The availability of rehabilitation services 7 days a week provides ongoing intervention that prevents deconditioning, maintains functional gains and keeps the planned discharges on track.
- Clear link to the integration of Assess & Restore with other system initiatives (E.g. Senior Friendly Hospitals, GAIN, GEM) is imperative to maintain momentum of positive results.
- In-home A&R care with a focus on functional enhancement that is goal oriented resulted in better health outcomes, significantly improved patient satisfaction and an increased ability to independently complete activities of daily living (ADL).
- For many high-risk seniors in the hospital setting (including ED and acute care), the availability of an appropriate mix of targeted ‘Assess and Restore’ services has led to:
    - increased functional status
    - reduced LOS/expedited discharge to the community
    - decreased rate of conversion to ALC
    - reduced premature institutionalization/LTC demand
    - reduced return visits to the ED or readmissions to hospital

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| CEN | Enhancing Assess & Restore Capacity within the Central LHIN | Screening Tool Adoption<br><br>Enhanced Service Delivery<br><br>Community Service Delivery (Home-based) | The overarching objective of both partners is to focus on enhancing services to high risk seniors in the North York Central region, with the goal of intervening and delaying the loss of functional ability.<br><br>The combined goal of the in-hospital and in-home therapy enhancements was to reduce the hospital length of stay, as well as to test an alternative to the transfer of patients to a specialty rehabilitation hospital or convalescent care facility where possible. | The Central CCAC developed an "A&R Home First" pilot project and partnered with NYGH to develop and test a new model of Care Coordination that follows A&R patients across care settings (i.e. from in-patient hospital care through in-home and community care provided post discharge). This approach reduces unnecessary "hand-offs", transitions of care and assessments, and increases continuity of care for patients and families.<br><br>NYGH provided standardized rehabilitation services on acute inpatient units to frail seniors who meet the A&R target population definition. This program includes weekend mobility to ensure patients maintain functional gains while keeping planned discharges on track. The implementation was conducted in three phases:<br><br>1. Screening and identification of patients who are currently designated as alternate level of care (ALC) awaiting placement in a specialty rehabilitation hospital | The availability of rehabilitation services 7 days a week provides ongoing intervention that prevents deconditioning, and prepares the patient for discharge and subsequent rehab follow up. Feedback from physicians and care team members on providing this level of service has been positive, and early qualitative results indicate patients are maintaining physical/functional status.<br><br>Patients that are discharged home with CCAC A&R services have benefitted from a dedicated CCAC Care Coordinator assigned to follow the patient from inpatient care to in-home care. This single point of contact facilitates a seamless transition for patients into the community following their hospital visit. Inter-professional meetings involving staff from NYGH and the CCAC, and A&R patients and families has facilitated warm handoffs and proved to be very beneficial in collaborative care planning.<br><br>The in-home component of the A&R program has been shown to be effective with 82% of clients stating their goals were achieved, as well as |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | or convalescent care.<br>2. Screening and identification of patients admitted to Medical and Surgical beds that are at risk of becoming ALC.<br>3. Screening and identification of patients that present to the Emergency Department and whose admission could be avoided through direct referral to the CCAC.<br><br>All three phases utilized a CCAC-led "A&R Home First" approach that provides enhanced rehabilitation services in the community to support patients discharged from hospital in regaining their baseline functional status. Additional supports in the community are provided following hospital discharge, including enrolment in NYGH's Geriatric Day Hospital or alternative senior's day programming within close proximity to the patient's home (where appropriate). | significant improvements in functional ability outcome measurement tools, and on the Health-Related Quality of Life scale. Effectiveness of the inpatient component of the program is more difficult to evaluate due to challenges tracking physical functional progress within the short inpatient duration. An assessment tool will be piloted in 2016/17 to assess clinical efficacy of the A&R program for the inpatient stay.<br><br>Sustainability plans are continuously under review as more results and direction become available. It is critical to determine how to continue to support the A&R project, as patients discharged at a high level of physical function and independence supports effective discharge planning in acute care and smooth transitions to home and community.<br><br>Patients and caregivers have shared positive feedback regarding the program in supporting them to regain independence. |
| **LHIN** | **Project Title** | **A&R Project Type** | **Project Goal** | **Brief Description of Initiative(s)** | **Lessons Learned/Key Messages** |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| CE | Assess and Restore Mobile Team | Screening – Screening Tool Adoption<br>Assessment – Assessment Tool Adoption & Care Coordination Tool<br>Navigation & Placement – Standardized Program Criteria<br>Interventions – Best Practices Adoption, Enhanced Service Delivery, Geriatrics Training & Transitions of Care | To target early screening and standardize geriatric assessment, facilitate navigation, implement an individualized comprehensive plan of care and coordinate transitions to the next most appropriate level of care. | The RMH Assess and Restore Mobile (ARM) Team concept is outcome based, patient focused care that promotes early identification and targeted standardized assessment, coordinated navigation, and individualized interventions for those seniors screened and assessed at risk. The model connects and ingrains the "in-reach" of the City of Kawartha Lake Community Geriatric Assessment and Intervention Network (GAIN) team, Community Care Access Centre (CCAC), primary care, and other community services.<br>The ARM Team will assess the inpatient clients regardless of bed designation and will focus on this frail senior/medically complex patient population in acute care and consult in post-acute care. The team will augment the use of evidenced based geriatric assessments and individualized interventions to support both the in-hospital management of geriatric syndromes and the successful transitions home or other destination in the care continuum. Treatment will be aimed at increasing strength, mobility, and | Visibility of the role and function of the team required constant emphasis to the front line staff and the interdisciplinary team. Role clarity, referral criteria, and collaboration with the existing inpatient team were also required.<br>The value of 1:1 consultations with individual team members (especially physicians) related to function and role of team and strategies was apparent.<br>Earlier emphasis on building on the foundation of geriatric education would have been helpful.<br>The role of pharmacy in medication reconciliation and the follow-up with the MRP and PCP was very valuable.<br>Development of strategies required to retain qualified staff for one time funding projects was required.<br>ARM team involvement is extremely valuable to patient flow related to high risk for discharge. Having the ARM team to identify needs and facilitate hospital and community resources was very valuable.<br>Implementation of a communication |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | functional ability, with the goal of returning to the community or the next most appropriate level of care.<br>The ARM team will target early screening and standardized geriatric assessments, facilitate navigation, implement an individualized comprehensive plan of care, and coordinate transitions to discharge home or the most appropriate level of care. | tool with primary care for ongoing follow-up and the ability to utilize phone follow-ups post discharge was useful.<br>It is important to streamline and link GAIN patient to GEM to ARM and back to GAIN.<br>A standardized approach to working with patients with delirium is needed.<br>The value of standardized comprehensive assessments was evident. |
| CE | Northumber-land Hills Hospital Assess and Restore Intervention Proposal | Multi-element<br>Direct Access Priority Process | To provide comprehensive gerontological assessment, identification of geriatric syndromes and interventions for those older persons who are frail high risk seniors; therefore being most at risk both in hospital and in the community. To provide early screening and standardized geriatric assessment, facilitate navigation, implement | The NHH Assess and Restore Intervention model of care provides comprehensive gerontological assessment, the identification of geriatric syndromes, and intervention for frail at-risk seniors. The focus of this initiative is to prevent the cascading effects of health decline that often result in more complex health needs, or failure of the person to live at home.<br>NHH Assess and Restore Intervention is led by a Nurse Practitioner-Gerontology who is progressively developing expertise in gerontological best practices, | Medical comorbidities and geriatric syndromes must be addressed together in order to create efficiencies and best practice in gerontology. This management leads to deeper resolution to the chronic illness/frailty situation. Dedicating the resource of the gerontological NP is critical.<br>NP led A&R initiatives, in collaboration with the GEM nurse, maximized efficiencies, capacity development, and patient outcomes.<br>Evidence that a Gerontological NP led A&R is ideal for primary care physicians, front line, and the broader health care. This service removes the |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | an individualized comprehensive plan of care and coordinate transitions to the next most appropriate level of care. | complex gerontological assessments, and an understanding of gerontology syndromes and interventions. | burden for a deeper gerontological assessment from the primary care physicians and introduces gerontological knowledge and research data related to care of frail older persons.<br><br>Utilizing comprehensive gerontological assessments to support care based in geriatric syndromes, effectively targets the frail and functionally declining population. This is evidenced by the number and type of geriatric syndromes observed in this population.<br><br>87% of A&R patients had 4 to 10 geriatric syndromes. Efficiencies with geriatric syndromes will diminish use of healthcare resource cost over time and maintain people living in the community.<br><br>Some geriatric syndromes presented with very high incidence (i.e. mobility/ falls at 97%, pain at 70%, mental health at 68%, functional decline at 57% and incontinence at 47%).<br><br>A focus on polypharmacy as a geriatric syndrome is pivotal to minimizing other geriatric syndromes, which if left unmanaged would create other health |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | crises in the frail population.<br><br>49% of A&R admissions were direct admissions from the community via the ED to post-acute beds. This is evidence of gerontological best practice and avoidance of acute care bed usage; and provides necessary service opportunities and flow of patients within the hospital and healthcare system. Management of geriatric syndromes to improve LOS, readmission rates, patient flow, and ALC rates.<br><br>A new definition of high risk population for increased frailty is occurring through geriatric syndromes data. Management of a cluster of geriatric syndromes will prevent increased healthcare costs and maintain older people living in their communities.<br><br>Current data creates a foundation for a new screening assessment tool for A&R. This tool will be based on the number of geriatric syndromes, type of geriatric syndromes, and /or intensity. Current data and service provision provides opportunity to define "restorable" in this population. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| CE | Assess and Restore - Scarborough hospital virtual ward | Assessment – Formal Partnerships<br>Navigation & Placement – Formal Partnerships<br>Interventions – Enhanced Service Delivery<br>Transitions Home – Transitions of Care | To establish collaboration between social workers and therapy teams and to enhance program operations and performance. | A specialized community based ambulatory rehabilitation service to patients discharged from Acute Care for Elders (ACE).<br>Components of the daily program include: 1) Therapeutic Exercise; 2) Functional Teaching; 3) Complementary Activities; and 4) Peer Support<br>Linked with Virtual Ward to pull patients into the community. | The evolution of the Needs Identification and Stratification Tool was essential to broaden the scope of discharge options for the health care team and to have more tailored pairing of patient and program. The tool enabled the health care teams to identify highly complex patients that may benefit from Health Links and are linked with hospital and or community based GAIN teams for further assessment and intervention post discharge.<br>Utilizing a LEAN methodology to develop the tool in collaboration with community partners helped to establish the process maps across the continuum of care from acute care to community.<br>Utilizing electronic tracking systems would support sustainability efforts and easier review of performance metrics. A variety of clinical indicators are tracked and additionally, the ERP is participating in the upcoming pilot project through the RCA to assess:<br>• Patient Self Report Tool & In Clinic Assessment of Function<br>• Patient Experience Measure tool |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| CE | CATCH Program | Screening – Screening Tool Adoption<br>Transitions Home – Transitions of Care | The purpose of the CATCH program is to improve patient flow by reducing length of stay and readmission rate through a multidisciplinary approach in post discharge risk assessment and intervention. Patients are referred to ensure they have a safe discharge home from hospital. | The CATCH program is an outpatient program that is delivered by an interdisciplinary team of health professionals. There is also a linkage to our general internists.<br>Patients are first assessed by a PT, who develops an individualized reconditioning program for the patient. Through reconditioning, the PTA helps to reach optimal physical functionality and independence. The registered practical nurse assesses the patient's discharge milestones, and will do a risk assessment to address aspects of the patient's discharge that still require follow-up. The nurse supports the patient in following discharge instructions, addressing risk factors and reinforcing health teaching that is focused on understanding your condition and how to prevent deterioration. | A key lesson learned is the significant impact a post-discharge program can have on keeping patients safe in the community. CATCH helps ensure patients are connected to community supports by monitoring patient's risk factors and providing appropriate interventions as needed. These risk factors can leave patients susceptible to readmission to hospital. Many can be managed with ongoing support during this critical transition from hospital to home. Among this population, the most significant risk factors addressed through the CATCH program have been falls, medication safety, and discharge instruction compliance.<br>In terms of linking with the community, the program bridges the gap between the inpatient hospital stay and independent living in the community, ensuring patients do not fall between the cracks to prevent readmission. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| CW | Home Independence Program (HIP) | Interventions – Community Service Delivery (home-based) | To provide support to patients experiencing functional decline and/or limitations in their ability to independently care for themselves. | The HIP was offered to all eligible seniors throughout the entire CW LHIN. This program serviced eligible patients from both community and hospital. Early identification and program implementation decreases the risk of further deterioration thereby decreasing dependence on the healthcare system. We know that falls are a major contributor to ED visits and readmissions. This program contributes to a reduction of injurious falls in the home. | The program demonstrates that early intervention with specialized homecare services can have a significant impact on a patient's recovery and reduces the likelihood that they will rapidly decline.<br>Outcomes show improvement of functional ability among seniors as noted through improved timed up and go measures and decreased rates of falls. Participants also showed a significant decrease in risk for presenting at ED, while simultaneously increasing their engagement with PCP.<br>The data suggests the efficacy of patient focused, goal oriented and individually tailored care resulted in significantly improved patient satisfaction, better health outcomes, and an increased ability to independently complete the activities of daily living (ADL). Patients reported that their overall pain levels were lower, their emotional wellbeing improved, and their ability to accomplish their goals was greater.<br>Standardized assessment and early identification approaches have been successful due to integrated care |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | coordinator approaches as noted through primary care alignment and the integrated acute care coordination models. Smooth transitions from acute care into the HIP model and then to independence in the community are monitored and overseen by an integrated interprofessional team.<br><br>Technology improves efficiencies in communication and care planning for upcoming years. Providers utilize personal computer video conferencing as a communication enabler, which also includes linking with the primary care provider thereby ensuring a strong team based care approach. The program continues to benefit from telemedicine approaches. |
| CHAM | Clinical Patient Flow Algorithm from Acute to Sub-Acute Care | Navigation & Placement – Formal Partnerships | To formalize standardized and shared protocols for A&R interventions for managing the placement of targeted seniors into post-acute care beds from acute care. | The project enabled the expansion of the Clinical Pathway Flow Algorithm. These new resources collaborated with existing resources at the sub-acute facility to improve transitions for frail seniors. This Clinical Flow Algorithm improved wait-times and transitions to sub-acute beds and benefited patients in the Ottawa region through reducing the time for 80% of the consults to be seen to a | Expansion of the Clinical Patient Flow Algorithm to other hospital partners has been successful through the collaboration of the stakeholders committed to ensuring success.<br><br>Physician and staff working on the acute care units have provided very positive feedback regarding the streamlined “one-stop shopping” approach. Once a patient is identified |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | target of 48 hours. In addition, the program improved the time to acceptance to the program and discharge of the patients to the sub-acute beds. | it is the triage team that completes the referral form and determines most appropriate destination, simplifying navigation and reducing workload for physicians. It is expected that automating this activity with e-referral will further speed-up the process and invite transparency. Moving toward e-referral and including smaller hospitals will be important to expanding this endeavor. |
| CHAM | Rural Assess and Restore in Champlain LHIN | Interventions – Community Service Delivery<br>Transitions Home-Transitions of Care | To pilot a flexible rural A&R community program that leverages current services (e.g., RGP of Eastern Ontario, GEM services, CCAC care coordination services) and purchasing services to address system gaps. The model would support diverting high risk seniors from unnecessary hospital utilization (unnecessary ED visits and hospital admission). | This project developed and implemented a flexible model of care and navigation to identify and assess high risk seniors. It combines the Geriatric Emergency Management (GEM) Nurse and Community Geriatric Outreach Assessor roles - to improve the access to specialized geriatric and community support services in the Carleton Place area.<br>The effectiveness of the Assessment Urgency Algorithm (AUA)/ Emergency Department (ED) screener in the Emergency Department was also implemented as a screening tool to assist in identifying seniors at risk.<br>This project improved coordination of services and continuity of care in a | Based on the extensive evaluation process completed, which included both quantitative and qualitative results, the rural A&R pilot project was extremely successful. The combined role of GEM/Geriatric Assessor, a role not previously implemented, proved to be a beneficial one. In particular, the continuity that the role offered to high risk seniors was recognized immediately by primary care providers as valuable. ED staff & physicians felt more confident in discharging frail, high-risk seniors knowing that the appropriate follow up services were in place.<br>Learnings included the value of recruiting the right person with the right skills and knowledge of the rural |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | number of ways. It increased access to Specialized Geriatric, Community Support Services, Service level agreements and Going Home services to provide patients timely access to these services. Stronger partnerships, and more consistent referral processes, were created with Community Support Agencies, Lanark Mental Health Geriatric Psychiatry Outreach, and the CCAC. A feedback loop was provided to local family physicians regarding rostered patients receiving any of these services. | environment and resources. In terms of improved access to specialized geriatric services and community support services, outcomes demonstrated the success of the pilot. For example referrals to the CCAC and the Going Home Program doubled and proved instrumental in maintaining high risk seniors in their homes. Patients accessing the geriatric clinic doubled and the hospital significantly improved functional capacity for all attendees and served a new segment of the high risk population.<br><br>Testing of the AUA as a screening tool to identify high risk seniors demonstrated that the tool appears to be more sensitive than the current tool used in the region. In addition, the clinical pathway developed to identify resources based on AUA score proved to be a valuable resource which contributes to sustainability and transferability of the program.<br><br>An important system level outcome of the pilot is a possible impact on Carleton Place Hospital's overall ALC rates. The findings were that the percent of ALC patients decreased by 31% and percent ALC days decreased |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | by 29%. If we then apply the lower ALC rates of the pilot to the pre-pilot 2014-15 sample of 448 patients, there would have been 25.4 fewer cases admitted that became ALC and 444.8 fewer ALC days. |
| CHAM | AUA Screening Tool Adoption | Assessment - Assessment Tool Adoption | The project will focus on training, education for screening tool users, and engage system providers. Additionally, The RGPEO and CCAC will work on mapping out the Clinical Pathways based on the scores of the AUA. | The project focused on the training personnel from the Champlain CCAC, Community Support Services sector, and Regional Geriatric Program of Eastern Ontario for the adoption of the AUA. Mapping of the clinical pathways was completed, specific to Champlain, based on a client's AUA score. Collaboration among project partners allowed the review of referral processes and established new/refined processes for the pilot project. Formal links were made with the Personal Support Services Early Adopter project to integrate the use of the AUA into client service planning. A communications script was developed and used by both CCAC and CSSA staff. Evaluation of the implemented processes and tools developed for the project was performed by the clinical lead. | It was determined that an e-referral process with transfer of completed AUAs is valuable to the receiving CSS agency.<br>The agencies are also reporting that the Champlain AUA pathway document was useful for follow up visits and engagement with clients and caregivers once a relationship was established.<br>Further exploration is needed to discuss referrals to other organizations.<br>Of interest, it was determined that educating clinical staff on the worth of a geriatric assessments, the importance of early intervention, and the way in which requests for equipment by clients/caregivers may be an indicator for both specialized geriatrics and therapy services. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| ESC | Seniors Mobile Assess and Restore Teams (SMART) | Interventions – Enhanced Service Delivery | To increase access to and the capacity of Assess and Restore interventions by allied health team to frail seniors admitted to acute care settings. | For 2016/17, the previous base funding allocations have been pooled (i.e. previous "Activation" funding plus the new A&R funds) and work to standardize these programs into a Seniors Mobile Assess and Restore Team (SMART) approach has been initiated.<br><br>The SMART project continues to provide ongoing focus on the risk of seniors' loss of independence because of hospitalization and acute illness, and highlights the need for a broad Assess and Restore philosophy across our organizations.<br><br>Convened an Assess and Restore Working Group to manage the enhanced service delivery project and collaborative planning and coordinate standardization of project implementation.<br><br>Further standardization of data collection amongst the organizations is needed and will occur for 2016-17. We have now refined the data reporting sheet for a more streamlined and standardized process for this coming year. | There is growing appreciation of the functional impacts on activities of daily living when acute illnesses occur in older adults, and the benefits of early engagement of PT and OT expertise. Early opportunities to recognize restorative potential, and identify patients for ongoing rehabilitative care have been realized.<br><br>Utilization of electronically available data submitted by organizations to the DAD was found to be possible. This avoided utilization of front line staff for data collection which would have taken away from direct patient care time. Overall, data collection is challenging with limited resources and the significant pressures on organizational Decision Support teams. The mobile aspect of the approach is very beneficial and not limiting to a specific geographical location.<br><br>Availability of GEM nurses on the inpatient units (only at one site) continues to provide enhanced geriatric care expertise with the care teams which facilitates identification of geriatric syndromes. Geriatric |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | conditions are appropriately managed in a timely fashion which assists in the prevention of functional decline early in their acute care stay. In larger sites, the capacity of the GEM RN to leave the ED is not available, and the need for Clinical Nurse Specialists in Geriatrics on medical units continues to be recognized.<br>The ability to have rehabilitative care providers in the ED has enhanced the GEM RN role and resulted in patients being able to access an inpatient rehabilitation bed directly from the ED - at one site.<br>Allowing for 7 days per week service delivery even on weekends has been helpful. Funding supports efforts to reduce ALC, facilitate discharge planning and enhances the necessary rehab HR needs. |
| HNHB | Seniors Mobile Assess and Restore Teams (SMART) | Interventions – Enhanced Service Delivery | The SMART model aims to provide hospitalized seniors that have restorative capacity with access to a mobile dedicated inter-professional team-based integrated | Mobile, rehabilitative care provided in hospital for frail seniors who have experienced functional decline and are at risk for further functional decline. The SMART team develops and provides an intensive restorative program that targets individuals' specific recovery needs with the goal of earlier discharge home. | • For seniors who are high risk, SMART should be a standard of care provided in parallel with acute medical care (ED/Acute) at all hospital sites.<br>• A mobile assess restore model has the potential to reduce functional decline. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | model.<br>SMART Improves the Patient Experience Through Quality, Integration & Value<br>Improves Quality of Care<br>• Improves access to rehabilitative care (Increases capacity)<br>• Prevents functional decline<br>• Improves function as measured by the Barthel Activities of Daily Living Index<br>• Promotes discharge home<br>• Decreases need for post-acute rehabilitative care<br>Integrates Services<br>• Eliminates transition points, associated | Individuals are identified and receive care in the emergency department (ED) and acute medical units. Individuals are screened within 24 hours of ED arrival with the Early Intervention Screener (EIS); individuals who screen positive, are screened for SMART. Individuals begin the SMART interventions within 48 hours in parallel with acute medical care.<br>The SMART intervention includes two funded full time equivalents of rehabilitative care staff (i.e. occupational therapists (OT), physiotherapists (PT), OT assistants and PT assistants). The core SMART team members work together with in kind interdisciplinary team members to deliver a SMART rehabilitative assess restore philosophy of care 7 days a week. Additional SMART team members include social workers, nurses, and pharmacists. | • Individuals benefit from receiving rehabilitative care in parallel with acute care.<br>• The majority of individuals who receive SMART in acute care are able to return home.<br>• There is an increase in function pre and post SMART as measured by the Barthel Activities of Daily Living Index.<br>• The majority of individuals who receive SMART do not require a bedded level of post-acute rehabilitative care.<br>• Individuals who receive SMART and require post-acute bedded rehabilitative care require a shorter length of stay.<br>• A subsequent systems impact is observed related to the number of days individuals are waiting for post-acute rehabilitative care beyond those enrolled in SMART.<br>• There is a potential significant cost avoidance related to the decreased LOS required within post-acute rehabilitative care following SMART; the decreased need for bedded rehabilitative care for individuals who |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | referrals, assessments and wait times<br>• Improves flow to post-acute rehabilitative care<br>• Rehabilitative care provided in parallel with acute care<br>• Provides the right support at the right time<br><br>Adds Value<br>• Improves the patient experience<br>• Decreases length of stay (LOS)<br>• Decreases need for bedded rehabilitative programs<br>1. • Cost avoidance | | have received SMART and the decrease in acute ALC to LTLD bed days. Results as follows:<br>**SMART Improves the Patient Experience Through Quality, Integration & Value**<br>Patient experience:<br>Please refer to the SMART video: Voices in the Community. SMART participant story from the NHS 2015/16.<br>https://youtu.be/TiNEpsTcvHg<br><br>**Improves Quality of Care**<br>• 4028 Individuals served<br>• 27% increase in function as measured by pre and post administration of the Barthel activities of daily living index<br>• 83% discharged home<br>• 8% require post-rehabilitative care.<br><br>**Integrates Services**<br>• 20% decrease in the number of ALC days for patients discharged to Complex Care – Low Tolerance Long |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | Duration (LTLD) which includes complex care restorative, assess restore and slow stream rehabilitation within the HNHB LHIN.<br>• 20% decrease in ALC to LTLD noted in HNHB LHIN level data from 12 month period from fiscal year 2014/15 compared to the same 12 month period fiscal year 2015/16 for the six SMART hospitals sites 7373 ALC days for April 2015 -Mar 2016 compared to 9253 ALC days April 2014 –March 2015 (Source: HNHB LHIN level data. 6 SMART hospital sites. Access to care iPort).<br><br>**Adds Value:**<br>Decreases LOS<br>• Average LOS in post-acute care bed for patients with a similar CMG; 26 days<br>• Average LOS in post-acute rehabilitative care for SMART patients; 20 days<br>• Average difference in LOS between SMART patients and patients with similar CMG; 6 days. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | • (Source for LOS 6 hospital site specific SMART reports).<br>Decreases need for bedded rehabilitative care programs<br>• 8% require post-rehabilitative care.<br><br>**Cost Analysis 2015-16**<br>• The SMART cost analysis indicates a potential cost avoidance for the system associated with the decrease in post-acute rehabilitative care length of stay (LOS) when compared to individuals with a similar case mix group (CMG); the potential avoidance of a post-acute rehabilitative care admission and subsequent LOS; as well as the decreased acute ALC days to Low Tolerance Long Duration days (LTLD). Detailed cost analysis information is included in the 2015-2016 Final Report. |
| MH | Enhanced Rehabilitation to Support Community Transition<br>step up | Transitions Home – Transitions of Care | To assist clients and their families with the adjustment from hospital to home in a shorter time by providing on-going individualized | | Patients attending the program are frail and present with multiple chronic and co-morbid conditions. The presentation necessitates 1:1 interventions with regulated health professionals to ensure patient's needs are met in a safe and successful |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | programming within an OP setting. | | manner.<br><br>A holistic and patient-centered approach is important to the success of the program. Inclusion of caregivers in the program and providing them with education and support is key in enabling better supported patients in the community. Connecting and educating patients regarding the different community supports and services in their area.<br><br>The ability to refer patients to specialized clinics and working collaboratively with these specialists is important. An interprofessional approach to patient care was beneficial to both the patients and their caregivers. A need for Social Workers is identified as a current gap in the model.<br><br>Low functioning patients are experiencing a gap in community services once discharged from the program. Wait lists for day programs are reported to be lengthy.<br><br>Incorporating a variety of outcome measures such as the Berg Balance, MOCA, Pre-driver screen, Boston Naming Test provides an objective |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | means of communicating with both patients and their caregivers on the progress. |
| MH | VON SMART In-Home program | Interventions – Enhanced Service Delivery | To increase services to clients who would not otherwise have been accepted into the A&R program due to the added complexity of their needs. | The program focused on two populations; those from hospital and those from the community utilizing the evidence based, nationally accredited SMART program. The upstream approach is for frail seniors. Frail Seniors who were identified as meeting the established criteria received in home 1:1 exercise sessions to increase their strength, mobility and functional abilities. The program consists of 15 gentle exercises geared towards the frail elderly and other vulnerable individuals that have experienced a recent loss of functional abilities following a medical event or decline in health. | Client engagement is important to improve compliance with the program. Encouraging clients to be accountable to continue with the exercises even when a clinician isn't present.<br>The AUA has been very beneficial in correctly identifying appropriate referrals for the program.<br>Using the Time-Up and Go (TUG) pre and post exercise outcomes showed a variety of results. It is important to remember the TUG is a measure to assess mobility associated with falls and additional performance measures will be needed to truly identify other functional gains such as the BERG Balance Scale, Barthel Score, Tinetti and the 30 second sit-to-stand test.<br>A portion of the funds was used to develop an eLearning module on depression that supports provincial knowledge transfer initiatives to build capacity and improve quality in the care of frail seniors. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| MH | MH CCAC Rapid Recovery Program | Interventions – Community Service Delivery | To enable safe and timely discharge from hospitals for patients waiting for in-patient rehabilitation or for those patients who require enhanced rehabilitation from a multi-disciplinary team to maintain, improve, or restore to optimum function in their homes. | The Rapid Recovery Program at the MH CCAC helps to prevent unnecessary prolonged hospital lengths of stay and admissions to inpatient rehabilitation. The uniqueness of the program is the provision of intensive in-home rehabilitation services during the first 2 weeks post-discharge.<br><br>The Rapid Recovery Program offers a viable and more cost-effective alternate to patients who may be:<br>• Awaiting inpatient rehab while in an acute-care bed.<br>• Admitted to inpatient rehabilitation by can be discharged early to resume their rehabilitation within the in-home setting. | The program has seen continued growth, with ongoing high rates of referral. Assessment urgency and rehab algorithm scores suggest we continue to see patients within the target group.<br><br>The program is looking at reconfiguring it in order to target issues such as hospital readmission, patient population, lower than expected Occupational Therapy utilization, and challenges scheduling the intensive physiotherapy services to meet patient preference. Key changes under considering include:<br>• introducing Rapid Response Nursing to the care delivery team<br>• working with hospitals to create a more direct referral model<br>• further defining anticipated outcomes and expected interventions delivered<br>• increasing flexibility of service scheduling to address patient and family preference<br>• implementing a quality improvement initiative to ensure accurate coding of patients when transitioning off the program |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| NE | Assess & Restore Collaborative (ARC) | Multi-Element Project<br>Direct Access Priority Process Initiative (DAPP) | The goal is to develop and test a local process for direct admission to facility based Assess and Restore interventions within the suggested time frames. | The project is piloting the Direct Access Priority Process in 2 Hub communities and includes aspects of timely identification and assessment of older adults who meet the criteria for the target population. The goal is to develop and test a local process for direct admission to facility based Assess and Restore interventions within the suggested time frames. Areas of focus are the first 3 elements of the Assess and Restore approach to care – Screening, Assessment and Placement/Navigation.<br>Step 1 – Early Identification<br>Step 2 – Assessment<br>Step 3 – Navigation & Placement | The ARC project team has identified 'Essential Elements' for DAPP implementation and has developed a checklist to assist in identifying current state readiness. These 'Essential Elements' fall into 6 categories: Local Leadership, Key Stakeholder Commitment, Specialized Geriatric Services, Community-based Pilot Site, Bedded Levels of Rehabilitative Care and Community-based Levels of Rehabilitative Care.<br>Further alignment with the RCA initiatives is critical for development of infrastructure necessary to support a proactive shift in health care delivery for the target population and beyond.<br>The uptake of RCA and NE LHIN Rehab/CCC Steering Committee rehabilitative care-related information varies significantly by Hub area and health service provider. Knowledge translation is person-dependent and leadership-focused. As a result, initial ARC project implementation required considerable investment in engagement and planning activities to achieve suitable readiness.<br>This project has highlighted the |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | significant gap in the NE healthcare systems' awareness and understanding of specialized geriatric services as an area of clinical expertise and the role of the North East Specialized Geriatric Centre (NESGC) as a Regional Geriatric Program.<br><br>A 'geriatric/senior-friendly' approach to care is fundamental. Within the different districts and HSPs, there is significant variability in the infrastructure that exists to support and standardize the delivery of 'geriatric' care.<br><br>For project outcomes to be sustained and spread beyond March 2017, a system-wide, regionally coordinated approach to geriatric care and geriatric rehabilitation delivery is required and should be inclusive of district-level leadership and contextualization. |
| NSM | Geriatrics Training & Best Practices Adoption | Interventions – Best Practices Adoption<br><br>Interventions – Geriatrics Training | Developing a learning plan in collaboration with providers and in alignment with the RCA's "Compendium" document that will include: | To increase the flow to Assess & Restore facility based interventions this project will:<br><br>- Increase the number of health care professionals AND skillsets of health care professionals in the care of frail seniors. | It was challenging to recruit a registered staff person for a short-term contract position.<br><br>Significant travel time was involved as the CCP sites are situated in different areas in NSM LHIN – this resulted in significant in-direct time. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | • Education events<br>• On-site mentoring, coaching and support<br>• Program planning and implementation<br>• As appropriate, policy and procedure development. | - Standardize and disseminate leading practices.<br>- Increase the self-management capacity of frail seniors and their caregivers.<br>This local work will also support implementation of transitions of care work stemming from the second NSM LHIN Project, Enhanced SMART & Transitions of Care. | It was determined that multiple sites had similar learning needs, i.e. Falls Management. Interpretation of "Fall" was different from site to site which results in reporting differences. |
| NSM | Enhanced SMART & Transitions of Care | Interventions-Enhanced Service Delivery<br>Transitions Home-Transitions of Care | To increase access to A&R facility based interventions (CCP, ACE). Enhanced SMART and Transitions of Care builds on the current SMART program. Enhanced SMART is designed to support those complex frail seniors with higher intensity needs and increase access to Assess & Restore facility based interventions (CCP, ACE). | Seniors Maintaining Active Roles Together (SMART) became operational in NSM LHIN in 2007/08 to serve approximately 1,385 seniors. The SMART program offers exercise classes to community members 55+ who wish to improve their strength, balance and flexibility, regardless of their physical abilities.<br>Enhanced SMART currently offers advanced rehab 2 x 0.5 days/wk to up to 12 individuals per class for a 6-12 week period. Three separate classes/groups per week are hosted. It also provides post discharge follow-up and monitoring and system navigation. | It has been challenging to secure a venue that is cost-free, accessible and has adequate space to hold exercise classes on an on-going basis.<br>Clients being admitted are of higher frailty than originally expected and are admitted into the In-Home program rather than Group, which has increased recruitment requirements to meet the needs of the increased numbers of In-home participants.<br>Preliminary data analysis from the first 21 clients to complete the care in the Enhanced SMART Program illustrates improvement in all qualitative and quantitative outcome measures collected at admission and discharge. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| NW | Enhanced Service Delivery – Thunder Bay Regional Health Sciences Centre (TBRHSC) | Interventions – Enhanced Service Delivery | To reduce hospital admission, length of stay and improve functional status of A&R patients in an acute care setting. | This project was a continuation of the geriatric care coordinator position from the 2014/15 project. The coordinator actively assessed "at risk" elderly patients from the target population by using standardized tools to identify geriatric syndromes and facilitate care for patients experiencing dementia, depression, delirium, falls, mobility issues and frailty. The coordinator worked closely with the gerontologists, rehab staff and community partners to provide care coordination for safe and reasonable discharge. | The project showed great potential to reduce length of stay, improve functional ability and continue safe discharges back to home.<br>Standardized tools were used to better screen 'at-risk' individuals. The geriatric coordinator worked closely with other professionals and was an integral part of the hospital's A&R team. Based on the evaluation and engagement with the health service provider, this role would be continued in the next fiscal.<br>Overall, implementation of this initiative demonstrated improved patient outcomes and an opportunity to maintain gains. From those enrolled, 42% were discharged home, 39% were discharged to post-acute services. |
| NW | Navigation & Placement – Process Standardization | Navigation & Placement-Standardized Program Criteria | The purpose of this project was to improve access to post-acute in-patient services directly from the ED/community. | The purpose of this project was to improve access to post-acute in-patient services directly from the ED/community by standardizing actives and processes involved in accessing in-patient rehab beds. Direct access to these services will avoid inappropriate admissions to the acute care facility; thereby | Stakeholder engagement and knowledge sharing happened between the rehab and acute care hospitals. A process for community to rehab admission was developed.<br>Education was provided to CCAC case managers. Formalization of referral pathways from ED to rehab are being considered in the coming months. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | decreasing acute care utilization and improving patient outcomes by providing relevant care in the most appropriate way. In addition to this, the project goal was to review all rehab/CCC services within the North West LHIN and develop a regional integrated service delivery model for rehab services. | Streams of care concept is being introduced at the post-acute care facility to create ease of access to rehab care.<br>The importance and benefits of having direct admission to rehab beds from ED/community was validated and work will continue to formalize and utilize these processes on an ongoing basis. This is extremely essential to improve patient flow and the overcapacity pressures in the acute care sector.<br>The creation and the implementation of the regional integrated service delivery model will improve access to quality rehab services across the region including direct access to rehab beds. |
| NW | Enhanced Service Delivery (Lake of the Woods District Hospital) | Interventions – Enhanced Service Delivery | To facilitate earlier and more intensive rehabilitation intervention on the acute care floor, specifically for activities of daily living. | This project is a continuation of Physical Medicine Occupational Therapist position (0.4) from the 2014/15 project. The therapist has been able to augment positive impacts of the program by introducing rehab services to seniors with restorative potential earlier, improving functional status, resulting in decreasing length of stay and | The A&R program has addressed the issue of long wait times and travel to other communities, by providing the means for the small community hospitals to offer a level of service that is comparable to a regional rehabilitation hospital, without the long wait and the need to travel away. The result is a significant improvement in patients' functional status and in |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | facilitating safe discharge back to the community. Specifically, the target population will be supported to enhance independence with activities of daily living through improved basic motor functions. | the ability to return to home. In addition, on discharge, these clients have actually had a significantly reduced need for home care services, as patients and families have been enabled to a level of independent functioning. As well, their hospital lengths of stay have decreased as they have improved to a discharge status much faster with the increased treatment. Furthermore, LTC admissions have been prevented through supportive and comprehensive treatment focused on a return to home.<br><br>Clients of the A&R program are seeing benefits of working with rehabilitation staff and are aware that participation in this program means that they will have greater chance of success at home. Many clients feel the program has become their second chance at independent living. Others describe it as a chance to wait at home for long term care rather than “living” in hospital for months on end. |
| SE | Enhanced Service Delivery | Interventions – Enhanced Service Delivery | The intention under the Assess and Restore model is to maximize and enhance bedded | Providence Care will increase assess and restore capacity in Acute care by providing resources to support the operation of 5 additional IP beds at | |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | level of care (increased rehabilitation frequency and intensity) for increased functional independence and sustained patient outcomes, while supporting safe and efficient transitional care planning via associated functional patient outcomes - Uptake and enhancement of best practice - activation and therapeutic intensification. | Existing OTA/PTA staff be maximized with FTE increases for the three-month period January to March, 2016. Staff under the direction of existing OT/PT team members will work closely with patients to maximize activation, participation and self-management relating to mobility and home safety function (e.g., falls prevention, kitchen safety, ADL function) for safe transition and sustained independent living in the community.<br>As part of transitional care planning, high and low tech solutions are required and acquisition pending currently, in support of the practice of our Predictive Discharge Planning model (alignment with A&R Transitions in Care) and application in support of A&R documentation, communications and transition care planning. | |
| SE | Transitional Restorative Care Unit (TRCU) at Brockville General Hospital | Interventions – Enhanced Service Delivery | The emphasis of the program is identification of frail elderly de-conditioned inpatients that may have potential for improvement of | BGH will increase assess and restore capacity in Acute care by providing resources to support the operation of 5 additional IP beds at the Charles Street Site. This pilot, the Transitional Restorative Care Unit, will cluster similar patients to an IP area that | Length of stay was reduced due to the intensive rehab available during the patients stay and the use of GAIN as an additional resource post-discharge. Incorporating the senior friendly project also showed reduction in LOS for patients experiencing delirium |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | function at Brockville General Hospital | consolidates the expertise of a multidisciplinary geriatric rehabilitation team. The goal of assessing the viability of providing high intensity rehab in the acute care setting prior to discharge or transiting into the more traditional slow-stream, low endurance restorative care program.<br><br>The multidisciplinary rehab program for seniors transitioning from acute care, but that still require a degree of active medical management that would make it unsafe or impractical to receive A&R interventions at our Restorative Care sight. Through intensive rehab during the acute care stay we will be able to reduce the length of stay and potentially avoid an admission to the Restorative Care Program. | The prevention of delirium and the maintenance of functional ability in older hospitalized patients was a key outcome in supporting independent living in the community. At present, delirium is under-recognized and under-reported condition. This practice is an important step toward preventing the decline in patients' functioning that limits safe and enduring transition to the community.<br><br>A longer term analysis of process and outcome results will provide information to help establish appropriate standards of practice for these important aspects of care.<br><br>The goals of discharge planning are to help patients and their families receive the most appropriate level of care, remain in the hospital for shortest possible time, and have a planned post-hospitalization program to meet their continuing care needs. A prevalent clinical issue facing hospital professionals is how to discharge older patients in a timely manner while ensuring the appropriate medical, social, and healthcare safety nets are implemented. The hospitalized elderly |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | are at high risk for poor post-discharge outcomes including re-hospitalization, frequent ED visits, and institutionalization, the GAIN Clinic is a valuable resource to bridge this gap. |
| SE | Providence Care - Education | Interventions-Geriatrics Training | Providing education and training for hospital staff to enhance their ability to care for frail seniors. | This funding was directed towards the implementation of a training program for hospital staff to enhance their ability to care for frail seniors with functional and/or cognitive impairments. This will enhance outcomes for this patient group. | Increased clinician knowledge specific to the care of older adults improved their understanding of assess and restore practice standards through specialized geriatrics training.<br>Provided knowledge needed to adopt and implement evidence-based care, an increased sense of ability in assessing geriatric patients for syndromes related to frailty.<br>Provided them with the tools they need to provide better patient care and improve outcomes for the geriatric populations. |
| SE | Implementing the Acute Care for the Elderly (ACE) Program | Assessment - Assessment Tool Adoption<br>Interventions-Geriatrics Training | The goal is to provide inter-professional care planning to address the needs of the hospitalized elderly beyond the acute presenting illness to enhance (or prevent decline of) cognitive and physical | The Acute Care for the Elderly (ACE) program will address the needs of hospitalized elderly through implementation of standardized inter-professional restorative care practices for elderly patients in acute medical units, including high-risk screening, assessment and restorative interventions, targeting common geriatric syndromes such as | The A&R funding was imperative to create a foundation of knowledge to support and complement IPCT to enhance elder care. The education was well received and vital to prepare staff to care for geriatric syndromes.<br>Our greatest challenge was opening a new unit at the same time we were providing education and building the care team. It was an overwhelming |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | functioning resulting in the ability to return to an equivalent care setting post discharge | mobility, frailty, dementia, delirium, nutrition, and caregiver support.<br>It will include the development of Geriatric Resource Nurses (clinical leads) for BGH and PECM, training of staff on the ACE model, and the development of Assessment (including Comprehensive Geriatric Assessment) and Seniors Care Protocols. This transitional investment will enable a realignment of the model of care to one that reflects the Assess and Restore model of care. There will be a restorative focus to enhance the recovery of lost functional abilities of seniors through this model. | process to look at all processes to ensure we were implementing all aspects of care and to have metrics to support all the new processes within a new unit. It was very difficult to blanket the geriatric syndromes at one time so we have taken a "layering in" approach in which we have looked at baseline measures of # of conversions to ALC, LOS and transfers back to prior place of disposition.<br>We are now focusing on mobility score to focus on preventing functional decline. Nutrition and dementia screening are the next big syndromes that we will build into the program. |
| SE | Geriatric Assessment and Intervention Network (GAIN) Clinic | Assessment - Assessment Tool Adoption<br>Assessment - Formal Partnerships<br>Navigation & Placement - Formal Partnerships | The Geriatric Assessment and Intervention Network (GAIN) clinic will provide support to seniors living in the community who are physically or cognitively frail, increasing in frailty and/or at risk of using hospital EDs and inpatient services. An | The GAIN Clinic will provide support to Seniors living in the community who are physically or cognitively frail, increasing in frailty and/or at risk of using hospital emergency department and inpatient services. The clinic will strive to strengthen the capacity for frail seniors to live at home safely and independently for as long as possible. The clinic's goal is to help patients avoid ED visits, inpatient stays and ALC placements in | It is important for everyone to understand their role and how this service can benefit their patients. We tried to combine HealthLinks/SHIIP and the GAIN clinic together as we saw it as a benefit but adding too many things at once did not allow for clear roles and responsibilities.<br>It takes time to get established and develop relationships. Being too aggressive with timelines and goals makes the team feel like they are |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | inter-professional team of health care professionals will work collaboratively with patients and families and their primary care providers to strengthen supports and capacity for older adults whose health concerns threaten their ability to live independently at home. | the hospital. An inter-professional team of health care professionals will work collaboratively with patients and families and their primary care providers to strengthen supports and capacity for older adults.<br>GAIN teams provide services to Seniors typically aged 75+ who present as frail and require a comprehensive geriatric assessment or may be experiencing; multiple complex medical, functional, mental health and psychosocial problems, recent functional or cognitive decline and/or frequent falls, or those at risk for them. | failing. The amount of referrals and patients has increased greatly but it has taken more time than expected.<br>Continually evaluate and make changes as necessary. Look for gaps that patients are experiencing and evaluate what the team is offering, change if not meeting the needs or is a duplication of services. |
| SW | South West Assess and Restore Project Team | Screening-Screening Tool Adoption<br>Assessment - Formal Partnerships<br>Navigation & Placement - Formal Partnerships<br>Interventions-Best Practices | Implementing an Assess and Restore approach to care for community-dwelling seniors and to evaluate the projects within the South West LHIN | St. Joseph's Health Care London's Parkwood Institute has hired a project team to lead the implementation of an Assess and Restore approach to care for community-dwelling seniors in the South West LHIN, and to support implementation and evaluation of Assess and Restore pilot projects within SW LHIN organizations that have received Assess and Restore funding.<br>The South West Assess and Restore | Through supporting the implementation of proactive screening and Direct Access pilot projects it has become evident that A&R care/referral pathways will vary greatly by region and that successful implementation must focus on leveraging regionally available resources. It has also highlighted the disparity of specialized geriatric services across regions; limited access to specialized geriatric resources in the community makes it very difficult to facilitate access to comprehensive |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | Adoption<br>Interventions-Enhanced Service Delivery<br>Interventions-Geriatrics Training<br>Transitions Home-Transitions of Care | | project team is leading implementation, data collection, and evaluation of an Assess and Restore approach to care across multiple pilot sites including: | geriatric assessment for high-risk older adults.<br>Primary care has been identified as a key player in providing a proactive A&R approach to care, and in managing the complexity of frail older adults in the community. Clinical capacity building related to geriatric expertise in primary care has been identified as key piece of implementing this approach to care. The creation of formalized cross-sectoral partnerships is essential for the implementation of an A&R approach to care.<br>A small number of older adults are identified as falling into the target population for facility-based A&R (high risk, having restorative potential and requiring a level of care that cannot be provided in the community). |
| SW | Specialized Geriatric Services Direct Access Priority Process pilot project | Screening – Screening Tool Adoption<br>Assessment - Formal Partnerships<br>Navigation & | Providing high risk older adults who are identified as having restorative potential with the appropriate care. | Proactive screening using the AUA during the intake process for the RGP Outreach program and the inter-D clinic within SGS was implemented. The AUA is used as a decision support tool to inform referrals for further assessment or to restorative interventions. Following | A small percentage of high risk older adults are identified, through a comprehensive assessment, as both having restorative potential and requiring a level of care that cannot be provided in the community. Through comprehensive assessments, out-patient geriatric rehab is more often |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | Placement - Prioritization Protocols | | comprehensive assessment, high risk older adults who are identified as having restorative potential & requiring a bedded-level of rehab care are referred to Geriatric Rehab program for specialized geriatric rehab. | determined to be an appropriate referral than inpatient rehab.<br>The AUA score indicates some utility related to triaging patients who to in-home vs. ambulatory assessment. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| TC | Fast Access for Seniors to Community Assess & Restore Services (FAST CARS) | Multi-element Project<br><br>Direct Access Priority Process Initiative | The goal is to identify frail seniors declining or at risk of declining, in the community and to intervene to avoid an acute care admission, maintaining the individual in the community or if admitted to rehab, returning the individual to the community with a coordinated plan of care among partners (and others as needed). A secondary focus is to measure caregiver | Providence developed, implemented, and is currently spreading, evaluating and working to sustain a standardized care path to promote rapid admission to A&R, in-patient and out-patient rehab programs at Providence for complex, vulnerable patients and frail seniors.<br>The services facilitate direct admissions from the ED, primary care and/or community to inpatient and outpatient geriatric rehabilitation programs at Providence.<br>The program is aligned with the mandate of the MOHLTC and TCLHIN regarding the utilization of | The ability to admit directly from the ED has aided in increasing the volume of patients served using the referral pathway.<br>Clinician training with the assessment and quality of life tools, as well as, training with the Coordinated Care Plan and the development of the patient/client satisfaction tool was essential.<br>Development and education of the community referral checklist and pathway and the direct from community or ED to inpatient rehab was helpful in the project's success.<br>By creating an easy access pathway |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | burden and act where needed. | Coordinated Care Planning (CCP) for complex seniors. | with a minimum data set referral (single sided page) that could be integrated into primary care teams' eHR, Providence could support front line teams, CCAC care coordinators in patient homes and the GEM nurse in the ED to access their programs. |
| TC | TC LHIN Northern Tier Assess & Restore Collaboration | Multi-element Project<br><br>Direct Access Priority Process Initiative | A collaborative Knowledge-to-Practice process to implement the integrated vision underlying the framework of provincial A&R elements | The assessment and restoration of frail and complex seniors is the sole focus of Specialized Geriatric Services teams led by the Regional Geriatric Program (RGP) of Toronto. The RGP received funding in October, 2015 to implement a TCLHIN "Northern Tier" Assess & Restore (A&R) initiative focused on the following six activities.<br>1. Convene meetings and link the 4 ongoing TCLHIN A&R projects & consult with A&R initiatives across the province linked to the RGPs of Ontario Provincial Network.<br>2. Estimate the population of frail and complex seniors likely to be identified as 'at risk' by the AUA.<br>3. Identify services caring for frail and complex seniors in the region and survey their practices including | Despite the diversity of A&R initiatives there was consensus on the importance of the questions:<br>• How large is the population of frail and complex seniors at risk?<br>• How can interRAI and Comprehensive Geriatric Assessment (CGA) connect?<br>• How can decisions regarding restoration potential and location be optimized<br>• Can a common intervention set be deployed across the sectors of care?<br>While a diverse set of assessment processes are available across the region, two – the interRAI and CGA – were the most evident and commonly used as sources of additional expertise, and were perhaps the most commonly misunderstood.<br>Coordinated care plans appear to have limited penetration among the 41 |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | assessment processes, use of external resources and the coordinated care plan.<br>4. Conduct literature scans to identify a set of interventions most likely to be applicable across sectors.<br>5. Conduct focus groups of seniors to seek guidance on ways to proliferate senior friendly care.<br>6. Convene an expert panel to share information and address three questions (how to connect interRAI and comprehensive geriatric assessments?; how to optimize decision making regarding restoration potential and location?; and to identify the ways in which an 'ideal' restoration target set would be adapted for use across the sectors of care.) | surveyed services.<br>Literature reviews were conducted to identify the most productive focus for a common set of restoration interventions that could be adapted across the sectors of care. The importance of a core set that includes mobilization/exercise, nutrition, medication management, cognitive monitoring and stimulation, continence, pain and social engagement were identified.<br>Focus groups identified the importance of mobility in the maintenance of both independence and well-being. Despite its importance, communication on this issue was difficult because people are not responsive to the idea of 'exercise'.<br>A&R was seen as a fundamental function of specialized geriatrics service that includes geriatric rehabilitation and extends across the sectors of care. InterRAI and CGA can be complementary but the need for knowledge exchange is high. Effective restoration potential and location decisions should be based on a |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | | combination of knowledge arising from the use of assessment tools and algorithms, sound clinical judgment and contextual nuance. |
| TC | An integrated system of Transition Care Planning for frail high risk seniors | Formal Partnerships | By leveraging existing resources and developing an inter-sectoral care transition plan these patients will receive the right intensity of care at the right time. The inter-sectoral care transition planning will optimize health system resources in three sectors: acute care, CCC, and home and community care thereby improving patient outcomes while increasing system efficiency. | Existing resources are being leveraged to develop an inter-sectoral care transition plan to ensure frail seniors with multiple chronic co-morbidities receive the right intensity of care at the right time. The inter-sectoral care transition planning will optimize health system resources in three sectors: acute care, complex continuing care, and home and community care thereby improving patient outcomes while increasing system efficiency.<br>This project is designed to access community based services such as the Enhanced Day Program at WoodGreen prior to discharge. This builds a sustainable and comprehensive transition and discharge plan including linkages to community supports.<br>Seniors in the community will be closely monitored with an appropriated plan of care from the | Investing time in the early engagement of stakeholders is crucial to develop a shared understanding and new ways of working together.<br>Training to enhance the skill set of providers that are now more intensively working with marginalized populations. Early learning has allowed us to have an important conversation for risk tolerance to discharge to the community. “Safe discharge” has different interpretation across the continuum of care. It is crucial to define “safe discharge” and the risk tolerance associated.<br>Dedicating time for dialogue is required to identify and walk through process components to an existing established process. Introducing new process components created significant challenges.<br>Initial project start up time and resources are required to understand different processes and to recognize |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | integration of TC CCAC and WoodGreen Community Services and they will be linked with their primary care provider. Any potential signs of decline will trigger readmission to TGHC for additional rehabilitation to maximize health condition to prevent deterioration in functioning. | and understand how different organizations work.<br><br>There is a need to develop new ways of working inter-sectorally and inter-organizationally which requires senior leadership vision, dedicated time for dialogue and provider support as new roles and ways of working emerge. |
| TC | Admission Criteria & Placement Process to Assess and Restore Services | Multi-element Project<br><br>Direct Access Priority Process Initiative | A comprehensive integrated model of care for frail, community-dwelling seniors who have been identified as having potential for restoration of function. The project will establish an inter-professional geriatric clinic, and optimize existing resources within West Park to improve patient experience, and encourage equitable access to rehab services (e.g., direct access from community). | The West Park Assess and Restore Program is a comprehensive integrated model of care for frail, community-dwelling seniors who have been identified as having potential for restoration of function. It builds on the successes of the *Care Coordination and Pharmacy Management Project* that was funded at the end of FY 14 and continued into FY 14-15.<br><br>The 3 main components of service delivery include:<br><br>1. Enhanced case management & pharmacy management via the Seniors' Mental Health Service<br>2. Inter-professional Geriatric Clinic & Outreach services<br>3. Home-based restorative programs | The team discovered that the referrals varied, seeing clients with a variety of conditions and complex in nature; more medically complex cases, not yet diagnosed. They found the current partners were making referrals for clients with chronic but increasing complex issues who would benefit more from Outpatient /Community-based restoration.<br>The team has identified the need for education on advanced care planning and more opportunity for collaboration among services.<br>More education is necessary for community partners/primary providers as well to understand the benefit of CGA in the prevention of rapid functional decline & disability.<br>The team struggled with developing efficient methods of |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | via the partnership with St. Clair West Services for Seniors | communication/documentation among inter-professional team members, and determined that things are made easier by using electronic means. |
| TC | Independence at Home (IAH) Program | Community Service Delivery (Home-based) | To provide comprehensive, specialized assessment and rapid system navigation and access for medically complex frail older adults at risk of, or experiencing functional decline and who have restorative potential. | The program is a novel partnership between acute care, rehabilitation, convalescent, primary and community care providers/services to provide comprehensive, specialized assessment and rapid system navigation and access for the target population. The IAH programs community-based geriatric outreach and assessment team will triage referrals, conduct appropriate assessments, facilitate care and develop care plans in order to link frail older patients to the most appropriate services across the Assess and Restore continuum.<br>Key Assess & Restore policy elements provided include patient screening and assessment, system navigation & placement, timely interventions as needed and transitions home.<br>The IAH community based outreach team is:<br>• Supporting community dwelling | Individual assessments completed by the varied allied health professionals with IAH COT have resulted in the formulation of client care/service plans. The identified goals set out in the care plan being implemented by the IAH COT team members or referral(s) made to appropriate resources in the community on clients' behalf.<br>Application of 'different lenses' being applied by the allied health professionals with IAH COT in the completion of comprehensive assessments have ensured that care plans are client-centered and strength-based and ensures a seamless experience for clients in the navigation of resources and services. In addition, assessments have identified service gaps and the use of advocacy has been vital in clients' access to services. Furthermore, "closing the loop" prior to discharges |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | medically complex frail older adults who have experienced or are at the highest risk of experiencing functional loss<br>• Building on existing primary care integration strategies of local Health links<br>• Ensuring that primary and community care providers are involved in the decision-making during assessment and care planning. | from IAH COT has assisted in sustaining clients' independence to reside at home as long as it is deemed safe and viable.<br>Recognition that caregivers play a pivotal and instrumental role in overseeing the care of their loved ones and that caregiver burnout and stress is a reality for most caregivers is essential.<br>Triaging of referrals as volumes increase, ensuring ongoing efficiency in processes including triaging of referrals is paramount to maximize timely access to services and prevent lengthy waitlists. |
| WW | AUA Implementation in Primary Care and the ED | Screening – Screening Tool Adoption | To implement the AUA in primary care settings throughout Waterloo Wellington. | At 14-15 year end, WW LHIN had started the implementation process in two primary care pilot sites in WW (Mount Forest Family Health Team in Rural Wellington and New Vision Family Health Team in KW). Focus group and individual interviews with community and primary care providers, and older adults were conducted. Care referral maps, associated with AUA risk-levels, have been developed based on the information gathered during these consultations. Referral process | Although the AUA was originally developed for the acute care sector, it was proven to be helpful in primary care. The project allowed primary care providers to identify patients who are need of services and/or further assessments, and the ability to coordinate the care in a timely fashion.<br>Broader adoption of the AUA, with a particular emphasis on non-affiliated physicians and rural communities and in the ED would further these aims.<br>Ongoing education and supports for |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| | | | | mapping was completed with each provider. AUA training sessions were given to providers who will be administering the tool. Caredove, an online referral tool, is being used to make referrals across the system. An AUA site within the Caredove platform has been developed and will assist with the referral process (based on the AUA score).<br>The project continued in the 15/16 year, where evaluation of implementation in the pilot sites will took place through qualitative interview techniques and referral tracking from Caredove.<br>The project will also be extended to using the AUA in the Emergency Room. | sustainability, capacity building and quality improvement related to the interRAI suite of tools is needed across multiple health sectors.<br><br>The tool was well tolerated by patients and providers. Particularly noteworthy is the high percentage of patients in primary care who scored within a low to moderate risk level (95%) which suggests that this screening tool is well situated within primary care and captures those who may benefit from early intervention.<br><br>Additionally, there are many barriers to accessing health services in rural communities, including transportation difficulties, social isolation and financial constraints (Goins et al., 2005). Feedback from the rural site confirms these findings as providers indicated they have difficulty accessing services that are free of charge for the patient or services that do not require transportation. |

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
|---|---|---|---|---|---|
| WW | Rapid Recovery Model Implementation | Interventions – Community Service Delivery | Significantly impact transition concerns, positively affect ALC rates, reduce # of direct LTCH admissions from hospital, support transitions for frail clients to community based restorative and exercise programs. | The WWCCAC, in partnership with the regional rehab system, was funded in 15/16 and will continue for 16/17 to implement and evaluate the Rapid Recovery model in WWLHIN.<br>There will be an enhanced focus on transitioning these patients from the Rapid Recovery program to community-based physiotherapy or exercise programs. | The model targets patients in post-acute rehab/restorative care beds nearing their discharge. Patients are discharged days to weeks earlier and complete their rehab goals in their home, reducing the impact of the illness and the hospital stay on seniors. |