

A Provincial Integrated Model to Improve Care for Patients following a Hip Fracture: Helping Patients to Return Home

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Background

Hip Fracture Care in Ontario



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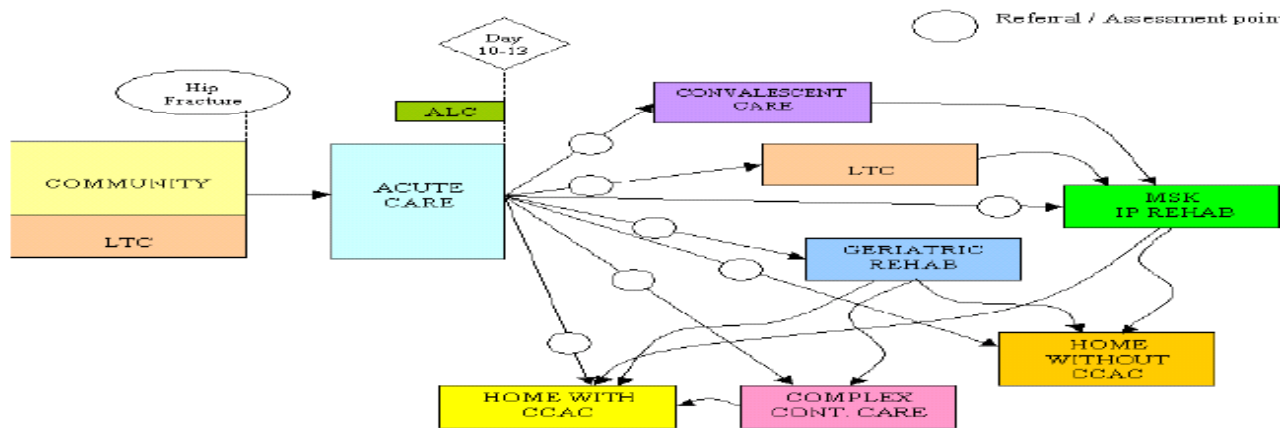
Significance of the Problem

- A hip fracture is a catastrophic event and a significant threat to an older persons' independence and ability to live in the community (Heruti et al., 1999).
 - Frailties & multiple co-morbidities
 - Long waits for surgery (Weller, 2005; Zuckerman et al. 1995)
 - High Mortality (March et al., 1996)
 - Functional impairment and unable to achieve previous level of functioning (GTA Rehab Network, 2006)
 - Osteoporosis (Goeree et al. 1996; Bogosh et al., 2006)
 - Cognitive issues of the 3 D's (Min, 2005; Marcantonio, 2001)



Significance of the Problem

- Health services are fragmented and limited and particularly for older persons with frailties and cognitive issues (GTA Rehab Network, 2006).

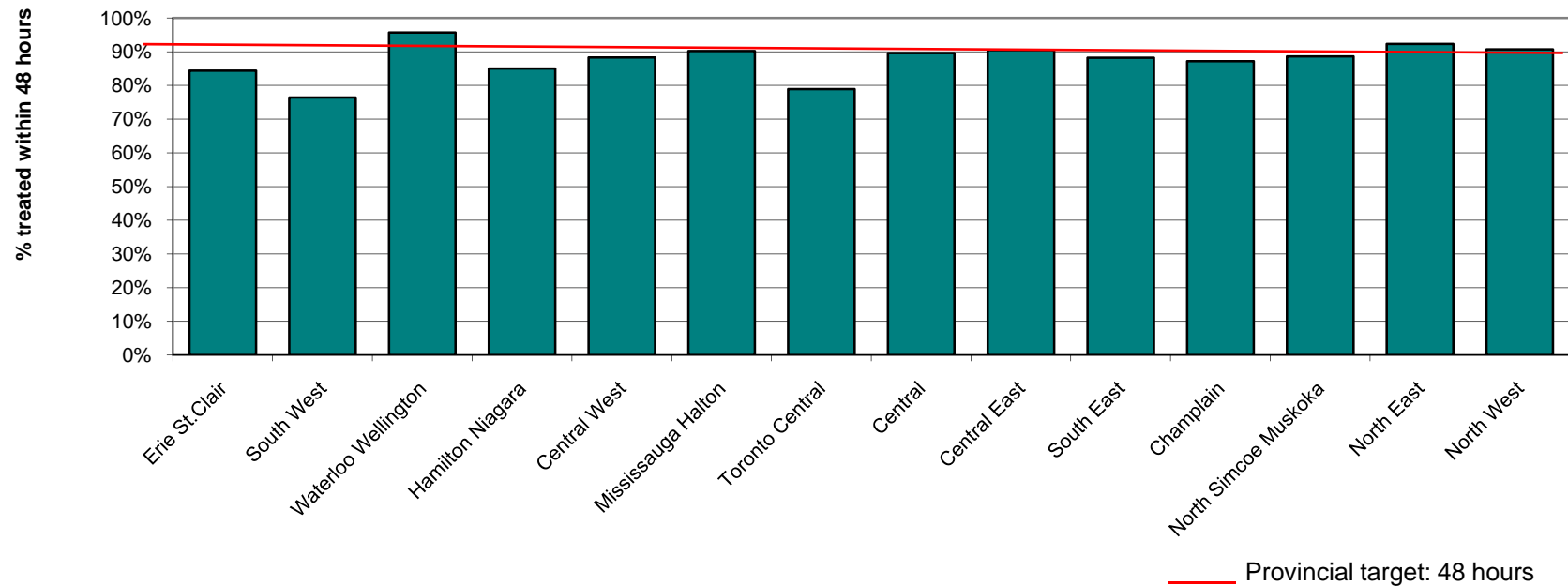


- Canadian Health care system direct cost average \$27,000
 - Discharge to long term care, as high as \$47,000
 - Discharge home 21,000 (Wiktorowicz et al., 2001)

Ontario Hip Fracture Surgical Wait Times

Percent of Ontario hip fracture cases treated within 48 hours by LHIN

- In 2007/08 -86.8% of cases were treated within 48 hours (n=9578)



Review of the Literature

- Surgical Wait >48 hrs times are critical to outcomes (Weller, 2005,)
- Optimized, comprehensive and interprofessional management are vital to effective care across the health care continuum. (Currie & Hutchison, 2005; Pederson, Finn, Birgette et al. 2008 ;Chong, Christou, Fitzpatrick, Wee, & Lim, 2008)
- Several Models of optimized hip fracture care
 - SIGN Guidelines – comprehensive “journey of care” (Currie & Hutchison, 2005)
 - OARS – Ortho Aged Care and Rehabilitation Service (Chong et al., 2008)
 - Total Joint Network (Mahomed et al., 2008)



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Total Joint Network

An Integrated Model of Care for Patients with a Hip Fracture
(2006-2008)

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Total Joint Network



Project Description

- Redesign of Care Process
- Repatriation Principles
- An Education Initiative
- Performance Measurement Processes
 - 80% of patient will transition at Day 5 -8 post op to rehab
 - Average LOS in rehab will be 28 days
 - 75% of patients return home



Total Joint Network

Results: Acute Care

All patients: n = 2,178 patients, **Home Stream Patients:** n = 1,761 patients

Home Stream Patients (patients who had been living at home prior to their hip fracture)	Project Target	2008 February
Discharged directly home from acute care		12%
Transferred to inpatient rehabilitation from acute care ¹	80%	71%
¹ Discharged directly to LTC from acute care	<20%	2%



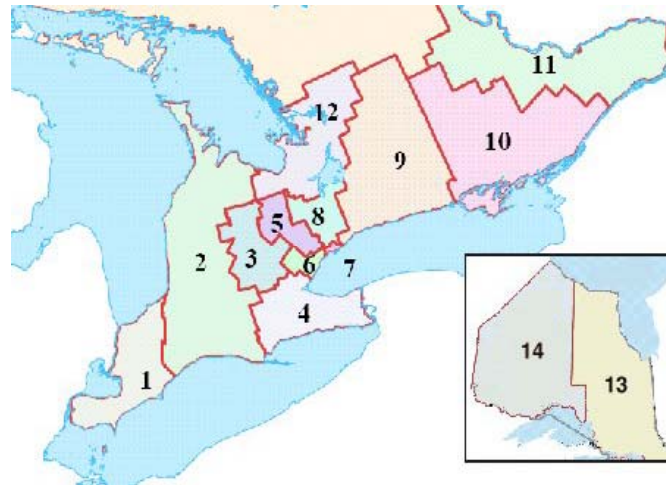
Results: Inpatient Rehab

Home Stream patients: n=1132 patients

- Range of levels of cognition

Home Stream Patients (patients who had been living at home prior to their hip fracture)	Project Target	2008 February
Inpatient rehabilitation ALOS	28 days	24 days
Discharged home after inpatient rehabilitation	75%	76%
Discharged to LTC from inpatient rehabilitation	<20%	11%

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Improving Hip Fracture Care Across Ontario



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Introducing the ...

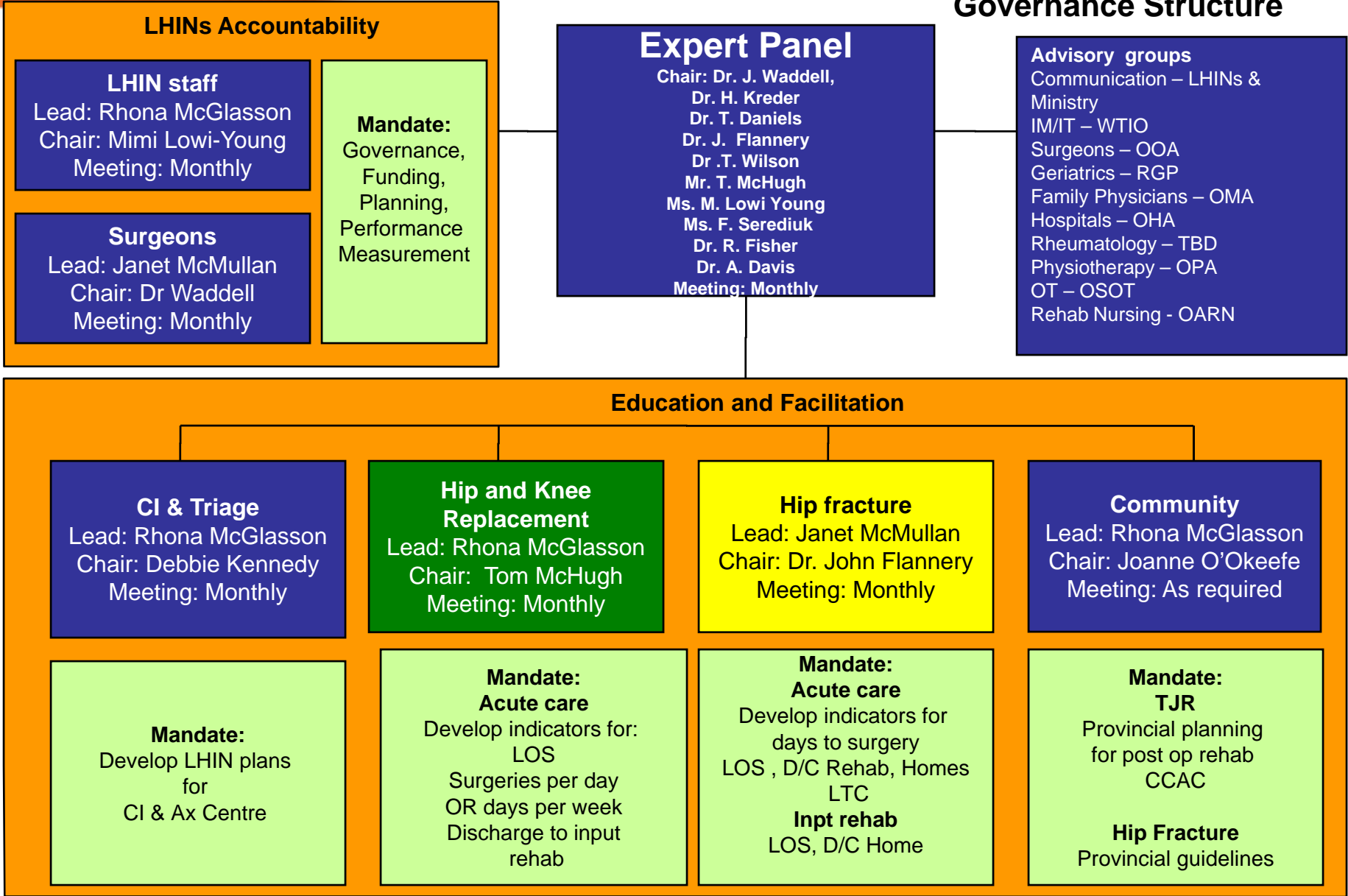
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- Support the expanded mandate for the Orthopaedic Expert Panel ...improving orthopaedic care for people across Ontario
- Focus on Wait Times for:
 - *Hip and knee replacements* of 182 days from the surgeon's office to surgery
 - *Hip fracture* care of 48 hours from admission to surgery
 - *Foot and Ankle, and Spine* access to care
- Governance Structure, Principles, Knowledge Translation & Spread Approaches



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Orthopaedic Expert Panel Governance Structure



Governance structure managed through the Bone and Joint Health Network

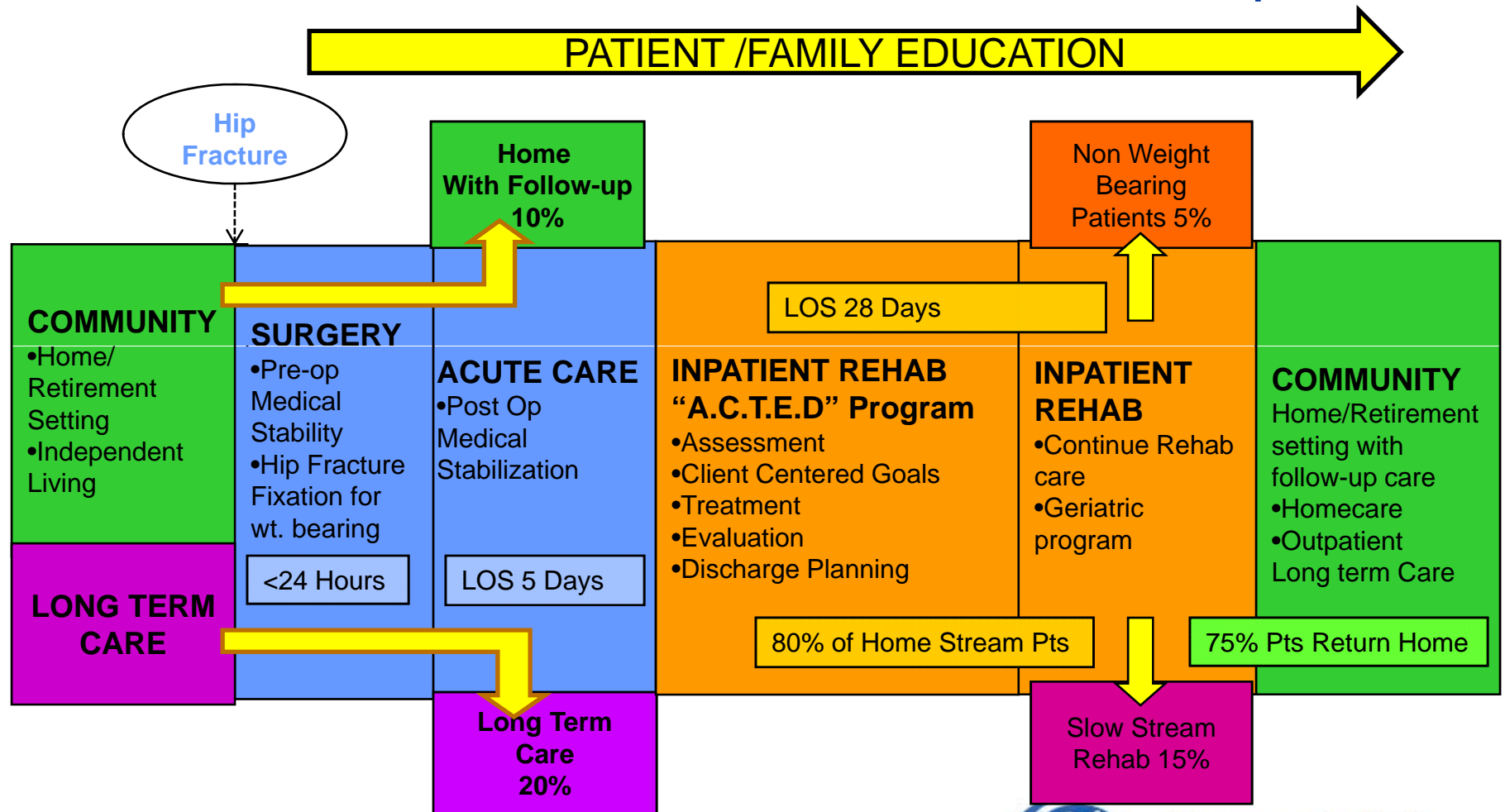
Hip Fracture Principles

- Timely access to surgery within less than 48 hours of admission to a hospital
- Surgery to optimize functioning
- Prevention, screening and management of the 3D's - delirium, dementia and depression across the care continuum
- Discharge on Day 5 for all long term care patients
- Early access by Day 5 to inpt rehab for all pts coming from home
- Discharge home for most or seamless transfer to the most appropriate care option



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Model of Care for Hip Fracture



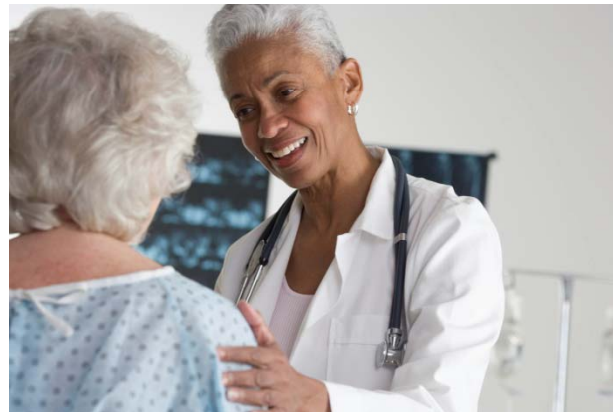
Adapted from Mahomed et al., 2008; McGilton et al., 2009
Chong et al., 2008; Currie & Hutchinson, 2005

Tools Kit for Hip Fracture

- Surgical Practice to Optimize Function
- Care maps – acute care, inpatient rehab, CCAC
- Pre admission order sets
- Performance management – Indicators and Technical Reports for measurement
- Patient/ Family Education tools
- Anticoagulant thromboprophylaxis protocol
- Education workshop/materials for health professionals
- Delirium, Dementia & Depression tools
- Osteoporosis protocol
- Standardized discharge –Smooth Steps to Discharge



Bone and Joint Health Network Progress to Date



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Process Indicators

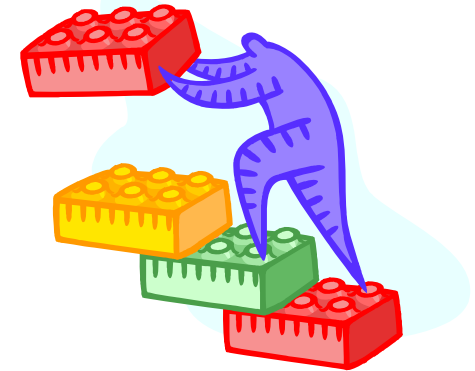
- Steering Committee
- Implementation Target Dates
- Data Evaluation Processes
- Relationships Established to Enable Systematic Patient Flow i.e. Acute, Rehab, Geriatrics , CCC, CCAC, other
- Wait time Surgery < 2days
- Implementation of Best Practice
 - Acute Care Care Map
 - Inpatient Rehabilitation Care Map
 - Community Care Guidelines
- Education for Health Professionals



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BJHN Next Steps

- Disseminate provincial models of care
- Continue knowledge spread through
 - Provincial Hip Fracture KT Teleconferences to continue
 - Clinical Coach/Facilitator Teleconferences
- Determine Next Steps within each LHIN
 - Governance structure
 - Accountability
 - Sustainability planning
- Support organizations to go LIVE
- Begin Provincial Benchmarking Initiative



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Acknowledgments

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Dr James Waddell – Chair, Orthopaedic Expert Panel

Ms. Rhona McGlasson - Project Director

Orthopaedic Expert Panel

University Health Network

Dr. Nizar Mahomed - Director of MHA

Dr. Aileen Davis –Scientist, Outcomes & Population Health

Total Joint Network

35 TJN Partnering Organizations

Toronto Rehab

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Dr. Kathy McGilton – Scientist

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Membership for Ontario Health Care Professionals



Thank you and questions?

