Rehabilitative Care Alliance

2016/2017 Assess & Restore Initiatives

Overview and Summary Analysis

November 2017

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This document provides a high-level overview of the Assess and Restore (A&R) initiatives, completed in each LHIN, with 2016/17 Assess and Restore funding. This summary was developed as a repository of information, to support knowledge exchange related to A&R approaches and outcomes.

Summary of A&R Initiatives Objectives and Approaches

In 2016/17, 30 A&R initiatives were undertaken across the province. These initiatives were implemented across the continuum of care, from primary care, home and community care, and emergency departments, to acute care, and facility-based (bedded) rehabilitative care.

The overarching objectives of these A&R initiatives were to 1) enhance and improve access to restorative care services for older adults; 2) move care, for older adults, from facility-based to community-based, wherever possible, by implementing proactive models of risk screening and navigation; and 3) improve outcomes for older adults by implementing best practice care, including comprehensive geriatric assessment and geriatric interprofessional rehabilitative care.

There was significant variety in the types of A&R initiatives undertaken. However, there were consistent themes that emerged, across multiple initiatives, in terms of approaches utilized to implement an A&R approach to care. These included:

- **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**
- **Supportive transitions across sectors**
- **Interventions to prevent falls; reduce falls risk**
- **Building clinical capacity to provide best practice care to frail older adults**
- **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**
- **Increased 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**
- **Developing online resources to support education and best practice care**
- **Developing and utilizing online resources to support implementation of evidence based care pathways**

Summary of Outcomes

During the 2016/17 funding period, more than 23,000 older adults received care through A&R initiatives. As detailed in the summaries below, these initiatives demonstrated a number of positive outcomes, including:

- **Improved function and independence**
- **Improved quality of life**
- **Decreased frailty**
- **Decreased depression**
- **Improved navigation to, and linkages with, community resources**
- **Decreased caregiver strain**
- **Decreased falls and falls-risk**
- **High rates of discharge home**
- **Decreased ALC days**
- **Increased clinical knowledge and awareness of best practice geriatric care**
- **Decreased admissions to Long Term Care**
- **Optimized utilization of specialized resources**
- **Prevention of avoidable acute care admissions**
- **Decreased hospital readmissions and ED visits**
- **Positive patient and caregiver experience**

Summary of Lessons Learned

- Implementing a proactive A&R approach to care requires linkages with primary care. Primary care is uniquely positioned to identify at-risk older adults and implement care pathways to evidence-based preventative and restorative care. Linkages with primary care also provides an opportunity for clinical capacity building between specialised geriatric services and primary care providers
- Clinical geriatric education can help embed best practice approaches to care
- Frail older adults often require, and benefit from, concurrent delivery of medical intervention together with restorative, interprofessional management of geriatric syndromes
- Frail older adults require comprehensive assessment, interprofessional case management approaches, and supportive care transitions
- Cross sectoral integration improves care, patient experience and health outcomes; technology can help support smooth transitions and integration of care across sectors
- Standardized tools allow for better screening and identification of risk level; standardized screening processes, together with standardized referral pathways, improve navigation to the right care, in the right place, at the right time
- A care coordination/navigator position can improve transitions across sectors and increase the likelihood of patients receiving the right care, in the right place, at the right time

- Pharmacological management is a key component of providing best practice geriatric care, and improving outcomes

Summary of Key Messages

A cross-sectoral integrated approach to restorative care improves outcomes for community-dwelling older adults

- Proactive interprofessional restorative care improves clinical outcomes, and can lead to improved quality of life as well as cost avoidances, by preventing avoidable hospital and Long Term Care admissions. A comprehensive, interprofessional approach is needed to meet the needs of the frail older adult population
- Holistic, comprehensive intervention often requires that care be integrated across multiple partners and sectors
- A system of care for frail older adults needs to flexible and adaptable, in order to meet the complex needs of this population. Cross-sectoral, integrated care pathways increase flexibility and increase the likelihood that older adults can age-in-place
- Cross-sectoral collaboration, and in integrated care pathways create a single point of access model of care for community-dwelling older adults, which allows for streamlined and timely navigation to the most appropriate care, to support aging in place
- A single point of access model can also reduce workload and save time, for physicians (including primary care providers), and can reduce delays in accessing appropriate care, ensuring timely access to restorative care and preventing waiting periods in which restorative potential could be compromised
- Improving outcomes for older adults requires smooth transitions across sectors, best achieved when cross-sectoral health care partners/teams working as one “system” or “one community of care”, to assess needs, develop a plan of care, and navigate patients to the most appropriate service/resource

Proactive access to comprehensive assessment and restorative interventions improves outcomes and reduces avoidable admissions

- Outcomes for community-dwelling older adults are improved when existing resources are leveraged in the development of restorative care pathways for low, moderate and high-risk older adults
- Proactive access to comprehensive assessment and restorative interventions results in positive patient and system outcomes; preventing avoidable hospital admission and optimizing community independence.
- Although resources and patient needs can vary across regions, rapid access to comprehensive assessment, and proactive referral to appropriate supports can help prevent hospital admissions in both urban and rural areas
- Improving function reduces caregiver burden, which can lead to prolonged community independence/delayed admission to long term care

Geriatric education and senior friendly care are essential components of successful A&R implementation

- Implementation of Senior Friendly Care practices, and geriatric education efforts, are essential to the successful implementation of A&R models of care, and to ensuring that health service providers are able to provide best practice care to frail older adults

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central LHIN	Enhancing Assess & Restore Capacity within the Central LHIN	The overarching objective of this project was to enhance services for high risk seniors in the North York Central region, with the goal of intervening and delaying the loss of functional ability. The combined goal of the in-hospital and in-home therapy enhancements was to reduce the hospital length of stay, as well as to test an alternative to the transfer of patients to a specialty rehabilitation hospital or convalescent care facility where possible.	The Central CCAC developed an "A&R Home First" pilot project and partnered with North York General Hospital to develop and test a new model of coordinated care that follows A&R patients across care settings. This approach aims to reduce unnecessary transitions of care and assessments, and increase continuity of care for patients and families. NYGH provides standardized rehabilitative care on acute inpatient units to frail seniors who meet the A&R target population definition. Patients are also screened and identified in the ED, in order to prevent avoidable admissions, through direct referral to the CCAC. In FY 16/17, the A&R Therapy (ART) Program was developed as an outpatient resource aimed at continuing support for patients after discharge from the in-home component of the program. The goal of the ART program was to support maintenance of the functional gains made through patient involvement with Assess & Restore.	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 722 Clinicians trained: 80 % of unplanned readmissions to hospital within 30 days of discharge: 12.3% % of unplanned, less-urgent ED visit within 30 days of discharge from hospital: 1.2% Key findings also include consistent, statistically significant improvements, post A&R, on the Geriatric Depression Scale, MAPLe Level, CHESS Scale, ADLs & IADL Difficulty, Timed Up and Go, Berg, Tinetti Gait and Balance, Manual Muscle Testing and Health Related Quality of Life score **Patient/Caregiver/Provider Experience** Patients and caregivers have shared positive feedback regarding the program supporting them to regain independence **Lessons Learned** Development and implementation of referral pathways, which included primary care as a referral source, was necessary to identifying eligible older adults and facilitating access to the A&R program. Transportation is a barrier to patients accessing outpatient A&R programs **Key Messages** Cross sector collaboration allows for the successful identification and assessment of high risk older adults, and the provision of enhanced rehabilitation services in outpatient settings, on inpatient units, and in-home, as well as in supporting patients through transitions between care settings.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central East LHIN	Assess and Restore Mobile Team – Ross Memorial Hospital (RMH)	The objective of the RMH Assess and Restore Mobile Team (ARM) is outcome based patient focused care that promotes early identification, targeted standardized assessment, coordinated navigation and individualized interventions for those seniors identified as at-risk.	The ARM team focuses on frail senior/medically complex patient populations, in acute care, and provides consultation in post- acute care. The team uses evidenced-based geriatric assessments and individualized interventions to support both the in- hospital management of geriatric syndromes and the successful transitions to home or other destination in the care continuum. Treatment is aimed at increasing strength, mobility and functional ability with the goal of returning to the community. The ARM Team provides early engagement for patients; utilizes standardized geriatric and risk assessment tools; collects collateral information necessary to coordinate the patient's care and anticipate transitions for discharge; and implements a coordinated comprehensive plan of care with targeted interventions, including coordination with community resources such as GAIN and CCAC Home First, to transition the patient back safely the community.	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 376 % of patients screened who maintained or improved function: 92% % of patients discharged home to baseline living environment in the community: 100% Average functional improvement (FIM): 19.2% **Lessons Learned** Complex cases require comprehensive assessment, treatment and planning, and requires a case management approach by the team beginning at the time of admission and continuing through the transition home. Earlier emphasis on building a foundation of geriatric education leads to greater success in sustainability and imbedding best practice. Coordination of hospital and community services helped improve care transitions and coordinated care plans. **Key Messages** Case management and navigation are key components in maintaining community independence for the frail older adult population, by allowing for early identification, referral and connection to services in hospital and in the community. There is also value in following up with patients post discharge to ensure smooth transitions.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central East LHIN	Northumberland Hills Hospital (NHH) Assess and Restore Intervention	The purpose of this initiative is providing early screening and standardized geriatric assessment, facilitate navigation, implement an individualized comprehensive plan of care and coordinate transitions to the next most appropriate level of care, for high risk/frail older adults.	The NHH Assess and Restore Intervention model of care provides comprehensive gerontological assessment, the identification of geriatric syndromes, and intervention for frail at-risk seniors. The focus of this initiative is to prevent the cascading effects of health decline that often result in more complex health needs, or failure of the person to live at home. NHH Assess and Restore Intervention is led by a Gerontology Nurse Practitioner, who is progressively developing expertise in gerontological best practices, complex gerontological assessments, and an understanding of gerontology syndromes and interventions.	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 578 Clinicians trained: 36 % of admission to rehabilitative care bed that were direct admissions from community/ED: 55% % of patients directly admitted from community who were discharge home: 85% Average Functional change: 15 points (FIM) % of unplanned readmissions to hospital within 30 days of discharge: 16% Annual ALC rate (for patients in the post-acute rehab service) decreased from 18% - 8.9% LTC destination rate for direct admissions was 2.8%; LTC destination rate was 12% for non-direct admissions (admitted through acute care) **Lessons Learned** Medical comorbidities and geriatric syndromes must be addressed together, to provide best practice geriatric care. Inpatient restorative care, in collaboration with the GEM, maximized efficiencies and outcomes. Frail older adults require care that combines medical diagnoses and recognition of geriatric syndromes and interprofessional gerontological care. Proactive management of geriatric syndromes will decrease healthcare resource costs, over time, and help maintain community independence.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central East LHIN	Assess and Restore - Scarborough Hospital virtual ward	This project involved implementation of a virtual ward, to support the transition of patients back home, post discharge, through the role of a navigator.	Patients are identified for the virtual ward program using the LACE tool to flag inpatients who are at higher risk for readmission. Virtual ward patients receive, at a minimum, weekly contact with the navigator to reach 5 key milestones after discharge including a follow-up appointment with primary care and medication reconciliation. Patients who require further reactivation support are referred to the Enhanced Recovery Program at Carefirst and are integrated into a basket of services, provided within the community, to sustain their ability to remain at home	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 403 % of unplanned readmissions to hospital within 30 days of discharge: 11.4% % of patients discharged home: 77.3% Key findings also included: average increase in walking distance of 26.6m, an avg. increase in walking speed of 0.09m/second, and improved mood for 100% of patients, in the enhanced restorative care program. **Patient/Caregiver/Provider Experience** Patients and caregivers have shared positive feedback regarding the program supporting them to regain independence **Lessons Learned** Use of a patient identification tool allowed for better identification of needs (functional, cognitive and/or social) to ensure alignment with appropriate supports. The identification tool, together with referral pathways, served as an algorithm to better match patient need to the basket of community services available. **Key Messages** The integration of services including inpatient restorative care, the GAIN clinic, Virtual Ward, falls prevention program, and the Home at Last Program has created a system of services that support older adults to return to, and remain in, the community. The services together enable patients to have one point of access for multiple services. A broader referral source within the Emergency Department is being explored. These combined strategies will optimize older adults' ability to maintain community independence, through continued support and follow-up, post discharge from bedded care or ED.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central East LHIN	CATCH Program	The purpose of the CATCH program is to improve patient flow by reducing length of stay and readmission rates, through an interprofessional approach to post discharge risk assessment and intervention. The aim of the program is to enable patients to leave the hospital sooner, transition home more smoothly and remain safe and independent in the community	The CATCH program is an outpatient program, delivered by an interdisciplinary team of health care professionals, with linkage to general internists. Patients are first assessed by a PT, who develops an individualized reconditioning program for the patient. Through reconditioning, the PTA helps patients reach optimal physical function and independence. Registered practical nurses (RPN) assess patients' discharge milestones, and complete a risk assessment to identify aspects of the discharge plan which require further progress/follow-up. The RPNs support patients with discharge instruction follow through; addressing risk factors and reinforcing health teaching, with a focus on understanding one's condition and preventing deterioration.	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 248 % of unplanned readmissions to hospital within 90 days of discharge: 1.61% % of less urgent ED visit, within 30 days of discharge: 4.84% Average improvement on Timed up and Go (TUG): 24% % of older adults who reported a decrease in falls/falls risk: 98% **Patient/Caregiver/Provider Experience** 95% of patient respondents sampled indicted that they would recommend the program **Lessons Learned** A key lesson learned is the significant impact a post-discharge program can have on keeping patients safe in the community. Many older adults are discharged home with a number of risk factors, putting them at increased risk for readmission to hospital. Many of these risk factors can be managed with ongoing support, during this critical transition from hospital to home. Among this population the most significant risk factors addressed have been falls, medication safety and discharge instruction compliance. **Key Messages** In terms of linking with the community the CATCH program bridges the gap between the inpatient hospital stay and independent living in the community, ensuring patients do not fall between the cracks to preventing readmissions.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central East LHIN	Carefirst Seniors: Community Enhanced Recovery Program (ERP)	The purpose of this initiative is to support frail seniors, discharged from hospital to home, with the aim of optimizing physical and functional performance, enabling them to live well at home and avoid preventable re-hospitalization.	This initiative is a collaboration between Carefirst Seniors and Scarborough and Rouge Hospital (SRH). Through this initiative, Carefirst Seniors provides a Community Enhanced Recovery Program (ERP). For virtual ward (VW) patients discharged from SRH, other local hospitals who require reactivation support. The program is offered 6 days a week, and includes: •Initial and discharge assessment by PT •Small group individualized exercise prescription; adapted for cognitive/physical/functional impairment •Health teaching i.e., fall prevention, breathing strategies •Functional training i.e., gait, transfer and home safety equipment training	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 509 Clinicians trained: 5 90% of patients met the 5 key milestones identified for this program: follow-up with primary care, medication reconciliation, tests/specialist appointments, health education, and linkage to appropriate community services Key findings also included: average increase in walking distance of 26.6m, an avg. increase in walking speed of 0.09m/second, and improved mood reported by 100% of patients. **Patient/Caregiver/Provider Experience** Staff report that caregivers expressed relief and increased confidence, having joined the program, and upon seeing the maintained clinical and functional gains. **Lessons Learned** The needs of frail seniors are complex and changing. A program that is adaptable and flexible allows for a unique service delivery model, in which client needs and capabilities determine how the service is delivered. **Key Messages** Maintaining clinical gains can be challenging as patients transition back to the community. Having the direct support of a navigator, and regular access to a rehabilitative team, proved beneficial. Patients directly benefit from collaboration between organizations. Appropriate individuals are identified, through standardized processes and navigated to appropriate levels of care, through clear and comprehensive care pathways. Integrated care pathways increase the likelihood that older adults can age in place, by optimizing available resources to support safety and independence.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Central West LHIN	Home Independence Program (HIP)	The purpose of this initiative is to provide support to patients experiencing functional decline and/or limitations in their ability to independently care for themselves. In 2016/17, the program focused on frail, decompensated patients who had sustained a stroke.	The HIP program provides early identification and interprofessional support, to decrease the risk of further deterioration and increased dependence on the healthcare system. Falls are a major contributor to ED visits and readmissions. This program aims to reduce injurious falls in the home.	**Outcomes (indicators & Metrics) 2016/17 FY:** Patients served: 184 59% of patients received OT services, with an average of 3.2 OT visits. 72% of patients received PT services, with an average of 7.8 PT visits. 36% of patients received nursing services, with an average of 39 visits. 18% of patients received SLP services with an average of 2.2 SLP visits. 86% of patients received PSW services, with an average of 286 PSW visits. 34% (62) of the patients received interdisciplinary rehabilitation services Other key findings include a substantial reduction in overall hospitalizations, ED visits, and falls **Patient/Caregiver/Provider Experience** Patients reported a reduction in perceived overall health, 2months post program compared to intake. **Lessons Learned** Expectations regarding further improvement including return to previous lifestyle may not have been able to be met for patients. **Key Messages** The Home Independence Program was effective in improving overall safety and independence of older adults, post stroke; but not necessarily effective in making them feel better about their life, post-stroke. This may reflect the need to consider a more holistic approach to rehabilitation, and/or to consider partnerships with other programs, which can provide interventions aimed at improving self-perceived health and quality of life.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Champlain LHIN	The Champlain Acute to Sub Acute Care Navigation and Placement Project	The purpose of this initiative is to formalize standardized and shared protocols for accessing restorative services, in order to manage the placement of targeted seniors into post-acute care beds, from acute care.	This project includes: 1. Screening for frail, high-risk seniors in acute care settings • Once a patient is identified, a triage team completes the referral form and determines the most appropriate destination 2. Monitoring and integrating patient flow from acute care to sub-acute care or outpatient care services 3. Integration of sub-acute referrals and assessments for different rehabilitation and complex continuing care destinations 4. Improved navigation and transitions of care through "one-stop shop" model 5. Expanding and ensuring sustainability of a Regional Clinical Patient Flow Algorithm, to additional acute care hospitals in Champlain	**Outcomes (indicators & Metrics) 2016/17 FY:** Number of incremental visits/attendances: 3292 Number of clinicians trained/educated on clinical assessment: 9 Number of staff trained on referral form/processes: 224 Key findings include a substantial reduction in overall hospitalizations, ED visits, and falls **Lessons Learned** Cross-training of consult professionals to complete assessments 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 **Key Messages** A centralized consult model enables matching of patients with appropriate subacute destinations and ensures quick turn-around-time for Resource Matching and Referral (RMR) completion and acceptance/refusal responses. A "one stop shop" approach simplifies patient navigation and reduces workload for physicians. This model is ready for the final step of integration within Champlain LHIN.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Champlain LHIN	Rural Assess and Restore in Champlain LHIN	The purpose of this initiative is to pilot a flexible rural A&R community program that leverages current services (e.g., RGP of Eastern Ontario, GEM services, CCAC care coordination services), to improve timely access for the target population to specialized geriatric services and individualized bundles of short-term rehabilitative and restorative care services.	In 2015/16, this initiative developed and introduced a combined new role of a GEM Nurse and a Geriatric Outreach Assessor as a first step. Then, in conjunction with leveraging current community services, targeted restorative care and specialized geriatric services were introduced. In 2016/17, the GEM Nurse, Specialized Geriatric Clinic services and the Assess & Restore Day Hospital program services were extended to the Almonte area. Integration with CPDMH primary care physicians was also trialed, in order to test the role of the Geriatric Outreach Assessor in enhancing coordination between primary care and specialized geriatric services.	**Outcomes (indicators & Metrics) 2016/17 FY:** Number of older adults served: 359 % of High Risk/GEM Patients admitted at Index visit: Carleton Place: 1.64% compared to pre-pilot rate of 11.4% Almonte: 1% compared to pre-pilot rate of 10.8% Hospital Overall ALC Rates (Patients): Carleton Place: 27% ALC Rate compared to pre-pilot of 42.8% Almonte: 1.7% ALC Rate compared to pre-pilot of 0.7% Average # of ED-revisits (within one year) by High Risk/GEM Patients: Carleton Place: 0.5; compared to pre-pilot average of 1.3 ED re-visits Almonte: 0.37; compared to pre-pilot average of 2.3 ED-revisits **Patient/Caregiver/Provider Experience** 100% of clients attending AGH Day Hospital would recommend the program to a friend/family member **Lessons Learned** The combined role of GEM and Outreach Assessor is a successful model in a rural community, as it provides continuity and coordination for high risk seniors. There is a sub section of the high risk senior population that are not easily reached by regular health services. These are complex, socially isolated seniors that a targeted program such as this one was able to accommodate. **Key Messages** While rural populations differ in terms of available resources and demographics, the core needs are the same. Facilitating rapid access to specialized geriatric services and community support services allowed interventions to be put in place early, to prevent hospital admissions.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Champlain LHIN	Central Intake for Specialized Geriatric Services	The Central Intake and Triage for SGS project was undertaken to improve patient and family experience, across the continuum, by providing a more coordinated hospital, home, community and primary care service. The initiative aimed to implement triage to SGS, which is determined through one access point, in order to provide better coordination of care and system navigation, for both patients and providers, and ensure that patients are seen by the right provider in a timely manner.	Central Intake and Triage for Specialized Geriatric Services (SGS) entails a single point of contact for all referral sources and standardization of referral and triage processes for patients 65 years and over, who require specialized geriatric services. The Central Intake navigator reviews all referrals and determines the clinical need and urgency of the patient. The CI navigator then directs patients to the most appropriate service based on program wait times, structure, and patient and caregiver goals. This approach ensures patients are sent to the most appropriate service, based on their needs, and ensures that patients with restorative potential are being seen in the timeliest manner, in order to prevent and reduce functional decline.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 229 **Patient/Caregiver/Provider Experience:** 100% of referral sources stated that Central Intake form and processes made it easier to refer patients 74% of the patients were “definitely positive” that they were connected with the care they needed & 26% were “somewhat positive” that they were connected to care they needed 100% of patients felt they were respected; 96% felt they were listened to; 96% felt that explanations were given in a way they could understand; 91% - expressed confidence in the CI Navigator; 67% felt they were able to contribute to decisions; and 67% felt that time was taken to learn about them as a person **Lessons Learned** Referral sources are not always able to determine the most appropriate service for the patient and referral processes often vary across services. One referral form and a standard process was requested by a number of referral sources, especially primary care practitioners. Delays in accessing or identifying the right service for the patient can lead to compromised restorative potential. **Key Messages** Central intake and triage provides better coordination of care and system navigation for both providers and patients; facilitates timely access to Specialized Geriatric Services, reduces unnecessary delays and reduces duplication, maximizes communication, and reduces the chance of patients “falling through the cracks”.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Champlain LHIN	Path to Home Passport	The purpose of this project was to support patients and caregivers in preparing to be discharged home from restorative/ rehabilitative care.	The Path to Home Passport project was developed in partnership with patients and caregivers, to provide best evidence knowledge, in the form of a discharge workbook, to assist patients and their caregiver to prepare to be discharged to the community. The Path to Home Passport is targeted to patients and caregivers who are following the Home First Philosophy, in the Champlain LHIN. The Path to Home Passport has been rolled out in Bruyère Continuing Care geriatric rehab program, and the restorative care programs at Saint-Vincent Hospital.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 265 **Lessons Learned** Patients must be engaged in their own care and transition planning, understand their role, and be encouraged to ask questions of the health team. Reviewing the passport at weekly interprofessional bedside rounds helps ensure that patients understand their roles and responsibilities in preparing to return to their home in the community. **Key Messages** The older adult population (>80 yrs. old) would benefit from an easier to use Passport that directly addresses their needs when going home. The content of the passport is based on best practices and aligns with the work completed by the Open Lab at the University Health Network. A working group will partner with older seniors to revise the original Passport to meet their specific needs.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Erie St. Clair LHIN	Seniors Mobile Assess and Restore Teams (SMART)	The aim of this initiative was to increase access to, and the capacity of Assess and Restore interventions, by allied health care teams, for older adults admitted to acute care settings.	This initiative involved hiring additional, OT, PT and OTA/PTA staff within 5 hospitals sites in the ESC LHIN. These additional staff resources are deployed for enhanced service delivery for patients aged 65+ admitted to acute care inpatient medicine units (and some ICU, ED and surgical settings). These staff provide restorative care and activation, including restorative care on weekends.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 12476 (*Patients served defined as: # of discharges of patients over age 65 from acute care hospital medical units in all regions of ESC LHIN*). Across the 5 sites: 62.5% - 73.9% of patients were discharged home 8.3% - 15.48% of patients had ALC days, with an average of 10.3 - 33.9 day ALC length of stay 11.75% – 17.6% of patients were readmitted within 30 days discharge **Lessons Learned** The mobile aspect of this approach has been very beneficial, as it is not limited to a geographical unit in the organization. While having a proactive practice of an "Activation" referrals for all patients aged 65+ admitted to medicine was beneficial, finding a method of screening for which patients are at highest risk of functional decline would allow for improved efficiency and effectiveness of service. **Key Messages** This initiative has contributed to an appreciation of the functional impacts on activities of daily living when acute illnesses occur in older adults; and the benefits of early engagement of Physiotherapy and Occupational therapy expertise. Continued efforts are required in realizing early opportunities to recognize restorative potential, and identify patients for ongoing rehabilitative care needs either in bedded or home care services.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Hamilton Niagara Haldimand Brant LHIN	Seniors Mobile Assess and Restore Teams (SMART)	The SMART model aims to provide hospitalized seniors who have restorative capacity, with access to a mobile dedicated inter-professional rehabilitative care team. SMART aims to improve the patient experience by: • Improving access to rehabilitative care (Increases capacity) • Preventing functional decline • Improving function (as measured by the Barthel Activities of Daily Living Index) • Promoting discharge home • Decreasing need for post-acute bedded rehabilitative care.	This initiative involves mobile, rehabilitative care provided in-hospital for frail seniors who are frail and experience functional decline and/or at risk for further functional decline. The SMART team develops and provides an intensive restorative program that targets individual's 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. The SMART intervention includes two funded full-time equivalents of rehabilitative care staff (i.e. OT, PT OTA/PTA). The core SMART team members work together with in-kind interdisciplinary team members to deliver a SMART rehabilitative philosophy of care, 7 days a week. Additional SMART team members include social workers, nurses and pharmacists.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 3923 Increase in function: 33% increase in function as measured by the Barthel Activities of Daily Living Index (Barthel) Promotes discharge home: 89% discharged home; 7% require post-acute bedded rehabilitative care Decrease in ALC days: 27% decrease in ALC to LTLD noted in HNHB LHIN level data from fiscal year 2014/15 compared to fiscal year 2016/17, for the six SMART hospitals sites Decreased LOS: 4.13 day decrease in post-acute rehabilitative care length of stay (LOS), for patients of a similar Case Mix Group (CMG) Patient/Caregiver/Provider Experience: Patients report positive experience and appreciation for continued independence and ability to return home. Lessons Learned A mobile A&R model can increase the extent to which individuals can function independently at home as measured by the Barthel Activities of Daily Living Index Barthel and the rate of discharge home. Key Messages Older adults who are frail 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 complex care (CC) Low Tolerance Long Duration (LTLD) bed days.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Mississauga Halton LHIN	Community Step Up Program	The purpose of this initiative is to assist clients and their families with the adjustment from hospital to home, in a shorter time-frame, by providing on-going individualized programming within an outpatient setting. The goal of the program is to restore patients function, so they can participate in their ADLs, and to provide caregivers with ADL strategies, to make caring for their loved one easier, reducing the risk of injury to themselves and their loved one.	The Community Step up Program is a multi-disciplinary approach to rehab including physiotherapy, occupational therapy and speech and language pathology. It is a 6-week program that requires patients to attend 2 half day clinics for one to one therapy; three clinics operate two days per week, with each clinic able to treat up to 8 clients per week. •Clients are screened using the Assessment Urgency Algorithm, and must score a 4-5 to qualify for the program •Clients receive a joint assessment with a PT and OT •Therapists develop individualized interdisciplinary treatment plans •Throughout the 6-week program, therapists help to coordinate clients with other community based resources and programs that can help maintain independence in the home and reduce the risk of hospital re-admission or placement in LTC.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 61 Number of clinicians trained: 7 Number of clients that completed the program: 61 Number of clients that received PT therapy: 64 Number of clients that received OT therapy: 59 Number of clients that received SLP therapy : 27 **Patient/Caregiver/Provider Experience:** Increased confidence, in both the client and caregiver was evident, resulting in overall mental and emotional well being **Lessons Learned** Caregivers benefitted as much from the program as the clients. By increasing the functional levels of each client, clients are able to participate more in their ADL routines, decreasing the need for caregiver supervision and support. Through ongoing education and training, caregivers learn essential care strategies to make caring for the client easier and safer for both. **Key Messages** Working with hospitals, primary care, outpatient clinics and other health service providers has revealed a need for this program. The program is helping to address the wait times for other outpatient clinics, and helping to keep seniors at home longer, by restoring function and providing caregivers with necessary strategies, thus delaying long-term care placement.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Mississauga Halton LHIN	SMART Enhanced	This purpose of this initiative is to provide an upstream approach for frail seniors who: • Have been discharged from acute care PT services; • Have functional goals that can be addressed through standardized exercise programs; • Cannot attend community group exercise classes; • Have at least 2 co-morbidities • Have been screed at 3-5, on the Assessment Urgency Algorithm • Have been identified as being at risk for adverse "geriatric" outcomes • Have been identified as not appropriate for facility based restorative care	The VON SMART Enhanced In-Home program is a component of the MH LHIN Assess and Restore model of service delivery. Utilizing the evidence based, nationally accredited SMART™ (Seniors Maintaining Active Roles Together) Program, the Victorian Order of Nurses for Canada (VON) provides a coordinated and integrated program, within the Southwest and East Mississauga Health Links within the Mississauga Halton LHIN. Frail Seniors who are identified as meeting the established criteria, receive in-home one on one exercise sessions, to increase their strength, mobility and functional abilities. The program is 6 weeks long; 2 one-hour visits/week; consisting of 15 gentle exercises, geared towards frail older adults.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 235 TUG: Average improvement on the Timed Up & Go (TUG) was 4.2 seconds BERG: Average improvement on the Berg Balance scale was 7 points QoL: Average improvement in self-rate quality of life was 3 points **Patient/Caregiver/Provider Experience:** Patients reported satisfaction with the care they received: *"I feel the exercises have helped me a lot. I was very weak and couldn't manage well on my own."* *"I feel I have gotten stronger with my balance."* *"I am getting stronger and feel I have more energy."* *"The program has helped my confidence in walking."* **Lessons Learned** Client compliance/engagement and accountability for improvement is a key driver of success. The project supports seniors to participate in exercise in home for approximately 2 hours per week for 6 weeks. Encouraging exercises to continue when an exercise leader is not in the home is essential. **Key Messages** This type of program can result in significant outcomes, related to improved mobility, balance, quality of life, and wellbeing. This model improves access to restorative care and reduces isolation for frail, homebound older adults.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Mississauga Halton LHIN	Assess & Restore – Halton Health Care	This purpose of this initiative is to provide 1:1 therapy services to the frail elderly population, in an outpatient setting. The goal of the program is to improve function and reduce hospital admissions.	This program provides interprofessional restorative care services for older adult (OT, PT, OTA/PTA and SLP services). Clients typically attend 2 days per week for a total of 6 weeks Referrals are accepted from acute care centres, physician offices, and family practices within the Mississauga Halton region.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 81 Clinicians trained: 4 **Patient/Caregiver/Provider Experience:** Positive patient experiences were noted, as measured by the WatLX Patient Experience Measure. Patients also reported satisfaction with the care received: *"Wonderful experience & treatment. Felt better at end of treatment…"* **Lessons Learned** Patients who present with severe frailty (as per the Rockwood Frailty Scale) may require additional interventions and additional visits outside the standard allocation. Based on feedback from the interdisciplinary team and patients, social work would be an important addition to the interprofessional team. **Key Messages** Patients attending this program presented with moderate to severe frailty, as per the Rockwood Frailty Scale. Moderately to severely frail older adults require 1:1 interventions, with regulated health professionals, in order to ensure needs are met in a safe and successful manner.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
North East LHIN	North East Assess & Restore Collaborative	This purpose of this initiative is to develop and test a local process for direct admission to facility based restorative interventions, within the suggested time frames.	The project is piloting the Direct Access Priority Process in 2 Hub communities and includes aspects of timely identification and assessment of older adults who meet the criteria for the target population. The goal is to develop and test a local process for direct admission to facility based Assess and Restore interventions within the suggested time frames. Areas of focus are the first 3 elements of the Assess and Restore approach to care : Step 1 – Early Identification Step 2 – Assessment Step 3 – Navigation & Placement	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 39 Number of older adults who received comprehensive geriatric assessment: 36 Number of older adults referred & admitted to bedded rehab: 31 Average time-frame from identification to admission to bedded rehab: 12.3 days **Lessons Learned** There is limited awareness and understanding of geriatric syndromes and knowledge of geriatric best practice at all levels of the healthcare system. This gap in knowledge directly impacts readiness to implement Assess & Restore approaches to care Implementation of a senior-friendly framework which integrates geriatric principles into all aspects of care, is fundamental for A&R implementation. **Key Messages** There is a critical need to mandate standard components of an assess and restore approach to care, in order to support a more consistent and equitable approach to care, for frail older adults. These components include: 1. Geriatric Knowledge 2. Early Identification & Screening 3. Comprehensive Geriatric Assessment 4. Geriatric Rehabilitative Care Services 5. Transitions 6. Regional Governance and Accountably for Outcomes

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
North Simcoe Muskoka LHIN	Geriatrics Training & Best Practices Adoption	This initiative was developed to improve flow to facility based restorative interventions (Convalescent Care Program (CCP) beds, Acute Care of the Elderly (ACE) beds). This project aims to: • Increase the number of health care professionals *AND* the skill sets of health care professionals in the care of frail seniors. • Standardize and disseminate leading practices. • Increase the self-management capacity of frail seniors and their caregivers.	Building on the work completed in 2014/15 and 15/16, the NSM LHIN provided education and mentorship to front-line staff within CCP and ACE Units. A learning plan was developed, in collaboration with providers and in alignment with the Rehabilitative Care Alliance's Compendium of Evidence-Based Assessments and Interventions to Support the Management of the Geriatric Syndromes. The education plan included: • Education events • On-site mentoring, coaching and support • Program planning and implementation; and • Policy and procedure development	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of clinicians trained: 1183 • 287 education events for clinicians • 44 resident education sessions In alignment with work being completed in other LHINs, the NSM LHIN developed the Nutrition Frailty e-learning module in March 2016 and the Delirium Frailty e-learning module in June 2016. **Lessons Learned** It is challenging to recruit registered staff for short-term contract positions. Significant travel time was involved, as the CCP sites are situated in different areas in NSM LHIN; resulting in significant non-direct time. Multiple sites had similar learning needs, ie. Falls Management Interpretation of "Fall" was different from site to site which results in reporting differences

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
North Simcoe Muskoka LHIN	Enhanced SMART & Transitions of Care	This purpose of this initiative is to increase access to facility-based restorative interventions (CCP, ACE). Enhanced SMART and Transitions of Care builds on the current SMART program, and is designed to support complex frail seniors with higher intensity needs.	The Enhanced SMART program is built on the foundation of the VON SMART Program (Seniors Maintaining Active Roles Together), established in 2007/2008. Enhanced SMART uses the same principles; however, it is 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. 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 are offered, out of 3 sites, each week. The program also provides post discharge follow-up and monitoring and system navigation.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 39 Average improvement on Quality of Life Scale: pre = 76.9%, post = 84.6% Average improvement in Gait Speed: pre = 0.55 m/s, post = 0.76 m/s (a change of 0.1m/s is clinically significant, less than 0.6m/s is a red flag) Average improvement in Clinical Frailty Score (1-7): pre = 5, post = 4; less frail by 1 category Patient Knowledge & Confidence (/55): pre =36/55, post =50/55; improved by 14 points **Lessons Learned** Clients being admitted were more severely frail than originally expected, and were admitted into the in-Home program, rather than the outpatient group program, more often than anticipated. This has implications for recruitment requirements. **Key Messages** Both quantitative and qualitative data show promising results and referrer feedback has been very positive. Overall, this program is a success.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
North West LHIN	Enhanced Service Delivery - Thunder Bay Regional Health Sciences Centre (TBRHSC)	The purpose of this initiative is to reduce hospital admissions, decrease lengths of stay and improve the functional status of older adults, in an acute care setting.	This project is a continuation of the geriatric care coordinator position from the 2014/15 and 2015/16 project. The geriatric care coordinator initiative demonstrated positive impacts during the short pilot phase in 2014/15. The coordinator assesses "at risk" older adults, using standardized tools to identify geriatric syndromes and facilitate care for patients experiencing dementia, depression, delirium, falls, mobility issues and frailty. The coordinator works closely with the gerontologists, rehab staff and community partners to provide care coordination for safe and reasonable discharge.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 763 Of those patients enrolled, 42% were discharged home, 39% were discharged to post-acute services. **Lessons Learned** Standardized tools allowed for better screening for 'at-risk' individuals. The geriatric coordinator worked closely with other professionals and was an integral part of the Assess and Restore team **Key Messages** The project showed great potential to reduce length of stay, improve functional ability and continue safe discharges back to home. Overall, implementation of this initiative demonstrated improved patient outcomes and an opportunity to maintain gains.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
North West LHIN	Navigation & Placement – Process Standardization	This purpose of this initiative is to complete development of an integrated service model, based on best practice guidelines; including bedded levels of care, outpatient and ambulatory rehabilitative care, and community based programs, across the region.	This project is a continuation of the 2015/16 project. The focus of the initiative is on direct access to rehabilitative beds from the community. Direct access to these services will help prevent avoidable admissions to acute care; thereby decreasing acute care utilization and improving patient outcomes.	**Outcomes 2016/17 FY:** A comprehensive model for rehab services across the North West LHIN has been developed. Key care streams have been identified that would enable integrated rehab care. Discussions and planning continue, with key stakeholders, to develop a pathway to facilitate direct access and reduce ED utilization. • Integrated service delivery model has been developed. • Care streams have been implemented. Regional alignment with the care streams will follow. • Stakeholder engagement and knowledge sharing completed. **Lessons Learned** Having a dedicated resource, who is familiar with the current system and has a vision for the future, leading and facilitating the work is valuable. **Key Messages** A comprehensive capacity plan for Complex Continuing Care and Rehabilitation has been developed, in an effort to optimize service utilization and improve the patient/client experience. An integrated service delivery model for rehab services has been proposed. Additionally, recommendations have been identified that will enable establishment of the regional integrated model.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
North West LHIN	Enhanced Service Delivery – Lake of the Woods District Hospital (LWDH)	The purpose of this initiative is to facilitate earlier access to, and more intensive, rehabilitation intervention on the acute care floor, specifically for activities of daily living.	This project is a continuation of Physical Medicine Occupational Therapist position from the 2014/15 and 2015/16 project. This approach has seen positive impacts by introducing rehab services to seniors with restorative potential earlier, thus improving functional status, and resulting in decreased length of stay and safe discharges back to the community. Specifically, the target population is supported to enhance independence with activities of daily living, through improved basic motor functions.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 84 Average improvement is Quality of Life: 22.5% % of older adults discharged home: 60% Average Length of Stay: 15.6 days **Lessons Learned** Upon discharge, these clients have had a reduced need for home care services, as patients and families have been supported to achieve a level of independent functioning. Hospital lengths of stay have also decreased as patients have been able to achieve their goals much faster, with the increased treatment. LTC admissions have been prevented, through supportive and comprehensive treatment focused on a return to home. **Key Messages** Current funding allocations and system structures do not provide rehabilitation professionals in small community hospitals with the time or resources required for the average elderly client (with multi-system and social failure, who will require coordinated family involvement) to rehabilitate to an independent level of functioning. The Assess and Restore Program addressed this issue by providing a small community hospital with an similar level of service, without the long wait and travel required for a rehab hospital admission. The result is a significant improvement in patients' functional status and ability to return to home.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
South East LHIN	Safe, Early Mobilization – Quinte Health Care (QHC)	The purpose of this initiative was to develop a mobility score tool that all team members were familiar and comfortable using, to shift ambulation to a care team approach.	This initiative focused on creating a mobility score assessment tool for all patients, in order to identify patients' baseline activity level and ensure that patients are improving, or maintaining functional ability. The initiative aims to standardize information transfer of the mobility score, mobility ratings, and safe ambulation techniques for all team members. It also aims to enhanced knowledge of transfer maneuvers, to improve patient and staff safety. The program utilizes Recreational Therapy to provide education to volunteers, to support an assisted ambulation program using the "HELP" approach.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 562 Clinicians trained: 100% of program staff **Lessons Learned** It is important to involve all disciplines, as well as patient and family members, in learning and education. Screening tools should be simple and easy to adopt. Recreational Therapy can play an essential role in creating the motivation for patients and families to be ambulating regularly. **Key Messages** QHC has been very engaged with NICHE (Nurses Improving Care for Healthsystem Elders), and is committed to creating a philosophy of care for older adults that is interprofessional, rather than discipline specific.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
South East LHIN	Geriatric Assessment and Intervention Network (GAIN) Clinic	This purpose of the Geriatric Assessment and Intervention Network (GAIN) clinic is to provide support to seniors living in the community who are increasing in frailty and/or are at risk of using hospital EDs and inpatient services.	GAIN teams provide services to Seniors, typically aged 75+, who present as frail and who require a comprehensive geriatric assessment (older adults who may be experiencing; multiple complex medical, functional, mental health and psychosocial problems, recent functional or cognitive decline and/or frequent falls, or falls risk). An inter-professional team of health care professionals work collaboratively with patients and families, and their primary care providers, to strengthen supports and capacity for older adults whose health concerns threaten their ability to live independently at home.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 81 The GAIN team also offered health promotion group classes for clients involved with the clinic as well as at local retirement homes. This strategy engaged local seniors in geriatric-focused health promotion strategies **Lessons Learned** Patients and families preferred visits in their homes and usually outside of normal working hours so that caregivers could attend. This was also beneficial, in that the team could make more practical recommendations to the clients, based on their in-home assessment. Introductory meetings with family physician teams and hospital physicians, to introduce the service to key stake holders in the community, helped to increase referrals. **Key Messages** The support of a geriatrician for this type of clinic should be included in any similar projects in the future, as the complexity of some patients were, at times, outside the expertise of the NP.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
South West LHIN	The South West Assess & Restore Project	This purpose of this initiative was to implement a regional assess and restore approach to care, across the south west LHIN, through pilot projects, capacity building and the development and implementation of proactive restorative care pathways for community-dwelling older adults.	In the South West LHIN, an A&R Project Team lead all A&R implementation efforts, including seven pilot projects within St. Joseph's Health Care London's Parkwood Institute; Grey Bruce Health Services (Owen Sound); Huron Perth Healthcare Alliance; Middlesex London Emergency Medical Services; Alexandra Marine and General Hospital; the Thames Valley Family Health Team; and London Health Sciences Centre Pilot projects implemented proactive risk screening, to identify older adults at risk for loss of independence. High risk older adults were provided with comprehensive assessment and system navigation, including referral for bedded rehab, when appropriate. Some of the pilot projects focused on better understanding and improving transitions from hospital to home. An online resource was developed to help health care providers implement restorative care pathways through identification of appropriate available resources.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 3000+ Number who received comprehensive geriatric assessment: 200+ 1000+ older adults were linked to community services, based on needs identified through proactive risk screening 100% of high-risk older adults directly admitted to bedded rehabilitative care were discharge home Clinicians trained: 400+ 2000+ individuals accessed the websites created to improve health care delivery for older adults (www.cgatoolkit.ca ; www.SWhealthyaging.ca ; www.swassessandrestore.ca), through the SW A&R Project **Patient/Caregiver/Provider Experience:** Analysis of patient and caregiver experience information indicates that community-dwelling older adults and their caregivers: • Appreciate a team-based approach to care • Feel relaxed and well cared for within a geriatric approach to care, and • Benefit from knowing what to expect, and who is involved in their care **Lessons Learned & Key Messages** Important next steps will include: • Helping primary care providers implement an A&R approach to care • Continued education for health care providers on caring for older adults • Improving access to comprehensive assessment across the SW LHIN • Sharing information, and spreading successful pilot projects, and working more closely with public health units, community support services, and primary care providers

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Toronto Central LHIN	The Community Referral Pathway (Formerly FAST CARS)	The goal of this initiative is to identify frail seniors who are at risk of functional decline, in the community, and to intervene to prevent avoidable acute care admission. If the individual requires bedded rehab, the program aims to support the individual in returning to the community, with a coordinated plan of care.	This program, developed by Providence, involved implementing a standardized care path to promote rapid admission to in-patient and out-patient rehab programs at Providence, for complex, vulnerable patients and frail seniors. The program facilitates proactive access to interprofessional geriatric assessment, and follow-up, through the Frailty Intervention clinic (FIT), and direct admissions from the ED/primary care/community, to inpatient or outpatient geriatric rehabilitation programs at Providence. The program also utilizes Coordinated Care Planning (CCP) for complex seniors.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 300 (Number assessed by FIT: 189; Number admitted from community to bedded rehab: 111) Number of coordinated care plans completed/updated: 186 Average improvement on Reintegration to Normal Living Scale: pre = 64.7; post = 78.2 Average improvement on caregiver Strain Index: pre = 10.5; post = 7.6 Average improvement on Depression Screening: pre = 1.8; post = 1.0 ED visit within 3 months of discharge: 7.2% % of older adults admitted to bedded rehab who were D/C to LTC: 4.7% **Patient/Caregiver/Provider Experience:** A Patient Satisfaction Tools was developed and implemented, and evaluation of the results is ongoing. **Lessons Learned** A key component of the care pathway is the Community Health Navigator (CHN), who connects with patients/caregivers prior to their FIT assessment and completes follow-up phone calls at two weeks, one month and three months. The calls offer an opportunity for the team to identify further functional decline and work with partners to explore programs and services to meet their needs. **Key Messages** By proactively working with hospital and community partners, this program provides timely access to restorative services, across the care continuum, to prevent functional decline and potential permanent loss of independence. This was achieved by creating an expedited care pathway, from the community, to assessment, and to both inpatient and outpatient restorative care programs.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Toronto Central LHIN	An integrated system of Transition Care Planning for frail high-risk seniors	By leveraging existing resources and developing an inter-sectoral care transition plan, the aim of this initiative is to ensure that patients, transitioning home from bedded care, receive the right intensity of care at the right time. Inter-sectoral care transition planning aims to optimize health system resources within acute care, CCC, and home and community care, improve patient outcomes, and increase system efficiency.	This initiative involved leveraging existing resource to develop inter-sectoral care transition plans, to ensure frail seniors receive the right intensity of care at the right time This project aims to facilitate sustainable and comprehensive transition and discharge plans, including linkages to community supports. Seniors in the community are closely monitored, with an appropriated plan, through home and community care services. Any potential signs of decline will trigger readmission for additional rehabilitation to maximize health condition management and to prevent deterioration in functioning.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 55 Rate of discharge home: 78% Unplanned readmission to hospital within 30 days of discharge from hospital: 18% **Lessons Learned** An integrated, transitional case management approach, together with a Care Coordinator position, helps to ensures durable transitions and community re-integration for medically complex, frail, marginalized seniors. Involvement of community partners, in acute care discharge planning, has improved navigation and understanding of patient needs, and brought a more community focused perspective to patient care. Integration of community care team members into rounds and family meetings has been valuable. **Key Messages** Frail older adults experience complexity in a number of areas (mental health and addictions, medical and social frailty). Despite this complexity, successful transitions to the community can be achieved through a coordinated approach that includes partnerships with acute care hospitals, post-acute care rehabilitation, CCAC, community services, and caregivers. This approach relies on the coordinated care of health service providers working as “one community” to assess needs and develop a resource plan based on a complete basket of services.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Toronto Central LHIN	West Park Health Care (WPHC) Assess & Restore Program	This purpose of this initiative is to, in alignment with a WPHC Geriatric Service Review (2014), increase geriatric services to respond to changing demographics and improve outreach to community-dwelling, complex/high-risk older adults.	The West Park Assess and Restore Program is a comprehensive integrated model of care for frail, community-dwelling seniors who have been identified as having potential for restoration of function. It was built on the successes of the *Care Coordination and Pharmacy Management Project*. 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 Interprofessional Geriatric Clinic & Outreach services 3) Home-based restorative programs via our partnership with Reconnect (formerly, St. Clair West Services for Seniors (SCWSS))	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 260 • 119 served through Senior Mental Health Service; • 120 served through geriatric clinic or outreach; • 21 served by PSW Clinicians trained: 41 **Patient/Caregiver/Provider Experience:** on-going evaluation continues, regarding an appropriate, user-friendly tool for assessing patient experience in the clinic environment **Lessons Learned** Outreach component of the clinic is essential to enable access to specialized services, for the frailest older adults in the community. Primary care was identified as an important participant; strong linkages are required; provides an opportunity for capacity building between the Geriatrician and the Family Health Team physicians/ Bidirectional linkages with Senior Mental Health Care services improves access to both specialized geriatric and/or mental health service **Key Messages** Clear linkage with the Senior Friendly Hospitals Strategy are needed to ensure implementation of best practices; Comprehensive Geriatric Assessments, completed in an interprofessional collaborative approach, provide a thorough, holistic assessment and offer clients practical recommendations to maximize their independence, dignity, and to support their quality of life

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Toronto Central LHIN	The Independence at Home (IAH) Program Supporting Frail Older Adults with Assess and Restore Needs	This purpose of this initiative is to provide comprehensive, specialized assessment and rapid system navigation and access to medically complex frail older adults, who are at risk of, or are experiencing, functional decline, and who have restorative potential.	The Independence at Home – Community Outreach Team, (IAH-COT) is a novel partnership between Acute Care, Rehabilitation, Convalescent, Primary and Community Care Providers/Services to provide comprehensive, specialized geriatric assessment and rapid system navigation and access for medically complex frail older adults, at risk of, or experiencing, functional decline. The IAH community based outreach team: • Supports community dwelling medically complex frail older adults who have experienced or are at high-risk of experiencing functional loss • Builds on existing primary care integration strategies of Health Links • Ensures that primary and community care providers are involved in the decision-making during assessment and care planning	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 366 IAH was able to provide a wide variety of linkages for both patients and caregivers: • 35% of patients were linked with community support services • 24% of caregivers were linked with caregiver supports • 20% of patients were linked with rehabilitative care services • 4% were linked with specialists • 3% were linked with 'home-bound' primary care • 11% were linked with CCAC • 3% were linked with another out-reach team **Patient/Caregiver/Provider Experience:** 90% of patients and caregivers reported they would recommend the IAH team to others **Lessons Learned** A key driver of success, to date, has been the unique inter-organizational model. This structure enhances care coordination, by eliminating the delays in communication which can occur when coordinating care from a number of organizations. Geriatricians are key members of IAH COT and are involved in all aspects of service delivery and team processes. Their participation in referral review, weekly patient care rounds and home visits greatly enriches the provision of care and ultimately the patient experience. **Key Messages** The IAH program ensures older adults are linked with the most appropriate care/service, a key support needed to ensure successful aging in place.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes, Lessons Learned & Key Messages
Waterloo Wellington LHIN	Rapid Recovery Therapy Model- Integrating an Assess and Restore Rehab Model Across the Care Continuum	The purpose of this initiative was to: •address transition concerns; •positively affect ALC rates; •reduce # of direct LTCH admissions from hospital; •support transitions for frail clients to community based restorative and exercise programs.	The Rapid Recovery program is a 30-day intensive rehab program, designed to shift care from inpatient rehabilitative care to community rehabilitative care. Patients are either referred from rehabilitative care, if they were discharged 5-14 days earlier than usual care, or from acute care if the patient would otherwise have been referred to inpatient rehabilitative care. The program provides daily therapy for the first 7 days after discharge, followed by additional visits (approximately 10) in the remaining 23 days.	**Outcomes (Indicators & Metrics) 2016/17 FY:** Number of older adults served: 138 Increase in functional independence: 3.7/28 point improvement (Change in ADL independence– Long Form RAI-HC) Average improvement on Timed Up and Go (TUG): 12 seconds 38% of patients referred for community support services Estimated inpatient rehab bed days saved: 2140 **Patient/Caregiver/Provider Experience** Patients indicated that they were happy to be able to continue their therapy at home and get home from the hospital sooner. Some patients referred to Rapid Recovery had refused inpatient rehabilitative care but agreed to intensive rehabilitative care in the home. **Lessons Learned** Staff engagement, with the rehabilitative care and acute care teams, helped to inform the design of the program and outcome measurement, and helped to increase awareness of the program, and encourage a shift towards earlier discharge with an intensive home-based rehabilitation program. Coordinated, intensive care requires additional administration and communication by therapy provider agencies. **Key Messages** This program created an option for accessing a level of intensive rehabilitative care in the home, which was not previously available. The estimated annual savings (based on an annual volume of 140 patients) was $1,000,000