Rehabilitative Care Alliance

2017/2018 Assess & Restore Initiatives

Overview and Summary Analysis

October 2018

Rehabilitative Care Alliance

2017/18 Assess & Restore Initiatives Overview & Summary Analysis

This document provides a high-level overview of the Assess and Restore (A&R) initiatives, completed in each LHIN, with 2017/18 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:

Many of the 2017/18 initiatives built on the work of previous years. The themes and key messages noted were therefore similar to that of 2016/17, including:

Themes:

- **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**
- **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**
- **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**
- **Developing online resources to support education and best practice care**
- **Developing and utilizing online resources to support implementation of evidence based care pathways**

Key Messages:

- **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**

For 2017/18, 28 A&R initiative reports were received from 14 LHINs across the province. These initiatives were implemented across the continuum of care. The overarching objectives of these A&R initiatives were similar to 2016/17:

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.

3) Improve outcomes for older adults by implementing best practice care, including comprehensive geriatric assessment and geriatric interprofessional rehabilitative care.

4) An additional focus noted in 2017/18 was the development of a regional strategy to address the operationalization and sustainability of the initiatives.

During the 2017/18 funding period, more than 33,000 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.

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__Jan_2018_.pdf*) The specifications include indicator definitions, relevance to and alignment with the objectives of the A&R Guideline, information on calculation of the indicator, and additional reference information.

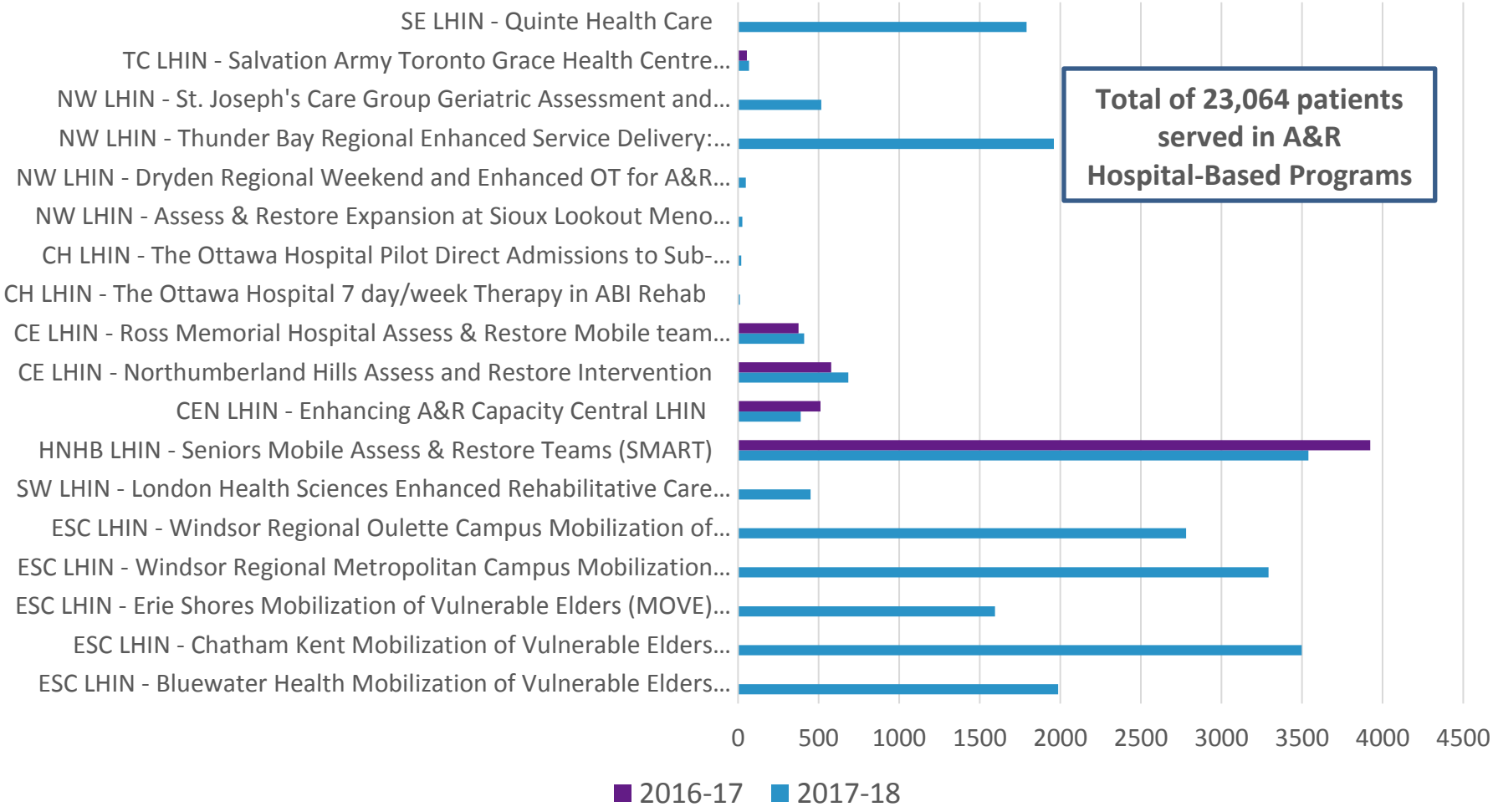
Indicator sets, by project type/sector, with technical specifications, are outlined below.

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		✓		✓	

The data presented below is an analysis of those sites who utilized the above-noted indicators, providing a baseline for future analysis. 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 are utilized to report Assess & Restore outcomes for future reporting.

Please note that the initiatives described below include those that were provided through Assess and Restore funding. This report does not include services that are provided to frail older adults that are funded outside of Assess and Restore.

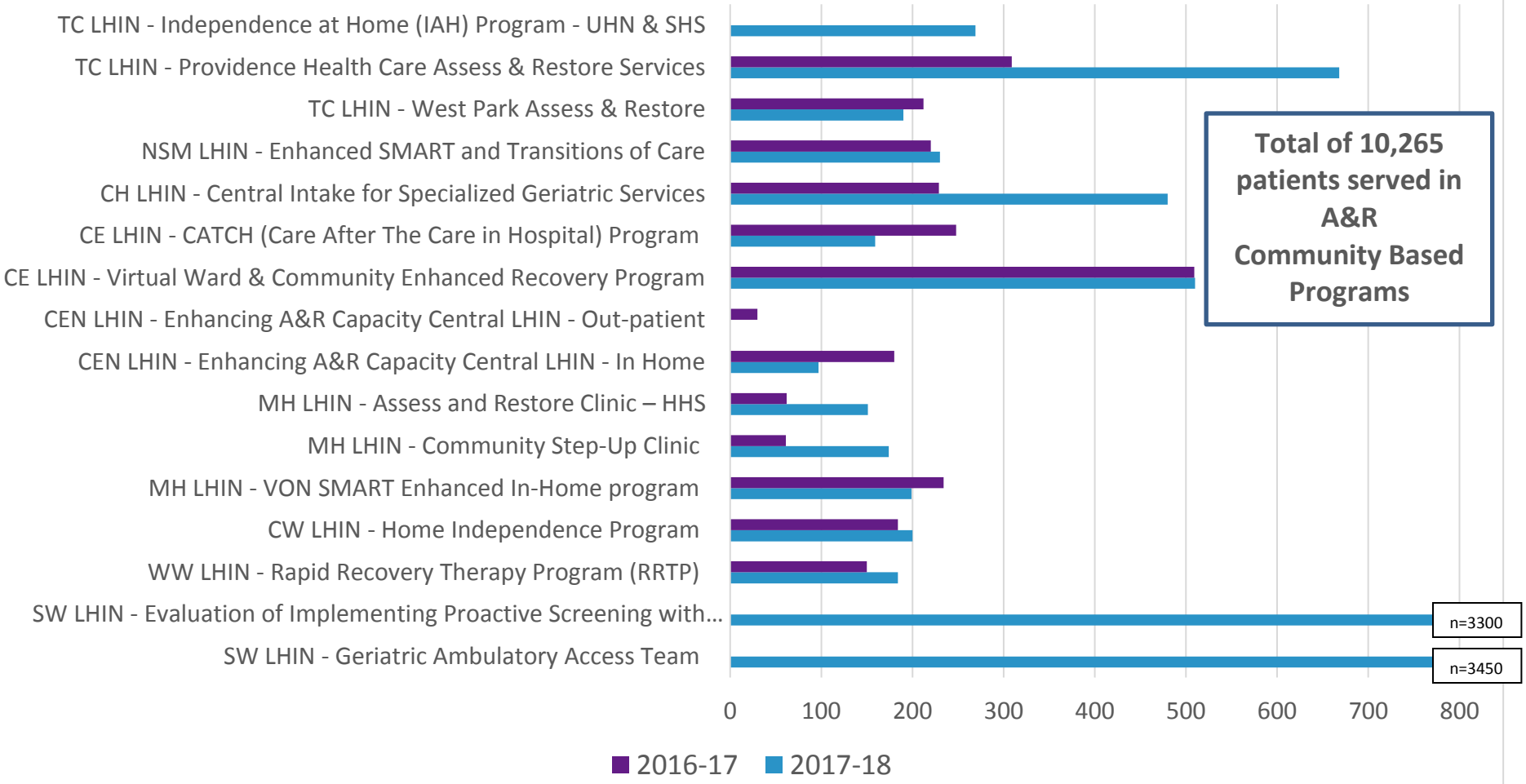
Indicator 1A: Volume of Patients/Caregivers Served - Hospital-based Programs*



*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 an A&R-funded intervention.

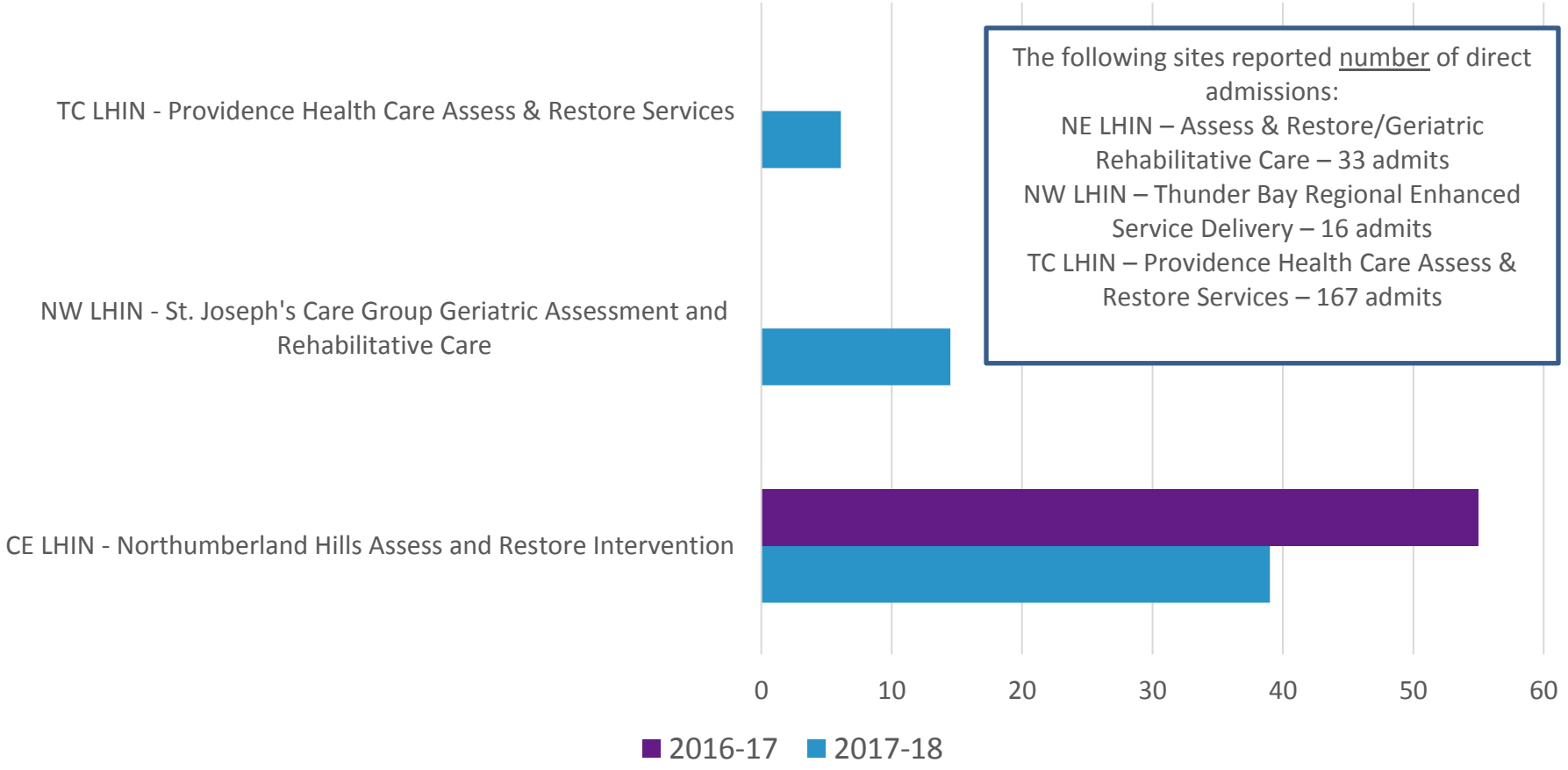
Indicator 1B: Volume of Patients/Caregivers Served - Community Based Programs*



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

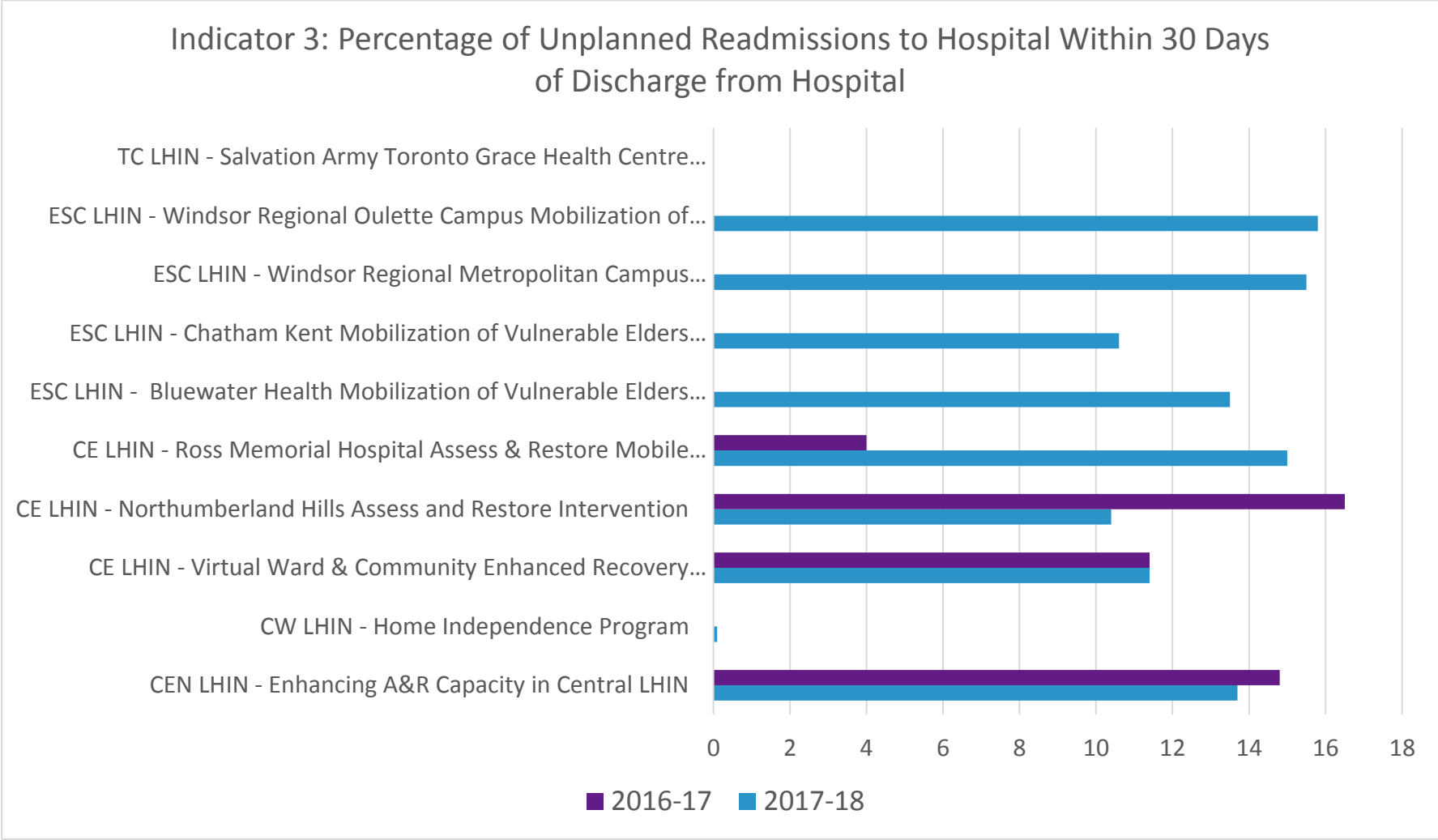
This indicator reports the total number of unique older adults who received an A&R intervention.

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

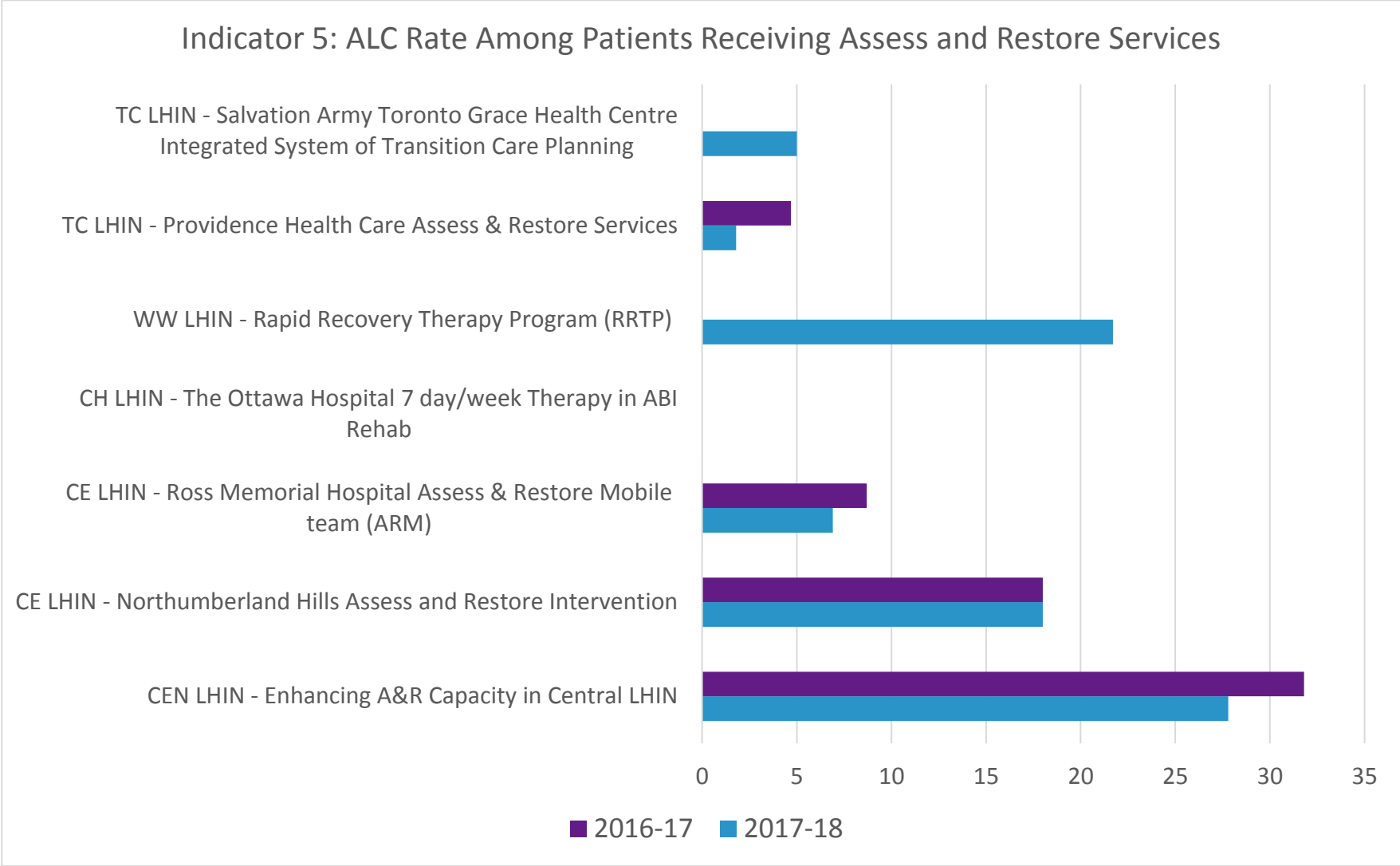


*In keeping with data reporting practices to maintain patient confidentiality, values of less than five (5) have not been identified at the organizational level.

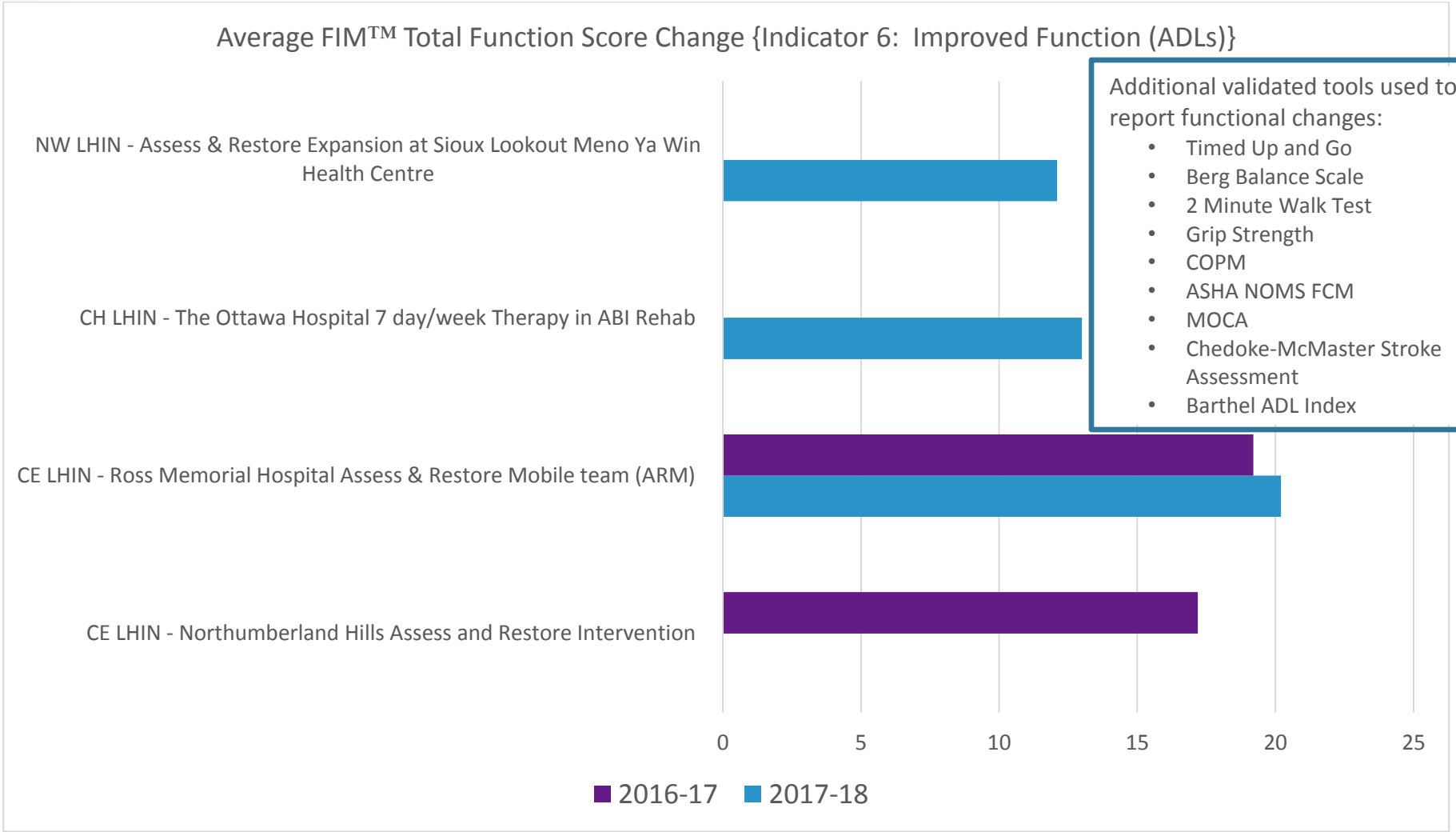
This indicator should be interpreted as the proportion of older adults, ≥ 65 years, admitted directly from community or emergency department (ED) to inpatient restorative intervention



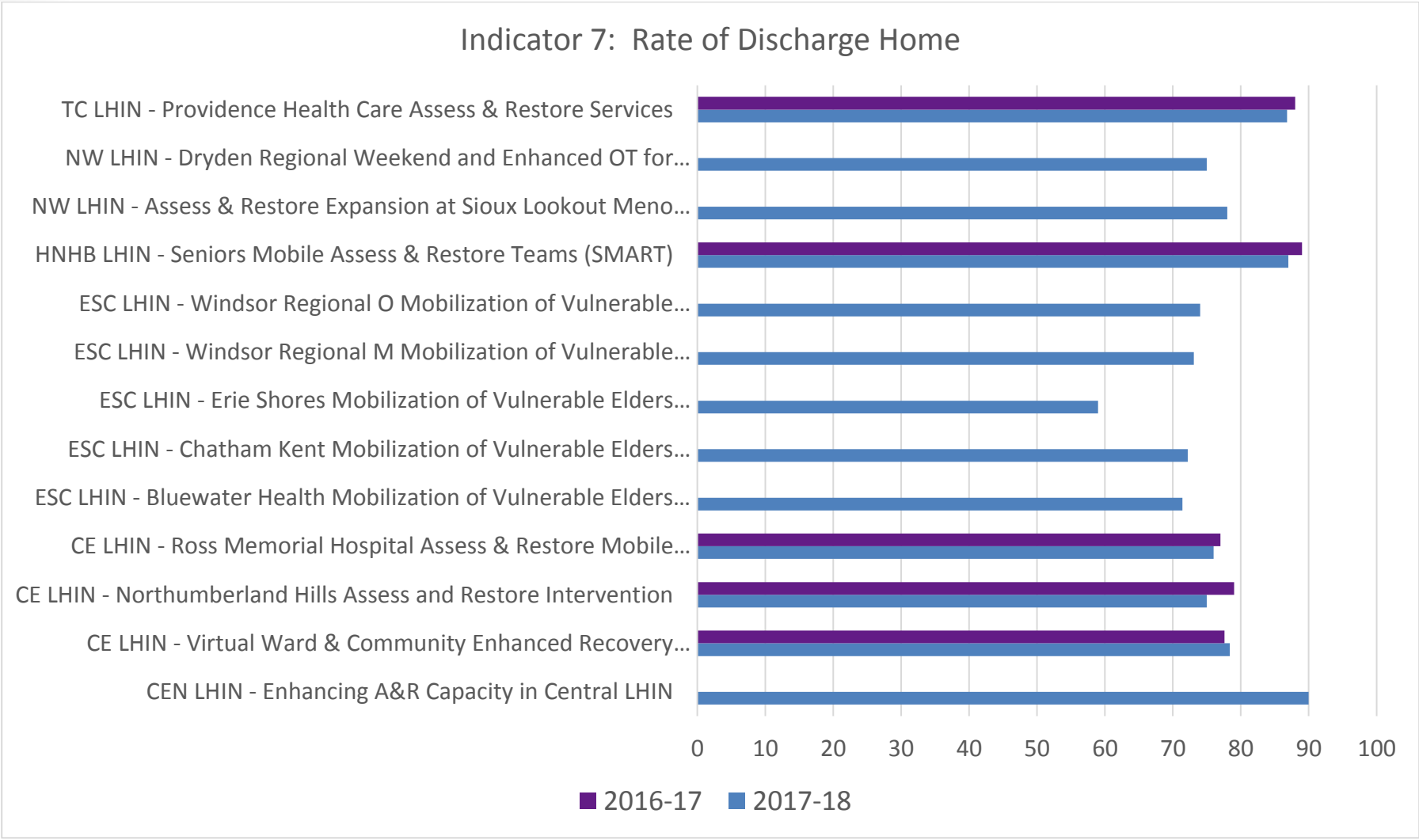
This indicator should be interpreted as the proportion of older adults who experienced an unplanned readmission to hospital within 30 days following discharge from a facility-based (bedded) restorative intervention.



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



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.



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.

Cross-Sectoral 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 LHIN</td>
<td>Enhancing Assess & Restore Capacity within the Central LHIN</td>
<td>To provide the right cross-continuum supports to regain and maintain functional independence so frail, high-risk community-dwelling seniors over the age of 75 are able to successfully transition home and remain in the community longer.</td>
<td>

Patients age 75 and older are screened using the Assessment Urgency Algorithm (AUA). High-risk patients are assessed further, including whether the patient has restorative potential.
Dedicated A&R Joint Hospital/Home and Community Care Coordinator (CC)
Dedicated Service Provider for Assess & Restore In-Home Services
Custom Outpatient Program (NYGH): For patients who do not require home-based rehabilitation services. Short-term, exercise-based conditioning so that patients can regain strength, flexibility, balance and/or walking endurance.
Patients admitted to hospital participate in a standardized rehabilitation program aimed to prevent deconditioning and enhance strength, mobility and functional ability during their stay.
Rehab resources are available 7 days/week to ensure patients maintain their functional gains while keeping planned discharges on track.

</td>
<td>
<u>Outcomes (Indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>In-Home LHIN : 97
In-patient: 388</td></tr>
<tr><td>Quality of Life Measure</td><td>Shift from initial mean score of 0.43 to 0.52 by the end of the program</td></tr>
<tr><td>% unplanned readmission to hospital within 30 days of discharge from hospital</td><td>13.7%</td></tr>
<tr><td>% unplanned, less-urgent ED visit within the first 30 days of discharge from hospital</td><td>2.5%</td></tr>
<tr><td>Annual ALC rate by: post-acute inpatient rehabilitative care services</td><td>27.8%</td></tr>
</table>
<u>Lessons Learned</u>

Quality of Life (QoL) measure continues to improve
Patients continued to experience positive outcomes
Very positive feedback from patients & families
Ongoing positive relationship between home & community care and NYGH teams
Patients benefit from increased PT in particular, which contributed to improved status

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<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.

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.</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>480</td></tr>
<tr><td>Number of frail seniors served</td><td>480</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
On-going meetings and regular communication with referral sources and SGS providers for feedback on processes is essential.</td>
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<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>To develop a regional and sub-regional approach to operationalizing & addressing the sustainability standards identified during 2016/17. This includes planning and development of the ‘geriatric rehab/senior friendly care clinical lead’ roles within all sub-regions, and on-the-ground implementation of the lead role in 1 sub-region.</td>
<td>

Algoma Sub-region: Clinical lead role piloted at SAH July 2017-March 2018 with a focus on early identification of baseline function in acute care and piloting of the AUA in ED. Action plan developed & initiated for alignment of a geriatric rehab unit with dedicated & specialized inter-professional team, led by newly recruited Geriatrician.
Cochrane Sub-region: Initiated planning for introduction of clinical lead role to transcend the local continuum of care. Early recommendations highlight the need for a focus within the acute care setting to facilitate early identification of functional decline, and broaden the understanding of restorative potential in the frail older adult inpatient population
Sudbury Sub-region: Geriatric Assessor (RN) trained in CGA to introduce CGA within bedded rehabilitative care. Geriatrician (Dr. Jo-Anne Clarke) supported at SJCCC 1-d/week to develop Geriatric Rehab Unit program
Nippising/Timiskaming Sub-region: Developed Senior Friendly Care Advocate Program

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<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number clinicians trained (Nursing Improving Care for Health system Elders – NICHE)</td><td>149</td></tr>
<tr><td>Number admissions to rehabilitative care beds that were directly admitted from community/ED</td><td>33</td></tr>
</table>
<u>Lessons Learned:</u>

Need for Alignment to Support a Population Health Approach for Frail Older Adults: Proactive and ongoing alignment of regional and sub-region work plans is critical to mitigating current duplication of efforts related to processes and care to support early identification, assessment, referral/navigation to bedded rehab, specialized intervention and an approach to transitions that all meet the needs of the frail older adult population
Knowledge Translation Using the Action Cycle is Foundational for Successful Implementation: The elements of an Assess & Restore approach to care involve numerous complex interventions that require a proactive, planned and contextualized approach to implementation across the care continuum.
A Multi-Factorial Change Management Plan is Essential: implementation of the elements of an Assess & Restore approach to care requires an evidence-informed change management plan and is often time-intensive

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LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South West LHIN	Assess & Restore Lead Organization: Project Team & Frail Senior Strategy Development	To develop a strategy to better align resources, to improve accessibility, integration and the consistency of care experienced by individuals with complex needs. These individuals often have multiple chronic diseases and tend to consume a large percentage of health system resources. The overall aim of this strategy is to improve patient experience. The target population for this strategy is defined as individuals with four or more chronic/high cost conditions.	• St. Joseph's will lead the South West regional frail senior strategy, under the oversight and guidance of a regional steering committee. • A coordinator was hired to support St. Joseph's leadership in developing a regional frail senior strategy, and collaboration began with Health Links, BSO and other sub-regional geriatric resources and stakeholders to begin planning and scoping a strategy, which will incorporate an Assess and Restore philosophy of care, and aim to improve sub-regional planning and equitable access to best practice care for frail older adults across the South West LHIN • The frail senior team also worked with the south west healthline.ca to update the South West Assess & Restore website, as well as a patient/caregiver website co-designed with older adults and caregivers to connect older adults with appropriate services and resources, depending on their risk level and their needs	**Lessons Learned:** • Developing a regional strategy requires the oversight of a regional steering committee with representation across both sub-regions and sectors • Considerable time and attention must be paid to planning and understanding how sub-regional planning will integrate and support the development and implementation of a regional strategy • Developing a regional strategy requires developing a solid understanding of current state, both regionally and at the sub-regional level, and the development of a regional future state visions that integrates sub-regional planning and priorities.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South West LHIN	Building on Resources to Support the Implementation/Sustainability of evidence-based Assess & Restore care pathways	In previous phases of this project, three on-line tools to support ongoing clinical capacity and A&R implementation efforts were developed over the last three years: http://swassessandrestore.ca http://healthyaging.ca http://cgatoolkit.ca 2017/18 goal is to focus on next steps and opportunities to improve functionality and to implement adoption identified during Phase 2 user testing and engagement activities.	These resources are available free of charge across the LHIN and to others with access to internet who are searching for resources/ information. 1. SWAssessandRestore.ca enhancements, health service provider(HSP) training/deployment activities and materials 2. SWHealthyAging.ca user testing and functionality improvements 3. Develop pathways for HSPs to connect patients/caregivers with resources The following methods were used by the healthline.ca to collect feedback: -Engagement sessions with older adults and caregivers to gather feedback and recommendations for improvement to site usability and effectiveness of swhealthyaging.ca were held -An online survey was developed and available as a pop-up on swhealthyaging.ca and distributed among the mailing lists for caregiverexchange.ca and the Age Friendly London Network.	**Lessons Learned:** • When engaging older adults and caregiver to get feedback on resources developed to support their navigation of the system, a multi-method approach is needed in order to obtain a variety of perspectives. • The following specifications and design changes were implemented on the caregiver site, as result of user feedback: • Re-formatting the header for all pages • Re-naming/organizing menu items to make services easier to find • Re-formatting the home page to make it more senior friendly • Location search and map view for listings • Adding additional sub-categories and ability to filter results by cost for services; free services; transportation available, etc.

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<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>Providence Health Care Assess & Restore Services</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 Nurse)
• 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</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>130 FIT Clinic</td></tr>
<tr><td>Number of frail seniors served</td><td>130 FIT Clinic
167 Inpatient
195 Falls Prevention Program
76 Orthopaedic & Amputee Clinic
100 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 61.8 to 77.7
Improved from 13.2 to 10.6
Improved from 2.0 to 1.1</td></tr>
<tr><td>Number clinicians trained</td><td>7 – SAFE Talk 1 day workshop</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>6.1% (167 patients)</td></tr>
<tr><td>% patients directly admitted to a rehabilitative care bed* from the community who were discharged home</td><td>145/167 = 86.8%</td></tr>
<tr><td>Annual ALC rate</td><td>1.8%</td></tr>
</table>
<u>Lessons Learned</u>
• A key component of the care pathway continues to be having the Community Health Navigator (CHN) connect with patients/caregivers prior to their FIT assessment to identify baseline
• Developed a one page information sheet to support identification of patients in acute care Emergency Departments that could be served in the community
•Geriatricians building capacity via team education. FIT Team Physicians with Care of the Elderly certification
•Introducing the Clinical Frailty Scale with A&R Physician Outreach service and will be implementing across inpatient rehab</td>
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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>The Scarborough and Rouge Hospital, Centenary Site Care After the Care in Hospital (CATCH) Program</td>
<td>To improve patient flow by reducing length of stay and readmission rate through a multidisciplinary approach in post discharge risk assessment and intervention.</td>
<td>

Outpatient program delivered by an interdisciplinary team of health professionals including a physiotherapist, physiotherapy assistant, a nurse and a pharmacist with a linkage to a general internist
Patients are referred to ensure they have a safe discharge home from hospital with follow-up on risk factors such as falls, nutrition, medication, pain, depression/cognition, wounds/skin breakdown, multiple medical conditions and/or advanced chronic diseases as well as to follow-up with reconditioning needs.
The average program length is three weeks, with patients seen twice a week. There is an average of 7-10 days between discharge from inpatients and admission to CATCH, which is often dependent on when transportation can be arranged to support attendance.

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<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>159</td></tr>
<tr><td>Functional Outcome Measure Improvement:</td><td></td></tr>
<tr><td>2 Minute Walk Test</td><td>31%</td></tr>
<tr><td>Timed Up and Go</td><td>23%</td></tr>
<tr><td>Falls Prevention Improvement</td><td>80%</td></tr>
</table>
<u>Lessons Learned</u>

Significant impact of a post-discharge program on keeping patients safe in the community and socialization.
Most significant risk factors addressed through the CATCH program have been: falls, medication safety, discharge instruction understanding and community isolation.
CATCH helps ensure patients are connected to community supports by monitoring patient risk factors and providing appropriate interventions as needed.
Bridges the gap between the inpatient hospital stay and independent living in the community; a slow stream exercise program to help patients reach their baseline from the effects of deconditioning from lying in a hospital bed.

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<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 - Virtual Ward (Carefirst Seniors and Community Services Association in collaboration with Scarborough and Rouge Hospital)</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) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>510
395 Virtual Ward + 210 Enhanced Recovery (95 both)</td></tr>
<tr><td>Number of incremental attendances/visits:</td><td>3214 (ERP)</td></tr>
<tr><td>Number of clinicians trained</td><td>5</td></tr>
<tr><td>% unplanned readmission to hospital within 30 days of discharge from hospital</td><td>11.4%</td></tr>
<tr><td>% of clients discharged home that were home prior to admission:</td><td>78.4%</td></tr>
<tr><td>Functional Outcome Measure: Average distance ambulated</td><td>8.8 metres to 29.5 metres</td></tr>
</table>
<u>Lessons Learned</u>
• Patients directly benefit from the collaboration between the two organizations.
• Participation in this specialized program results in physical, functional and emotional changes for the client.
• The adaptable nature of this program/staff allows for a unique service delivery where client needs and capabilities determine how the service is delivered
• While transportation does continue to be a challenge, patients that have transitioned from the hospital to our transitional care program are potentially more likely to continue attending the ERP post discharge.</td>
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<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>The average length of stay in the program was 8 weeks and average service utilization per discipline was 3 visits OT, 3 visits PT and 12 visits/hrs PSW.

Eligibility criteria:

• At risk seniors (65+ years) patients who have experienced a recent loss of functional ability related to a medical condition or life event
• Patients who have had a recent fall (within the last 30 days) requiring medical attention (MRPCP, NP, ED) or recent discharge from the hospital
• Seniors who are at risk of hospitalization admission into a long-stay Long-Term Care (LTC) home bed as a result of functional loss
• Patients who have the potential to regain that functional ability through participation in individualized in-home short-term rehabilitative program (i.e. have ‘restorative potential’)
• Patients who experiences some difficulty with 1 or more Activities of Daily Living (ADLs) and will benefit from a program to enable independence
• Patients who are motivated to be more independent in their own home</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>OT 417
PT 256
PSW 1104</td></tr>
<tr><td>Number of frail seniors served</td><td>200</td></tr>
<tr><td>Quality of Life measure</td><td>68% patients reported improvement</td></tr>
<tr><td>Number clinicians trained</td><td>>50 clinicians</td></tr>
<tr><td>Functional Outcome Measures:
Average change in score
Timed Up and Go
COPM Performance
COPM Satisfaction</td><td>

-20
+3
+3.2</td></tr>
<tr><td>% of unplanned readmission to hospital within 30 days of discharge from hospital</td><td>9.6%</td></tr>
<tr><td>% of unplanned, less-urgent ED visit within the first 30 days of discharge from hospital</td><td>9.6%</td></tr>
</table>
<u>Lessons Learned</u>
• The Home Independence Program is a restorative philosophy to enable patients accomplish their restorative goals in the community. This helps contribute to our knowledge within the CWLHIN of the care continuum as it relates to levels of care and enabling patients to return to functional independence.
• Majority of patients enrolled in the program are classified as mild-moderately frail as per the Rockwood Frailty Scale.
• Training of contracted service providers and care coordinators in the restorative approach contributes towards enabling patients to accomplish their goals and ensures program success and fosters an environment of learning, collaboration and implementation of best practices to ensure a goal oriented approach to service delivery.
• Dedicated Rehab Program Co-ordinator from the CWLHIN provided oversight of the program and was a key contact for internal and external stakeholders.
• Increase in job satisfaction reported by some service providers</td>
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<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.</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 compliment 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) 2017/18 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>2147</td></tr>
<tr><td>Number of frail seniors served</td><td>199</td></tr>
<tr><td>Quality of Life Measure</td><td>Pre: 46.76
Post 50.41
+3.65</td></tr>
<tr><td>Functional Outcome Measures
Timed Up and Go
BERG
30 sec Sit to Stand</td><td>
-5.35 sec
+7.27
+1.3
97.2% of patients sustained or improved 3+ outcome measures</td></tr>
</table>
<u>Lessons Learned</u>

Improved screening of referrals continues to improve the outcomes of the project
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

</td>
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</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>Community Step-Up Clinic – Acclaim Health & LifeMark Seniors Wellness</td>
<td>To ensure that every patient is successful in maintaining their gains while living in the community.</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
This clinic will accept referrals from all acute care centers, primary care physicians, Home and Community Care, Designated physiotherapy clinics and other health service providers. Physician referral is not required for the program.
Currently operate 3 mobile clinics 2 days per week treating up to 8 clients per location with 1 week of assessments and 5 weeks of direct care time
Lifemark’s Community Step Up program has established strong partnerships within the community to optimize existing resources

</td>
<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>2088</td></tr>
<tr><td>Number of frail seniors served</td><td>174</td></tr>
<tr><td>Number of clinicians trained</td><td>5</td></tr>
<tr><td>Functional Outcome Measures:
Average Change in Score</td><td></td></tr>
<tr><td>Timed Up and Go</td><td>-4</td></tr>
<tr><td>BERG</td><td>8</td></tr>
<tr><td>2 minute Walk Test</td><td>22</td></tr>
<tr><td>COPM Performance</td><td>2.46</td></tr>
<tr><td>COPM Satisfaction</td><td>3.2</td></tr>
<tr><td>Grip Strength</td><td>9</td></tr>
<tr><td>ASHA NOMS FCM (speech)</td><td>1</td></tr>
<tr><td>ASHA NOMS FCM (swallowing)</td><td>2</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

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<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>Assess and Restore Clinic – Halton Healthcare Services</td>
<td>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) 2017/18 FY:</u>
<table>
<tr><td>Number of incremental attendances or visits</td><td>1542</td></tr>
<tr><td>Number of frail seniors served</td><td>151</td></tr>
<tr><td>Number of clinicians trained</td><td>4</td></tr>
<tr><td>Functional Outcome Measures:
Average Change in Score
Timed Up and Go
BERG
MOCA
Chedoke-McMaster Stroke Assessment (hand/arm)
Grip Strength
ASHA NOMS FCM (comprehension/speech/problem solving/reading/memory)</td><td>

-11.5
+6
+2.1
+1.8
+7.4
+0.53</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 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

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<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>Victoria Order of Nurses Enhanced SMART and Transitions of Care</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.
• Piloting current hospital services in the community supports system re-design.
• 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</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>2727</td></tr>
<tr><td>Number of frail seniors served</td><td>230</td></tr>
<tr><td>Quality of Life measure</td><td>Average Gain:
4.68 points or 9.1%</td></tr>
</table>
<u>Lessons Learned</u>
• Clients being admitted are of higher frailty than originally expected. The use of the In-Home component of the program indicates that there is a gap in in-home services of this nature within the LHIN. Continued monitoring of the level of frailty of clients and the request for in-home support of this nature will be key to further development of the program.
• Although there has been a marked increase in referrals since program initiation, referral patterns vary between Orillia and Barrie and the success of referrals correlates with the support and involvement of a Geriatrician within the program.
• Both quantitative and qualitative data have consistently shown positive overall client results and referrer feedback has been very positive.</td>
</tr>
</table>

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes & Lessons Learned
South East LHIN	Restorative Mobility Program – Back in Motion – Perth and Smith Falls District Hospital	To increase strength and mobility in patients identified with potential to regain strength and functional ability after a recent admission/discharge to hospital.	• Priority was given to high risk frail vulnerable seniors and other patients with complex medical conditions that potentially were at risk for readmission and unplanned visits to the Emergency Department • Patients attended twice a week for 6 weeks. Sessions were between 90 and 120 minutes consisting of: (i) and education session re: benefits of exercise (ii) warm-up (iii) chair exercise targeting both upper and lower extremity (iv) balancing exercise (v) core exercises (vi) supine strengthening (vii) 20 minute walk and (viii) cool down. • Delivered by PT and 2 PTAs	**Outcomes (indicators & Metrics) 2017/18 FY:** None reported.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes & Lessons Learned
South East LHIN	Providence Care Centre	To provide navigation and support for frail elderly individuals living with dementia To provide better outcomes for older adults via capacity building and safe transitioning	No description reported.	**Outcomes (indicators & Metrics) 2017/18 FY:** Navigation and Support for Frail Elderly Individuals Living with Dementia: • Emergency Department Diversion • Reduction in Acute Care Admissions • Reduced Acute and/or Sub-Acute length of stay • Improved patient outcomes • Support functional independence in the community • Mitigate ALC for LTC conversions (zero conversions during pilot) • Increased incremental attendances/visits under new service • Increased volumes of frail seniors living with complex illness supported Better Outcomes for Older Adults: Capacity Building and Safe Transitioning: • Improved patient functional outcomes, self-management abilities and functional independence and coping in the community • Increased volumes of cross-sectoral linkages supporting continuity of care and mitigation of adverse outcomes • Improved cross-sectoral care transitioning • Increased volumes of frail elderly individuals supported • Increased incremental attendances/visits • Improved patient satisfaction through improved cross-sectoral continuity of care

<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 West LHIN</td>
<td>Geriatric Ambulatory Access Team St. Josephs Health Care London</td>
<td>To improve access to ambulatory comprehensive geriatric assessment and geriatric rehabilitative care in London/Middlesex and community-based comprehensive geriatric assessment in the sub-regions across the LHIN</td>
<td>• Build integrated pathways to access ambulatory specialized geriatric services
• These pathways will be supported by the development of a coordinated intake and access team which will receive referrals for all ambulatory geriatric services in Middlesex/London and community geriatric nurses across the LHIN. This team will consist of enhanced administrative support, as well as registered nurses, who will complete clinical triage for all referrals, in order to facilitate timely access to the right care, at the right time, and as close to the patient's home as possible</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Baseline Referral Volume</td><td>3300</td></tr>
<tr><td>Estimated Referral Volume following implementation</td><td>5500</td></tr>
</table>
<u>Lessons Learned</u>

• Implementation of a coordinated intake and access that includes skilled clinical triage allows for the development of referral form that focuses on patient needs, and does not require referral sources to be aware of all of the different services that are available. This will help optimize referring physicians' time and effort, and better facilitate access to the right care, at the right time, in the right place.
• Implementing new referral and intake processes requires a robust communication plan, built-in time to transition to the new processes, and the incorporation of transition processes that support continued communication as well as ensuring that no door is the wrong door.</td>
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</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 West LHIN</td>
<td>Evaluation of Implementing Proactive Screening with AUA into frontline EMS in Middlesex/London</td>
<td>To explore whether the AUA vs the PERIL tool is more effective and clinically relevant than the other, in identifying older adults who are at risk of poor outcomes, and who require further assessment.</td>
<td>• London-Middlesex EMS partnered with key partners in the South West LHIN to develop an evaluation team that examined the effectiveness of the AUA vs. the PERIL tool (which is used by EMS across the province, to identify older adults who need supports)</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><th></th><th>AUA</th><th>PERIL</th></tr>
<tr><td>Admission to Hospital</td><td>441 High Risk
225 Moderate Risk
247 Low Risk</td><td>28 scored 3 or 4
118 scored 1 or 2
13 scored 0</td></tr>
<tr><td>Deceased</td><td>251 High Risk
99 Moderate Risk
73 Low Risk</td><td>50% scored high risk
50% scored low risk</td></tr>
<tr><td>Referred to community Paramedicine</td><td>Majority scored High Risk
-50% of individuals had 4 or more chronic conditions
-169 people were on 4-7 medication
-131 people were on 8-11 medications</td><td></td></tr>
</table>
<u>Lessons Learned</u>
• Qualitatively, paramedics found the AUA to be effective in identifying high risk older adults, however paramedics did say they were not always clear on what to do next with patients scoring at different levels
• Based on this analysis, higher AUA scores seem to be a good predictor of poor outcomes (in this case, hospital admissions and death)</td>
</tr>
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<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) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>SMHS – 520 (162 face-to-face; 358 telephone)
Geriatric clinic (MD & allied health) - 431
Geriatric Outreach – 104
SCWSS PSW visits – 238</td></tr>
<tr><td>Number of frail seniors served</td><td>SMHS – 79
Geriatric clinic & outreach – 97
SCWSS PSW - 14</td></tr>
<tr><td>Number clinicians trained</td><td>5 nursing staff
6 clinic staff
3 PSWs</td></tr>
<tr><td>Patient Satisfaction Survey</td><td>100%</td></tr>
</table>
<u>Lessons Learned</u>
• Extensive knowledge of the SF framework and standards ensures implementation of best practices
• Consistent approach to Comprehensive Geriatric Assessment facilitated by an inter-professional team and rooted strongly in the Competency Framework for Interprofessional Comprehensive Geriatric Assessment developed by the RGP
•Outreach services beneficial for those who are unable to attend traditional community based exercise and essential for those with limited supports, advanced frailty and/or cognitive impairments that limit their ability to access specialized care
• 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
• Continued participation by team members in RGP and RCA (Rehab Care Alliance) committees to maintain awareness of best practice standards
• Partnership with Reconnect Community Health
• Collaboration with WPHC SMH service (bidirectional) to provide frail older adults in the community with access to specialized geriatric services</td>
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<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 client's 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) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>911</td></tr>
<tr><td>Number of frail seniors served</td><td>269 referrals</td></tr>
<tr><td>Clinical Frailty Scores</td><td>53% patients within moderately to severely frail category</td></tr>
<tr><td>Patient Satisfaction Survey – Would you recommend?</td><td>90%</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>
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</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>Waterloo Wellington LHIN</td>
<td>Rapid Recovery Therapy Program (RRTP)</td>
<td>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.</td>
<td>• 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).</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>184</td></tr>
<tr><td>ALC Rate: post-acute rehabilitative care</td><td>21.7%</td></tr>
</table>
<u>Lessons Learned</u>
• A third party evaluation of the RRTP program was conducted by Optimus SBR in 2016/17. The evaluation reviewed patient, system and program outcomes.
• Total volume of acute ALC patients waiting for rehab and low intensity rehab and Total ALC Days for those patients have decreased since the implementation of the RRTP, continuing a downward trend since 2014/15 Q4.
• The ADL Long Form Score from the RAI-HC (Home Care Assessment Tool) was used as the primary outcome measure. A lower score indicates greater functional independence. Overall, RRTP patients showed improvements in the 30 days following hospital discharge.
• A lower score represents greater functional independence.
• RRTP patients from rehab achieved a similar score at Day 7- 9 as those patients who stayed in rehab and were discharged to home care from inpatient rehab at the usual time (2.2 vs 2.5).
• RRTP patients from acute care achieved a similar level of functional independence as those patients who were discharge from inpatient rehab at the usual time (2.6 vs 2.5).
• RRTP patients from rehab completed the program with greater functional independence that the RRTP patients from acute care (did not receive inpatient rehab before RRTP) (0.8 vs 2.6). A 14-day extended program is now available to RRTP patients from acute care to continue their rehabilitation.</td>
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</table>

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 East LHIN</td>
<td>Northumberland Hills Assess and Restore Intervention Proposal</td>
<td>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>

Best practice related to supportive care, symptom management, advanced care planning and end of life will be woven into the care provided supported by the approach of self-identified needs of the at-risk senior and their caregiver and their quality of health / life.
Led by a Nurse Practitioner (NP) Gerontology with expert advice from a Gerontology Lead supported by the Interprofessional Team
‘Organization wide service,’ with the Nurse Practitioner providing comprehensive gerontological assessments for at risk patients, including support to the GEM nurse.
Nurse to patient ratio lower than what would be normally practiced on the Restorative Care Unit during day and night shifts to support the medical complexity of this at-risk patient population
Comprehensive care plans are based on patient/caregiver self-identified needs and goals and comprehensive gerontological assessment with engagement strategies such as communication boards and patient/family meetings.

</td>
<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>685 (135 inpatients)</td></tr>
<tr><td>Number of clinicians trained</td><td>0</td></tr>
<tr><td>% patients designated ALC within two days of acute care admission who are d/c to rehabilitative care bed</td><td>16.3%</td></tr>
<tr><td>% admissions to rehabilitative care beds that were directly admitted from community/ED</td><td>39%</td></tr>
<tr><td>% patients directly admitted to a rehabilitative care bed from the community who were discharged home</td><td>75%</td></tr>
<tr><td>% unplanned readmission to hospital within 30 days of discharge from hospital</td><td>10.4%</td></tr>
<tr><td>Functional Outcome Measure Changes: Average Change in Total Function Score on FIM</td><td>17.19</td></tr>
<tr><td>Annual ALC rate by: post-acute inpatient rehabilitative care services</td><td>18%</td></tr>
</table>
</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 objectives of the program include:

-improve patient outcomes (prevent deconditioning, maintain or improve mobility)

-improve patient/caregiver support and satisfaction with hospital experience

-reduce Alternate Level of Care (ALC) LTC rates

-reduce 30 day re-admission rates</td>
<td>• Referrals are received by the ARM Team Clinical Nurse Specialist or Social Worker.
• Referrals are generated by Emergency Department GEM Nurse, Community Partners, and members of the RMH interdisciplinary team.
• The ARM team may also proactively screen acute care inpatients using validated standardized tools (SPICES, Blaylock and AUA screening Tools).
• Current focus is on the frail/medically complex senior patient population in acute care with additional consultation occurring in post- acute care.
• Treatment is aimed at increasing strength, mobility and functional ability with the goal of returning frail seniors to the community or the most appropriate level of care.
• Consultation provided for areas such as Consent and capacity, elder abuse, referral support, care conferences, determining restorative potential, complex geriatric issues, Behaviour and Psychological Symptoms of Dementia, etc.
• LACE Index Scoring Tool for Risk Assessment of Hospital Readmission utilized</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>410</td></tr>
<tr><td>Number of clinicians trained</td><td>30</td></tr>
<tr><td>% patients designated ALC within two days of acute care admission who are d/c to rehabilitative care bed</td><td>21.4%</td></tr>
<tr><td>percentage of clients discharged to RH/home (from RH/home prior to admission)</td><td>76%</td></tr>
<tr><td>% unplanned readmission to hospital within 30 days of discharge from hospital</td><td>15%</td></tr>
<tr><td>Functional Outcome Measure Changes:
Average Change in Total Function Score on FIM</td><td>20.2%</td></tr>
<tr><td>Annual ALC rate by: post-acute inpatient rehabilitative care services</td><td>6.9%</td></tr>
</table>
<u>Lessons Learned:</u>
• ARM patients are very complexed and decondition quickly. Early interventions, standardized care and training/education are required.
• Clear admission criteria parameters required
• Enhance the identification of patients with high risk/high vulnerability
• Use of advanced evidence based screening tools
• Identify patients who are high risk for readmission and notify ED
• Enhance communication with RMH team regarding outcome of screening
• Implementation of a standardized quality framework for the assessment and treatment of Behavioral & Psychological Symptoms of Dementia
• Enhance the collection of relevant data to assist in program evaluation and development</td>
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<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</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 ensure sustainability of the use of a Regional Clinical Patient Flow Algorithm to additional acute care hospitals in Champlain

</td>
<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of incremental attendances/visits</td><td>3433</td></tr>
<tr><td>Number of clinicians trained</td><td>11 staff trained
26 Clinical Leaders informed</td></tr>
<tr><td>% patients ALC on discharge from Acute Care to Rehabilitative Care</td><td>48%</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. Examples include:

Electronic referral from TOH partner hospitals to TOH Rehabilitation Centre
On-line RMR
On-line follow-up notes

Subacute navigation is linked to flow out of acute care
The subacute navigation model can be used to support achievement of QBP targets. Examples include:

Stroke QBP
Hip Fracture QBP

On-going education is important to maintaining process knowledge and referral efficiency

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<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>• Developed and tested a model of 7 day/week physical and cognitive rehabilitation therapy for individuals with Acquired Brain Injury.</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 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>13</td></tr>
<tr><td>Annual ALC rate by: post-acute inpatient rehabilitative care services</td><td>0</td></tr>
</table>
<u>Lessons Learned:</u>

Preliminary findings indicate a reduction in overall average length of stay
Patients have provided positive feedback about the ability to access their therapy team throughout the week and there has been enhanced communication between team and families / caregivers
This type of rapid and intense therapy program requires strong inter-professional 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

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<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>Direct Admissions to Sub-Acute from the Emergency Department – The Ottawa Hospital</td>
<td>To introduce processes to allow directed access to sub acute services from the emergency department and community;

To implement RCA standardized direct access priority process tools to access rehabilitative care from the community</td>
<td>• Focused on identifying a cohort of patients from the GEM nurse's caseload that could be transitioned directly from the ED and/or community. The processes would be presented at the GEM Plus Project Leadership Team to push out a regional implementation
• Shaped an algorithm to drive the process including testing the algorithm to determine opportunities for improvements
• Utilized the work completed by the Direct Access Priority Process (DAPP), specifically the DAPP three step process and the DAPP logic model
• The targeted population were high risk seniors (65 plus) who had restorative potential. The patients that were targeted for the pilot were patients directed to the GEM nurse caseload. The patients had a two or more ED visits in the past 180 days, lived in the community (excluded LTC), and had a Canadian Triage Acuity Scale (CTAS) of 2 or lower.</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>20</td></tr>
<tr><td>Number of clinicians trained</td><td>10 GEM Nurses</td></tr>
<tr><td>% admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>15% of 20 identified patients admitted from ED

35% of 20 identified patients admitted from the community</td></tr>
</table>
<u>Lessons Learned:</u>
• Created a forum for dialogue related to transitions from ED/Community to Sub acute care.
• The pilot validated that the targeted population of pelvic and compression fractures were a good fit with GRU from the ED. The GEM plus program was able to utilize going home so when patients were sent home, they would get going home start and within 72 hours be transferred to the GRU. The purchase service agreements provide the necessary warm hand offs needed to support delays in accessing GRU beds.
• Opportunity to continue working with sub-acute in further defining targeted population such as other patients presenting in the ED with fractures.
• People centered care provides access to the right services in a timely manner to a vulnerable patient population
• Creates an opportunity to expand role of existing resources (GEM Plus) with transitioning patients to the sub acute services. The pilot program only focused on a sub set of the system.</td>
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<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>To emphasize early activation to maintain or increase the functional capacity of hospitalized older adults through Rehabilitation Assistants working with Physiotherapists and/or Occupational Therapists employed by the Hospitals.</td>
<td>

A LHIN-wide Assess & Restore Working Group was formed to coordinate standardization of project implementation.
For years 2 and 3 of A&R, previous “Activation” base funding allocations were pooled with the new A&R funds and work was initiated to standardize these programs into a Seniors Mobile Assess and Restore Team (SMART) approach, modeled after the program developed at Hamilton Health Sciences Centre and led by HNHB LHIN.
In Q4 of 2016-17, adoption of the Senior Friendly Hospital Mobilization of Vulnerable Elders (MOVE) approach as an additional means of engaging the full hospital team in the philosophy of early activation was discussed. All HSPs have agreed to work toward 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 will be assessed for mobility status within 24 hours of admission and mobilized with the MOVE A, B, C algorithm, on minimum two units at each hospital site.

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<td>
<u>Outcomes (indicators & Metrics) 2017/18 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>1987</td><td>3498</td><td>1595</td><td>3292</td><td>2780</td></tr>
<tr><td>% patients discharged home</td><td>71.4%</td><td>72.2%</td><td>59.0%</td><td>73.1%</td><td>74.0%</td></tr>
<tr><td>% patients with ALC days</td><td>9.4%</td><td>9.7%</td><td>9.5%</td><td>11.5%</td><td>11.3%</td></tr>
<tr><td>% of patients readmitted in 30 days</td><td>13.5%</td><td>10.6%</td><td></td><td>15.5%</td><td>15.8%</td></tr>
</table>
<u>Lessons Learned:</u>

This funding continues to support efforts to promote recovery and optimal function outcomes for patients, reduce ALC rates, facilitate discharge planning and enhances necessary rehabilitation human resources.
Adopted the Senior Friendly Hospital Mobilization of Vulnerable Elders (MOVE) approach as an additional means of engaging the full hospital team in the philosophy of early activation
Recognized the importance of consistent messaging to patients and their families regarding early mobilization so that it is not only experienced during one part of the care continuum but is a message facility wide
Connecting with Occupational Health & Safety regarding ongoing staff education in the safe moving and handling of patients, as a frequent barrier that was brought forward was not effectively utilizing the tools/equipment we have when transferring/moving patients
The seven-day a week staffing coverage supported by this funding has been crucial – especially for new admissions to medicine and new therapy referrals to allow for early assessment and intervention.
The coaching support provided by the MOVE team has been a further positive addition to advance this work in our organization.

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<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.

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<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>3539</td></tr>
<tr><td>percentage of clients discharged home</td><td>87%</td></tr>
<tr><td>% requiring post-acute bedded rehabilitative care</td><td>7%</td></tr>
<tr><td>Functional Outcome Measure Changes:
Independent functioning on Barthel ADL Index</td><td>44%</td></tr>
<tr><td>ALC to LTLD level of care</td><td>47% decrease</td></tr>
<tr><td>Difference in Average LOS between SMART patients and patients with similar CMG</td><td>1.28 days</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.
SMART teams and SMART leaders have the ability to implement successful rehabilitative care initiatives that have the potential to change the trajectory of an individual's healthcare journey and life story from a discharge from hospital to a long term care home to a discharge from hospital to home as evidenced by the patient story shared in the voices in the community video found here: https://youtu.be/TiNEpsTcvHg.
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.

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<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 Expansion at Sioux Lookout Meno Ya Win Health Centre</td>
<td>To enable capacity to meet demand for services and provide coverage on weekends</td>
<td>

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.

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<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>26</td></tr>
<tr><td>Rate of discharged home</td><td>78%</td></tr>
<tr><td>Functional Outcome Measure Changes:
Functional Independence Measure – Total Change in Function Score</td><td>+12.1</td></tr>
</table>
<u>Lessons Learned:</u>

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.

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LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
North West LHIN	Weekend and Enhanced OT for A&R Program Dryden Regional Health Centre	To enhance the existing Assess and Restore / frail elderly inpatient population	• Enhanced Rehab Assistant and Occupational Therapy services were provided. The Rehab Assistant provided additional support over the weekends and an extra OT day of coverage during the week was added	**Outcomes (indicators & Metrics) 2017/18 FY:** Number of frail seniors served: *48* Number incremental attendances/visits: *Additional 269 encounters* Rate of discharged home: *75%* **Lessons Learned:** • The extra weekend support allowed patients to continue making gains 7 days a week instead of functional decline over the weekend. • As well, the nursing staff is one less over the weekend on the inpatient unit. If there are patients that require extra time for their ADLs or require assistance (especially if more than one person) this program supported patients and staff to fully practice the patient's independence. • The Rehab Assistant staff enjoyed the weekend coverage as well as they could focus on a select group of patients during that time.

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
North West LHIN	Enhanced Rehabilitation Services Thunder Bay	To enhance inpatient rehabilitation by providing care for patients with chronic health problems who are particularly vulnerable to the risks of iatrogenic illness and functional decline	• The enhanced in-patient rehabilitation program provided increased mobilization and rehabilitation services	**Outcomes (indicators & Metrics) 2017/18 FY:** Number incremental attendances/visits: *1608* **Lessons Learned:** • These enhancements will help improve outcomes, minimize hospital length of stay and optimize discharge planning options by maintaining the physical functionality of admitted patients

<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>Enhanced Service Delivery: Geriatric Care Coordinator/Lead for Senior's Clinical Pathway Development Thunder Bay Regional Health Sciences Centre</td>
<td>To develop and implement the Frail Seniors Clinical Pathway.

The Geriatric Care Coordinator continues to act as an expert resource for the healthcare team, a liaison for patients and families and an advocate for safe, quality care of frail seniors.</td>
<td>• The Geriatric Care Co-ordinator delivers targeted, emergency geriatric assessment to frail seniors in the Emergency Department, and helps seniors' access appropriate services and/or resources that will enhance their functional status, independence and quality of life.
• The GCC nurse also builds geriatric and senior-friendly programming within the ED and throughout the hospital through collaboration, knowledge transfer, and education opportunities for all staff.
• The GCC nurse is positioned to have strong networks and affiliations in the community to further support seniors as they leave the hospital.
• The Frail Seniors Clinical Pathway addresses patients aged 65+ who present at the TBRHSC ED exhibiting any symptoms indicating risk
• A process to address the needs of patients, as well as build the confidence of both formal and informal caregivers was developed; identified patients are being discharged home with a referral to be seen in their home by a NWLHIN Rapid Response Nurse (RRN) within 48 hours, and with an appointment for the Geriatric Assessment Clinic within 4 days of ED discharge.</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>2992 Patient Interactions</td></tr>
<tr><td>Number of frail seniors served</td><td>1960</td></tr>
<tr><td>Number clinicians trained</td><td>31</td></tr>
<tr><td># patients designated ALC within three days of acute care admission d/c to rehabilitative care bed*</td><td>36</td></tr>
<tr><td># admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>16</td></tr>
<tr><td># patients directly admitted to a rehabilitative care bed* from the community who were discharged home</td><td>9</td></tr>
<tr><td>ALOS to ALC or Discharge</td><td>3.32 days</td></tr>
</table>
<u>Lessons Learned:</u>
• Enhanced collaboration and coordination of services noted
• Further review of supportive services and processes needed to facilitate the easy transition of patients from the acute to non-acute or home environment
• Further standardization of assessment tools used across care continuum
• Ongoing physician engagement needed to support the implementation and initiation of clinical pathways
• Permanent clinical resource i.e. GCC or similar, to facilitate the early identification of frail seniors, begin risk assessment, and coordinate care</td>
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<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>Geriatric Assessment and Rehabilitative Care St. Josephs Care Group</td>
<td>To facilitate direct admission to Rehabilitative Care.</td>
<td>• Continued collaboration with the ED department at TBRHSC to direct admit from emergency to avoid an acute care admission.
• Continued efforts to collaborate with our partners at the LHIN Home and Community Care to admit directly from the community who are at risk for a potential hospital admission</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>516</td></tr>
<tr><td># admissions to rehabilitative care beds* that were directly admitted from community/ED</td><td>14.5%</td></tr>
</table>
<u>Lessons Learned:</u>
• The target for clients discharged from the program home was not met due to the high number of clients who became acute once on the program, were transferred to a more appropriate unit in the hospital, larger number of clients being discharged to Long Term Care, Supportive Housing and those who expired.
• The program is serving a population who make huge gains in the program and are discharged with the knowledge of how to continue living in their own environments with or without community supports.</td>
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<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>Quntie Health Care</td>
<td>To identify frail seniors using established & easy to use tools in the ED to improve focused care & transitions resulting in better patient outcomes

To provide a standardized and detailed process for an initial comprehensive assessment built on the clinical frailty score and inform a 48 hour care plan covering key indicators known to influence readmission.

To improve communication of key information between ED therapists and Inpatient staff to ensure reduction of duplication, reduce inpatient length of stay and/or patient risks.

To select a tool that can be used by front line staff to measure quality patient outcomes</td>
<td>• The QHC ED Deployment Team began using the Clinical Frailty Scale to measure frailty and risk with elderly patients presenting to the ED
• Patients were treated by an OT in the ED
• Established standard assessment, providing basic information to front line nurses for mobility, toileting and transfers and more complex details (multi-medication consultation, behaviour intervention planning, etc.) informing practices by the larger interprofessional team.
• AlphaFIM tool utilized on ACE unit. Staff were familiarized with the tool and detailed care plans and measurement language called Precision Care Plans were established.</td>
<td><u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>1745 ED patients
45 in-patients</td></tr>
<tr><td>Functional Change:
AlphaFIM Efficiency
Average Admission AlphaFIM Score
Average Discharge AlphaFIM Score</td><td>
2.2
75
91</td></tr>
</table>
<u>Lessons Learned:</u>
• Clinical Frailty Scale levels 6&7 are being used to build focused care plans for inpatients on the ACE unit and may have an ability for a larger focus across all inpatient medical beds
• Anticipate a final comprehensive assessment form to be completed in 2018 with electronic reporting of key indicators flowing from this work
• Spread AlphaFIM measurements to a larger population</td>
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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.	• Gentle Persuasive Approach (GPA) is an innovative dementia care education curriculum based on a person-centred care approach designed for those caring for clients with dementia. GPA is delivered in four modules over an 8 hour day. GPA s also includes respectful staff-protection and gentle redirection techniques to use in situations of safety risk. • Education provided January to March 2018	**Outcomes (indicators & Metrics) 2017/18 FY:** Number of staff trained: *173* **Lessons Learned:** • Evaluation comments included: "I did not know the actual hands on techniques to respond to behaviours.", "I like the small class size; it made me more comfortable and confident during the interactive activities.", "I will use the redirection technique – using all the steps instead of jumping to the end." and "I learned gentle ways to get out of a grab."

LHIN	Project Title	Project Goal	Brief Description of Initiative	Outcomes and Lessons Learned
South East LHIN	Kingston Health Sciences Centre: My Discharge Plan (MDP) Process Project	My Discharge Plan (MDP) is an enhanced Patient-Oriented Discharge Summary (PODS) process. MDP was coupled with an education plan for providers that included the use of specific health literacy strategies (plain language and teach-back) when reviewing the MDP with patients and families. Prior to and throughout implementation , staff education has been ongoing. Goal to provide a 3 month extension of the role of the Health Literacy Specialist (HLS) leading to the implementation of MDP and continued staff education.	The 3 month extension of the HLS achieved the following: • Developed the electronic MDP form and program • Assisted providers to develop standardized templates for use with MDP • Developed and implemented an education plan for frontline providers • Use quality improvement methodology to solicit feedback from patients and families • Create a health literacy section of the clinical resources section of the hospital intranet • Obtained and shared information about available translation and interpreter services across the in-patient units • Maintain and update newly created plain language glossary on the KGH eternal website • Raise awareness of MDP and associated health literacy strategies by providing education sessions • Collect process and outcome measure data • Consider future steps in enhancing transitions from hospital to home • PDSA cycles of MDP in the Medical Short Stay Unit (MSSU)	**Outcomes (indicators & Metrics) 2017/18 FY:** Too early for in-depth analysis of data **Lessons Learned:** • MDP went live across KHSC on April 4, 2018 • Initial focus in the General Internal Medicine program allowed for the collection of specific metrics

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<tr>
<td>South West LHIN</td>
<td>Enhanced Rehabilitative Care in Acute Hospital to Frail Elderly London Health Sciences</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) 2017/18 FY:</u>
<table>
<tr><td>Number incremental attendances/visits</td><td>2250</td></tr>
<tr><td>Number of frail seniors served</td><td>450</td></tr>
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<u>Lessons Learned:</u>
• Ongoing monitoring is required to ensure intended population is being captured, modify inclusion/exclusion criteria as needed.</td>
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<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.</td>
<td>
• The population served experiences complexity in a number of areas including issues with mental health and addictions, medical complexity and social frailty
• Developed and implemented inter-organizational integration.
• Ongoing transition of potential ALC clients into the community.
• Successful transitions into the community were achieved through a coordinated approach that included a partnership with acute care hospital, post-acute care rehabilitation, TCLHIN, community staff and their caregivers.
a) Mental Health partnerships with SMH (OTN and in-house consults with mental health specialists from SMH)
b) Other community services when patients not living in TCLHIN
c) Created Outpatient clinics at TGHC to ensure patients are follow up post discharge
</td>
<td>
<u>Outcomes (indicators & Metrics) 2017/18 FY:</u>
<table>
<tr><td>Number of frail seniors served</td><td>68</td></tr>
<tr><td>Number clinicians trained</td><td>10 Nurses & 1 SW</td></tr>
<tr><td>% of unplanned readmission to hospital within 30 days of discharge from hospital</td><td>0%</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.
• These organizations will support those frail elderly with appropriate visits and assessments to trigger re-admission if necessary to TGHC to enhance or maintain their health condition with rehabilitation and to prevent ER visits. This is a crucial pathway to prevent the recidivism of emergency department/acute care readmission.
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