The following is a high level description of the Assess and Restore initiatives that are being completed in each LHIN with the 2013/14 Assess and Restore funding. This summary was developed to support the development of a repository of information about the Assess and Restore initiatives in order to support knowledge translation. Note: Responses have been included where provided.

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
HNHB	Dedicated inter-professional team-based integrated assess restore model.	1. Increase Access 2. Increase Capacity	1. Care Coordination 2. Education	1. Increase care coordination capacity of Geriatric Outreach Teams/Specialized Geriatric Services. 2. Enhance the ability of clinical staff to care for frail seniors.	A mobile assess restore team model for seniors in hospital. The program provides hospitalized seniors that are at risk of functional decline or have experienced functional decline and have restorative capacity with access to a dedicated inter-professional team-based integrated model. The team develops and provides an intensive time limited restorative program that targets the patient's specific recovery needs (i.e. increasing strength, activities of daily living abilities and mobility) with the goal of earlier discharge home with or without supports. The teams are located in four HNHB LHIN hospitals and the interventions are provided to patients in their current location (i.e. emergency department and acute inpatient). Patients admitted to restorative or rehabilitation programs would not be eligible for this mobile model. Patients requiring access to in-home or clinic based rehab will be identified and early referral to the Community Care Access Centre (CCAC) or outpatient rehabilitation is initiated. The approach is also intended to increase clinical staff knowledge on the care of frail seniors

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					through modeling and working with the dedicated inter-professional team. Patients identified to receive assess restore (AR) interventions as an alternate to transition to an AR bedded program would not be designated as waiting for an Alternate Level of Care (ALC).
SE	Training for HSPs clinical staff to enhance care for frail seniors	Increase Capacity	Education	The proposed training program for hospital staff to care for frail seniors with functional and/or cognitive impairments, will enhance the outcomes for this patient group	
SE	Enhancing the capacity of SE LHIN Hospital's Restorative Care Programs to accept specialized patient groups	1. Increase Access 2. Increase Capacity	Other	To enhance the capacity of SE LHIN hospitals to provide restorative care to specialized patient groups (including bariatric patients) and therefore improve access to enhanced activation / restorative care for this group of clients with complex care needs.	

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SE	Home Adaption and Equipment Project	1. Increase Access 2. Increase Capacity	Home Adaptation	The goal of the project is to allow the purchase of equipment or minor renovations that will allow seniors to return to their homes safely.	
SE	Elder Patient Cognition Enhance/Therapies	1. Increase Access 2. Increase Capacity	Other	To improve the cognitive ability of hospital admitted seniors by employing cognitive therapies that are delivered through the use of tablet computers with purpose-built software, and other technology.	
SE	Seniors Day Rehabilitation	1. Increase Access 2. Increase Capacity	1. Care Coordination 2. Ambulatory Rehab	1. Ambulatory Care – redesign of existing service to increase capacity for day rehabilitation for at-risk seniors provided by an inter-professional team of experts in senior health. Expand patient populations to include orthogeriatrics and stroke. 2. Care Coordination - Care Coordinator role includes navigation and the coordination of care within	

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				Providence Care (i.e. Geriatric Clinics), community providers (i.e. Health Links) and CCAC.	
Champlain	Collaboration Space - Community Landing Page	Increase Access	Information Sharing	To provide information sharing opportunities for health care communities in Champlain, including Small Hospitals and Health Links providers.	This project will create a common landing page in the Champlain LHIN Collaboration Space for various communities in the Champlain LHIN, including Small Hospitals, and their associated local providers. Providing a common place for parties to access existing services in the Collaboration space. It will be customizable for the specific community using the tools and include services including Scheduling, Physician search, Resource booking, eConsult, IRIS, Learning tools, SMART referrals to Hospice/Palliative Care, Transportation booking, and several others.
Champlain	Outpatient Ambulatory Rehabilitation	1. Increase Access 2. Increase Capacity	1. Education 2. Care Coordination 3. Ambulatory Rehab	Geriatric clinic, Outpatient PT/OT, Pelvic floor programs-PT, Geriatric consult team	1) Geriatric Clinic Many high-risk seniors have difficulty remaining safely in their homes following a discharge from acute care. The Geriatric Clinic looks to support patients discharged from hospital (primarily from the geriatric inpatient unit (20 beds) at The Ottawa Hospital's Civic campus and patients cared for by the Geriatric Consult Team. The Geriatric Clinic team will be comprised of a Geriatrician, an Advanced Practice Nurse, and, when required, a Physiotherapist. The team will assess the high-

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					risk senior's potential to manage at home upon discharge and will develop a plan of care plan to increase strength, improve ADLs and mobility, and support independent living. For those in the inpatient geriatric unit, this program will provide continuity of care between the inpatient stay and the transition to home. For those patients discharged directly from the acute care units the clinic will support patient safe and independent in the home. Visits will tailored to individual need, ranging from 1 to 6 weeks after discharge. 2) Physiotherapy and Occupational Therapy The rehabilitation clinic at The Ottawa Hospital's Riverside campus strives to provide care for post-surgical and acute patients within few days. As such, non-surgical patients, who have often lived with their pain or disability for an extended period of time, become waitlisted. There is, unfortunately, a 3+ year waitlist for patients choose to continue to wait (most often those who cannot afford a private clinic). The proposed intervention would provide each patient a comprehensive assessment, self-management education, a home exercise program, and two follow-up visits. A small number of patients may be referred internally to a specific education class (ex: back management class). The Ottawa Hospital is the provider offering post-operative and acute therapy to complex

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					hands, wrists, and upper extremities. The Occupational Therapists (Certified Hand Therapists) work very closely with the plastic and orthopaedic surgeons, hosting joint clinics to patients on their first post-op visit. Additional 1:1 rehab is provided for splitting, therapy, pain/swelling modalities, exercise prescription, and home programs. This program is in high demand and has a long waitlist, though clinically these cases should be seen quickly to maximise recovery to ensure long term independence at home. 3) Pelvic Floor Program- Outpatient Physiotherapy According to the World Health Organization, incontinence affects at least 10% of the population. There are some studies that demonstrate that 50% of women over 45 have experienced some form of incontinence. This problem also often affects men with prostate cancer and other urinary tract issues. The Ottawa Hospital Rehabilitation department (located at the Riverside campus) would like to provide a more objective assessment of the root cause of this issue, and provide clients with home based solutions to ensure exercises are being executed correctly. Using the Biomation/Femiscan system, we can track and monitor patient progress over time and provide in home training units to optimize and speed recovery. This allows the

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					patients to better be able to self-manage, while reducing the number of physiotherapy visits, decreasing the wait list and improving access to this very specialized service only offered (publicly funded) at The Ottawa Hospital. 4) Geriatric Consult Team A Geriatric Consult Team is currently operating at two of The Ottawa Hospital's campus (the General and the Civic). The team includes 1 Geriatrician, 1 Nurse Specialist, and 1 Physiotherapy Geriatric Specialist. They work with the inpatient acute care teams to quickly identify the high-risk seniors and provide comprehensive geriatric assessments and plans of care (including medical co-management, management of geriatric co-morbidities). The early identification and intervention of this team contributes to safe discharges to home. The Geriatric Consult Team supports the acute care team to send high-risk seniors home quickly, and with proper strategies for successful transition. The addition of an Occupational Therapist will improve the care offered by the team, including cognitive assessments, additional mobility/seating aid supports, etc.
Champlain	Reducing Patient Deconditioning in Hospital	Increase Capacity	1. Education	To reduce patient deconditioning in hospital and speed patient restoration	The project that aims to promote early and consistent mobilization of older patients admitted to hospital in order to prevent

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				through mobilization. This is a further implementation of the best practices of the MOVE ON program	functional decline. Mobilization shifts from being a task assigned to a single professional group to a shared team responsibility. It has been shown that without mobilization senior patients lose 1-5% of muscle strength each day in hospital. Early mobilization strategies have been shown to decrease length of stay by 1.1 days, shorten duration of delirium by 50%, and improve the return to independent functional status, decrease risk of depression, increase rates of discharges home and decrease hospital cost by $300 per day. The project costs are associated with implementation, education and evaluation.
Champlain	Transitional Care Program – Reactivation Project	Increase Access	Other	To Provide restorative care to vulnerable, mild to moderate frail elderly at risk of cognitive and functional decline, hospitalisation, long-term care admission, and/or inadequate caregiver support considering other risk factors related to social frailty such as isolation, low income, and inadequate caregiver support	The "Transitional Care Project –Reactivation Project" created a 24 bed A&R unit at the Queensway Carleton Hospital. These beds are intended to provide specialized restorative care focused on patients requiring an alternative level of care (ALC) to their highest level of independence in the community and diverting these patients away from long-term care (LTC) home placement wherever possible. The municipality of Ottawa, particularly those who live in the west, will benefit from the project. As will clients across the healthcare system in Champlain and this unit will enable systemic flow.

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SW	Provide planning resources to Huron Perth to facilitate development of a cross continuum model that encompasses assess and restore services.	Increase Capacity	Capacity Planning	Quantify and qualify the current and future availability of clinically relevant programs and services across LHIN settings and providers.	The purpose of this project is to bring hospital and community partners, many of whom are partners in the Huron Perth Health Link, together to develop a cross continuum model that clearly identifies siting of assess and restore services within the hospital and community systems. This aligns with the work of the Huron Perth Health Link.
SW	Provide funding to enable the purchase of equipment or renovations to enable safe return home	Increase Access	Home Adaptation	Purchase equipment or renovations to enable safe return home.	Retrofitting and conversion of apartments and homes to enhance accessibility to universally accessible bathrooms complete with grab bars, a walk in shower and a raised toilet; ramps and other home adaptations for identified high risk seniors with restorative potential to improve ability to remain independent in the community.
SW	Provide training dollars to enhance the ability of clinical staff to care for frail seniors.	Increase Access	Education	Enhance the ability of clinical staff to care for frail seniors	Enhance skills and knowledge of members of inter-professional teams that will allow them to deliver services to meet the ever changing needs of frail seniors. Coordinate and offer skills based and knowledge building training on patient engagement, Baycrest model of Mild Cognitive Impairment support, Montessori based approaches to care, and the health and safety of staff working with high risk seniors.
SW	Provide one-time funds to Grey Bruce Health Services to facilitate	1. Increase Access 2. Increase	1. Capacity Planning 2. Care	1. Quantify the current and future availability of clinically relevant programs and	In December, 2013, the South West LHIN Board of Directors issued an integration decision that will result in the realignment of some Complex Continuing Care (CCC) and Rehabilitation (Rehab)

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	earlier opening of Complex Continuing Care beds to enable Assess and Restore service provision in Grey Bruce.	Capacity	Coordination	services across LHIN settings and providers. 2. Increase coordination capacity through CCAC coordinated access.	beds. As part of this integration, Grey Bruce Health Services (GBHS) will be opening 10 new CCC beds at its Wiarton site. There are currently no beds of this type in the Grey Bruce region of our LHIN. The population served by these beds will include those with Assess and Restore needs as defined within the sub-acute Complex Care and Geriatric Rehabilitation levels articulated in the draft Asses and Restore policy. The South West LHIN is in the process of implementing Coordinated Access to CCC beds through the South West CCAC. The eligibility criteria encompass those with Assess and Restore care needs. The CCC/Rehab bed realignment integration involves closure of unused CCC beds in the south part of our LHIN and the opening of CCC beds in Grey Bruce. Funds will be reconciled from those hospitals that are closing unused CCC beds and allocated to GBHS to enable them to operate the beds. Based on the current timelines, funds will become available for GBHS to open beds in a staged fashion beginning November 2014. GBHS has some one-time costs such as information technology requirements, purchase of equipment associated with the addition of the beds and minor infrastructure changes and training to accommodate the additional beds. These costs would be covered through the facilitated integration funding transfers.

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					Using one-time funds available through the Ministry of Health's Assess and Restore initiative to fund GBHS's one-time costs will enable them to open the all 10 beds in August 2014, significantly ahead of the current schedule. This will bring the much needed rehabilitative care services to residents of Grey Bruce in a more timely way. People served in these beds will be those with assess and restore as well as with complex continuing care needs
SW	Provide funding for information technology software enhancements to enable e-notification tool implementation for CCAC and hospitals in Huron Perth (HPHA) and Grey Bruce (GBHS).	Increase Access	Information Sharing	Further implement Electronic Medical Records and other information-sharing technology to be used in frail seniors' circle of care (including primary care and HealthLinks providers).	eNotification gives care providers across the health care system the opportunity to fully work as a team to provide support for those who are at risk of losing function due to change in condition. This is accomplished by the electronic notification of hospital and community team members that a mutual client has sought hospital services. In more technical terms, eNotification provides hospitals with access to the CHRIS database to confirm the CCAC client status of patients when they present in the ED and will notify CCAC as they are being discharged from the ED. This is an automated query based on personal identifiers. The benefits of eNotification are that it will allow the CCAC to cancel scheduled Client in-home appointments based on their presence in hospital, hospital staff may make different care planning decisions knowing the patient has supports already in the community and

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					community caregivers will know that their client has had a change in condition requiring an emergency visit and/or a hospital admission. This tool will assist providers with identifying those frail seniors whose status has changed and who can benefit from assess and restore services. Early identification of status changes means that changes to services can be provided to meet the changed needs of the client. In doing this, it can assist in preventing unnecessary acute care admissions. Implementation has been in partnership with the OACCAC, the SW CCAC, and the hospitals. It is built for Cerner South and is successfully operating at LHSC and STEGH with plans to implement at other hospitals on the Cerner South platform as opportunities arise during the HUGO implementation. Planning is underway to fully implement eNotification in Cerner North (Grey Bruce) and Meditech (Huron Perth) with outgoing messages from hospital expected to be implemented by March 31/14 and incoming messages to hospital by end of Q2 14/15. Timelines for implementation at all Cerner South Hospitals is being finalized.
Central	Assess & Restore	Increase Capacity	Home Adaptation	To purchase equipment or renovations to enable safe return home	

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Central	Assess & Restore	Increase Capacity	In-home Rehab	Increase volume of short term in home rehab therapy services to assist patients, post hospitalization, achieve a level of independence in their mobility for a new level of self-management, improve mobility and ADL, and teach appropriate mobility and/or transfer techniques to caregivers.	
CE	Enhancement of physiotherapy	Increase Capacity	Ambulatory Rehab	To enable physiotherapy services on the weekend to provide 7 day a week therapy for high risk populations during seasonal surge Jan - March	Capitalizing on the *Essential Elements of Assess and Restore Framework*, *Ontario's Senior Strategy* and the Draft work in progress at the Rehabilitative Care Alliance, specifically the work stemming from the Frail Senior/Medically Complex Task Group and the Definitions Task Group, this proposed pilot aims to focus on patients along their continuing of care during hospitalization to: • Reduce the rate of deconditioning for medically unstable patients who are frail seniors • Provide interventions when the patient is ready, regardless of the bed in which they occupy should the patient have restorative potential. The Physiotherapist, Rehabilitation Assistant and

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					Occupational Therapist, GEM will have added hours to cover evenings and weekends, social work and part time clinical pharmacist who will work in collaboration with existing inter-professional teams.
CE	Interprofessional Team	Increase Access	Care Coordination	Comprehensive gerontological assessment and interventions will be provided by a Nurse Practitioner (NP) led Inter-professional team who possess the required clinical competencies in gerontology. The Assess and Restore model will be an extension of the Restorative foundation which focuses on restoring, and is crucial to our ALC strategy. This model will be integrated into the Emergency Department, and the Geriatric Emergency Management (GEM) nurse practice	Through the development of an expert Inter-professional team on the Restorative Care Unit, comprehensive gerontological assessments and corresponding interventions will guide the plan of care to meet the unique needs of this complex, at-risk patient population. The main focus in addressing this complexity consists of: (1) The immediate health need (from the person and/or caregiver perspective) and (2) The underlying gerontological needs The focus, aforementioned, is known within gerontology 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. This new model will provide efficiencies in concentrated gerontological care that reflects the depth and breadth of the specialty of gerontology. Comprehensive gerontological assessment and interventions will be provided by

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					a Nurse Practitioner (NP) lead Inter-professional team who possess the required clinical competencies in gerontology. The clinical practice content (interventions) will focus on the gerontological syndromes which are known to be the contributing factors to frailty. In gerontology these individuals present with medical conditions; their health status and quality of life are affected by geriatric syndromes.
CE	World of Gerontology Workshop	Increase Capacity	Education	World of Gerontology is a two day program that provides education and discussion of the norms of gerontology best practices. The workshops are provided by point of care staff with the expertise in Gerontology and are having a positive impact on the care provided to seniors.	The Assess and Restore model will result in targeted and timely interventions to restore loss of function in frail seniors, reduce further functional decline, reduce readmission of the complex, frail/pre-frail population, decrease caregiver burden, decrease use of LTC, and direct admission from the Emergency Department to the least deconditioning environment of Post-Acute Care, as opposed to Acute Care. Foundation work in gerontology for the Assess and Restore model includes: (1) Staff participation in World of Gerontology Workshops (2) Education for support staff in gerontology and responsive behaviors

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CE	Interprofessional Team	Increase Access	Care Coordination	Assess and Restore Team responsible for early identification of frail seniors 'at risk' for loss of independence through early assessment and focussed restorative interventions to reduce the risk of deterioration	• Referrals to be received via GEM, ED teams and through screening by the assess and restore team of the ED Census of admitted patients • Case load of the assess and restore team will be flexible depending on the required amount of interventions required by the patients on the roster. Interventions by the assess and restore team are not to take the place of regular patient care by the inpatient team. • Minutes of care to be recorded for the purposes of evaluating future need in such a program • The Assess and Restore Team will operate at the site, where 65% of the ED visits of patients 65 years old and over occur. Potential for future roll out across all sites.
CE	Patient Navigator	Increase Access	Care Coordination	The navigator will focus on acute, complex medicine patients that have had a least 2 previous visit within the last 6 months and are greater than 65. The navigator role at LH will focus on the continuum of the patient's journey – from arrival in the	An electronic flag will identify patients at registration at all ED sites at LH. This flag will notify the navigator of a patient's arrival and thus trigger the process for connecting with a patient/family and the inter-professional team to start early development of a care plan. The addition of 2 RN's to cover all three sites including weekends will allow the team to assess

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				ED to supporting connections within 72 hour post discharge.	the appropriate care provider that would best support system navigation for these complex patients and will ensure we optimize our ability to avoid duplication in services and care being provided for future planning. Connecting with a patient on arrival in the ED will allow the navigator to participate in daily huddles and connections with established resources in ED and determine care needs from the inter-professional team's perspective. As the starting point for communication related to possible admission avoidance, care planning early in an admission and notification of an identified family physician that a patient has been assessed in the ED will create a foundation for the next steps in the patient journey. This communication will continue as a patient moves to an inpatient setting to ensure continued development of a care plan, focused on patient needs.
CE	Enhancement of physiotherapy	Increase Capacity	Ambulatory Rehab	To improve care transitions for ACE patients to discharge home. These care transitions include the coordination of care at the point of discharge, navigating support to enable patients to successfully	The introduction of a community based ambulatory rehab service enables the continuity of an Assess and Restore model between hospital and home for our most frail seniors. This is an opportunity to expand upon collaborative relationships within the community including specialized ambulatory rehab providers

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				follow-up and manage their care in the community, and the opportunity to build capacity in collaboration with primary care to support continuity of care. The model will also see an expansion of OP physio and occupational therapy services for the targeted population, which will in turn improve patient flow through the Acute Care for the Elderly (ACE) unit	(i.e. Providence HealthCare) and community support service providers (i.e. Carefirst) in junction with acute care hospital based services (i.e. ACE unit, GAIN clinics and virtual ward follow-up). The link with community based services better integrates with the essential functional, cognitive and social elements of care to keep seniors at home (i.e. congregate dining, day programs, meals on wheels). The Assess and Restore service models would promote flow between hospital and home by extending the rehab philosophy of care to continued care into the community. The primary target is to increase the number of patients discharged home again by funding a concentrated allocation of therapy resources (OTA/PTA) to support increasing ACE patient volumes and supporting an integrated community based ambulatory rehab at Carefirst within the adult day program. As ACE patients are referred to GAIN upon discharge, this would allow for a link to community based services for the ongoing geriatric case management from the GAIN community based team offering seniors a "full service plan" upon discharge. This would in turn enable flow through the ACE unit allowing for access to other patients requiring the service and diverting ALC .

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CE	Enhancement of physiotherapy	Increase Capacity	Ambulatory Rehab	Extend Rehabilitation Assistant coverage on weekend for the coverage of the walking program	• Increase patient access in acute and post-acute care to the existing walking program. • Maintain patient functional gains over the weekend and reduce functional decline • Increased weekend therapy staffing by one rehabilitation assistant dedicated to a walking program for all eligible patients in acute and post-acute care.
CE	Gerontologial Capacity	Increase Capacity	Education	Explore, develop and implement program format and interprofessional care path for "3 Moments of Mobility"	• Therapy led project related to inter-professional practice that supports 3 moments of purposeful activity per day per patient- (geared to patients over the age of 65)
CE	Gerontologial Capacity	Increase Capacity	Education	Explore, develop and implement program format and interprofessional care path for "3 Moments of Mobility"	Same as above
CE	Enhancement of physiotherapy	Increase Capacity	Ambulatory Rehab	To enable physiotherapy services on the weekend to provide 7 day a week therapy for high risk populations during seasonal surge Jan - March	Typically during the months of Dec- April, hospitals typically have seasonal surges in volumes. The Intended outcome for individuals will be to decrease the risk of the iatrogenic effects of hospitalization and decrease the risk of need for LTC placement due to hospital acquired deconditioning.

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					The intended outcome for the system is to expedite discharges from hospital to the community so that hospital resources can be freed up and re-purposed for A&R care.
CE	Enhancement of physiotherapy	Increase Capacity	Ambulatory Rehab	To enable physiotherapy services on the weekend to provide 7 day a week therapy for high risk populations during seasonal surge Jan - March	Same as above
CW	Home Independence Program	Increase Capacity	Inhome Rehab	Increase volumes of short-term in-home rehab therapy services	
CW	Assess and Restore Unit Physiotherapy Equipment	Increase Capacity	Other	To improve the delivery of rehabilitation therapy to patients on the Assess and Restore unit with the goal of improving patient function and decreasing length of stay.	
CW	Assess and Restore Care Coordinator	Increase Access	Care Coordination	The goal is to maximize patient accessibility to services and minimize duplication through streamlined handoffs among specialists, primary care and	

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				hospitals.	
CW	Assess and Restore Patient Care Equipment	Increase Capacity	Other	To improve care for frail elderly patients on the Assess and Restore unit (STAR) with the goal of improving patient function and decreasing length of stay.	
ESC	Assess Restore Chatham Kent Health Alliance	1. Maintain Capacity 2. Increase Access	Other	1. One time capacity sustainability and increased in unit rehabilitation services for functional capacity maintenance and home adaption. 2. The project utilizes existing Complex Continuing Care Capacity (of approximately 10 beds) and creates an enhanced restorative environment for frail seniors in the Chatham Kent area.	The funding supported the Chatham-Kent Health Alliance during the closure of their Assess-Restore beds. The funding was to help to extend the operations during a transitional period.

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MH	Enhanced Service Delivery for complex Assess and Restore	1. Increase Access 2. Increase Capacity	Other	1. Increase services available to those clients who would benefit from and A&R program 2. Increase access by increasing the level of service delivery and decrease their length of stay in the program which will increase flow and allow for more clients to be served and minimize the wait list	"Enhanced Service Delivery for Complex Assess and Restore Clients": *To increase services available (speech language pathology, a kinesiologist, nutritional education and support, and increased social worker hours) to those senior clients who would benefit from and A&R program "Enhanced Rehabilitation for Stroke Senior Patients to Support Community Transition": opportunity to work towards achieving the best practices outlined by the Stroke Network through the addition of PT, OT, and Speech Pathology resources. With increasing numbers of stroke patients in a constrained bed environment, service augmentation, to facilitate earlier transition is critical. Working to augment the rehabilitative care process for these patients an enhanced team of PT, OT and Speech will facilitate the restorative care and successful transition to the community earlier with ongoing support in an ambulatory environment. Based on best practice as outlined and identified by the GTA Stroke Network "Early Discharge and Enhanced Service (Assess & Restore)": To provide increased supports and services in the community that will assist patients who are waiting in hospital for assess

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					and restore rehab, convalescent care programming, and/or individuals that would benefit from early discharge from hospital and require an assess and restore rehabilitation approach . This will reduce the length of stay in hospitals, influence the hospitals ability to reduce ALC rates, reduce the current wait list for A & R programming in the community and reinforce a Home First philosophy.
MH	Home Adaptation for Independence Program	Increase Capacity	Home Adaptation	Enable the resident to regain their independence to return home from an A&R program, through physical space adaptation	Funding for Home Adaptation for Assess and Restore clients": Support the purchase of assistive devices and rehabilitative aids to support a safe and early transition from the CCU to home
NE	"Assess and Restore Philosophy – Bringing it to the Frontline"	Increase Capacity	Education	Demonstrated maintained/improved level of independence and function for clients	The provision of education specific to: care of the elderly, prevention of functional decline and general approaches to rehabilitative/restorative care to front line personal support workers. The Center for Activity and Aging will provide workshops for front line staff utilizing a train the trainer model. Specifically the "Home Support Exercise Program" provides training so that PSW's can train an individual in ten simple exercises that will promote flexibility and mobility - this could easily be incorporated into care plans for patients.

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NE	Timely Home Assessment and Support for Mobility and Adaptive Aids	Increase Capacity	Home Adaptation	To undertake a client assessment in a timely fashion to determine need for equipment and/or home modification/adaptation	Increased number of patients served and in-home visits for seniors referred to PT or OT at the NE CCAC (for assessment of home modifications, adaptive equipment, increased safety and functional abilities at home). Increase in the funding provided directly to patients for the one-time purchases of adaptive equipment or home modifications determined through the assessments..
NE	"Chapleau Health Services- BSO Training "	Increase Capacity	1. Education 2. Capacity Planning 3. Care Coordination	To provide BSO training to staff in order to build capacity in small hospitals.	Provide BSO training (PIECES and Gentle Persuasion) to all SSCHS front line staff who have direct interactions with seniors within their 19 ELDCAP, 6 Complex Continuing Care, and 14 acute beds. The training will also incorporate the opportunity to conduct full assessments on ELDCAP and CCC residents in order to incorporate BSO techniques into their care plan
NE	"In-Home Restorative Care"	Increase Capacity	1. Inhome Rehab 2. Education	1. Decreased number of falls 2. Improved balance 3. Decreased number of 911 calls for assistance	An in-home Rehab/Exercise program will be delivered to residents of this Assisted Living facility. The target population will be those who have been discharged from hospital and would benefit from in-home assistance to improve function.

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NE	"Short Term Assessment & Treatment (STAT) Enhancement" (equipment)	Increase Capacity	Ambulatory Rehab	1. Expedite discharge from hospital to community and reduce LOS 2. Demonstrated improvement in patient's functional potential 3. Increase clinic volumes related to improved access for the frail senior	Seniors need assistance with accessing the exam table and a low adjustable barrier free power exam table would accommodate the frail elderly adults being served by this program. *** This project has been provided additional funding: The Consultation for Older Adults with Compromised Health (COACH) Team at HSN is instrumental in implementing the 48/5 research project. One of the main goals of the project is to educate and train front line staff and physicians to recognize and address common problems that affect the outcomes of older adults in the acute care setting. The 48/5 model includes a geriatric focused assessment of medications, mobility, bowel/bladder, nutrition/hydration and cognition. The absence of bladder scanners available on all units poses a significant barrier to the COACH team in their efforts to support staff and physicians in changing their current practice; therefore bladder scanners will be purchased for various units.

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NE	"Short Term Assessment & Treatment (STAT) Team Enhancement" (resources)	Increase Capacity	Ambulatory Rehab	1. Frail seniors referred to the clinic will be engaged and risk for social isolation and depression minimized 2. Safety and independence will be maximized for frail elderly when accessing community services	This initiative would enhance the interdisciplinary STAT team by adding the resources of a Recreation Therapist to build capacity and develop linkages with existing community partners, i.e. YMCA, Park Side Centre/Seniors Programs, ICAN, MOD, VON day program, Stand up Exercise Classes etc. Providing integration into community activities will increase their quality of life and social integration as well as maintain their current physical and cognitive abilities.
NE	"Screening Tool for Restorative Care Potential"	Increase Access	Care Coordination	1. Development of a screening tool designed to evaluate for 'restorative' potential of high risk community dwelling seniors 2. Integration of this tool into existing community assessments completed by CCAC and CSS staff in select areas e.g. assisted living	The purpose of this project would be to pilot the use of a draft screening tool designed to evaluate the 'restorative' potential of high risk community dwelling seniors in the North East. The pilot would start in Sudbury and may expand to other districts if appropriate.

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
NE	Assess and Restore Philosophy – Bringing it to the Frontline - Curriculum Development for Future Regional Education and Knowledge Transfer"	Increase Capacity	Care Coordination	Development of a curriculum based on best practices which is specific to elder care, the fundamentals of rehabilitative/restorative care and the prevention of functional decline	Project on hold and will not be completed with A & R funding at this time.
NE	"Increasing Capacity and Enhancing Transitions Through Knowledge"	Increase Capacity	1. Education 2. Care Coordination	1. To Enhance the ability of clinical staff to care for frail seniors through knowledge uptake (RN, RPN, PSW, Allied Health, Activity Therapy) including increased risks of hospitalization and immobility and interventions to mitigate 2. Work with new A & R Team, Multidisciplinary Geriatric Clinic/NESGS to develop standardized tools and A & R care plans for frail elderly patients which will result in increased care coordination capacity (this could include care plans, pathways and/or order sets)	Many of the staff on the work team were those who previously attended Restorative Care training in March 2013; this project is allowing them to continue use of the elements learned in that training to further design exercise programs and initiatives to promote mobility. Activities include audits, tool development/adoption, mobility aid purchases, education of staff etc

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
NE	"Improving Functional Outcomes in the Frail Elderly"	Increase Access	Other	To add PSW resources to the interdisciplinary restorative care team to achieve 7day/week supportive care for patients with restorative potential to determine impact on outcomes	Adding resources to provide active therapy, exercise and walking program would assist in a timely recovery and potentially decrease LOS. This short term pilot project could assist in developing a framework to enhance the assess and restore philosophy and culture at TDH.
NE	"Improving Mobility in ICU in the first 24/48 hours"	Increase Access	Other	To purchase a portable ventilator which will allow us to mobilize frail elderly medically unstable and complex vented patients	To increase mobility in patients that are admitted to ICU and are on a ventilator. The hospital does not currently have a portable ventilator which impedes the ability of staff to mobilize patients and reduce functional decline.
NE	"Expansion of Hospital Activity Program"	Increase Access	Other	To increase resources in the Activities Program to enhance restorative care programming.	Increase the hours of the Activity Coordinator to facilitate an enhancement and expansion to the Activity Program. Daily exercise programs and structured walking programs will be offered to all seniors benefiting from restorative care.
NE	"Knowledge Transfer Regarding Best Practices in Geriatric Care "	Increase Capacity	Education	1. 100% of Activity Staff will receive training in best practices in the care of geriatric patients 2. Demonstrated competencies in care of the frail elderly 3. Measure of staff satisfaction with the	Staff have participated in a recognized educational program (CCAA) in order to champion the program's targets and promote increased functional activities

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
				education and training in March 2014	
NE	"Knowledge Enhancement & Standardization of Care"	Increase Capacity	Education	1. Consistent application of assessment tools 2. Earlier identification of frail elderly population at risk and opportunity for early intervention 3. Reduced incidence of functional decline	Education on standardized risk assessment screening tool such as the TORBSST dysphagia screen, the CAM delirium screen, and the Mini Cog dementia screen will improve early identification.
NE	"Meeting the Needs of Bariatric Geriatric Patients"	Increase Capacity	Other	1. To purchase Bariatric equipment which will improve access to quality standardized care which is otherwise often inaccessible to the bariatric frail elderly due to equipment limitations	Bariatric equipment will allow standardization of care for all patients. A bladder scanner will enhance early risk identification by providing a standardized assessment tool.

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
NSM	Waitlist reduction for ambulatory rehab services at home	Increase Capacity	Ambulatory Rehab	Increase access / volumes of community rehab services for seniors by managing current wait lists between January and March 31/14.	
NSM	Convalescent Care Program (CCP) Education / eLearning	Increase Capacity	Education	To augment and enhance the ability, skills and knowledge of convalescent care clinical staff to care for frail seniors / target population.	
NSM	Convalescent Care Program (CCP) Equipment	Increase Capacity	Home Adaptation	To purchase equipment in order to expand capacity for the provision of restorative care to clients in convalescent care beds prior to their return home	Equipment needs were identified by our "facility-based assess and restore" providers to address barriers to admission, or expand their capacity to provide rehabilitative care to frail seniors with high restorative potential.
NSM	Community Restorative Care Equipment & Education - Outpatient Care & Community Health Centre	Increase Capacity	1. Education 2. Adaptation	To purchase equipment and/or provide training in order to expand capacity for the provision of restorative care to seniors requiring outpatient or community rehab services to maintain functioning level for independence in their home.	Equipment needs were identified by our "facility-based assess and restore" providers to address barriers to admission, or expand their capacity to provide rehabilitative care to frail seniors with high restorative potential.

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
NW	Enhanced Inpatient Rehabilitation Services at Thunder Bay Regional Health Sciences Centre	Increase access	Education & Capacity Planning	The purpose of the project is to identify and provide additional therapies and psychosocial supports for rail elderly patients, which are aimed at facilitating the patient's discharge home and reducing admissions to long-term care.	One rehab assistant will be added to each medical and surgical unit and the ED 7 days per week to provide timely assessment and treatment to patients identified as "frail" by the clinical team. An additional social worker will provide services to patients and families.
TC	Health Links - Community based rehabilitative care	Increase Capacity	Ambulatory Rehab	Expand the capacity of programs providing community based A&R interventions	1. Collaboration between CHC, Geriatric Day Hospital and RGP to develop in home exercise coaching enabled by telehealth 2. CHC led in home fitness program post bedded rehabilitative care
TC	Hospital based Ambulatory Care	Increase Capacity	Ambulatory Rehab	Increase volumes of clinic based rehabilitation services provided by hospital outpatient dept	Early start of several planned 14/15 programs: - Ambulatory Rehabilitation Improvement Project; - two new out-patient clinics for frail elderly; Extended pilot program for geriatric service for patients flagged in ED. Increased inter-professional capacity in specialized geriatric and mental health community outreach programs.
TC	Staff Education	Increase Capacity	Education	Enhance the ability of clinical staff to take care of frail seniors	Concentrated educational program re: cognitive frail seniors in a rehabilitation hospital.

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
TC	System Capacity Planning	Increase Capacity	Capacity Planning	Quantify the current and future availability of clinically relevant services across LHIN settings and providers	Note: utilized TC LHIN funding for this initiative.
TC	System Capacity Planning	Increase Capacity	Capacity Planning	Quantify the current and future availability of clinically relevant services across LHIN settings and providers	
WW	Assessment Urgency Algorithm (AUA) Pilot	Access	Care Coordination	Fewer repeat ED visits for complex patients and more residents being able to remain independent in the community	A coordinated initiative that will support providers in the ED to adopt the use of a standardized screening tool – Assessment Urgency Algorithm (AUA) that will identify seniors at risk of frailty. After seniors have been identified, providers will be supported to connect these at risk patients with appropriate services.
WW	Community Referral by Emergency Medical Services (CREMS) Pilot	Access	Information sharing/care coordination	Reduction in the number of EMS calls, number of falls, number of ED visits and number of hospitalizations among the most frail seniors in our community.	Community Referral by Emergency Medical Services (CREMS) – The intent of this initiative is to build the expertise, education, and information management infrastructure to more effectively connect residents accessing emergency medical services with the appropriate health service providers in Waterloo Wellington LHIN.

LHIN	Project Title	Project Category	Project Type	Project Goal	Brief Description of Initiative(s)
WW	Easy Coordinated Access (ECA) Expansion	Access	Care Coordination	Frail adults with restorative potential and functional goals will be supported to access the system at the most appropriate point.	Expansion of the Easy coordinated access process and appointment sharing to include more services that would support frail seniors in the community. This will allow providers to identify, select and book services for frail seniors, easily, either on the web or by a single referral form.
WW	Staff Development and Capacity Building.	Capacity	Education	To train approximately 500 front-line staff in Waterloo Wellington related to the principles of assess and restore.	This plan will include training sessions (and associated backfill costs) for staff that are involved in implementing the rehab care pathways in a number of care settings, including hospital and community. Training is being offered in a variety of formats (web-based, in person, etc.)