Rehabilitative Care Alliance

2018/2019 Assess & Restore Initiatives

Overview and Summary Analysis

January 2020

As per the *Assess & Restore Guideline (2014)*, Assess & Restore (A&R) initiatives are intended to: extend the functional independence of community-dwelling frail seniors and other persons for as long as possible; reduce caregiver burden by improving psychosocial and health outcomes for community dwelling frail seniors and other persons; and facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors and other persons. A&R initiatives target high-risk seniors who have begun to experience serious functional decline and are reaching a stage where that decline threatens to become precipitous and permanent. This A&R approach to care encompasses a range of programs and settings and is multidisciplinary and cross-sectoral in design and nature.

Over the course of the last 5 years, regions have collaborated to deliver a variety of A&R initiatives. During the 2017/18 funding period, the dollars allotted to A&R initiatives became base funding. This decision has facilitated the provision of sustainable rehabilitative care to frail older adults, recruiting knowledgeable regulated health professionals with expertise in geriatric care. With the introduction of Ontario Health Teams, a continued focus on an A&R approach will be important to serve this complex population, improving care in the right setting, reducing hallway health care and providing positive patient and caregiver experiences.

This document provides a high-level overview of the Assess and Restore initiatives completed in each LHIN with 2018/19 Assess and Restore funding. This summary also provides a year over year comparison of outcomes from 2016/17 to present and was developed to support knowledge exchange related to A&R approaches and outcomes.

A&R Key Messages have remained consistent since 2016/17 and have become building blocks upon which A&R initiatives have been developed.

The A&R Key Messages are as follows:

- **A cross-sectoral integrated approach to restorative care improves outcomes for community-dwelling older adults**
- **Proactive access to comprehensive assessment and restorative interventions improves outcomes and reduces avoidable admissions**
- **Geriatric education and senior friendly care are essential components of successful A&R implementation**
- **A planned regional strategy with an aligned vision is required to support a population health approach for frail older adults**

Summary of A&R Initiatives Objectives and Approaches:

Many of the 2018/19 initiatives built on the work of previous years. The focus of geriatric and rehabilitative care noted across initiatives has therefore remained consistent over the last several years. Examples include:

- **Proactive risk screening**
- **Implementing evidence based geriatric assessment, and management of geriatric syndromes**
- **A focus on optimizing function and independence**
- **Implementing strategies to prevent avoidable acute care admissions**
- **Supporting transitions across sectors**
- **Interventions to prevent falls; reduce falls risk**
- **Coordinating and integrating care across sectors**
- **Improving access to comprehensive geriatric assessment**
- **Enhancing, and improving access to, interprofessional rehabilitative care**
- **Providing intensive, interprofessional rehabilitative care in the community**
- **Increasing focus on prevention, proactive health promotion, and health teaching, to empower older adults to maintain independence**
- **Providing a single point of access, to improve proactive navigation to both preventative and restorative services**
- **Building clinical capacity to provide best practice care to frail older adults**

For 2018/19, 40 A&R initiative reports were received from 14 LHINs across the province. These initiatives were implemented across the continuum of care.

During the 2018/19 funding period, more than 27,000 older adults received care through A&R initiatives. Many positive outcomes were noted, as detailed in the shared provincial indicator data and initiative summaries presented below. It should be noted that the initiatives described include those that were provided through Assess and Restore funding. There are many effective geriatric rehabilitative care services provided to frail older adults in a variety of care settings; however, this report does not include services that are provided to frail older adults outside of Assess & Restore funding.

Shared Provincial Indicators

In 2017, the Rehabilitative Care Alliance (RCA) proposed a more concise set of shared provincial indicators, which align with the Ministry mandated indicators as well as the stated objectives of the A&R Guideline (*Improve Outcomes; Extend Functional Independence; Best Practice Adoption*). The standardized indicators are intended to allow LHINs to demonstrate progress towards implementing the A&R Guideline and demonstrate the collective provincial impact of A&R funding, while satisfying the Ministry reporting requirements.

Technical specifications supporting standardized measurement and reporting of the shared provincial indicators were provided in the *Assess & Restore Shared Provincial Indicators and Technical Specifications* document released in January 2018. (*http://rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/A_and_R_FSMC/A_amp_R_Shared_indicators__amp__technical_specifications_-_FINAL_updated.pdf*) The specifications include indicator definitions, relevance to and alignment with the objectives of the A&R Guideline, information on calculation of the indicators and additional reference information.

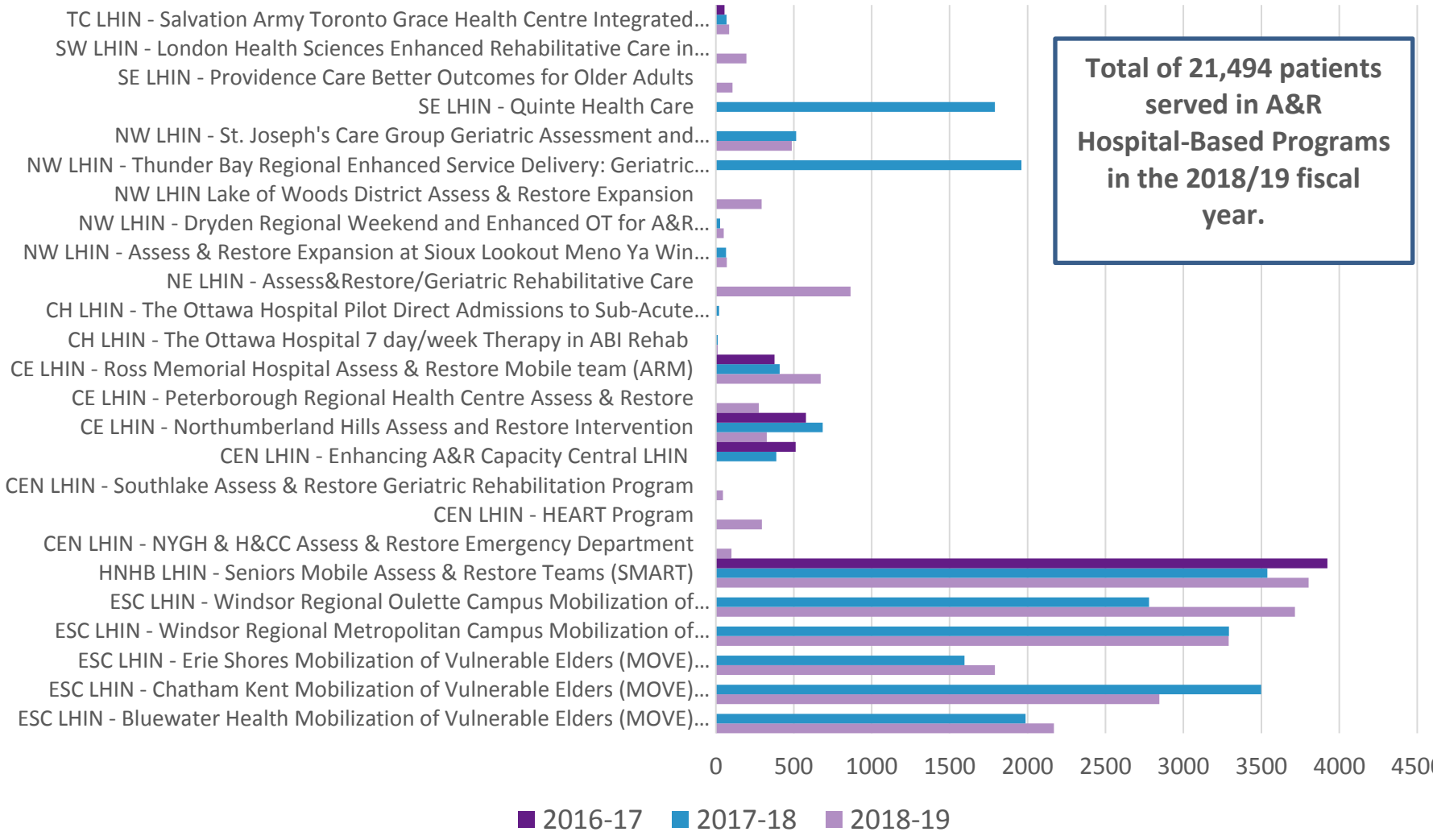
The data presented below is an analysis of those sites who utilized the shared provincial indicators, providing a baseline for future analysis and comparison year over year. It should be noted that many initiatives reported positive outcomes, as outlined in the initiatives summary; however, not all sites utilized the same indicators or technical specifications making provincial comparison difficult. It is recommended that these technical specifications be utilized to report Assess & Restore outcomes for future reporting.

Shared Provincial Indicator sets, by project type/sector

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

Technical specifications are accessed via the following link:
http://rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/A_and_R_FSMC/A_amp_R_Shared_indicators__amp__technical_specifications_-_FINAL_updated.pdf

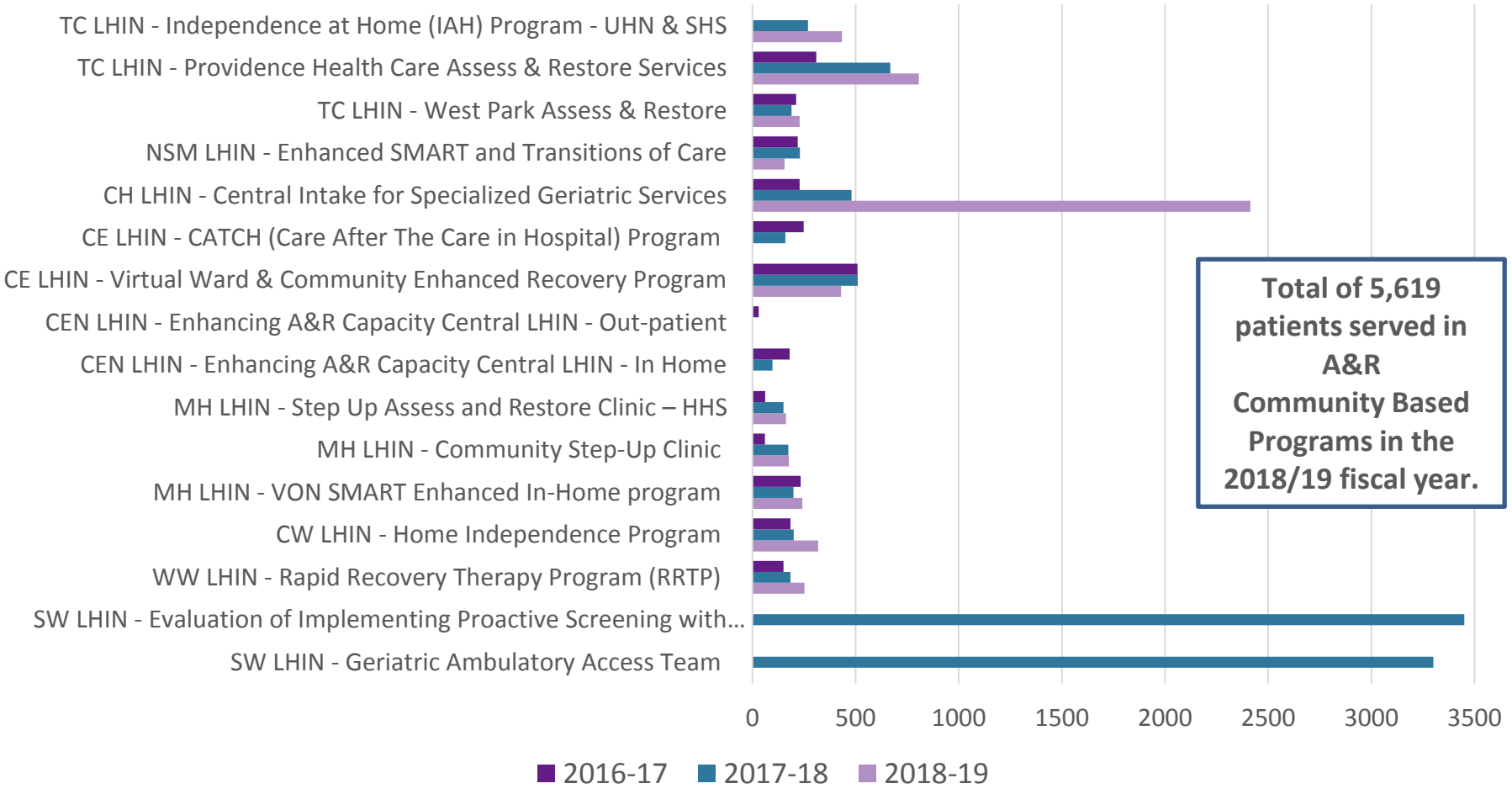
Indicator 1A: Volume of Patients/Caregivers Served - Hospital-based Programs*



*In keeping with data reporting practices to maintain patient confidentiality, values of less than five (5) have not been identified at the organizational level.

This indicator reports the total number of unique older adults who received a hospital-based A&R-funded intervention.

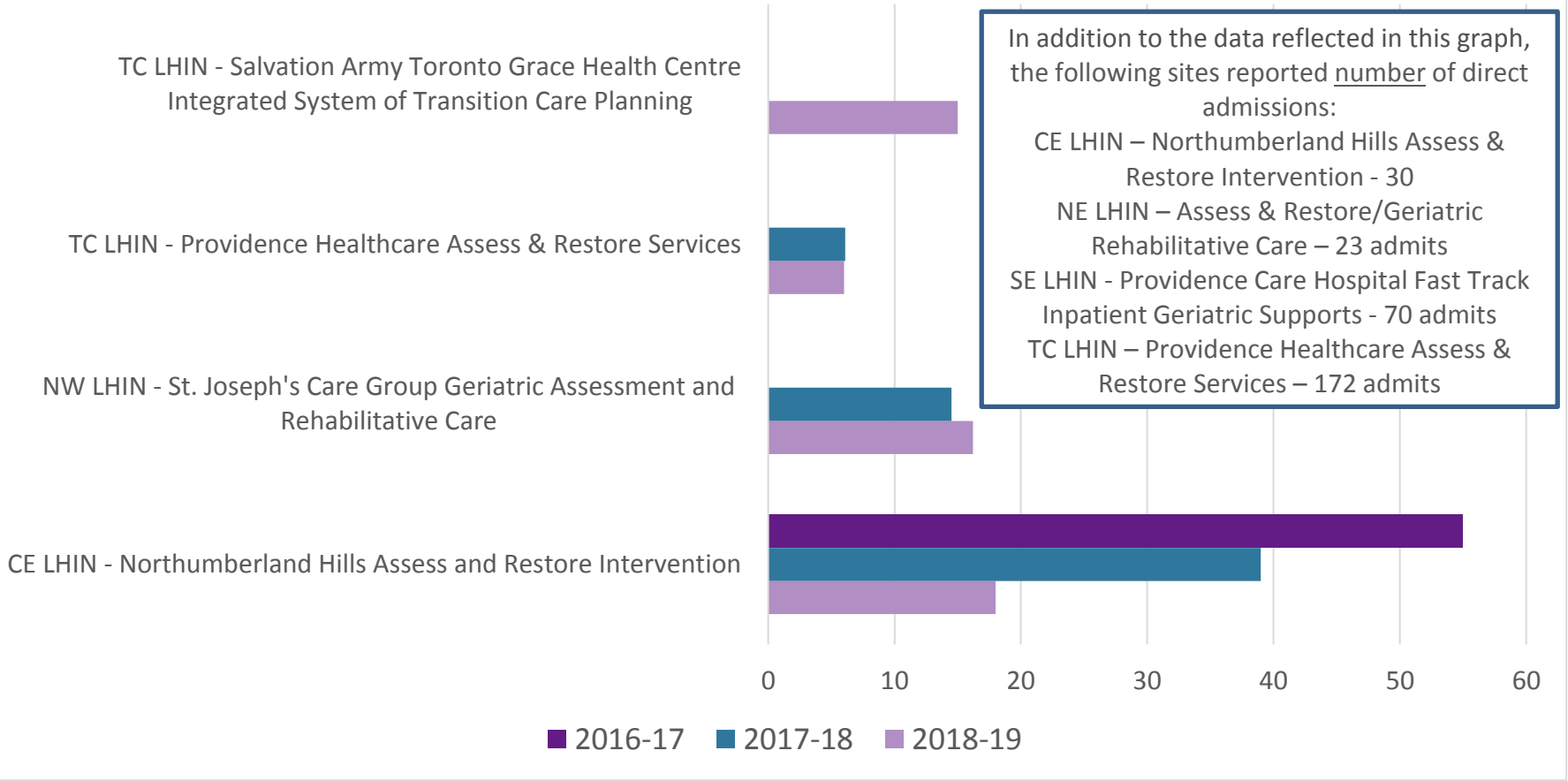
Indicator 1B: Volume of Patients/Caregivers Served - Community Based Programs*



*In keeping with data reporting practices to maintain patient confidentiality, values of less than five (5) have not been identified at the organizational level.

This indicator reports the total number of unique older adults who received a community-based A&R intervention.

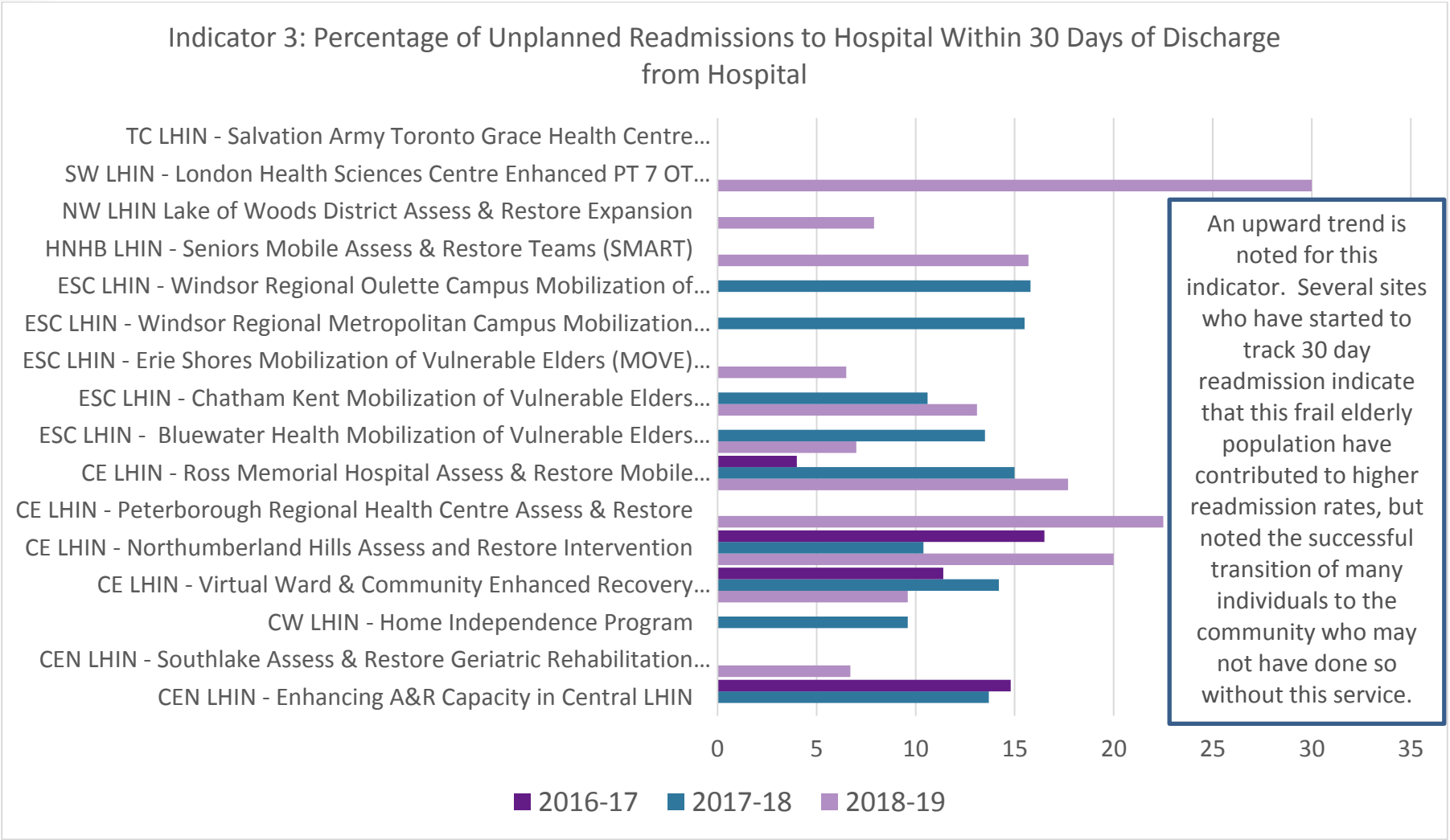
Indicator 2: Percentage of admissions to rehabilitative care beds that were directly admitted from community/ED*



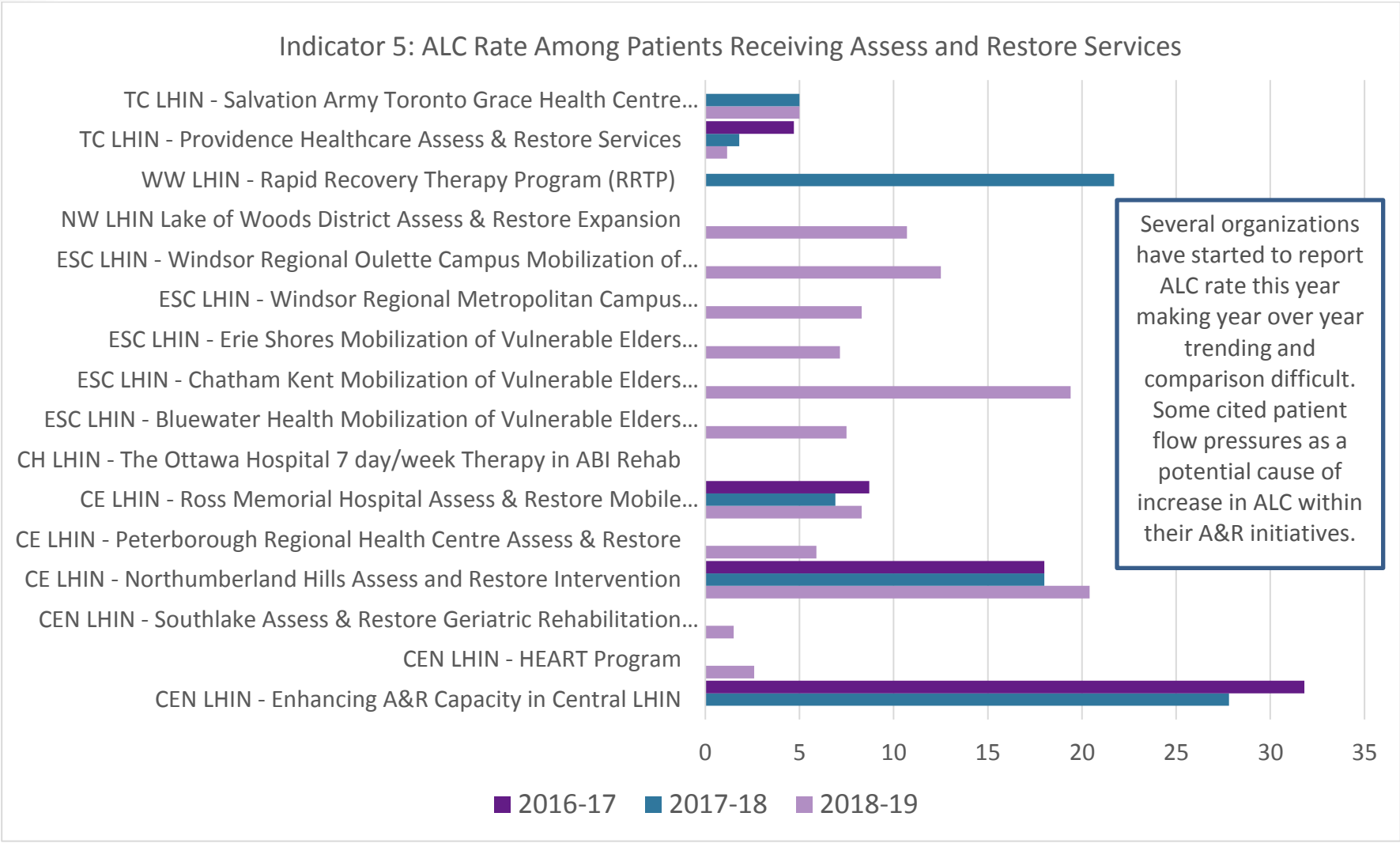
In addition to the data reflected in this graph, the following sites reported number of direct admissions:
CE LHIN – Northumberland Hills Assess & Restore Intervention - 30
NE LHIN – Assess & Restore/Geriatric Rehabilitative Care – 23 admits
SE LHIN - Providence Care Hospital Fast Track Inpatient Geriatric Supports - 70 admits
TC LHIN – Providence Healthcare Assess & Restore Services – 172 admits

*In keeping with data reporting practices to maintain patient confidentiality, values of less than five (5) have not been identified at the organizational level.

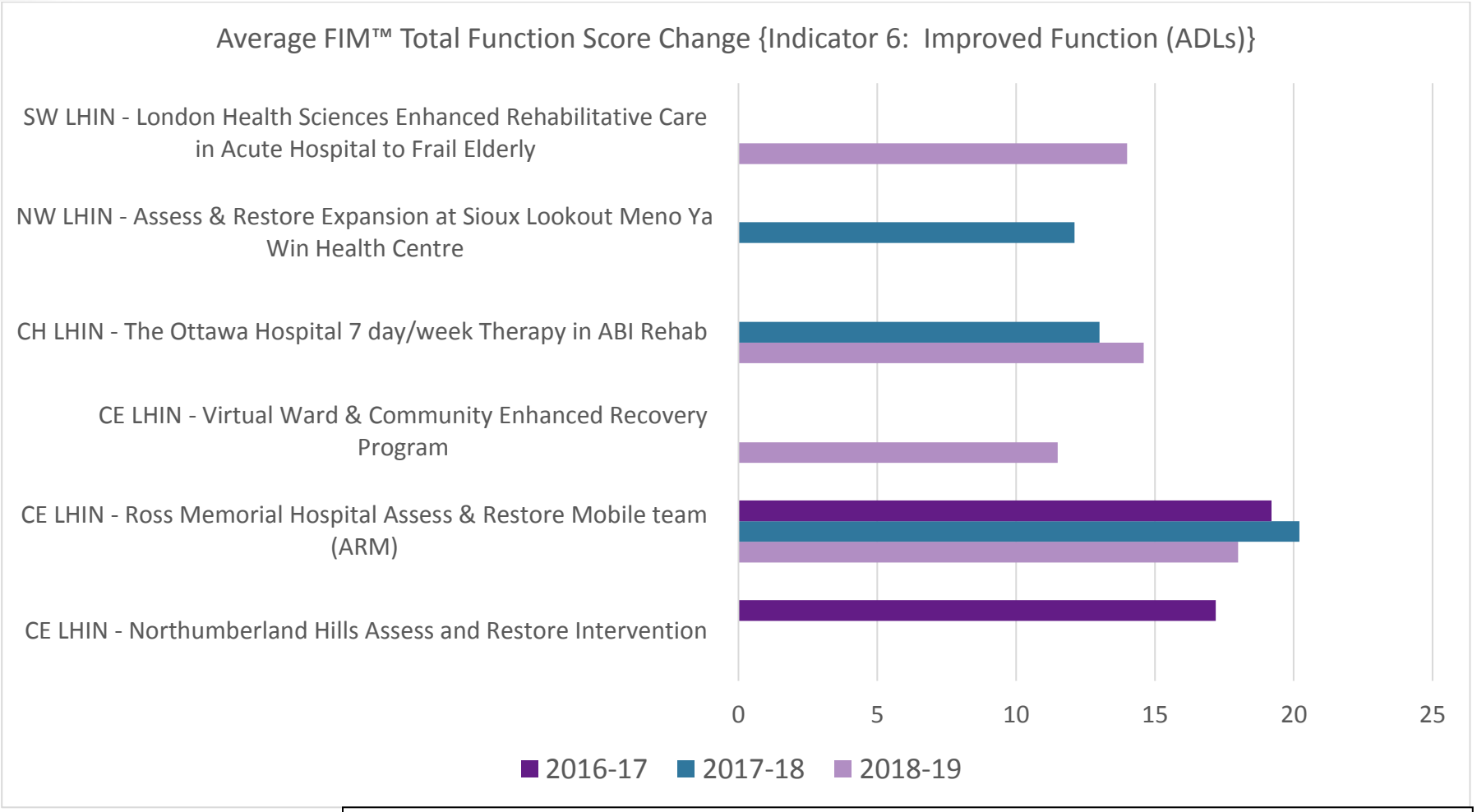
This indicator should be interpreted as the proportion of older adults, ≥ 65 years, admitted directly from community or emergency department (ED) to inpatient restorative intervention



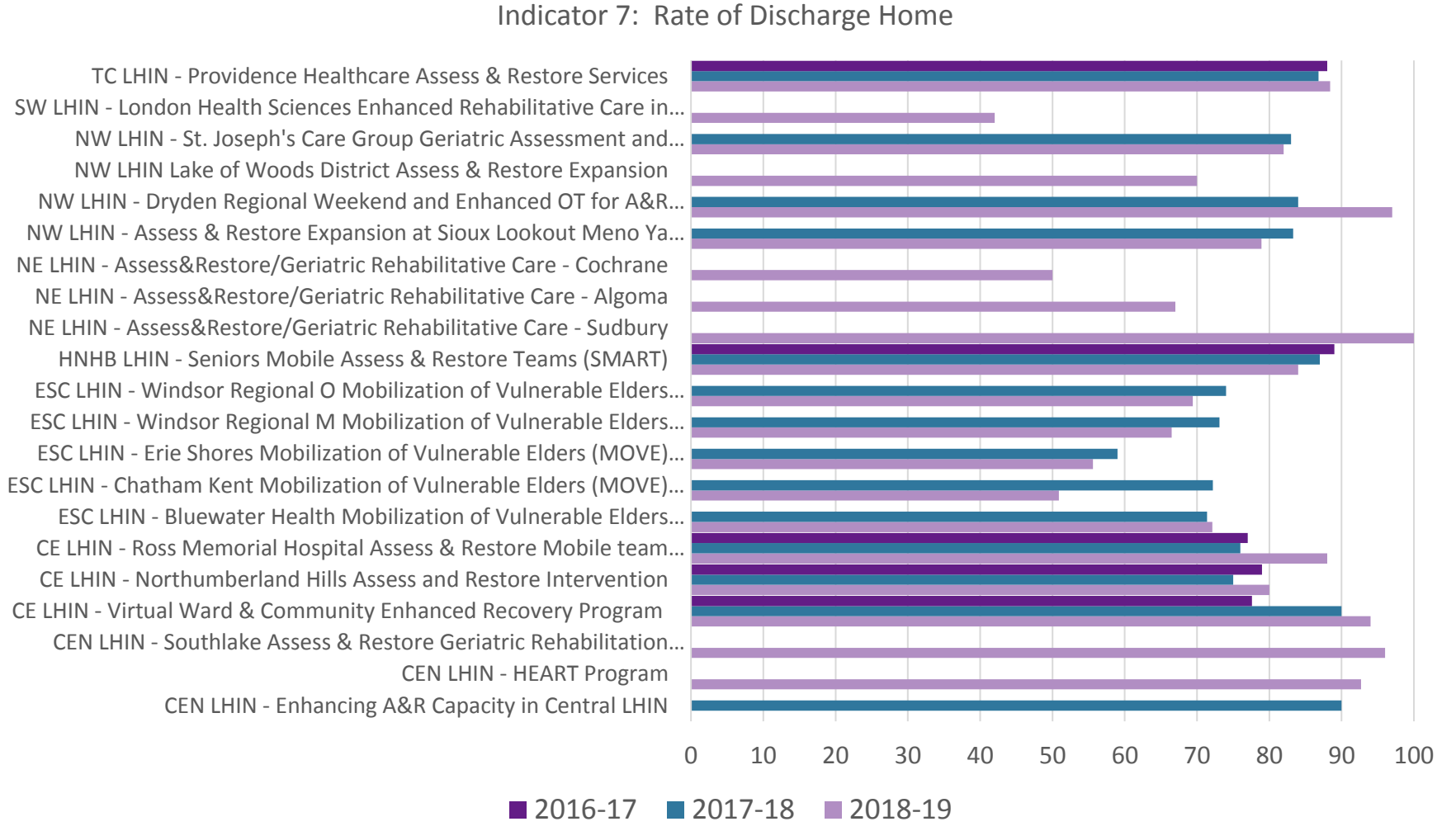
This indicator should be interpreted as the proportion of older adults who experienced an unplanned readmission to hospital within 30 days following discharge from a facility-based (bedded) restorative intervention.



This indicator describes the ALC rate for patients receiving A&R restorative interventions



Indicator 6 – Improved Function (ADLs): This indicator should measure average functional change, expressed as a %, achieved by patients who received A&R restorative intervention, as measured by a standardized, validated measure of function. Many sites measured average change in function using different validated measures, not allowing for cross-comparison. Shown here is FIM™ average change in total function from admission to discharge.



This indicator should be interpreted as the percentage of older adults receiving care through the A&R-funded initiative, who are discharged home to their baseline living environment. Comparators for future analysis: Baseline Rate, Pre-Initiative Rate or Similar Case Mix Group.

A&R Initiatives Summary:

Below is a summary of Assess & Restore Initiatives based on each LHIN's A&R Project Report submitted to the Ministry of Health for the 2018/19 fiscal year. LHINs were required to report a project description, timeframe, mitigation plan, one or more project indicators and lessons learned. Several initiatives have measured indicators that were not included in the RCA Shared Provincial Indicators. They were therefore not included in the above analysis; however, these indicators have been shared in the summary below.

The summary is organized by LHIN under the following headings:

Cross-Sectoral Initiatives:
These initiatives span both the hospital and community health care sectors.

Community-Based Initiatives:
These initiatives are based in the community, such as in home, outpatient ambulatory or primary care.

Hospital-Based Initiatives:
These initiatives are based in hospital and serve the emergency department and/or inpatient population.

Cross-Sectoral Initiatives

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes & Lessons Learned
Central LHIN	Assess & Restore, Emergency Dept., NYGH & Central LHIN H&CC	To successfully rehabilitate older adults over the age of 65 in the community who present to the NYGH emergency department and do not require hospital admission but meet the following criteria: • At risk seniors 65 years and older who reside in the CLHIN • Have an AUA score of 3-6 • Many have had a recent fall(S) and/or recent visits to the ED • Medically stable for discharge • Deemed to have restorative potential based on: ○ Premorbid functioning ○ Tinetti Score ○ Medical diagnoses and Ability to participate in care and establish achievable rehab goals	• Patients receive a comprehensive assessment by the Geriatric Medicine Emergency CNS (GEM CNS) and the ED physiotherapist who developed a discharge plan and would refer appropriate patients to the Assess and Restore Program. • The physiotherapist completed a Tinetti Score on each patient and the GEM CNS completed the AUA. • Patients that were accepted into the ED Assess and Restore Program would receive services coordinated by HCC were eligible for up to 3 visits by a physiotherapist, 11 visits by a physiotherapy assistant, a visit within 24 hours by a rapid response nurse, and a PSW for up to 60 days • Admission criteria required that the patient resides in the CLHIN in order to be eligible for HCC services. Frail seniors over the age of 65 who had rehabilitative potential and could actively participate in care were accepted into the program. Patients with mild cognitive impairment were eligible.	**Outcomes (Indicators & Metrics) 2018/19 FY:** Number of attendances: *H&CC PT/PTA visits: 403* Number of frail seniors served: *Assessed: 100; Eligible: 84; Accepted: 65; Served: 47* % average functional change achieved by patients: *100% patients with pre and post Tinetti scores showed improvement; 37.5% average improvement noted on the Tinetti* Referral rate for community dwelling frail seniors screened at risk for loss of independence: *84% referral rate; 16% not eligible due to residence outside CLHIN* **Lessons Learned** • Selection of patient population who can fully participate improves results • Patients benefitted greatly from returning home rather than remaining in ED • PT in the ED to complete the assessment aided in identifying patient for the program and appropriate services in the community for those that did not meet the criteria • Collaboration between NYGH & CLHIN H&CC enabled sharing of assessment information, reduced duplication and provided continuity of care from the ED to the community

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Central LHIN</td>
<td>HEART Program (Humber Elderly Assess & Restore Program)</td>
<td>To prevent/minimize functional decline and support independent living in the community for inpatients over the age of 65 from home or Retirement Home, whom have experienced a reversible loss of functional ability and are at risk of losing their independence, and have the ability to transition home following HEART program interventions

Expected outcomes and impact:
• Improved quality of care: improve functional abilities, promote discharge home
• Integrated services: improve flow to post-acute rehabilitation, outpatient programs
• Increased value: for the patient, hospital and the system</td>
<td>• Team consists of PT, OT, Rehab Assistant and RPN
• PT/OT complete interRAI ED Screener for all admitted patients over the age of 65 within 24 hours of admission
• Enrolled patients are assessed within 48 hours of admission
• PT/OT develop an individualized care plan with the goal of restoring functional ability
• Team works in collaboration with the inpatient Allied teams in delivery of adjunct treatment to provide 7 day/week treatment
• Following discharge, team provides outpatient follow up including patient & family teaching, information and referral</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>295</td></tr>
<tr><td>% average functional change achieved by patients</td><td>34% average improvement on the Barthel Index</td></tr>
<tr><td>% inpatient A&R patients who are discharged home to their baseline living environment compared to a baseline rate, pre-initiative rate, or similar case mix group1</td><td>92.7% discharged home</td></tr>
<tr><td>ALC Rate for A&R patients discharged to post-acute rehab care services</td><td>2.6%</td></tr>
</table>
<u>Lessons Learned</u>
• Utilization of quality improvement methodology (PDSA) allows rapid enhancements
• Staff recruitment over summer months is challenging
• Engagement of key stakeholders early is key
• Focus on patients that have higher complexity for discharge planning and risk (as per the interRAI ED Screener) allowed the team to dedicate limited HEART resources to those most in need
• Commitment to the program and diligent work to meet volume targets</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Champlain LHIN</td>
<td>Central Intake for Specialized Geriatric Services</td>
<td>To improve the patient and family experience across the continuum by providing a more coordinated hospital, home, community and primary care service. The patient and providers interact with less agencies and triage to SGS is determined through one access point.

Centralized access to Specialized Geriatric Services provides better coordination of care and provides system navigation for both patients and providers and ensures that patients are seen by the right provider in a timely manner.

One of the goals of the central intake was to decrease wait times to ensure that patients with restorative potential are being seen in the timeliest manner to ensure their needs are met and restorative care is provided as soon as possible to meet their goals.</td>
<td>• Single point of contact for all referral sources and standardization of referral and triage processes for patients 65 years and over that require specialized geriatric services.
• The Central Intake navigator reviews all referrals and determines clinical need and urgency of the patient. The CI navigator then directs patients to the most appropriate service based on the program's wait times, structure and patient and caregiver's goals. This ensures a patient centered approach where patients are sent to the most appropriate service in a timely manner based on their needs.
• The target population that benefited from CI include high risk seniors who are 65 years of age and older, resident of urban regions of the Champlain LHIN and not living currently in Long Term Care.
• Referrals received for patients that are out of catchment area (Ottawa) are redirected to appropriate services within their catchment area.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>2413</td></tr>
<tr><td>Number of frail seniors served</td><td>2413</td></tr>
<tr><td>Number of clinicians trained</td><td>2</td></tr>
<tr><td>% satisfied with ease of referral process</td><td>100%</td></tr>
<tr><td>% satisfied with referrals made to CI</td><td>98%</td></tr>
<tr><td>% satisfied with overall experience with CI</td><td>85%</td></tr>
</table>
<u>Lessons Learned</u>
• This patient centred system provides better integration with other health care providers by moving them seamlessly from one care setting to another.
• Centralized access to Specialized Geriatric Services provides better coordination of care and provides system navigation for both patients and caregivers.
• Creates timely access to Specialized Geriatric Services, reduces unnecessary delays and reduces duplication.
• Delay in accessing or identifying the right service for the patients can lead to compromised restorative potential or delay it.
• Central Intake maximizes the communication loop and reduces the chance of patients "falling through the cracks".
• Engaging all stakeholders before and during the pilot project contributed to buy-in and successful outcomes. Key medical leads participated in reviewing the Central Intake triage process
• A Champlain regional steering committee for Central Intake and Triage for Specialized Geriatric Services remains active. The goal of the committee is to get participation from key medical and operational leads from each partner organization and create a regional framework that aligns with coordinated access.</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>North East LHIN</td>
<td>NE LHIN Assess & Restore/Geriatric Rehabilitative Care: Implementation & Contextualization Across the Continuum</td>
<td>With annualized funding secured, 2018-19 activity was focused on continuing to develop a regional structure and sub-region approach to Assess & Restore (A&R) across the NE LHIN. The A&R Sustainability Standards, a product of the 2015-16 and 2016-17 A&R funded project in the North East (NE), directly informed 2017-18 planning and development. 2018-19 A&R implementation and evaluation, including continued planning and development, were the next iteration of work informed by the original sustainability standards.</td>
<td>

As part of the North East Specialized Geriatric Centre (NESGC), the regional provider of SGS, a clinical team was created to formally support the planning, development, implementation, evaluation & continuous quality improvement of the regional deliverables & sub-region action plans, including the Regional Geriatric Rehab Lead, Regional Geriatric Knowledge Translator, Medical Lead and Sub-Region Senior Friendly Care Leads (SFCL).
At a sub-region level, A&R implementation continued based on 2017-18 activity and local readiness. The priority focus was to hire 4 SFCLs and embed them within the local context. The SFCL role is intended to provide support and leadership across the continuum of care (Community, Emergency Department (ED), Acute Care, Post-Acute Care), through development, planning, implementation and sustainability of the elements of an A&R approach to care: Early Identification; Assessment; Referral and Navigation; Intervention; and Transitions.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number frail seniors served</td><td>864</td></tr>
<tr><td>Number clinicians trained</td><td>1265</td></tr>
<tr><td>Number admissions to rehabilitative care beds that were directly admitted from community/ED</td><td>23</td></tr>
<tr><td>% patients directly admitted to a rehabilitative care bed from the community who were discharged home</td><td>Sudbury – 100%
Algoma – 67%
Cochrane – 50%</td></tr>
</table>
<u>Lessons Learned:</u>

Logistics: With the goal of working along the patient trajectory across sectors, access to electronic information is essential.
Human resources: The skill mix required for the SFCL is in high demand yet low capacity in the North East. Recognizing the need for an experienced clinician, recruiting desired candidates to these roles has been challenging given the uncertain healthcare climate, overall job security, & loss of accrued benefits (e.g. vacation, pay).
Integration within local SGS: As a NESGC-resource embedded within the sub-region context, formal integration of the SFCL role within local SGS programs is essential.
Local system readiness: Implementing the SFCL clinical leadership role that transcends organizational boundaries and supports adoption of best-practice care for frail older adults across sectors requires an evolved level of leadership and willingness amongst partners.
Approach to implementation: The nature of creating an integrated and robust system of care for frail older adults is inherently complex. In order to adequately address these complexities, implementation led by the SFCL requires an adaptive versus technical approach.
An approach to knowledge translation using the Knowledge to Action Framework is foundational for successful Implementation.

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>South West LHIN</td>
<td>South West Frail Senior Strategy</td>
<td>The goals of the Strategy are to create an integrated system of care for older adults with frailty by streamlining and improving equitable access to geriatric care. This will be achieved by leveraging the combined resources and efforts of disparate initiatives and programs across the region.

Vision includes:
• Formalized cross-sectoral teams of geriatric care
• Standardized best-practice care pathways and guidelines
• Improved equity through optimization of technology, and the spread and standardization of best-practice, culturally safe care
• Capacity planning tools
• Coordinated information translation and dissemination
• One source of information
• A regional Education Strategy</td>
<td>St. Joseph’s Healthcare London, together with a regional steering committee, has been leading the development of a South West Frail Senior Strategy (the Strategy).

2018/19 work included:

• 25 online and in-person engagement events, across each region of the South West LHIN, to understand the current state of healthcare access and delivery for older adults with frailty
• Engagement of 500+ stakeholder across the region (older adults, caregivers, and healthcare providers) in developing the strategic vision
• Pilot testing the Senior Friendly Self-Assessment from RGP Toronto across sectors
• Planning development of an online resource which will provide one source of information for patients, caregivers and healthcare providers
• Transfer of Geriatric Resource Nurse Team from LHIN Home and Community Care to St. Joseph’s Healthcare London to more closely align this program with Specialized Geriatric Services
• Streamlining access, flow, documentation and communication processes within the Geriatric Resource Nurse Program
• Dementia Capacity Planning
• Needs analysis identifying priorities for investment in 2019/20</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table><tr><td>Wait list of patients waiting for Geriatric Resource Nurse Assessment</td><td>2017/18 – 99
2018/19 - 20</td></tr><tr><td>Maximum wait time for a Geriatric Resource Nurse Assessment</td><td>2017/18 – 5 months
2018/19 – 4 weeks</td></tr></table><u>Lessons Learned:</u>
• Caring for older adults generally involves multiple providers and services, making integration vital
• The multiple services and sectors involved in the care of older adults with frailty face barriers to sharing and accessing information across organizations
• In general, older adults with frailty access specialized care too late, when frailty has advanced too far to be meaningfully managed and/or they are in crisis.
• One reason older adults with frailty are accessing specialized services too late, is because there are not clear guidelines around when to refer to a specialist or specialized service
• Lack of proactive identification of frailty or risk for frailty also impacts older adults’ access to specialized services. There is an interest in and need for standardized implementation of screening tools and proactive identification processes with clear care pathways
• Caregivers are often not included in the full spectrum of care planning and delivery. This greatly reduces the success rate of a care plan and increases the chance of admission to hospital or Long Term Care
• The inability of home care services to provide assistance with instrumental activities of daily living (i.e., meal prep, cleaning, grocery shopping) is a significant barrier to helping older adults maintain community independence. Although such services are provided by Community Support Service agencies, wait lists are lengthy.
• Older adults with frailty and their caregivers often receive multiple similar assessments. There is a need to implement a standardized approach to best-practice comprehensive assessment for older adults with frailty and improve information sharing to limit the number of assessments and resulting delays.</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Toronto Central LHIN</td>
<td>Assess & Restore Initiative, Unity Health Toronto</td>
<td>To proactively work with acute care and community partners - Primary Care, including Telemedicine Impact Plus Nurse, Toronto Central Local Health Integration Network (TC LHIN) and Central East Local Health Integration Network (CE LHIN)

To identify at-risk older adults and provide timely access to restorative services across the care continuum to avoid a decline in function and potential permanent loss of independence.</td>
<td>• Frailty Intervention Team (FIT) – Interprofessional team assessment (Physician, Pharmacist, Occupational Therapist, Physiotherapy, Registered Nurse, Social Worker, Community Health Navigator- offered on site at Providence or via Ontario Telemedicine Network (OTN) with Telemedicine Clinician)
• Direct Admission from the Community Referral Pathway to Providence Inpatient Rehabilitation from the community
• Direct Admission to Providence Outpatient Rehabilitation from the Community Referral Pathway
• Access to Providence Healthcare Ambulatory services, as needed
• Receive and accept referrals for clients/ patients from Primary Care, Home and Community Care, and Emergency Departments from the TC LHIN, CE LHIN, and Central LHIN.
• Offer both in-person appointments in our FIT Outpatient Clinic or appointment via Ontario Telemedicine Network (OTN) to support those clients/ patients that are unable to leave the home or attend the clinic.
• Outpatient Administrative Coordinator to support the Assess & Restore team
• Geriatricians provide consultation across programs</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>185 FIT Clinic</td></tr>
<tr><td>Number of frail seniors served</td><td>185 FIT Clinic
172 Inpatient
228 Falls Prevention Program
108 Orthopaedic & Amputee Clinic
113 Stroke & Neuro Clinic</td></tr>
<tr><td>Quality of Life
Reintegration to Normal Living Index
Caregiver Strain Index
Depression Screening Questionnaire</td><td>
Improved from 69.51 to 85.52
Improved from 9.83 to 6.72
Improved from 1.91 to 0.65</td></tr>
<tr><td>Number clinicians trained</td><td>Health Partner Gateway eCCP access training</td></tr>
<tr><td>% patients designated ALC within two days of acute care admission d/c to rehabilitative care bed*</td><td>0%</td></tr>
<tr><td>% admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>6.0% (167 patients)</td></tr>
<tr><td>% patients directly admitted to a rehabilitative care bed* from the community who were discharged home</td><td>152/172 = 88.4%</td></tr>
<tr><td>Annual ALC rate</td><td>1.16%</td></tr>
<tr><td># Coordinated Care Plans initiated/updated</td><td>180/185</td></tr>
<tr><td>Discharged home with a primary care follow up visit within 7 days</td><td>71.8%</td></tr>
</table>
<u>Lessons Learned</u>
• Community Health Navigator (CHN) connect with patients/caregivers prior to and at intervals following their FIT assessment
• Developed a one page information sheet to support identification of patients in acute care Emergency Departments that could be served in the community
• The Clinical Frailty Scale has been implemented with our Assess & Restore Physician Outreach service and across our inpatient rehabilitative care programs.</td>
</tr>
</table>

Community-Based Initiatives

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Central East LHIN</td>
<td>Assess & Restore Project (Carefirst Seniors and Community Services Association in collaboration with Scarborough Health Network)</td>
<td>The Virtual Ward Program (VW) supports the transition of patients in the Scarborough region back home post discharge from acute care, through the role of a navigator.

The Community Enhanced Recovery Program's aim is to optimize patients returning home upon discharge from hospital.</td>
<td>• Virtual Ward Program: The high-risk to-be-discharged patients are screened and identified using: LACE risk score >10 and the Patient Need Stratification Tool. A team of transition navigators: a) assist the patient in meeting five milestones of the Virtual Ward, which are: 1.follow-up with primary care; 2.medication reconciliation; 3.tests/specialist appointments; 4.health education; and 5.linkage to appropriate community services. b) Coordinate referral to Enhance Recovery Program (ERP), c) Monitor patients participation and progress in ERP, and participate in Health Links care conferences with clinical team and d) Arrange appropriate community services after ERP discharge.
• Community Enhanced Recovery Program (ERP): For VW patients as well as discharged patients from other local hospitals who require reactivation supports. Program is offered 6 days a week and includes: PT assessment, therapeutic group exercise, individual treatment, health teaching and functional training</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>430</td></tr>
<tr><td>Number of incremental attendances/visits:</td><td>3348</td></tr>
<tr><td>Number of clinicians trained</td><td>5</td></tr>
<tr><td>Average LOS</td><td>14 days</td></tr>
<tr><td>Number of unplanned ED visits related to current diagnosis</td><td>4</td></tr>
<tr><td>Number of caregivers who received training</td><td>92</td></tr>
<tr><td>Rate of falls
Rate of falls with harm</td><td>0.08%
0.02%</td></tr>
<tr><td>%patients who received self-management instructions</td><td>91%</td></tr>
<tr><td>% of clients discharged home that were home prior to admission:</td><td>94%</td></tr>
<tr><td>Functional Outcome Measures:
Average distance ambulated
FIM scores
Elderly Mobility Scale</td><td>
11.2 metres to 44.9 metres
Pre – 87.5 Post – 99.0
Intake – 7.6 D/C – 11.2</td></tr>
<tr><td>Patient/caregiver Satisfaction Survey
Quality of Care
Overall Experience</td><td>
61/64=95% positive rating
62/64=97% positive rating</td></tr>
<tr><td>Caregiver Burden Scale (Zarit, short form)</td><td>Pre – 28.8 Post – 24.6</td></tr>
</table>
<u>Lessons Learned:</u>
• Collaboration between all health system partners is key</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Central West LHIN</td>
<td>The Home Independence Program (HIP)</td>
<td>To prevent further deterioration in compromised seniors, minimize ED utilization and readmission into hospital, and improve independence in function</td>
<td>All patients enrolled in the program were assessed by the OT who determined program eligibility and if criteria was met, delegated activities to the PSW. PT services provided as needed based on patient goals. The average LOS in the program was 9 weeks with 3 OT visits, 4 PT visits and 13 hours PSW.

Eligibility criteria:
• Senior (65+ years) patients and frail adult (55 years +, by exception only)
• Patients who would benefit from a short-term, home based, early intervention approach to deconditioning to improving daily function
• Patients who have had a recent fall requiring medical attention (MRPCP, NP, ED) or recent discharge from the hospital
• Patients who experiences some difficulty with 1 or more ADLs and will benefit from a program to enable independence
• Patients who are motivated to be more independent in their own home
• From Intake: RAI-CA SCORE 11-15; PS Score of 1, 2 or 3</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>OT 1219
PT 823.5
PSW 4272</td></tr>
<tr><td>Number of frail seniors served</td><td>319</td></tr>
<tr><td>Referral rate for community-dwelling frail seniors screened at-risk for loss of independence</td><td>58%
585 patients identified
319 received service
229 declined or did not meet criteria</td></tr>
<tr><td>Functional Outcome Measures:
Average change in score
Timed Up and Go
COPM Performance</td><td>

Admit – 41 sec D/C – 22 sec
Intake – 3.2 D/C – 6.2</td></tr>
<tr><td>COPM Satisfaction</td><td>Intake – 3.0 D/C – 6.0</td></tr>
</table>
<u>Lessons Learned</u>
• Ongoing and regular communication between centralized Rehab Care Coordinator from Home and Community Care and SPO staff is essential
• Appropriate and motivated patients achieve positive outcomes and managing patient and family expectations is an important aspect of program success
• Base funded yearly funding enabled program success and increased # of unique patients completing the program and ensures engagement with the contracted service providers and program sustainability.
• Multiple service providers involved with individual patient due to market share arrangements present challenges in communication with staffing availability challenges at SPOs
• Addition of therapy assistants for some patients can optimize program as therapists sometimes reluctant to delegate rehab tasks to PSW.
• A significant number of patients referred to the program were deemed inappropriate (39% of referrals) indicating that efforts are required to ensure that referral sources are educated further regarding program criteria</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Mississauga Halton LHIN</td>
<td>Victoria Order of Nurses SMART Enhanced In-Home Program</td>
<td>To assist “high risk” clients in re-establishing their level of independence, confidence and overall health, mitigating the need for LTC placements.

To determine the frailty of the seniors that we are servicing, we used the Rockwood Clinical frailty scale. Based on the scale, our population average is a 5.5 which suggests that they are mildly to moderately frail.</td>
<td>• Utilizing the evidence based, nationally accredited SMART™ (Seniors Maintaining Active Roles Together) program, the Victorian Order of Nurses for Canada (VON) has offered a highly coordinated and integrated program primarily within the Southwest and East Mississauga Health Links within the Mississauga Halton LHIN.
• Frail Seniors who were identified as meeting the established criteria received in home one on one exercise session to increase their strength, mobility and functional abilities with a kinesiologist. The program is a 6 week period, 2 x 1.0 hours / week and consists of 15 gentle exercises geared towards the frail elderly and other vulnerable individuals that have experienced a recent loss of functional abilities following a medical event or decline in health.
• Physiotherapy interventions will be accessible to complement the SMART program to benefit frail seniors who have neurological disease that may require additional interventions outside of the current 15 gentle exercises</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>2211</td></tr>
<tr><td>Number of frail seniors served</td><td>242</td></tr>
<tr><td>Quality of Life Measure</td><td>+3.33</td></tr>
<tr><td>Functional Outcome Measures
Timed Up and Go
BERG
30 sec Sit to Stand</td><td>
-9.24 sec
+6.60
+2.03</td></tr>
<tr><td></td><td>97.2% of patients sustained or improved 3+ outcome measures</td></tr>
</table>
<u>Lessons Learned</u>
• Base funding supports improved retention which has been an ongoing challenge with the project due to the consistent turnover of staff related to contracted work
• Improved screening of referrals continues to improve the outcomes of the project
• The Assessment Urgency Algorithm (AUA) Is beneficial for understanding the client’s current state; however, exercise does not seem to significantly impact the outcome measure
• Client compliance/engagement and accountability for improvement is a key driver to success
• Encouraging exercises to continue when an exercise leader is not in the home is essential
• To address the large amount of client initiated cancellations, the program has implemented a cancellations policy to encourage a reduction of cancellations</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Mississauga Halton LHIN</td>
<td>Lifemark Seniors Wellness Community Step-Up Program</td>
<td>The goal of the program is to ensure that every patient is successful in maintaining their gains while living in the community. The program has proven to reduce emergency department visits and hospital admissions and delaying long-term care placement in clients that at risk or reported to be on the list for placement.</td>
<td>

The Community Step Up Program is a 6 week multi-disciplinary rehabilitation approach for frail seniors and older adults with complex medical conditions who are living in the community
Utilizes an inter-disciplinary team approach to provide 1:1 individual therapy including PT/OT and SLP
The mobile clinic services frail seniors (waiting for Assess and Restore Rehab, Convalescent Care programming and or patients that would benefit from an Assess and Restore Rehabilitation approach).
Community Step-Up offers 3 mobile clinics in: Milton, North West Mississauga and South West Mississauga each providing clinics 2 days per week for 6 weeks. Each client receives a week of assessments (between initial and discharge) and 5 weeks of direct intervention care time. We primarily serving frail seniors and older adults in the Milton, Halton Hills, SouthWest Mississauga, East Mississauga, North West Mississauga and South Etobicoke sub regions. Lifemark’s Community Step Up program has established strong partnerships within the community to optimize existing resources.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>2069</td></tr>
<tr><td>Number of frail seniors served</td><td>176</td></tr>
<tr><td>Number of clinicians trained</td><td>5</td></tr>
<tr><td>Referral rate for community-dwelling frail seniors screened at-risk for loss of independence2</td><td>100%</td></tr>
</table>
<u>Lessons Learned</u>

Community outreach is a critical success factor for this program. This is an ongoing activity that helps generate direct referrals and build capacity for the program
Caregivers benefit as much from the restorative program as the clients. Through ongoing education and training caregivers learn essential care strategies for home to make caring for the client easier, more efficient and safer for both of them
Reducing the risk of falls has certainly been a by-product of the program
Last minute cancellations for treatments has been an obstacle with scheduling clients and delaying the completion of the full six week program. Managing expectations upfront with clients and caregivers about committing to the full six weeks and attending both half days is another critical success factor to maximizing the reach of clients.

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Mississauga Halton LHIN</td>
<td>Step Up Assess and Restore Clinic – Halton Healthcare Services</td>
<td>A&R interventions are targeted to frail seniors and other persons who have experienced a recent loss of functional ability following a medical event or decline in health, are at high risk for imminent hospitalization or admission into LTC as a result of that functional loss and/or have the potential to regain that functional loss so that they are no longer at high risk.

To extend the functional independence of complex frail seniors, reduce caregiver burden by improving psychosocial and health outcomes for community- dwelling frail seniors and other persons, and facilitate the adoption of evidence-based clinical processes and interventions that have demonstrated efficacy in improving functional independence for community-dwelling seniors.</td>
<td>• One on one therapy services to the frail elderly population in an outpatient setting
• Integrated team that includes regulated health professionals (i.e. OT, PT, SLP) with expertise in geriatrics directed at increasing strength, mobility, and functional ability
• Patients receive at least 2 out of 3 disciplines and may receive all 3 (i.e. OT, PT, SLP) in order to reach their functional goals of increase functioning and independence</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>1574</td></tr>
<tr><td>Number of frail seniors served</td><td>162</td></tr>
<tr><td>Number of clinicians trained</td><td>6</td></tr>
<tr><td>Quality of Life Measure – SF-36</td><td>+26.2</td></tr>
<tr><td>Referral rate for community-dwelling frail seniors screened at-risk for loss of independence</td><td>30%</td></tr>
<tr><td>#days reduction in LOS Hospital beds</td><td>1.4 acute days
4.6 inpatient rehab days</td></tr>
<tr><td>% Reduction in Readmissions within Hospitals</td><td>4%</td></tr>
</table>
<u>Lessons Learned</u>
• Ensures continuity of care for patients that have received care on our inpatient rehab floor and/or acute medical/surgical units
• Assists with decreasing overall inpatient length of stay (LOS), allows timely discharges and helps prevent hospital readmissions
• Minimizes duplication of service by ensuring timely access to the program within 7 days of discharge (if on an inpatient floor). This allows for a reduction of a duplicate referral to home and community care as our patients receive education and referral date as part of their discharge package from the hospital
• Worked very collaboratively with the LifeMark Community Step Up Program over the last year to facilitate timely access for the patients
• Focus of a very successful LEAN event to improve clinical efficiency and to optimize resources by developing standardized practices, central registration and increased synergies between discharge staff and the A&R Program</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>North Simcoe Muskoka LHIN</td>
<td>Enhanced SMART and Transitions of CARE, Waypoint Centre – Specialized Geriatric Services</td>
<td>The Enhanced SMART program was built upon the foundation of the VON SMART Program (Seniors Maintaining Active Roles Together), established in 2007/2008 to support those more independent individuals aged 55+. Enhanced SMART uses the same principles however, was designed to support complex, frail seniors with higher therapy needs. Specifically, frail seniors with restorative potential being discharged from CCP and ACE Units in the Barrie and Orillia areas.</td>
<td>• Enhanced SMART currently offers advanced rehab 2 half days/wk for up to 12 individuals per class for a 6-12 week period. Four groups running out of 3 sites per week are hosted. It also provides post discharge follow-up and monitoring and system navigation.
• Increased professional therapy staff = increased ability to serve more complex, frail seniors with restorative potential.
• Program will include classes and in-home services for seniors whose level of frailty may temporarily limit class attendance.
• Clients will transition between SMART-level programs based on need
• Supporting clients discharged from CCP and ACE through continued therapy will reduce length of stay, support transitions of care and support post-discharge follow-up.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>1813</td></tr>
<tr><td>Number of frail seniors served</td><td>156</td></tr>
<tr><td>Quality of Life measure
(Barthel, Knowledge confidence, AOL, COPM performance, COPM Satisfaction)</td><td>Pre score: 108.6/160 (68% change)
Post score: 134.1/160 (84% change)
Average Gain = 16%</td></tr>
<tr><td>% average functional change achieved by patients
Tinetti
Grip strength
Gait Speed</td><td>15.2% Total average percent change
12.3%
7.2-8.6%
24.6%</td></tr>
<tr><td>Referral rate for community-dwelling frail seniors screened at-risk for loss of independence</td><td>171/188 (90%)</td></tr>
</table>
<u>Lessons Learned</u>
• The Victorian Order of Nurses will not be moving forward with the Enhanced SMART program in 2019/20; the management, monitoring and development of this service has been transitioned to the North Simcoe Muskoka Specialized Geriatric Services. This program will continue to operate in the Barrie and Orillia area with goals of expansion to the North Simcoe region.
• Referral rate declined over the year; noted increased medical complexity and higher level of frailty with 49% scoring 6 on the frailty scale. Recommendation that referrals include medical clearance by the referral MD / NP.
• Continue to note that referral patterns align with Geriatrician clinics (in particular in the Orillia area). Recommend building partnerships and promoting the program across the Barrie and Orillia areas. Continue to plan development of new locations for the Midland area.</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>South East LHIN</td>
<td>Healthy Living and Falls Prevention Group, Providence Care</td>
<td>To target early access to a comprehensive geriatric physiotherapy assessment focused on identifying at-risk older adults that are experiencing strength, balance, and functional decline and could benefit from timely access to a Healthy Living and Falls Prevention group program.

The focus will be on enhancing services to high risk seniors in the SE LHIN, with the goal of intervening and delaying the loss of functional decline.</td>
<td>• The group will offer early interventions for those older persons who are experiencing a decline in function and are at a high falls risk. High risk fallers would be those attending Emergency Department or family physician urgently relating to a recent fall, or who have experienced multiple falls in last 90 days (flagged by family physician or community services) and/or fear of fall (flagged by family physician or community services).
• To address transportation concerns by supporting working spouses/family members that provide the transportation, the groups will be run in the evenings and will be led by a Physiotherapist and Physiotherapy Assistant. The program will provide health education to address risk factors and promote a safe discharge to the community.
• Through reconditioning, the goal is to help the person to reach optimal physical functioning and independence in efforts to avoid more costly healthcare services.
• The program will provide access to up 30 patients per week and will run in 12-week increments.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>122</td></tr>
<tr><td>Number of frail seniors served</td><td>28</td></tr>
<tr><td>Number of clinicians trained</td><td>1</td></tr>
<tr><td>Total Additional Therapy Minutes</td><td>7320</td></tr>
</table>
<u>Lessons Learned</u>
• Due to the time constraints for implementation associated with later funding approval and fiscal year end completion requirements, system outcomes have not been measured.
• We had difficulty recruiting a full time Physiotherapist and part time Assistant to support this project. In the end, we were only able to hire a part time PT to support this work. While we were able to start two new Falls Prevention and Exercise groups, we did not have enough time to complete a full 12 week cycle; therefore, could not collect total data. At year-end, the outpatients from this project were absorbed into existing caseloads.
• As Senior's Day Rehab had a long waiting list for physiotherapy, this additional PT FTE was very helpful to ensure patients were assessed quickly and assigned to an exercise group. We feel that this project would have long term benefits to keeping the frail senior population safely residing in the community. Feedback from our patients was positive, as they enjoy both the one to one and group support from the Physiotherapist.</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Toronto Central LHIN</td>
<td>West Park Assess & Restore Program</td>
<td>The West Park Assess and Restore Program is a comprehensive integrated model of care for frail, community-dwelling seniors who have been identified as having potential for restoration of function.

The 3 main components of service delivery included:
1) Enhanced case management & pharmacy management via the Seniors' Mental Health Service (SMHS)
2) The establishment of an Inter-professional Geriatric Clinic & Outreach services
3) Home-based restorative programs via our partnership with Reconnect</td>
<td>• SMHS Service supported vulnerable seniors with mental health challenges, covering parts of Etobicoke, North York, and York (west of Dufferin).
• Clinic & Outreach Services were accessed by community-dwelling, frail elderly living in the Northwest end of Toronto, as well as residents living in supportive housing supported by Reconnect.
• Referrals received from the Family Health Team, SMHS, Reconnect, and community physicians.
• Recipients of the home-based restorative program have primarily been residents of supportive housing, referred from Reconnect.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>SMHS – 598 (222 face-to-face; 376 telephone)
Geriatric clinic (MD & allied health) - 514
Geriatric Outreach – 69
SCWSS PSW visits – 354</td></tr>
<tr><td>Number of frail seniors served</td><td>SMHS – 87
Geriatric clinic & outreach – 125
SCWSS PSW - 17</td></tr>
<tr><td>Number clinicians trained</td><td>3 clinic nurses – CGA workshop
3 clinic staff – Aging & Alzheimer's disease workshop</td></tr>
</table>
<u>Lessons Learned</u>
• Flexibility of interprofessional team model enables appropriate expertise to be accessed based on client needs; optimizes resource utilization
• Triaging and scheduling management strategies enabling rapid access as for patients with more urgent care needs
• Strong referral base from in-patient services within the West Park Healthcare Centre to provide follow-up services to those with geriatric issues identified during inpatient stay
• Referral of patients to appropriate community and/or medical services
• Continued participation by team members in RGP and RCA committees to maintain awareness of best practice standards
• Increased integration with our Seniors' Mental Health Service has led to referrals being triaged between services to improve access to appropriate, timely care
• Regular communication and shared coordination of care needs with circle of care for each patient
• Use of OTN to conduct Geriatric Consultations have been initiated</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes & Lessons Learned</th></tr>
<tr>
<td>Toronto Central LHIN</td>
<td>The Independence at Home (IAH) Program Supporting Frail Older Adults with Assess & Restore Needs – The University Health Network and Sinai Health System</td>
<td>• To support community dwelling, medically complex, frail older adults who have experienced or are at risk of experiencing functional loss
• To build on existing primary care integration strategies of local Health Links
• To ensure that primary and community care providers are involved in the decision making during assessment and care planning</td>
<td>• The allied health professionals within the IAH-COT complete a client focused, comprehensive assessment which facilitates a seamless navigation of resources and services.
• The assessments also identify any service gaps and the use of advocacy has been vital in clients' access to services.
• The IAH-COT has focused to ensure there is closure prior to discharge to ensure sustainability of the management strategy set in place to allow client's to continue residing at home with the appropriate services.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>1236</td></tr>
<tr><td>Number of frail seniors served</td><td>434 referrals</td></tr>
<tr><td>Clinical Frailty Scores</td><td>29% patients within moderately to severely frail category</td></tr>
<tr><td>Patient Satisfaction Survey – Would you recommend?</td><td>93%</td></tr>
</table>
<u>Lessons Learned</u>
• The interprofessional and inter-organizational approach of the IAH-COT allows for a unique model of care within the community, which improves communication between health professionals while coordinating care for patients.
• The Geriatricians within the IAH-COT are key members of the team that are involved in all aspects of care. The Geriatricians participate with reviewing referrals, attend weekly patient care rounds and conduct home visits. The immersive approach of the Geriatrician enhances the provision of care and directly impacts the patient's experience.
• The IAH-COT has enhanced the specificity and accuracy booking through the patient scheduling system which has allowed for a more thorough understanding of time allocation as well as improved tracking of resources required.</td>
</tr>
</table>

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes & Lessons Learned
Waterloo Wellington LHIN	Rapid Recovery Therapy Program (RRTP)	To improve healthcare for frail seniors and others who have experienced a recent loss in functional ability, and have shown restorative potential. (Assess and Restore Guideline, 2014) To optimize the use of healthcare resources to serve this population, increasing capacity of rehab and low intensity beds by shifting some care/capacity to community care with a Rapid Recovery Therapy Model.	• Daily therapy (physiotherapy or occupational therapy) visits are provided for 6 of the first 8 days after hospital discharge. Up to 16 additional visits are provided over a 30-45 day period post-discharge. • Patients can be referred from inpatient rehabilitative care or referred from acute care to avoid an inpatient rehabilitative admission. • This project involves great collaboration between hospitals, WWLHIN care coordinators, home and community care therapists (OT, PT, RN).	**Outcomes (indicators & Metrics) 2018/98 FY:** Number of frail seniors served: *252* ALC Rate: post-acute rehabilitative care: *21.7%* **Lessons Learned** • Evaluation focus in 2018/19 considered program sustainability and the ongoing education, clinical engagement, and buy-in from the clinical teams across the system. To that end, adverse events were explored for this program to determine if RRPT is reaching the appropriate target population and to ensure that, now that we have over 500 patients who have been through the program, there are not unexpected differential outcomes for specific patient populations. • Initial data review has indicated the following: Of the 581 Rapid Recovery records reviewed: o 17 deaths (2.9%) within 30 days of Rapid Recovery initiation o 40 deaths (6.9%) within 90 days of Rapid Recovery initiation o 2 patients with delirium within 30 and 90 days post discharge o 18 patients with infection within 30 days post discharge o 45 patients with infection 90 days post discharge • HSPs are considering option of a collective chart review to understand these data better and to contextualize them with an appropriate control population.

Hospital Based Initiatives

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Central LHIN</td>
<td>Assess & Restore Geriatric Rehabilitation Program, Southlake Regional Health Centre</td>
<td>Inpatient program designed to target frail seniors and facilitate community transitions through enhanced care provision using an interdisciplinary model and a combination of individualized and group programming.</td>
<td>

Population: patients over 65 years of age, with home address within the Central LHIN whose discharge destination has been established. Patients with multiple medical comorbidities and high scores on geriatric frailty indices are given priority. Length of stay should not exceed an average 55 days. Patients are admitted from acute units within the hospital. Early identification of appropriate patients is a priority.
Type and volumes of services: Services are provided by an interdisciplinary team, including but not limited to Physiotherapy, Occupational Therapy, Speech-Language Pathology, Recreation Therapy, OTA/PTA, CDA, Social Work, nursing. Patients flow through 8 dedicated, geographically co-located, geriatric rehabilitation beds with a maximum length of stay of 12 weeks (90 days). This will allow for an annual volume of a minimum of 32-56 patients per year.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>45</td></tr>
<tr><td>% inpatient A&R patients who are discharged home to their baseline living environment compared to a baseline rate, pre-initiative rate, or similar case mix group</td><td>96% discharged home or home with supports from CLHIN</td></tr>
<tr><td>Referral rate for community-dwelling frail seniors screened at-risk for loss of independence</td><td>81% H&CC
6% Geriatrics
13% No services</td></tr>
<tr><td>% unplanned readmission to hospital within 30 days of discharge from hospital</td><td>6.7% (3/45)</td></tr>
<tr><td>% of unplanned, less-urgent ED visit within the first 30 days of discharge from hospital</td><td>5% (2/45)</td></tr>
<tr><td>Annual ALC rate by: post-acute inpatient rehabilitative care services</td><td>1.5%</td></tr>
</table>
<u>Lessons Learned:</u>

Early discharge planning is a fundamental component of community transitions. Early discussions with Patient Flow Navigator and interprofessional team allows for greater efficiency in LOS
Measurement of frailty allows capture of complexity of admitted patients from a functional and medical perspective
Formalized schedules and standardized care delivery improve efficiency
Explore more formalized community partnerships

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Central East LHIN</td>
<td>Assess and Restore Mobile Team (ARM) Ross Memorial Hospital</td>
<td>To provide excellence in outcome-based, patient-focused geriatric care that promotes early identification, targeted standardized assessment, coordinated navigation, and individualized interventions for seniors 65yrs+ screened and assessed to be at risk.

The primary objective is to improve patient outcomes by:

-maintaining or increasing mobility and functional abilities

-improving patient and/or caregiver self-management skills

-providing standardized, coordinated, care for patients with Behavioural and Psychosocial Symptoms of

Dementia in alignment with HQO Best Practices

-facilitating seamless transitions in care</td>
<td>• Provide early engagement of the patient/caregiver into the circle of care
• Complete Geriatric screening using standardized and validated tools to promote patient flow
• Complete CGA using standardized and validated tools
• Initiate early referral/engagement of appropriate care team members and community partners
• Support the implementation of a coordinated and comprehensive plan of care
• Coordinate and mobilize community resources to support the patient's smooth transition
• Provide comprehensive standardized assessment and navigation for patients with Behavioural and
• Psychological Symptoms of Dementia (BPSD)
• Provide Consultation in specific areas of geriatrics (ie: Consent and capacity, Elder Abuse etc)
• Provide documentation and measures to support ongoing evaluation of the effectiveness of the program and identify opportunities for further program development
• Participate in actively pursuing ongoing program development opportunities</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>673 (+53 not seen)</td></tr>
<tr><td>Number of clinicians trained</td><td>67</td></tr>
<tr><td>% patients designated ALC within two days of acute care admission who are d/c to rehabilitative care bed</td><td>21.7%</td></tr>
<tr><td>percentage of clients discharged to RH/home (from RH/home prior to admission)</td><td>88%</td></tr>
<tr><td>% unplanned readmission to hospital within 30 days of discharge from hospital</td><td>17.7%</td></tr>
<tr><td>% patients improved or maintained:
Elderly Mobility Score
Clinical Frailty Scale</td><td>
100%
97%</td></tr>
<tr><td>% patients with Clinical Frailty Scale of 7 (mildly frail) – 7 (severely frail)</td><td>93%</td></tr>
<tr><td>% patients with AUA who score 6 (family overwhelmed)</td><td>82%</td></tr>
<tr><td>Number patients referred for BPSD</td><td>55</td></tr>
<tr><td>LACE Index Scoring Tool for Risk of Readmission
Readmission diversion success rate</td><td>94% high risk
77%</td></tr>
<tr><td>% LTC placements where client could have stayed somewhere else in community</td><td>13%</td></tr>
<tr><td>Annual ALC rate by: discharge destination to ALC-LTC</td><td>12%</td></tr>
<tr><td>Blaylock Discharge Planning Risk Assessment Screen

ALC diversion success rate</td><td>63% at risk for placement other than home
81%</td></tr>
</table>
<u>Lessons Learned:</u>
• Adjust service delivery model to continue to increase efficiency, productivity & funding fidelity
• Increase simple data collection to maximize reporting indicators
• Growing need for intervention and navigation for patients with BPSD</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Central East LHIN</td>
<td>Northumberland Hills Assess & Restore Intervention</td>
<td>The NHH Assess and Restore Intervention model of care provides comprehensive gerontological assessment, the identification of geriatric syndromes and interventions for those older persons who are frail at-risk seniors; therefore being most at risk both in hospital and in the community. 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.</td>
<td>Facility-Based Assess and Restore Interventions model of care provides the key elements of:
Integration of Gerontological Syndromes, End of Life and Futile Care
Nurse Practitioner Lead Assess and Restore Intervention
Gerontology Lead (GL)
NHH Assess and Restore Intervention Interprofessional Health Care Team (IHCT)
Care Processes:
NHH Assess and Restore Intervention team provides an ‘organization wide service,’ with the Nurse Practitioner providing comprehensive gerontological assessments for at risk patients in acute care as well as inpatient rehabilitation
Nurse to patient ratio on days, evenings and nights sufficient to conduct complex gerontological assessments & interventions
Comprehensive care planning based on interprofessional assessment and address all geriatric syndromes
Patient & caregiver engagement</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>327</td></tr>
<tr><td>% patients designated ALC within two days of acute care admission d/c to rehabilitative care bed</td><td>13.7%</td></tr>
<tr><td>% admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>18% (30/167)</td></tr>
<tr><td>% patients directly admitted to a rehabilitative care bed from the community who were discharged home</td><td>80% (133/167)</td></tr>
<tr><td>% of unplanned readmission to hospital within 30 days of discharge from hospital</td><td>same facility same unit = 1.2% (2/167)
same facility, any inpatient unit = 20% (34/167)</td></tr>
<tr><td>% of unplanned, less-urgent ED visit within the first 30 days of discharge from hospital</td><td>28.5% (38/133)</td></tr>
<tr><td>% of primary care follow-up visit within 7 days of discharge from hospital</td><td>100% within 7-10 days</td></tr>
<tr><td>ALC Rate - % ARI patients who become ALC-LTC</td><td>6.0% (10/167)</td></tr>
<tr><td>% of clients discharged home that were home prior to admission</td><td>48%</td></tr>
<tr><td>% of A&R inpatients who were discharged home (overall)</td><td>80% (133/167)</td></tr>
<tr><td>Rate of falls
Rate of falls with harm</td><td>26.6 falls/1000 patient days
0.68 falls/1000 patient days</td></tr>
<tr><td>Average FIM gain</td><td>17</td></tr>
</table>
<u>Lessons Learned:</u>
“Upstream” approach to advanced care planning and prevention of frailty
GEM nurse essential in early identification of frail elderly, patients for direct admission and those who may return home with increase supports</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Central East LHIN</td>
<td>Peterborough Regional Health Centre</td>
<td>To assess and create a treatment plan for frail seniors to prevent deconditioning and maintain mobility.</td>
<td>• Multidisciplinary SWAT program implemented on acute care with a focus on frail seniors</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td># incremental attendances/visits</td><td>304</td></tr>
<tr><td>Number of frail seniors served</td><td>258</td></tr>
<tr><td>Number of clinicians trained</td><td>4</td></tr>
<tr><td>% patients designated ALC within two days of acute care admission d/c to rehabilitative care bed</td><td>0%</td></tr>
<tr><td>% of unplanned readmission to hospital within 30 days of discharge from hospital</td><td>22.5% (66/293)</td></tr>
<tr><td>% of unplanned, less-urgent ED visit within the first 30 days of discharge from hospital</td><td>24% (70/293)</td></tr>
<tr><td>% of LTC placements where home care client could have stayed home or somewhere else in the community</td><td>22% (2/9)</td></tr>
<tr><td>Annual ALC rate by discharge destination to ALC-LTC</td><td>3.2% (10/304)</td></tr>
<tr><td>Average Acute LOS</td><td>8 days</td></tr>
<tr><td>Number of Caregivers who received training to support patients at home</td><td>149</td></tr>
</table>
<u>Lessons Learned:</u>

Clearly defined roles and responsibilities for team members with flexibility around duties of care and clear communication
Coordination and implementation of feedback pathways
Celebration of program successes
Timely data collection

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Champlain LHIN</td>
<td>7 day/week Therapy in ABI Rehab The Ottawa Hospital Rehab Centre</td>
<td>To enable a reduction in the median length of stay for ABI patients of 20 % while maintaining or improving related quality indicators.

The project links to 2 corporate hospital initiatives:

• Patient flow. There is a long wait time to access specialty ABI rehab beds in Champlain. Days waiting for admission to an ABI bed is 12.7 in Quarter 3 of 2017-18

• Increasing the patient experiences. TBI patients have expressed a wish to have more therapy on the weekends to decrease their time in hospital and because they find the current “downtime” on weekends to be very long.</td>
<td>• Provide an individualized program to ABI patients that is delivered with a higher intensity of rehabilitation care 7 days per week and where the same level of rehabilitation care is provided regardless of the day of the week.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td># incremental attendances/visits</td><td>294</td></tr>
<tr><td>Number of frail seniors served</td><td>12</td></tr>
<tr><td>Functional Outcome Measure Changes:

Average Change in Total Function Score on FIM</td><td>14.6</td></tr>
<tr><td>Annual ALC rate by: post-acute inpatient rehabilitative care services</td><td>Total of 12 ALC days during the pilot period</td></tr>
<tr><td>Reduced LOS</td><td>33.2</td></tr>
</table>
<u>Lessons Learned:</u>
• Increase in patient satisfaction scores
• The 7 day/ week therapy concept can result in an increase in bed turns using the same bedded capacity. The pilot suggests this concept can be cost neutral or better if there are available community resources for timely transition.
• Positive results for reduced LOS – reduced LOS by 7 days
• Improved patient choice for pre-discharge home visit when needed
• Better outcomes for patients- improved functional change scores
• An increase in admissions of 10-15% can be realized with the same number of beds. This type of rapid and intense therapy program requires strong interprofessional case planning and management. A framework for the establishment of goals and implementation of targeted activities to enable goal achievement is necessary.
• Enhanced and varied team communication strategies are necessary to ensure that multiple providers are consistent in their approach to providing acquired brain injury rehabilitation strategies.
• This model provides additional capacity to serve ABI patients and could potentially be applied to other specialized groups</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Champlain LHIN</td>
<td>Champlain Sub-Acute Care Navigation and Placement, The Ottawa Hospital</td>
<td>To formalize the standardized and shared protocols for A&R interventions to manage the placement of frail high-risk A&R-targeted seniors into sub-acute care beds from acute care.</td>
<td>

Screening for frail high risk assess and restore seniors in acute care settings
Monitor and integrate patient flow from acute care to sub-acute care or outpatient care services
Integration of sub-acute referrals and assessments for different rehabilitation and complex continuing care destinations, to ensure sustainability in the process
Improved navigation and transitions of care through “one-stop shop” model
Expanding and ensuring sustainability of the use of a Regional Clinical Patient Flow Algorithm to additional acute care hospitals in Champlain

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of incremental attendances/visits</td><td>4885</td></tr>
<tr><td>Number of clinicians trained</td><td>14 staff trained to perform assessments
218 staff trained on referral processes</td></tr>
<tr><td>% patients ALC on discharge from Acute Care to Rehabilitative Care</td><td>49%</td></tr>
</table>
<u>Lessons Learned:</u>

Centralized consult model enables matching of patients with appropriate subacute destination and ensures quick turn-around-time for RMR completion and acceptance/refusal responses
Tracking of various timeline points in the subacute navigation trajectory supports timely completion of referrals through resolution of barriers to efficient decision-making
Cross-training of consult professionals to assess for multiple subacute destinations minimizes hand-offs
A leader dedicated to focusing on subacute navigation supports success and sustainability
Technology can support and assist with timely and smooth referral processes.
Subacute navigation is linked to flow out of acute care
The subacute navigation model can be used to support achievement of QBP targets.
On-going education is important to maintaining process knowledge and referral efficiency
Consult model is applicable to many hospitals and scalable depending on hospital size and clinical structure
Increase in regionally centralized functions would be simplified and enhanced through technology to enable efficiency, tracking and data collection
Extra resourcing during surge periods ensures flow of increased referral volume

</td>
</tr>
</table>

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
Champlain LHIN	Coordinated Access – Project Management Support, The Ottawa Hospital	Develop a coordinated access model for subacute care in Champlain.	• A coordinated access workgroup was struck to build upon the assess and restore funded projects in Champlain, develop a coordinated approach to intake, assessment and alignment of patients with existing beds and program services. Using a phased in approach: ○ Acute/sub-acute to sub-acute beds. ○ Acute/Sub-acute beds to ambulatory sub-acute care. ○ Community to sub-acute bedded and ambulatory sub-acute care. • A series of workgroup meeting occurred with regional stakeholder participation to review current assess and restore projects, look at integration opportunities, review key enablers, review literature, consider application of the sub-acute evaluation framework and develop and refine a coordinated access conceptual model unique to the needs of the Champlain LHIN region.	**Outcomes (indicators & Metrics) 2018/19 FY:** • The conceptual model was created and approved by the Champlain Sub - Acute Network **Lessons Learned:** • Participation from rural and urban geographies is essential to developing a model that will work across the Champlain region. • Patient and family advisory member participation was valuable to the planning process. • The assess and restore projects in place in our LHIN were a great starting point to work from, allowing the focus to be on optimization and integration opportunities rather than starting from the beginning. • A key enabler to a coordinated access model is a technology-based referral option to have a regional view on bed activity, facilitate knowledge transfer across all levels of the system, to enhance transparency & access and facilitate planning. • Limited formal literature on evaluation and comparison of coordinated access models exists and at present no best practices have been identified to be extracted from. • Developing a hybrid model that blends both centralized and decentralized components allowed for local expertise and processes to be preserved within the sub regions while allowing for accountability, transparency and coordination regionally. This was essential due to the large geographic region of the Champlain LHIN.

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Erie St. Clair LHIN</td>
<td>Mobilization of Vulnerable Elders (MOVE) Initiative</td>
<td>In 2017-18, the Senior Friendly Hospital Mobilization of Vulnerable Elders (MOVE) approach was adopted, with the goal to engage the full hospital team in the philosophy of early activation. All HSPs began implementation of the MOVE model for the 2017-18 funding year with the help of available supportive resources from the MOVE Canada project.

All acute care admissions of patients aged > 65 years are assessed for mobility status within 24 hours of admission and mobilized with the MOVE A-B-C algorithm.

In 2017-18 a minimum of two units at each hospital site were engaged, with the goal of spread to additional hospital wards during 2018-19.</td>
<td>Bluewater Health:
2 Rehab Assistants support OT/PT to determine referral to the “A” team to provide/encourage activation and movement
Purchased MOVE Resource Package #1 for support in implementation coaching and data analysis & interpretation
Collaborative Model of Care (CMoC)
Chatham-Kent Health Alliance
Remainder of departments were education on Move and standard documentation developed
Erie Shores Healthcare, Leamington
Patient room whiteboards leveraged to support MOVE and implemented MOVE approach in rounds, safety huddles and documentation
Windsor Regional Hospital
Mobility Matters Bundle rolled out and spread to all units
Electronic care rounds boards support the work of the mobility program</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><th></th><th>BWH</th><th>CKHA</th><th>ESHC (LDMH)</th><th>WRH M</th><th>WRH O</th></tr>
<tr><td># frail seniors served</td><td>2169</td><td>2845</td><td>1791</td><td>3290</td><td>3716</td></tr>
<tr><td>average total LOS (days)</td><td>9.6</td><td>10.7</td><td>6.4</td><td>7.0</td><td>8.4</td></tr>
<tr><td># patients discharged home</td><td>1563</td><td>733</td><td>995</td><td>2188</td><td>2579</td></tr>
<tr><td>% patients discharged home</td><td>72.1%</td><td>50.9%</td><td>55.6%</td><td>66.5%</td><td>69.4%</td></tr>
<tr><td>% patients discharged to inpatient rehabilitation</td><td>8.4%</td><td>9.0%</td><td>11.9%</td><td>4.4%</td><td>10.4%</td></tr>
<tr><td>ALC patient count</td><td>198</td><td>279</td><td>128</td><td>274</td><td>463</td></tr>
<tr><td>% patients with ALC days</td><td>7.5%</td><td>19.4%</td><td>7.14%</td><td>8.3%</td><td>12.5%</td></tr>
<tr><td>average ALC LOS for ALC patients</td><td>15.2</td><td>6.91</td><td>16.39</td><td>21.7</td><td>15.0</td></tr>
<tr><td>% of patients readmitted in 30 days</td><td>7.0%</td><td>13.1%</td><td>6.5%</td><td>-</td><td>-</td></tr>
<tr><td>30 day readmissions to hospital</td><td>125</td><td>189</td><td>117</td><td></td><td></td></tr>
<tr><td>clinicians trained</td><td></td><td>203</td><td></td><td></td><td></td></tr>
</table>
<u>Lessons Learned:</u>
MOVE Resource Package was invaluable in its implementation on 2 Medicine Units
Opportunities identified such as the need for transfer training and lack of equipment or equipment that does not support MOVE
Next steps to incorporate MOVE into the implementation of a Collaborative Model of Care (CMoC) across the organization
The staffing coverage supported by this funding remain a critical component to its success, allowing early assessment and intervention of patients.
Support provided by the Movement Matters team continues to advance this work across the organization</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Hamilton Niagara Haldimand Brant LHIN</td>
<td>Seniors Mobile Assess Restore Teams (SMART)</td>
<td>To improve the patient experience through improving quality of care, integrating services and adding value.</td>
<td>

Mobile, rehabilitative care provided in hospital for seniors who are frail and experience functional decline and/or are at risk for further functional decline.
The SMART team develops and provides an intensive restorative program that targets individuals' specific recovery needs with the goal of earlier discharge home.
Individuals are identified and receive care in the emergency department (ED) and acute medical units. Individuals are screened within 24 hours of ED arrival with the Early Intervention Screener (EIS); individuals who screen positive, are screened for SMART.
Individuals begin the SMART interventions within 48 hours in parallel with acute medical care.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>3803</td></tr>
<tr><td>percentage of clients discharged home</td><td>84%</td></tr>
<tr><td>% requiring post-acute bedded rehabilitative care</td><td>9%</td></tr>
<tr><td>Functional Outcome Measure Changes:
Independent functioning on Barthel ADL Index</td><td>45%</td></tr>
<tr><td>% inpatient A&R patients who are discharged home to their baseline living environment compared to a baseline rate, pre-initiative rate, or similar case mix group</td><td>1.1% increase</td></tr>
<tr><td>ALC to LTLD level of care</td><td>45% decrease</td></tr>
<tr><td>Difference in Average LOS between SMART patients and patients with similar CMG</td><td>4 days</td></tr>
<tr><td>30 day readmission to hospital</td><td>15.7%</td></tr>
</table>
<u>Lessons Learned:</u>

Individuals benefit from receiving rehabilitative care in parallel with acute care; there is value related to the concurrent delivery of rehabilitative care together with the assessment and treatment of acute illness.
There is a potential significant cost avoidance related to the decreased LOS required within post-acute rehabilitative care following SMART; the decreased need for bedded rehabilitative care for individuals who have received SMART and the decrease in acute ALC to LTLD bed days.
A small investment in SMART teams positively impacts the journey of individuals, improves function, as well as demonstrates a significant potential cost avoidance for the healthcare system.

</td>
</tr>
</table>

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
North West LHIN	Assess & Restore, Sioux Lookout Meno Ya Win Health Centre	The addition of the 0.5 FTE Occupational Therapist will allow for a dedicated therapist to Assess and Restore patients who will be responsible for taking lead on the patients rehabilitation care, including facilitating collaboration with the broader care team. This is expected to promote a more timely and appropriate discharge. Throughout Q4, existing clinicians worked to provide weekend coverage while recruitment efforts were made for an Occupational Therapist or Physiotherapist. The additional position was filled effective April 15, 2019.	• The processes for screening, assessment, admission, treatment and discharge of the patient occurred as per existing practice for the current program and in accordance with the Assess and Restore Guideline. • Supporting transition to home and administering home and community-based care continued in accordance with the Home and Community Care Client Services Policy Manual, and Guideline for Collaborative Home and Community-Based Care Coordination.	**Outcomes (indicators & Metrics) 2018/19 FY:** Number of frail seniors served: *71* Rate of discharged home: 78.9% **Lessons Learned:** The Assess & Restore program has demonstrated valuable enhancement to patient care and a reduction in length of stay. By expanding services to include continued delivery of A&R programming over the weekend, patients were able to continue to make progress towards therapy and care goals without the delay or regression of progress experienced when there is a two-day gap in rehabilitation services. Expanded coverage on weekends also allowed for patients to be assessed and admitted to the program sooner, as well as assessed and discharged from the program sooner.

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>North West LHIN</td>
<td>Assess & Restore Weekend Coverage, Dryden Regional Health Centre</td>
<td>The goal of the program is to have patients discharged from hospital within 30-42 days with no admission longer than 90 days. This enhancement of the existing program will support the 40 patients per year with the hope of increasing capacity by 10 per year.</td>
<td>

This project funded weekend Rehab Assistant coverage for the inpatient unit at DRHC. It supports the existing Assess and Restore Program at DRHC by providing extra days of coverage as the previous Assess and Restore program provided care only Monday – Friday.
Patients that were already at high risk of functional decline tended to show decreases in function even over just a couple of days without structured rehab supports. As well, on the weekend, there is less nursing staff available on the inpatient unit which also decreases the amount of individual assistance that can be provided to patients that need extra time and support to complete their ADLs or need supervision for walking or other functional activities.
The weekend Rehab Assistant carries out the existing programing for the patient as per the OT or PT plan of care. They are also available to provide extra support to the nursing staff for two person care. No new assessments are completed during this time. An OT or PT is available for consultation by phone if required.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>50</td></tr>
<tr><td>Number incremental attendances/visits</td><td>933</td></tr>
<tr><td>% average functional change achieved by patients</td><td>24.4%</td></tr>
<tr><td>% inpatient A&R patients who are discharged home to their baseline living environment</td><td>97%</td></tr>
</table>
<u>Lessons Learned:</u>
The largest lesson learned is to request funding for full time jobs. Health human resources recruitment is one of the largest challenges for small towns in Northwestern Ontario. Unfortunately, difficulty recruiting for this positon has limited this project. This proposal initially was to fund a 1.0 FTE Rehab Assistant. This would have allowed for easier recruitment and retention of adequately trained staff. Base funding was approved for only for a 0.3-0.4 FTE which is almost impossible to recruit for. DRHC has been able to fulfill this project utilizing existing staff by paying over time or giving them time off during the week. This may not be sustainable in the long term.
</td>
</tr>
</table>

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
North West LHIN	Implementation of Assess & Restore Program, Riverside Health Care Facilities	In our district, we have an aging population. Our goal will be to expand the program with utilization of our internal resources and support from our community partners. Our aim is to provide safe and quality care to those clients within the scope of the project, to provide the rehabilitation required to return home.	Thus far, the program has had several challenges related to recruitment, extended closure of Rainycrest and continued surge capacity within the organization. When this proposal was originally submitted, we had a satisfactory complement of rehab professionals. Shortly thereafter, changes occurred. We have now recruited a full time Occupational Therapist (was a vacant position) in mid April 2019 and a Physiotherapist in February 2019. Our Occupational Therapist has more experience with the Outpatient population and very little recent experience with the inpatient population. We assisted with mentorship from our regional partners. Additionally, our new Physiotherapist has more experience with the outpatient clinic population, so intense mentoring has occurred with our Senior Physiotherapist, who will be retiring in November 2019. Recruitment, orientation and training has posed a challenge for the implementation of the program.	**Outcomes (indicators & Metrics) 2018/19 FY:** Number of clinicians trained: *1* **Lessons Learned:** • We are grateful for the funding provided to establish an Assess and Restore Program at Riverside and feel the program will be well utilized by the residents of the Rainy River District. With staffing somewhat now stabilized, and ongoing recruitment efforts continuing, we feel that we will be able to implement the program effectively and provide statistics to support this endeavor. • Additionally, in our proposal, Riverside suggested transfer to the CCP program for those patients requiring additional rehab time. We will track the # of admissions to the CCP from the Assess and Restore program. By monitoring this indicator, it will help us to determine if the Assess & Restore program is successfully implemented but will also help us determine whether our patients are more complicated and require longer Assess and Restore stays at LVGH. • Currently, rehabilitation staff work Monday to Friday only. If the program continues to expand, the need for weekend rehabilitation staff will be monitored for the success of the program. • We are also in hopes that the CCP beds will be reviewed and reopened in the near future at Rainycrest once LTC admissions are completed.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
North West LHIN	Assess & Restore Additional Coverage, Red Lake Margaret Cochenour Memorial Hospital	The intent of the Program is to reduce Alternate Level of Care (ALC) days by supporting a minimum of two (2) concurrent frail seniors in hospital to be able to safely return home · and remain independent for as long as possible in the community.	• Provide inpatient weekend Rehab Assistant coverage • Patients that were already at high risk of functional decline tended to show decreases in function even over just a couple of days without structured rehab supports. The Rehab Assistant carries out the existing programing for the patient as per the Physiotherapist's plan of care. They are also available to provide extra support to the nursing staff for two person care. No new assessments are completed during this time.	**Lessons Learned:** • The largest lesson learned is to request funding for full time jobs. Health human resources recruitment is one of the largest challenges for small towns in Northwestern Ontario. Unfortunately, difficulty recruiting for this positon has limited this project. If the initially proposal was to fund a 1.0 FTE Rehab Assistant, this would have allowed for easier recruitment and retention of adequately trained staff.

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>North West LHIN</td>
<td>Assess and Restore expansion at Lake of the Woods District Hospital Regional Health Sciences Centre</td>
<td>The project “Assess and Restore expansion at Lake of the Woods District Hospital” provided new baseline funding for a part-time Rehabilitation Therapist, thereby expanding capacity to meet the demand for Assess and Restore and Rehabilitation services by providing extended coverage on weekends.</td>
<td>

The processes for screening, assessment, admission, treatment and discharge of the patient occurred as per the existing practice and in accordance with the Assess and Restore Guidelines. Supporting transition to home and administering home and community-based care was provided in accordance with the Home and Community Care Client Services Policy Manual, and the Guideline for Collaborative Home and Community-Based Care Coordination.
The Assess and Restore Program services were provided to target populations as outlined in the Assess and Restore Guideline, including individuals who:
• Have experienced a recent loss of functional ability following a medical event or decline in health
• Are at high risk for imminent hospitalization or admission into a long-term care home bed as a result of that functional loss ('high-risk')
• Have the potential to regain that functional loss so that they are no longer at high risk ('restorative potential')

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>460</td></tr>
<tr><td>Number frail seniors served</td><td>294</td></tr>
<tr><td>Number clinicians trained</td><td>7</td></tr>
<tr><td>% A&R Patients treated that were successfully returned home</td><td>70%</td></tr>
</table>
<u>Lessons Learned:</u>

Current funding allocations and system structures do not provide rehabilitation professionals or other health care staff in small community hospitals with the time or resources required in order to provide weekend rehabilitation, with the result that patients languish and lose strength, mobility and function on weekends.
The project “Assess and Restore expansion at Lake of the Woods District Hospital” has addressed this issue by providing the means for a small community hospital to offer a level of weekend service that is comparable to a regional Rehabilitation hospital. The result in the first 5 months has been phenomenal, with extensive patient interaction and overwhelming support and appreciation from both patients, families and other health care providers.
With baseline funding in place, the enhanced Rehabilitation services will continue. Patient care, hospital length of stay, LTC admission and ALC rates will continue to be affected. The weekend therapy program at the LWDH will continue to be an excellent fiscal and cost-effective means for addressing the burgeoning need for ALC and LTC in the Kenora region.

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>North West LHIN</td>
<td>St. Josephs Care Group</td>
<td>To facilitate direct admission to Rehabilitative Care.</td>
<td>

Client goals generally can be met within 4-6 weeks on the program. On average clients should receive 1 hour of therapy per day Monday through Friday. The program follows the leading practices for the assess and restore approach to care and treatment. This includes screening, assessment, navigation, placement, delivery of interventions and transitions home.
Seniors 65 years of age or older residing within the North West LHIN. Seniors who have deconditioned and would benefit from a full assessment and therapy program to achieve goals of living longer with or without supports in the community.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>487</td></tr>
<tr><td>% admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>16.2%</td></tr>
<tr><td>% patients directly admitted to a rehabilitative care bed* from the community who were discharged home</td><td>82%</td></tr>
</table>
<u>Lessons Learned:</u>

Partnerships within the Frail Senior Pathway;
Development of internal & collaborative indicators;
Data collection with Partners; and,
Increased rehabilitative staff resources.

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>South East LHIN</td>
<td>Assess & Restore: Early Identification of Risk/Frailty, Quntie Health Care</td>
<td>QHC will continue to build on the 17/18 success of 2 separate short term funding projects by coordinating care between the Emergency Department and medical units to identify 20 moderate to high risk patients per month, and provide comprehensive and focused care aimed at improving key measurable factors that decrease the risk of readmission and use of community PSW services on discharge.</td>
<td>

A mobile and interprofessional team, internal to Quinte Health Care, Belleville General Hospital, using standardized identification and assessment tools to facilitate Type 1 (Sub Acute Complex) Assess and Restore interventions, providing measurable patient outcomes and reduced system costs for QHC’s complex, frail and elderly patient population.
Leveraging the ED Deployment Team (Occupational Therapy led), the team will use the Clinical Frailty Scale to identify high risk patients, resulting in earlier therapeutic services with a comprehensive and focused care plan built on the foundation of improving key Activities of Daily Living (ADLs) for patients in the Emergency Department and Acute Care.
The team will expand the use of the Alpha FIM instrument to measure and inform care in these key areas while also providing objective feedback to our Home & Community Care partners on specific ADL care needs at discharge.
Phase 1: Train & educate staff by Jan 1 to March 31, 2019
Phase 2: Program roll out with measured results during FY 2019-20 (March 31, 2019)

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of clinicians trained</td><td>6 OT
6 PT
6 PTA/OTA
4 PSW
3 RN
3 RPN</td></tr>
</table>
<u>Lessons Learned:</u>

Our concept for early identification and treatment (in the ED) was sound, however; space, available equipment and acuity limited the treatment portion of the interventions. Working with the ED Deployment Team, we used a succession of PDSA cycles to develop a plan to adjust trained therapy resources to spend more time on the medical unit with a decreased resource intensive assessment/treatment protocol used in the ED (better fitting the current state limitations).
This also allowed visibility to gaps in unit to unit communication that is being reviewed as we move through the 19/20 pathway.
2019/20 has been building on the plan to deploy trained resources to the correct point for timely treatment, follow-up assessment and improved outcomes using the Alpha FIM and FIM instrument as a standard tool.
The ED team is providing appropriate assessment and communication to other unit groups to limit gaps in care. Improved timely communication on early assessments is being built into standard practices. Early focused treatment on patient goals, with input from a larger interprofessional team, is showing positive results on both improved function and reduced use of home care resources. ED avoidance data will be retrospectively collected towards the end of the project.

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>South East LHIN</td>
<td>Better Outcomes for Older Adults: Capacity Building and Safe Transitioning, Providence Care Hospital</td>
<td>This initiative engages demonstrated successful BOOST® principles in ensuring safe, successful transitions, community reintegration and primary care/community handover to mitigate ER visits and readmissions, and to support independence in the home. By reducing the occurrence of discontinuity and fragmentation of care, this initiative will also reduce patient adverse events, such as medication errors, as well as improve patient experience by improving continuity and flow of relevant health care information. This initiative aligns with Ministry A&R and HQO efforts to coordinate responsive care, ensure access to care, and improve patient outcomes and experience.</td>
<td>• During the inpatient stay, in additional to existing Interprofessional Specialized Geriatric assessment, interventions and care planning at PCH, a newly dedicated OTA/PTA, under the direction of an Occupational Therapist and team Physiotherapist, will work closely with patients to maximize activation, participation and self-management relating to mobility and home safety function (e.g., falls prevention, kitchen safety, ADL function) for safe transition and sustained independent living in the community.
• A newly designated Occupational Therapist will hold a transitional support role to work closely with patients and families on a ‘teach-back’ model of discharge education, identify readmission risks, and work closely with primary care and outpatient service providers to improve communications and handover for high-risk patients. Care planning will involve telephone or in-person follow-up visits with patient and caregiver post-discharge, and contact and coordination with primary health care providers and ambulatory or community supports to ensure continuity of care planning.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td># incremental attendances/visits</td><td>619</td></tr>
<tr><td># frail seniors served</td><td>106</td></tr>
<tr><td>Number of clinicians trained</td><td>5</td></tr>
<tr><td>Total Additional Therapy Minutes</td><td>19,640</td></tr>
</table>
<u>Lessons Learned:</u>
• Due to the time constraints for implementation associated with later funding approval and fiscal year end completion requirements, system outcomes have not been measured
• The Occupational Therapist was able to teach the BOOST principles to her colleagues and this is an initiative that we feel is important to carry on with our patients outside of the project, as it ensures a safe and positive discharge experience for our patients. We have created a Discharge Questionnaire that we hope to implement with all of our patients leaving PCH.
• Patients and families shared positive feedback with regards to having additional therapy times during their stay; especially including weekend therapy.
• Challenges identified by OT were that when making follow up phone calls to patients at home, it was difficult at times to reach patients. Also, when doing follow up with the family physician’s office they sometimes were unclear of the purpose of the call.</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>South East LHIN</td>
<td>Assess & Restore: Fast Track Inpatient Geriatric Supports, Providence Care Hospital</td>
<td>This model will be based on an evidence based triage of recent ER attendees and/or recent unexpected functional decline from community with initial nurse led screen followed by targeted assessment, short term case management and coordinated, interprofessional care. The care plan will highlight intensive physiotherapy and occupational therapy assessment and intervention, and will engage Geriatricians and Pharmacy in polypharmacy risk mitigation strategies as well as patient education relative to medication needs. The goal of this program is to break the cycle of repeat Emergency Department visits and hospital utilization by identifying remedial contributors to frailty and functional decline.</td>
<td>

This program will target a sub cohort of at-risk frail seniors living in the community who are unable to access PCH outpatient interprofessional geriatric services, whether due to physical condition, paucity of social supports, transportation barriers or geographic constraints.
The framework identifies at-risk individuals in the community or recently identified in the Emergency Department to participate in a ‘fast-track’, short-stay intensive, geriatric inpatient admission. Comprehensive geriatric nursing and interprofessional assessment on admission will be key, with process and procedural revisions to tighten assessment and intervention timeframes in support of <14-day admission.
The program will be distinctive to the Region, with access to Geriatricians and Care of the Elderly Physicians, intensive interprofessional rehabilitation; geriatric pharmacist intervention and transition planning to support seamless community reintegration. These individuals will guide and direct intensive rehabilitation (up to three hours per day) with PT, OT, OTA/PTA supports.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td># incremental attendances/visits</td><td>858</td></tr>
<tr><td># frail seniors served/ # admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>70</td></tr>
<tr><td>Number of clinicians trained</td><td>12</td></tr>
<tr><td>Total Additional Therapy Minutes</td><td>32,111</td></tr>
</table>
<u>Lessons Learned:</u>

With the timing of the funding notification, recruitment and rollout, and fiscal year completion constraints, this pilot was limited to an implementation period of only 12 weeks. As this was a new project for the PCH teams, the planning and implementation took longer, as it involved training multiple staff and communication with our acute care partners.
As this model was based on an evidence based triage of recent ER attendee and/or recent unexpected functional decline from community, meetings were necessary with our acute care partner to ensure they understood what patients would be suitable to refer for the project. Given these meetings, new connections were formed that allowed for a smooth transition from ER to PCH. This project focused on patient flow from ER to rehab, resulted in positive feedback from our acute care partners. The acute care partners shared that this project is much needed to improve patient flow from ER, and or avoid visits to ER.
Geriatricians at PCH arranged clinic schedules to allow for quick referral from ER or community to be assessed in clinic for an inpatient stay. We included involvement from our RN from Senior’s Day Rehabilitation, as the patient could be assessed for both an inpatient and outpatient program.
As our RN was experienced with triage from ER, she was able to quickly assess and refer; however, the nurse was only available part time. With more time to complete the project, this work would have resulted in a greater number of ER diversions and an overall reduction in ER admissions.

</td>
</tr>
</table>

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South East LHIN	Navigation and Support for Frail Elderly Individuals with Dementia: ED Diversion to Specialized Geriatrics Supports, Providence Care Centre, Providence Care Hospital	There are increasing numbers of older adults with dementia and cognitive impairment presenting to acute care emergency rooms (ER) and inpatient medical and psychiatric services. Many of these individuals may be able to be transitioned to a safer and more appropriate environment through access to rapid assessment and care coordination to reduce ER wait times for this group, divert unnecessary hospital admissions, reduce hospital length of stay and ALC for those who are admit and delay or prevent LTC admission which would improve patient/family experience, improve quality of care and health system outcomes. Currently, there are dedicated resources in the SE LHIN for this complex patient population.	• Our proposal is to develop a robust evaluation and long-term sustainable plan for dementia patients at KHSC would be most beneficial. This would include establishing a current state and needs assessment using quantitative methods, qualitative methods and establishing a steering committee. • The evaluation would be formative in that early findings or existing knowledge can be acted on immediately while data is being collected. The continued development of an algorithm and understanding current state process map for people presenting to the ER (which is currently ongoing), streamlining processes for admission to psychiatry, integration with other work such as BSO Central Intake while the more fulsome evaluation occurs. • We are anticipating completion of this evaluation by the end of July, 2019. All of the planned case reviews at KHSC have been completed at this time (N=16). Five key informant interviews have been completed and we anticipate completion of another 5 – 7 interviews over the next month.	**Lessons Learned:** • Preliminary strengths of the current system of supports for older adults have been identified including: - implementation of screening protocols, pain assessment, delirium assessment - involvement of family/referral source in understanding context, access to interdisciplinary team in ED - access to consults and transition planning. • Some preliminary areas for that may the focus of future quality improvement include: - more person centred care planning, nonpharmacological interventions, dementia-friendly communication - avoidance of seclusion and restraint use - standardized behavioral documentation and communication - geriatric medicine consultation - standardized pathway for temporary hospitalization (dementia clinical pathway algorithm) - Access to immediate community placement or support options - Resources to support immediate transitions back to place of residence. • Future suggestions include potential formation of an advisory committee or working group involving key stakeholders to act upon the findings of the evaluation and also more focused efforts to improve clinical pathways in the ED and Burr 4 should be considered to align care with best practice frameworks. The lessons learned from the current evaluation also support the need for a broader evaluation to look at larger system challenges to address difficulties with timely access to community based services to prevent ED presentations using an upstream approach along with understanding potential barriers and solutions to challenges related to timely repatriation of individuals presenting to the ED.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South East LHIN	Kingston Health Sciences Centre: Gentle Persuasive Approach	To benefit patients, families and staff by way of building skills for safe and gentle interactions with aged clients and those with dementia.	• GPA is delivered in 4 modules over an 8 hr day and includes respectful staff protection and gentle redirection techniques to use in situations of safety risk • In addition 4 more regulated staff and one unregulated staff have been certified to become GPA coaches • Staff trained included 80 RNs, 28 RPNs, 33 PCAs, 21 Allied Health, 6 Unit Clerks, 5 Other • Benefits: Increase in reported self confidence and clinical skills by front line providers when working with patients that have dementia or other challenging behaviours and decrease use of restraints	**Outcomes (indicators & Metrics) 2018/19 FY:** Number of staff trained: *173* **Lessons Learned:** • Working on sustainability by increased number of GPA coaches (now 6). This is a sought after educational intervention by front line staff.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South East LHIN	Fall Prevention, Kingston Health Sciences Centre	Avoid fall injuries among the elderly by involving a continuous quality improvement process directed to the eliminations of preventable falls.	• 4 interventions introduces, including daily safety huddles	**Outcomes (indicators & Metrics) 2018/19 FY:** Number of staff trained: *534* **Lessons Learned:** • Of the 4 interventions introduces, the one anticipated to be the greatest challenge (daily safety huddles) has been the most successful and popular • The use of additional resources to implement these best practice interventions has been very successful in transitioning care and culture.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South East LHIN	Functional Assess Admission & Discharge, Kingston Health Sciences Centre	Implementation of the Canadian Health Outcomes for Better Information and Care (C-HOBIC)	• Canadian Health Outcomes for Better Information and Care (C-HOBIC) is the only nationally recognized validated tool for ADL and IADL data collection (based on the InterRAI AC measures.) The use of C-HOBIC facilitates provider ability to quantify risk for seniors complexity and frailty where timely intervention has greatest potential to prevent permanent functional loss. The detailed metrics enable targeted focus of clinical resources with evidence based interventions to address areas of functional loss for those identified at greatest risk.	**Outcomes (indicators & Metrics) 2018/19 FY:** Number of staff trained: *391* **Lessons Learned:** • Completion rates are significantly improved up to 75% completion rate on admission and 48% completion on discharge • More work is needed, e.g. continued auditing • Continue to work to demonstrate the value to the point of care staff (i.e. recognition of the value of the tool for their daily care)

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>South West LHIN</td>
<td>Enhanced Physiotherapy and Occupational Therapy Services to Frail Elderly in Acute Care – Preventing Deconditioning, London Health Sciences Centre</td>
<td>To address the functional decline of frail seniors through the provision of enhanced physiotherapy (PT) and Occupational Therapy (OT) services with the goals of restoring function and facilitating discharge to their home.</td>
<td>

Individuals are identified and receive care in the emergency department (ED), acute medical and cardiology units. Individuals are screened within 24 hours of ED arrival; those individuals who screen positive, are assessed by the team and rehabilitation interventions will begin within 48 hours in parallel with acute medical care.
The team is comprised of a dedicated complement of rehabilitative care staff funded through A&R funds (i.e. occupational therapists (OT), physiotherapists (PT), OT assistants and PT assistants), who will work together with in-kind interdisciplinary team members to deliver a rehabilitative assess and restore philosophy of care 7 days a week.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>4667</td></tr>
<tr><td>Number of frail seniors served</td><td>196</td></tr>
<tr><td>% inpatient A&R patients who are discharged home to their baseline living environment</td><td>42% home
18 % SAMU/Palliative Care
5% LTC/Retirement Home
2% Inpatient Rehab
7% deceased</td></tr>
<tr><td>30 day readmission to hospital</td><td>30%</td></tr>
<tr><td>Average Functional Change:
FIM

10 metre gait speed</td><td>
Baseline – 55
Discharge – 69
Baseline – 0.39 m/s
Discharge – 0.43 m/s</td></tr>
<tr><td>Average LOS</td><td>10 days</td></tr>
</table>
<u>Lessons Learned:</u>

This model may be better suited to the sub-acute medicine (SAMU) population as patients in SAMU tend to have longer lengths of stay and are more medically stable, allowing for greater ease of implementation.
This enhanced service model cannot be sustained without OTA/PTA resources. Dedicated OTA/PTA resources are necessary to allow for twice-daily treatment for patients on the Medicine and Sub-Acute Medicine units.
This enhanced service model did introduce standardized outcome measures to the Acute Medicine Service. Current resources do not allow for outcome measures to be routinely implemented for all frail elderly patients admitted to the Medicine and Sub-Acute Medicine units, though staff now possess the knowledge, skills and equipment to use when clinically indicated.
This enhanced service model introduced standardized treatment programs (exercise sheets, etc.) that were developed specifically for frail seniors.

</td>
</tr>
</table>

<table>
<tr><th>LHIN</th><th>Project Title</th><th>Project Goal</th><th>Brief Description of Initiative</th><th>Outcomes and Lessons Learned</th></tr>
<tr>
<td>Toronto Central LHIN</td>
<td>An integrated system of Transition Care Planning for frail high risk seniors – The Salvation Army Toronto Grace Health Centre</td>
<td>To have hospitalized frail, high-risk seniors receive the right intensity of care at the right time to support their return to home. Proactive, coordinated inter-organizational care transition planning optimizes health system resources in different sectors: acute care, complex continuing care rehabilitation, home and community care and Community Services thereby improving patient outcomes while increasing system efficiency.

Our goal is to achieve the ongoing and seamless transition of alternative level of care (ALC) clients and those at high-risk of becoming ALC back into the community</td>
<td>• The population served experiences complexity in a number of areas including issues with mental health and addictions, medical complexity and social frailty
• Transitional Care Coordinator (TCC) to assist with the flow of patients from acute care to Complex Continuing Care Rehabilitation and to the patient's final destination in the community.
• Partnering with a community agency who will provide appropriate staffing and technologies ensuring real-time monitoring.
Patients at TGHC receive:
a) Mental Health support for patients and families.
b) Rehabilitation up to 6 days a week (or as tolerated).
c) Coordination of care using TGHC as the HUB prior to discharge.
TGHC provides the following while the patient is transferred to the community:
a) TCC to follow the patient up to one month.
b) Option to be seen at Outpatient Clinic within 10 days of discharge from TGHC if needed.
c) Real-time monitoring while the patient is in the community—TGHC acts as a HUB to coordinate the patients' medical need.</td>
<td><u>Outcomes (indicators & Metrics) 2018/19 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>85</td></tr>
<tr><td>Number clinicians trained</td><td>All nurses on our Post-Acute Care Rehab (PACR) unit have been trained in our A&R Program</td></tr>
<tr><td>% admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>15%</td></tr>
<tr><td>% of unplanned readmission to hospital within 30 days of discharge from hospital</td><td>0%</td></tr>
<tr><td>Primary care (Outpatient) follow-up visit within 7 days of discharge from hospital</td><td>100%</td></tr>
<tr><td>LTC placements where home care client could have stayed home or somewhere else in the community</td><td>100%</td></tr>
<tr><td>Annual ALC Rate</td><td>5%</td></tr>
</table>
<u>Lessons Learned:</u>
• Integration of services from different organizations to ensure patients' care optimized. It is important to clarify with patients the available services as part of the plan of care (for discharge) in order to sustain community re-integration.
• It is important to clearly define the processes for community support and the available services for patients discharged back to the community. The notion of Bundle of Services following the patients will need to be clearly defined and who is responsible for these services in the community.
• Our goal is to expand our program to include other acute care facilities.
• The next step is to create an "Ontario Health Team" as part of the continuum of care (currently categorized 'In Discovery' by the Ministry). This will ensure patients are cared for in the community post-discharge. The notion of a "Hub and Spoke" model with establish community partnerships necessary to reduce and prevent recidivism of the ER and acute care admissions.</td>
</tr>
</table>