This document provides a high level description of the Assess and Restore initiatives that were completed in each LHIN with 2014/15 Assess and Restore funding. This summary was developed as a repository of information about the Assess and Restore initiatives in order to support knowledge translation. Note: Responses have been included where provided.

## Summary of Key Messages and Lessons Learned

- 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 the potential to:
    - reduce functional decline in hospital
    - reduce LOS/expedite discharge to the community
    - decreases their rate of conversion to ALC
    - reduce premature institutionalization/LTC demand
    - reduce return visits to the ED or readmissions to hospital
- The frail elderly populations that can benefit from assess and restore programs and interventions can be identified using the AUA. The AUA, embedded within existing standard assessments tools (e.g. InterRAI-CA, CHA), can be leveraged to support earlier identification of the target population.
- Intensive in-home, community or ambulatory outpatient 'Assess and Restore' services targeted at high risk, frail seniors who are being discharged from the hospital (i.e. ED, acute care or inpatient rehabilitative care) achieve the purpose of replacing the need for and/or facilitating discharge from more intensive acute-care or inpatient rehabilitative care.
- Assess and Restore services are most effective and sustainable when designed with a community-wide approach capitalizing on the variable resources in each community and focusing on the specific needs of the local target population in the context of local service gaps. Creativity is required in designing and implementing Assess and Restore service for people who live hours away from where the services are available.
- Competency of staff with specific expertise and training in geriatrics is a crucial component and requires ongoing building of capacity
- Change management principles are key including:
    - Defining governance and project scope
    - Effective evaluation that is defined collaboratively with stakeholders prior to implementation.

    - Communication, engagement and education to primary care and other front line providers is required
    - Clear link to the integration of Assess & Restore with other system initiatives (E.g. Senior Friendly Hospitals, GAIN, GEM)
- Connecting with the RCA and other LHINs assisted to frame the project and introduced approaches that could be leveraged
- Sustainability requires ongoing opportunities for capacity planning, capability building and knowledge transfer

| LHIN | Project Title | A&R Project Type | Project Goal | Brief Description of Initiative(s) | Lessons Learned/Key Messages |
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| 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 model. | The SMART team develops and provides an intensive restorative program that targets the patient's specific recovery needs with the goal of earlier discharge home with or without supports.<br>The interventions would be provided to patients in their current location i.e., ED or acute care with the exception of individuals admitted to a restorative or rehabilitation bed.<br>Identification of OT/PT as key disciplines for the SMART model. Interdisciplinary resources within each organization were identified to support the SMART model seven days a week. Early screening occurs within 24 hours and the SMART program is implemented within 48 hours. Targeted individuals who require acute medical intervention as well as rehab care in parallel. The Barthel ADL Index was adopted as a clinical outcome measure.<br>Developed common education and training power point related to the A&R guideline and the SMART model of care for the HNHB LHIN SMART Leads. | For seniors who are high risk, the SMART should be a standard of care provided where ever the individual is in the hospital i.e. ED/Acute<br>A mobile A&R model has the potential to reduce functional decline<br>Most effective when targeted to a specific unit i.e. ED or select medical units<br>Identified top 20 SMART common case mixed groups (CMGs) from 13/14.<br>SMART decision tree priority initiative algorithm developed to align with the work of the RCA related to admission to bedded level of care.<br>The model is very transferable due to collaboration with the MOHLTC, RCA, LHINS, and with HSPs to ensure alignment with screening, assessment, education and training.<br>Collaborated with other LHINS re: common metrics (number of seniors who are frail served, discharge destination, ALC to post-acute rehabilitative care and number of |

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| | | | | | referrals to post-acute rehabilitative care). |
| SE | Implementation of bedded level of restorative care at Providence Care | Interventions – Enhanced Service Delivery | To implement a new restorative care program at Providence Care, St. Mary's of the Lake site. | The program began with 2 beds and was fully operational at 14 beds as of April 1st, 2014. The program provides A&R model of care by an inter-professional team including geriatricians, PT, OT, SLP , SW and experts in care of the elderly nursing. The admission criteria was established to meet the person at risk of losing their independence, able to tolerate short periods of rehab and able to participate to some degree. The program was integrated onto the same unit with the already established Seniors Rehabilitation program to allow for seamless care. Clinical outcome measures were established to evaluate the functional and system gains (e.g., Discharge destinations include 53% returning home, 11% into LTC and 7% actually transferring into acute rehab due to their positive gains. To implement this program additional therapies and | The absence of capacity analysis and projections relating to A&R services presents some challenges to the optimal allocation of resources.<br>For many high-risk seniors in the hospital setting, the availability of an appropriate mix of restorative care services facilitates an expedited discharge to the community and decreases their rate of conversion to ALC.<br>A region-wide strategy on A&R needs to be developed – there is a need to emphasize systematic vs. transitory solutions. |

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| | | | | nursing were required. Internal efficiencies were identified that supported a small budget to provide additional staffing resources (.6 FTE PT, .5 FTE OT, 1FTE Rehab Assistant, and .5 FTE RPN). This program has been nominated for the Change Institute's 20 Faces of Change of award due to its great success in both patient and system outcomes. | |
| SE | Enhancing the restorative program 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 function. | The Restorative Care Program at Brockville General Hospital provides:<br>• An inter-professional and individualized care plan aimed at functional improvement over an extended period of time<br>• Evidence-based delivery of assessments, treatments and therapies in accordance with best practices<br>The goal is to maximize functional abilities/status and reduce burden and prepare for transition to another program or to the community/home<br>The use of specific criteria for admission, a length of stay target, a clear plan of care with specific goals, and a discharge plan with home as the primary discharge site where | The Restorative Care program has become a valuable asset in assisting frail elderly hospital patients to return to their homes. Sometimes patients who would not be able to return home safely from acute care can now be provided with additional therapies in hospital to optimize their independence and then enable them to be re-evaluated for a return to home.<br>The program is designed to change the approach to caring for patients who are at risk of becoming ALC patients. ALC patients no longer need acute hospital care but until now have had no option but to wait in hospital for another care destination that could meet their needs, typically a Long-Term Care |

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| | | | | feasible. | Home. |
| SE | Client Management System (CNS) upgrade for regional CSS initiative to enhance assessment and information sharing capabilities | Screening – Screening Tool Adoption<br>Assessment – Assessment Tool Adoption | Nesda Vault is the electronic client management program that is used by the Regional Care Coordinator (RCC) program in the SE LHIN. The main purpose of the tool is to provide a conduit for information between the RCC and the CSS agencies that provide services to clients. | The upgrade includes the following:<br>1. Incorporate the InterRAI Preliminary Screener with the Assessment Urgency Algorithm (AUA)<br>2. Include MAPLe, Caregiver Stress Index (CSI) Assessments<br>3. InterRAI CHA Integration<br>4. Enable the sharing of client records with other Health Service Providers in the circle of care through a secure web-based portal (primary healthcare, CCAC, SMILE, CHS, CNIB, etc.)<br>This project will enable the RCCs to identify high-risk seniors in the community setting. There is a subset of questions in the InterRAI CHA that is able to accurately predict restorative potential in high-risk seniors. The integration of the InterRAI CHA within the Nesda Vault environment will enable the Health Service Provider to flag these clients. The web-based portal will enhance the sharing of relevant client information and will begin to address asymmetries in this regard. | The development (and acceptance) of privacy agreements is a key piece. The change management piece associated with the development and acceptance of privacy agreements presents some challenges. |

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| CHAM | Assessments and Assessment Tool Adoption in Champlain – Part 1 | Assessment – Assessment Tool Adoption<br>Interventions – Enhanced Service Delivery | To establish a comprehensive assessment program in Champlain to identify and target interventions for high-risk frail seniors with restorative potential. | Leveraged learnings and knowledge from the WW LHIN AUA project in order to determine the feasibility of the adoption of the AUA screening tool in Champlain through working with partners such as the Champlain CCAC and the RGP. Reviewed data profiles of the Champlain CCAC population by AUA category, referral source, care need and outcome. Developed feasibility plan for the implementation of the AUA Tool across Champlain including, education and training. Worked with the RGP on the "Transitions of Care" project to coordinate efforts and expertise and reduce duplication of project efforts. Participated in provincial AUA education session. | The frail elderly populations that can benefit from assess and restore programs and interventions can be identified using the AUA applied to InterRAI assessments in the CCAC database. These analyses were applied to all clients with InterRAI – CA assessments completed in 2014 and were over the age of 65. Further analysis identified the AUA score by several categories, such as service needs, age range, and also compared them to Rehab score. The AUA screening tool can be fully rolled out in areas such as CCAC, RGP/GEM, CSS, and in Primary Care. |
| CHAM | Assessments and Assessment Tool Adoption in Champlain – Part 2 | Assessment – Formal Partnerships | To address the volume build up in the Geriatric Assessment programs and improve access for rural frail at-risk seniors to these services. | The project enhanced the capacity of the rural Geriatric Assessment (GA) program to identify more frail at-risk seniors in the rural community, in order to better understand their care needs, create a care plan and enable them to be appropriately directed to the most suitable restorative interventions. | |

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| CHAM | Assessments and Assessment Tool Adoption in Champlain – Part 3 | Interventions – Enhanced Service Delivery | To enhance the service delivery of, and expand access to, the Geriatric Emergency Management (GEM) program at rural hospitals. | The A&R initiative has been used to support the optimization of current GEM processes and practises, detailed analysis of data and lessons learned to date and the development of potential models that will specifically address the needs and realities of rural hospitals, so that sustainable access can be implemented in these facilities. The RGP and Carleton Place Hospital are implementing a 6 month demonstration project that combines the roles of the GEM Nurse and Geriatric Assessor. During the project, the GEM Nurse will replace the current screening tool with the AUA, providing opportunity to test in the AUA is able to effectively identify high risk seniors in a rural ED environment. Clinical pathways that are specific to the available services in the community of Carleton Place are being developed. The model supports diverting high risk seniors from unnecessary hospitalization through a partnership with a “Care of the Elderly Family Physician” who hosts clinics every two weeks. | The GEM program has reduced incomplete or inaccurate assessments, missed diagnoses, functional decline, premature institutionalization and return visits to the ED or readmissions to hospital. There is capacity building and knowledge transfer capabilities from the GEM program and the learnings can be expanded to other regions. |

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| CHAM | Clinical Patient Flow Algorithm from Acute to Sub-Acute Care | Navigation & Placement – Formal Partnerships | To improve the efficiency of patient transition from the Ottawa Hospital acute care to sub-acute beds at Bruyere Continuing Care and the Ottawa Hospital. | The project enabled the expansion of the Clinical Pathway Flow Algorithm through the addition of two health professionals at the Ottawa Hospital General campus site. 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 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. | Expansion of the Patient Flow program using the physician algorithm was successful and had excellent feedback from stakeholders. This process improved transitions of care through speeding up the process for patients to move the appropriate sub-acute Rehab and CCC destinations. This model can be expanded and learnings leveraged to other acute care facilities in the region to similarly improve the efficiency of placement of high risk seniors with restorative potential into sub-acute facilities. This will have a positive effect on the number of days patients wait in acute care facilities when they can be better cared for in another setting (ALC). |
| CHAM | Rural Assess and Restore in Champlain LHIN | Interventions – Best Practices Adoption | To complete a feasibility study for the implementation of Assess and Restore programs and best practices on behalf of the eight small rural hospitals and their community partners in rural Champlain. | The scope of the project included setting up a steering committee, hiring and external consultation to:<br>1. Provide overall project management<br>2. Determine the feasibility of proceeding with an inpatient and/or outpatient A&R approach among the rural hospitals | In smaller, rural hospitals it is critical to take a community-wide approach capitalizing on the role of these hospitals as a community hub.<br>Due to the variability of resources across communities, focus on the specific needs of potential users of an Assess and Restore program, and design the program based on the |

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| | | | | 3. Explore A&R options for rural communities and develop recommendations for moving forward.<br>4. Document findings in a report for the Champlain LHIN and Champlain Alliance of Small Hospitals<br>5. Complete a feasibility study that includes an understanding of the need of a Rural Assess and Restore approach (through best practice literature review and a survey of key stakeholders) and the design of a patient-centered integrated service delivery model to avoid adverse outcomes among at-risk populations. | gaps in the community.<br>Outpatient A&R programs do not necessarily need to occur at the hospital.<br>Involvement and collaboration of physicians in both the community and hospital will be essential for implementation.<br>Creativity in designing and implementing the program for people who are living hours away from where the program is offered. Design the evaluation collaboratively with stakeholders prior to implementation.<br>Identifying and securing resources needs to be addressed due to the small size of communities.<br>Training and change management support will be essential in order to clarify roles, assist care givers to have effective conversations with patients and families.<br>Design the model to ensure people can have access without going through the hospital. |

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| CHAM | Enhanced Rehab in Champlain | Interventions – Enhanced Service Delivery | To provide timely and appropriate access to programs such PT, OT, and Oncology Rehab for frail seniors. | These programs were provided in the Ottawa area and addressed long chronic waitlists for OT and PT services, and increased the capacity to provide rehab for oncology patients, which benefitted patients across the Champlain region. Outpatient hand therapy and PT resources were added to service additional patients and reduce waitlists. Services provided to at-risk seniors included comprehensive assessments, developing at-home programs, self-management education, and follow-up visits. A review of Oncology rehab capacity in the literature and at other centers was completed. A needs assessment was completed to determine what is required to increase the capacity and knowledge of the Short-Term Rehab team for Oncology Rehab. Based on the findings, educational sessions were prepared and completed and a repository of community resources was also compiled to support the needs of oncology patients that are available for staff. | The learnings from the enhancement of oncology rehab can be leveraged to other sites and facilities in Champlain. Educational sessions can be replicated and community background resources can be disseminated to better support the restoration of functionality of high risk frail seniors. |

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| CHAM | Transitions of Care | Transitions Home – Transitions of Care | To improve linkages, coordination and standardization protocols for the transition of high-risk elderly patients from acute care to community based services. For the first year, the goal was to determine capacity and resources necessary to implement Comprehensive Care for Seniors through care services such as Adult Day Programs, Hospital Day Programs, Assisted Living Services, CCAC services, CSS programs, and others. | The following recommendations were identified:<br>High risk seniors will be identified by CSS, CCAC< Primary Care, and GEM nurses using clinical judgement and decision making and/or the AUA. As part of the clinical pathway development, a map of specialized geriatric services across Champlain will be created including the CSS. Based on the AUA score, the patient can be referred to SGS or Primary Care. The AUA will be introduced into the primary care teams that have been implemented with the Dementia Care strategy and the Falls Prevention Strategy to build screening capacity. Adult Day programs can be strengthened to provide additional restorative care to fail high-risk seniors. Close collaboration and alignment with the Dementia Care and the Falls Prevention strategies will continue to offer continuum of care options for fail seniors with restorative potential in Champlain.<br>The Champlain LHIN, the SFH Steering Committee and the Rehab | There are multiple areas in Champlain region that could benefit from using the AUA as a screening tool for high risk seniors (e.g., Primary Care, Adult Day Programs, community support services).<br>Many strategies and programs have overlapping functions that would benefit from alignment and close collaboration to provide a smooth and efficient care experience and transition for patients<br>Rural communities have unique needs and limitations that will require a collaborative approach. |

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| | | | | Network of Champlain also hosted a Senior Friendly & Rehabilitation Network of Champlain Symposium that included presentations on local and regional initiatives on geriatric syndromes, specialized rehab, A&R, falls prevention and transitions in care. | |
| SW | Laying the foundation for Assess & Restore Implementation in the SW LHIN | Screening – Screening Tool Adoption<br>Assessment – Assessment Tool Adoption<br>Navigation & Placement – Formal Placements<br>Interventions – Community Service Delivery<br>Interventions – Enhanced Service Delivery<br>Transitions Home – | To lay the foundation for multi-year Assess and Restore projects/programs. | The project focused on the following deliverables:<br>1. A&R Project Lead and Quality Improvement / Knowledge Translation Facilitator have been hired.<br>2. Complete stakeholder engagement<br>3. Training of Project Staff, CSS Assessors, CCAC Coordinators, ED Hospital Staff, RGP staff and SGS staff.<br>4. Scoping activities for years 2 and 3 (30%)<br>5. Identifying participating agencies for years 2 and 3 including their roles and responsibilities as it relates to implementation (30%)<br>6. Identifying key indicators of focus for implementation (30%)<br>7. Identify the need for A&R services | We have the ability to leverage the AUA embedded within existing standard assessments and screening tools already in use in our region to advance earlier identification of persons with restorative potential (InterRAI-CA, CHA)<br>Project staff attended a meeting in ESC LHIN and heard Jacobi Elliot from Waterloo group speaking on the AUA. The information was very helpful and stressed the importance of standardize our training around the use of the AUA.<br>Created two Expressions of Interest for one time funding to interested HSPs within 1. Pilot sites and 2. HSP for one time funding to advance Assess and Restore initiatives. Webcast sessions were also |

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| | | Transitions of Care | | in the SW LHIN (75%)<br>8. Establish a year 2 and year 3 implementation plan including deliverables and sustainability plan. | provided to help support potential applications.<br><br>We can leverage existing Care Coordinator and Community Assessor resources to reduce the amount of new funding required to improve our work in screening patients.<br>More engagement and education will be needed to teach and train existing assessors on how to interpret and respond to known AUA scores with standardized referral pathways. |
| CEN | Enhancing Assess and Restore Capacity for ALC Patients | Interventions – Enhanced Service Delivery | To enhance rehabilitative therapy services to frail seniors who meet the A&R target population definition. | The goal was accomplished through the following activities:<br>1. Therapy enhancements – increased allied health staff coverage to manage the increased patient volume and acuity, particularly when overcapacity beds were opened with patients who are ALC to rehab and other. Patients were identified by professional staff through a variety of venues (e.g., daily huddles, joint discharge planning rounds) | Staffing model for enhanced rehab services required set-up time.<br>Modifications were required to discharge rounds model to consider A&R as an option for discharge. It is important to initiate discussion to identify potential for A&R as early after admission as possible.<br>Communications to Allied Health Professionals key as assessors for rehab potential. |

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| | | | | 2. Hiring of weekend rehab assistants to prevent deconditioning<br>3. Gentle persuasive approach training<br>4. Purchase of equipment required for ambulation<br>5. PDSA for capturing patients to study (in partnership with CCAC)<br>6. Project Management Recruitment | Link to other initiatives, such as Senior Friendly Hospitals, should be considered to identify parallels. |
| CE | 14/15 Assess and Restore Interventions | Screening, Assessment, Navigation & Placement, Interventions | To provide comprehensive gerontological assessment and interventions to the frail geriatric population. | 37 interprofessional team members received specialized geriatric education. This education supported the knowledge translation from assessment of the geriatric syndromes to the application of best practice interventions.<br>A&R interprofessional interventions are being provided to identified frail seniors 24 hours per day, 7 days per week. It was identified in the 2014 pilot that in addition to a comprehensive assessment and geriatric syndrome identification, there is a need to have available 24 hours per day appropriately applied interventions. | A Comprehensive Gerontological Assessment is vital in recognizing the patients' core reasons for complexity beyond medical diagnosis.<br>56.25% of frail geriatric patients displayed psychogeriatric conditions consisting of anxiety, depression, and cognitive impairment. More than half of these patients displayed multiple psychogeriatric conditions.<br>The dominance of the geriatric syndromes of Pain and Mobility/Falls is mirroring the 2014 pilot. 100% of the frail geriatric population were assessed to have a decrease or change in mobility and/or experienced a fall. 75% of this same population were assessed to experience significant |

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| | | | | | uncontrolled pain. |
| CE | Senior Friendly Equipment and Enhancement Implementation of the Gentle Persuasive Approach (GPA) | Interventions – Best Practices Adoption, Enhanced Service Delivery, & Geriatrics Training | To provide ongoing support via GPA education to staff in order to provide best practice geriatric care to the seniors we care for. | Education is key in the support of staff in their ongoing care. Responsive behaviours is on the increase with patients with dementia and those with other acquired brain injuries and provide multiple challenges to staff in the care of these patients. The education from Gentle Persuasive Approach (GPA) will support staff in meeting this challenge and supporting best practice care for our senior populations.<br>Funding to support the implementation of the GPA across the organization included 4 days of education (7.5 hrs) for a total of 102 staff. 3 coaches were trained and venue and supplies were purchased as well. | Education and knowledge on working with patients with responsive behaviours increase better outcomes for our fragile seniors with dementia.<br>Education on practical interventions in working with this population was supportive to staff in their day to day care.<br>Importance of sustainable funding to support additional staff both in hospital and with community partners. Many more staff wanted to attend this training opportunity. |
| CE | Assess and Restore Mobile Team | Screening – Screening Tool Development | To target early screening and standardize geriatric assessment, facilitate | The RMH A&R mobile team concept is out-come based, patient-focused care that promotes early identification and targeted | Early identification and targeted interventions are key to greater success and safer discharge back to the community. |

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| | | Assessment – Assessment Tool Adoption<br>Navigation & Placement – Standardized Program Criteria<br>Interventions – Best Practices Adoption & Enhanced Service Delivery | navigation, implement an individualized comprehensive plan of care and coordinate transitions to the next most appropriate level of care. | 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 CKL Community GAIN team, CCAC, primary care and other community services. Our concept aligns with current care philosophies such as CCAC Home First and projects such as Resource Matching and Referral and Health Links.<br>The A&R mobile team is led by a clinical nurse specialist navigator/ Core members of the team include social work, rehabilitation assistant, and enhanced support from pharmacy, speech language pathology, and dietary services. Strategic relationships with inpatient flow, the GEM nurse, community GAIN team, the in-hospital CCAC Care Coordinator and CSS will be robust. Communication processes will be developed with these teams. | Close collaboration and communication with GAIN and other community partners, as well as GEM.<br>ARM team must work in tandem with the inpatient interprofessional team.<br>A specialized team provides the opportunity one on one coaching and teaching on best practice in geriatric care.<br>Patient and family engagement is essential in the holistic care of hospitalized seniors. |
| CE | Assess and Restore - Scarborough hospital virtual | Assessment – Formal Partnerships | To establish collaboration between social workers and therapy teams and to | A specialized community based ambulatory rehabilitation service to patients discharged from Acute Care for Elders (ACE). | **Successes**<br>Enhanced team engagement & accountability through LEAN |

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| | ward | Navigation & Placement – Formal Partnerships<br>Interventions – Enhanced Service Delivery<br>Transitions Home – Transitions of Care | enhance program operations and performance. | 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. | approach to design and implement the models with front line staff and leaders. Promoted standardization in the discharge planning process (i.e., admission criteria, LACE tool) and operations (i.e., team rounds, patient tracker). Shared care model and team access to patient health record. Enabled integrated team development through rounds, IT solutions and monthly performance and operations meeting for quality improvement. Leveraged strong commitment to integration from partners including PACE model at Carefirst. Established linkages between services (GAIN, Virtual Ward, and Assess and Restore).<br>**Opportunities and Learnings**<br>Need for routine and affordable transportation patients' participation in community programs. Need engagement of primary care physicians and stronger linkage to other community services (i.e., RRN). Need to link communication back to primary care provider. Funding policies and different funding envelopes that segregate |

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| | | | | | program/service development |
| CE | CATCH Program | Screening – Screening Tool Adoption<br>Transitions Home – Transitions of Care | Patients are referred to the CATCH Program to:<br>1. Ensure they have a safe discharge back home from the hospital<br>2. There is follow-up with any risk factors including falls, nutrition, medications, pain, depression/cognition, wounds/skin breakdown, multiple conditions and advanced chronic diseases.<br>3. There is follow-up with reconditioning needs of patients; and<br>4. They have support so they can keep living safely in the community and don't need to be readmitted to the hospital. | The CATCH program is an outpatient program that is delivered by an interdisciplinary team of health professionals including a physiotherapist, physiotherapy assistant and a nurse. There is also a linkage to our general internists on an individualized basis which is assessed by the referring team.<br>Patients are first assessed by a PT, who develops an individualized reconditioning program for the patient. Individualized reconditioning programs are delivered by a PTA. Through reconditioning, the PTA helps to reach optimal physical functionality and independence. The registered practical nurse assessed 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 | The use of a LEAN Kaizen Event with all the key players was necessary for everyone to understand how to make the program successful by better understanding their roles and how CATCH fits in the continuum of care. Specifically:<br>1. In the implementation of the additional Pharmacy component, a deep dive into the understanding of populations that would benefit from this additional service was very helpful for the expansion of the service into 15/16 (i.e., COPD population).<br>2. The COPD population would benefit from having a best medication history discharge plan so that from a patient perspective, patient will be aware as how and when to take medications, and how to integrate new medications into their medication regime. If successful, this will avoid therapeutic duplications omissions, unnecessary medications and |

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| | | | | focused on understanding your condition and how to prevent deterioration.<br>A LEAN quality improvement event was also held on Mar 30 and 31st to implement the AUA and to identify the target population that would most benefit from Pharmacy intervention on transitions in care. | confusion for patients.<br>3. Having the key stakeholders available including referring areas and CCAC< GAIN membership was a critical success factor for having a common understanding for the differentiation of the services and a common understanding of the appropriate referrals to each of these services. |
| CE | Assess and Restore – Campbellford Memorial Hospital (CMH) | Interventions – Enhanced Service Delivery | To increase client functionality and reduce LOS for the restorative care program. | Enhancement of PT for the restorative care program will assist in ensuring extended service to reduce LOS and increase client functionality. Due to an increase in dependency equipment is also required to support the extension to the service. | Increased staffing enhanced mobility for our patients and decreased functional decline allowing more patients to return to their home. |
| CW | Home Independence Program (HIP) | Interventions – Best Practices Adoption<br>Interventions – Enhanced Service Delivery | 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. | Less emphasis on PSW services than seen in past waves: often patients and families/caregivers responded well to protocols implemented by rehabilitation professionals without additional support of PSWs. |

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| 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. | Convened an Assess and Restore Working Group to manage the enhanced service delivery project and collaborative planning with involved HSP's for the next phase of the project in 15/16, and 16/17.<br><br>Review of previously funded "Activation/Ambulation" teams at each HSP site (Aging at Home funds) was combined with an initiative to standardize programming toward a Seniors Mobile Assess and Restore Team (SMART) model as described in 2013-14 A&R Project summaries. Additional allied health staffing at four hospitals (CKHA, WRH, BWH, LDMH) were implemented to expand Activation programming for inpatient seniors in acute care, surgery, medicine, and ICU/PCU units to 6-7 days/week for Feb 1 – March 31, 2015. Varying degrees of staffing increase across the four sites.<br><br>LHIN-wide education initiatives:<br>• Screening for delirium and patient mobility status for nursing and allied health staff of the SMART program (WRH)<br>• Gentle Persuasion training, | Existing infrastructure of SGS services in our LHIN is at a different level than other areas in the province where the SMART model was initiated in the 13/14 fiscal year.<br><br>Competency of staff with specific expertise and training in geriatrics is a crucial component and requires ongoing building of capacity in this area for the next fiscal year, including identification of physician and nursing supports for geriatric assessment and care management.<br><br>Reaching a standardized level of programming within LHIN will be an evolving process over the coming two years, as will standardization of assessment tools, process and data collection across organizations.<br><br>**Key Success Factors:**<br><br>Comprehensive team including OT and blended assistant roles, such as OT/PTA focusing on functional activities of daily living vs. mobility or ambulation alone to patients' support ability to return home. |

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| | | | | Montessori training, FEES training, NDT training, Aphasia Training (CKHA)<br>• Supported attendance to the Canadian Hip Fracture Care Conference which highlighted the need for prevention and management of delirium, and access to rehabilitation in the hip fracture patient cohort of frail seniors. (all sites) | Increase in PT and OT service in the ED to facilitate timely assessment and treatment to avoid further decline.<br>Additional educational initiatives will be needed to assist with further implementation.<br>Concerns with any burden of manual data collection to take away from team time in direct patient care. In organizations with electronic charting, there may be capacity for flagging patients to monitor and demonstrate outcomes. Seeking a way to identify patients who received therapy service during acute stay and code in health records for data retrieval. |
| MH | Enhanced Rehabilitation to Support Community Transition | 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 programming within an OP setting. | The Step Up Program is a post discharge OP Clinic (PT/OT/SLP services) for frail seniors suffering from neurological conditions or deconditioned due to multiple medical comorbidities and/or falls. The program assists patients and their families to adjust to the return home from the hospital in a shorter time by providing safe management at home in addition to specific | It has become apparent that outpatient services for the frail elderly population are critical in maximizing their potential and functional gains. Having timely access to this service enables an efficient discharge from inpatient rehab and seamless transition in care and reduces the likelihood of readmission and or the need for LTC admission. |

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| | | | | therapy. The Step Up program also aims to prevent hospital readmission by working with individuals who are at risk for falls. It provides a continuum of care into the community through education and specific therapy aimed at gaining functional independence. In 14/15 HHS was able to increase services with this funding (up to 5 afternoons per week). | Providing the enhanced services 5 afternoons a week (in addition to the existing 5 mornings a week), HSS has been able to assess some patients while they are still active inpatients either on acute medicine or inpatient rehab which facilitates a timely, seamless discharge and transition to the outpatient program. |
| MH | Cooksville Care Centre RESTORE 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. The hospital population were assisted by decreasing their length of stay in hospital; working with deconditioned residents from hospital allowing them to be discharged from hospital sooner into the RESTORE program to gain strength and endurance before returning to the community. Those clients who were admitted from the community would have ended up in hospital or on the wait list for LTC due to their decreased functional ability which has an impact on their ability to live independently in the community. This program allows them to increase their functionality, | The frail elderly population continues to benefit by participating in the program. Having timely access to this programming supports a quick discharge from hospital and smooth transitions home. Having a direct impact on hospital LOS and LTC demand. |

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| | | | | avoid an ER visit, and remain in their homes living independently longer. There was an increase the level of service delivery for the traditional A&R clients through additional resources and equipment:<br>- Reduce LOS in program allowing for increased opportunity for clients to utilize the program<br>- Reduce ALC days in the system<br>- Reduce inappropriate applications to LTC placements | |
| MH | MH CCAC Rapid Recovery Program | Interventions – Community Service Delivery<br>Interventions – Enhanced Service Delivery<br>Transitions Home – Transitions of Care | 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 Rapid Recovery Program is the provision of intensive in-home rehabilitation services during the first 2 weeks post-discharge.<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 | The focus on the A&R population meant that after the 2 weeks of intense in-home rehab services came to an end, some patients required continuity of less intense services offered through in-home services, outpatient providers, and/or CSS.<br>This program achieves its purpose of facilitating discharge from acute-care or inpatient rehabilitation by initially offering intense services and subsequently referring patients on to other programs along the continuum, in an integrated manner, as appropriate.<br>Implementation represented a |

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| | | | | by can be discharged early to resume their rehabilitation within the in-home setting. | change management initiative to the prevailing mindset of intense rehabilitation services being offered solely within an institutional-based setting. Evidence of the success of the program is the increased number of referrals/admissions to the program since implementation. Implementation of appropriate screening tools is required to ensure the target patient population is being served. |
| NE | Frail Senior Clinical Pathway Development and Testing | Multi-Element Project<br>Direct Access Priority Process Initiative (DAPP) | To develop and test at a local level the Direct Access Priority Process (DAPP) for the target population i.e. high risk<br>(as per RCA FS/MC Task Group 2014) | To support the timely identification and comprehensive assessment of targeted frail seniors and others who have experienced a recent loss of functional ability, are at high risk for imminent hospitalization or admission to LTC, and have restorative potential.<br>The process will be facilitated through dissemination and adoption of provincially-recommended A & R screening tools e.g. Assessment Urgency Algorithm (AUA and/or clinical judgement.<br>Within the NE LHIN this project will be facilitated by the NE SGS, in partnership with the NE CCAC, Sault | Establishing the project governance structure is a critical first step and can take up to 6-8 weeks.<br>Early engagement of the front line health care providers is essential to project success.<br>Recruitment and retention of the project human resources takes considerable amount of time given multiple sites, broad partnerships and labour relations issues.<br>It is critical that the team take the time necessary to scope out the project in as much detail as possible.<br>Connecting with the RCA and other |

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| | | | | Area Hospital (SAH), Health Sciences North (HSN), St. Joseph's Continuing Care Centre (SJCCC), Primary Care and CSS.<br><br>NE SGS will lead the development and implementation of an inter-sectorial inter-professional capacity building /training plan in specialized geriatric services, emphasizing knowledge of the geriatric syndromes, functional decline and recognition of restorative potential. | LHINS assisted to frame the project and introduced resources that could be leveraged in the NE LHIN (i.e., AUA, Frailty Modules developed by the WW LHIN). |
| NSM | Geriatrics Training – CCC and CCP | Interventions – Geriatrics Training | To increase the knowledge of front-line providers related to the care of frail seniors. The focus was on providers within CCC and CCP settings across the NSM LHIN. | The project was led by the Regional Clinical Nurse Specialist; Seniors Health. The following was included:<br><br>1. A learning needs assessment was completed to determine baseline knowledge and opportunities for learning;<br>2. A learning plan was developed in alignment with the RCA's Draft Compendium, with particular emphasis on mental health issues and behaviours<br>3. The WW LHIN's Frailty eLearning Modules were explored as a possible platform to support learning. Access to the web-portal was provided by the WW LHIN and this link was | **Successes:**<br><br>Increased individual front line staff appreciation and knowledge of geriatric syndromes. Specifically geriatric mental health issues and illnesses.<br><br>**Lessons Learned:**<br><br>Lack of established evidenced based practice protocols for geriatric syndromes in CCC and CCP settings.<br><br>Need for ongoing front line staff education and support. |

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| | | | | distributed to all CCC and CCP providers in the LHIN.<br>4. Education sessions were provided for front-line staff from all NSM LHIN CCC and CCP settings. Educational sessions included:<br>a. Geriatric Mental Health Workshop<br>b. Geriatric Syndromes Short Sessions<br>c. Gentle Persuasive Approach Training<br>d. PIECES training support | |
| 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. | The project increased delivery of rehabilitation care services in an acute care setting at TBRHSC by introducing PT/OT, Geriatric Management (GM) and Social Work (SW). The OT/PT and Rehabilitation Assistants assessed patients from the target population to restore their mobility, with the focus on improving ambulation and functional status and improving the completion of ADLs.<br>The GM Research Nurse actively assessed "at risk" elderly patients from the target population, by using standardized tools to identify geriatric syndromes and facilitate and coordinated care for patients | The project showed great potential to reduce length of stay, improve functional ability and increase safe discharges back to home. New standardized tools were used to better screen 'at-risk' individuals. The GM research nurse role was new to the acute care setting and showed great potential, with the possibility of expanding it to the ED. Based on the evaluation and engagement with the health service provider, this role will be continued for the next fiscal. Sustainability of remaining services is being contemplated through other initiatives. Overall, implementation |

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| | | | | experiencing geriatric syndromes.<br>The SW met with patients/families and assessed their supports and services at home, to determine if there are any gaps that may interfere with the patient being able to return home safely with their needs being met. The SW provided education, recommendations, and referrals on available community resources to the patient and his/her family. | of these services over a longer time period would demonstrate valuable patient outcomes. |
| NW | Geriatrics Training in Frist Nations Communities (St. Joseph's Care Group) | Interventions – Geriatrics Training | To develop a community-based model to keep seniors and others living with chronic health conditions active. | A social worker with well-established connections with the North Caribou Lake First Nation developed and implemented an exercise program and, built interest and community-level commitment to address the health of community Elders holistically. The program included a range of activities, including exercises. Eleven individuals participated in the program with community youth joining to assist. The program was well received and there was an expressed interest to continue. | Success of a project in a First Nation very much depends on the buy-in and engagement of the community. A holistic approach to health is essential when introducing programs that fit with the First Nation lifestyle and culture.<br>Leveraging existing services could likely sustain this programming. The program developed for this community could be customized and expanded to other First Nation communities. |

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| NW | Best Practice Adoption in Hospitals (St. Joseph's Care Group) | Interventions – Best Practices Adoption | To build capacity of small and rural hospitals by providing evidence-informed geriatric interventions from screening to transition. | A current state analysis of A&R programming in all eleven hospitals was completed. In addition, a detailed gap analysis of leading practices vs. existing practices was conducted for three hospitals in the region that have specific A&R programming. Hospitals were engaged through surveys and education sessions. A total of 80 staff and 10 rehab students attended the sessions. In addition, each hospital site received information and resources, including specific tools and e-learning modules based on leading practices in geriatric assessment and rehabilitation, to cover areas of screening/identification, inpatient care – assessment and intervention; and transition to community. | A number of gaps and challenges were identified relevant to small and rural hospitals. Lack of standardization of processes and practices was evident. The in-depth analysis and recommendations provided will be incorporated in the overall regional rehab/CCC capacity planning project that is currently underway at the LHIN. |
| 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. | To increase delivery of rehabilitative care services in an acute care setting at LWDH. Funding provided an additional 0.4 FTE Physical Medicine Occupational Therapy to the existing A&R program.<br>A total of 90 patients were admitted to the A&R program. With the enhanced funding in the fourth | Given that the existing A&R program at LWDH has shown positive impacts and the expansion has demonstrated better outcomes, this project will be continued for the next fiscal. Complementing A&R services at LWDH will positively affect patient outcomes, and in turn decrease hospital length of stay, LTC admission and ALC rates. |

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| | | | | quarter, the average number of admitted patients significantly increased from 6.6 to 10 per month (49% increase) and the average number of patients who were discharged home increased from 5.6 to 6.7 per month (20% increase). In addition, the average number of patient days receiving A&R care significantly increased from 100 to 128 per month. | |
| WW | AUA Implementation in Primary Care | 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 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 | A major key factor in scalability of this project is the necessity to follow a standardized implementation process which includes:<br>1. Conducting community and primary care stakeholder consultations to understand local resources, current referral processes, and care team capacity.<br>2. Providing extensive AUA training to primary care teams.<br>3. Using the information from the consultations, develop appropriate referral maps including self-management supports, community services, and specialist referrals that can be used to make referrals in partnership with the patient/caregiver. |

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| | | | | 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 will continue in the 15/16 year, where evaluation of implementation in the pilot sites will take place through qualitative interview techniques and referral tracking from Caredove. | 4. Collecting data for ongoing monitoring and follow-up using appropriate evaluation techniques (observations, interviews, tracking forms, surveys).<br>It is necessary to have buy-in from the executive director and care providers when implementing changes to everyday practice. |
| WW | Geriatric Training: Frailty eModule Expansion and Implementation | Interventions – Geriatrics Training | To add two new e-learning modules (geriatric addictions, heart failure) and make e-learning modules available in both French and English through the 14/15 A&R funding. | Testing of the education modules was completed with stakeholders across the continuum and spanning the WWLHIN geographically: Community, Acute Care, ED, Mental Health and Addiction Services. The modules have been well received and viewed as providing skills and knowledge that will be implemented into service and care planning. The training tools will be included in the Regional Geriatric Program Central – Gerontology Certificate Program. The e-learning modules will provide students with credits towards their Gerontology Certificate. | A learning needs assessment is necessary prior to the development of educational materials and/or training models/educational programs.<br>There should be recognition of the amount of educational material in existence and the need to take stock before continued information development. Any future development should also consider materials produced by Regional Geriatric Programs of Ontario, and Rehabilitative Care Alliance, and maintain close alignment. |