Building Consensus for Programs of Care
• Government supported health care is expensive and costs are going up

• Cost containment is a top priority for public and private payers
How to balance these three priorities is the main goal for payers, providers and patients.
Engage government by bringing a solution to their problem. They know they have a problem – show them how to solve the problem.
Examples of consensus derived models of care:

- Hip and knee replacement
- Hip fracture care
- Knee arthroscopy
- Shoulder surgery
All of these are high volume and/or high cost; access to care for patients may be a problem because of patient numbers or procedural cost.
Example: Hip Fractures
Ontario Hospital Orthopaedic Inpatient and Day Surgery Activity
$1.226 billion total expenditure (12.1% of total 2011/12 hospital acute care costs)

**PRIMARY HIP & KNEE REPLACEMENT**
- $309.7M (25.3% of orthopaedic costs)
- 2 patient groups (HIGs)
- HQO to develop episode of care in 2013/14
- Revised evidence-based QBP funding implementation: 2014/15

**SPINE PROCEDURES**
- $148.7M (12.1% of orthopaedic costs)
- 8 patient groups (HIGs)
- HQO not tasked with analysis
- Originally planned for 2014/15 QBP implementation; now likely to be 2015/16 at earliest

**ORTHOHAEDIC TRAUMA CARE**
- Excludes hip fracture
- $101.2M (8.3% of orthopaedic costs)
- 14 patient groups (HIGs)
- Not planned for QBP implementation
- Significant cost implications for specialized trauma centres

**HIP FRACTURE**
- $179.6M (14.7% of orthopaedic costs)
- 2 patient groups (HIGs)
- HQO developing episode of care in 2013/14
- Planned QBP funding implementation: 2014/15

**ORTHOPAEDIC DAY SURGERY CARE**
- $138.9M (11.3% of orthopaedic costs)
- 17 patient groups (CACS)
- Not planned for QBP implementation
- Best orthopaedic candidates for shifting to community-based clinics

**FUTURE ORTHOPAEDIC QBPs:**
HQO also asked to consider these clinical areas for future analysis to support QBPs:
- Hip & knee revisions: $50.1M (4.1%)
  4 patient groups
- Foot and ankle surgery: $31.3M (2.6%)
  4 patient groups
- Other lower limb: $61.1M (5.0%)
  11 patient groups
QBP implementation: Likely 2015/16 at earliest; may take several years to conduct analyses in all areas

Each box represents a patient group (HIG)
Size of box = Group’s % of total orthopaedic costs
Darker shading = Greater # of cases within group

Increasing # of patient groups
Decreasing # of cases within each group
Decreasing cost impact in each group
Decreasing availability of group-specific evidence and guidelines
Increasing amount of time and resources required to develop QBP funding models using group-specific approach
The 90 day episode can provide a useful comprehensive perspective on total post-fracture utilization, costs and outcomes.

Hip fracture patient services and outcomes, acute hospitalization plus 90 days following acute discharge

All Ontario patients 2008/9 – 2009/10

Analysis in progress by Jason Sutherland (UBC) and Kevin Yu (MOHLTC)
Evidence Development Framework

Current Practices

“What it is”

Identifying Practice Gaps

Best Practices

“What it should be”

Current Practices

Evidentiary Lens

Expert Opinion

Data

Economic Review

Evidence Development Framework

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## Expert Panel Composition for Hip Fracture Care

<table>
<thead>
<tr>
<th>Name</th>
<th>Role</th>
<th>Organization</th>
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<tbody>
<tr>
<td><strong>Chair</strong></td>
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<tr>
<td>Dr. James Waddei</td>
<td>Orthopedic Surgeon</td>
<td>St. Michael's Hospital</td>
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<tr>
<td><strong>Orthopedic Surgery</strong></td>
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<tr>
<td>Dr. John P. Harrington</td>
<td>Orthopedic Surgeon</td>
<td>William Osler Health System</td>
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<tr>
<td>Dr. Mark Harrison</td>
<td>Orthopedic Surgeon</td>
<td>Queen’s University</td>
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<tr>
<td>Dr. Hans J. Kreder</td>
<td>Professor, Orthopedic Surgery</td>
<td>University of Toronto</td>
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<tr>
<td>Dr. Allan Liew</td>
<td>Orthopedic Surgeon</td>
<td>Department of Surgery, University of Ottawa</td>
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<tr>
<td>Dr. Mark MacLeod</td>
<td>Orthopedic Surgeon</td>
<td>London Health Sciences Centre</td>
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<tr>
<td>Dr. Aaron Nauth</td>
<td>Orthopedic Surgeon</td>
<td>St. Michael’s Hospital/University of Toronto</td>
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<tr>
<td>Dr. David Sanders</td>
<td>Orthopedic Surgeon</td>
<td>London Health Sciences Centre</td>
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<tr>
<td>Dr. Andrew Van Houwelingen</td>
<td>Orthopedic Surgeon</td>
<td>St. Thomas Elgin General Hospital</td>
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<tr>
<td><strong>Anesthesiology</strong></td>
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<tr>
<td>Dr. Nick Lo</td>
<td>Staff Anesthesiologist</td>
<td>St. Michael's Hospital</td>
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<tr>
<td><strong>Emergency Medicine</strong></td>
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<tr>
<td>Dr. Michael O'Connor</td>
<td>Emergency Medicine</td>
<td>Kingston General Hospital</td>
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<tr>
<td>Dr. Lisa Shepherd</td>
<td>Emergency Medicine</td>
<td>London Health Sciences Centre</td>
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<tr>
<td><strong>Family Medicine</strong></td>
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<tr>
<td>Dr. Christopher Jyu</td>
<td>Physician Lead, Primary Healthcare</td>
<td>Central East LHIN</td>
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<tr>
<td><strong>Geriatrics</strong></td>
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<tr>
<td>Dr. Anna Byszewski</td>
<td>Geriatrician</td>
<td>The Ottawa Hospital</td>
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<tr>
<td>Dr. Maria Zorzitto</td>
<td>Chief of Geriatric Medicine</td>
<td>St. Michael’s Hospital</td>
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<td><strong>Physiotherapy</strong></td>
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<tr>
<td>Ruth Vallis</td>
<td>Physiotherapist</td>
<td>University Health Network</td>
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<tr>
<td><strong>Rehabilitation</strong></td>
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<tr>
<td>Charissa Levy</td>
<td>Executive Director</td>
<td>GTA Rehab Network</td>
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<tr>
<td>Dr. Peter Nord</td>
<td>Vice President, Chief Medical Officer and Chief of Staff</td>
<td>Providence Healthcare</td>
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<tr>
<td>Role</td>
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<tr>
<td>Research</td>
<td>Dr. Susan Jaglal</td>
<td>Research Chair</td>
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<tr>
<td></td>
<td>Dr. Valerie Pauley</td>
<td>Associate Professor, Department of Medicine and Institute of Health Policy, Management and Evaluation</td>
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<tr>
<td>Administration</td>
<td>Jane deLacy</td>
<td>Executive Director, Patient Services</td>
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<td></td>
<td>Brenda Flaherty</td>
<td>Executive Vice President and Chief Operating Officer</td>
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<td>Jo-anne Marr</td>
<td>Executive Vice President and Chief Operating Officer</td>
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<td>Malcolm Moffat</td>
<td>Executive Vice President, Programs</td>
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<td>Kathy Sabo</td>
<td>Senior Vice President, Clinical Programs / Operations</td>
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<tr>
<td>Community Care Access Centres</td>
<td>Patricia (Tricia) Khan</td>
<td>Senior Director, Client Services</td>
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<td></td>
<td>Janet McMullan</td>
<td>Client Services Specialist</td>
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<tr>
<td>Professional Organizations</td>
<td>Ravi Jain</td>
<td>Director, Ontario Osteoporosis Strategy</td>
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<td>Rhona McGlasson</td>
<td>Executive Director</td>
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Quality-Based Procedures: Clinical Handbook for Hip Fracture

Health Quality Ontario & Ministry of Health and Long-Term Care

May 2013
Model of Care for Hip Fracture

1. **Hip Fracture**
2. **Home With Follow-up** 10%
3. **Long Term Care** 20%
4. **Non Weight Bearing Patients** 5%
5. **Inpatient Rehab**
   - “A.C.T.E.D” Program
     - Assessment
     - Client Centered Goals
     - Treatment
     - Evaluation
     - Discharge Planning
6. **Inpatient Rehab**
   - Continue Rehab care
   - Geriatric program
7. **Communtiy**
   - Home/Retirement Setting with follow-up care
   - Homecare
   - Outpatient Long term Care
8. **Patient/Family Education**
   - 80% of Home Stream Pts
   - 75% Pts Return Home
Patient's pre-fracture level of care

- Community 'Healthy'
  - N = 7,066
  - Pr = 0.548
- Community 'Complex'
  - N = 3,557
  - Pr = 0.276
- LTC
  - N = 2,275
  - Pr = 0.176

Patient presents with suspected hip fracture
- N = 12,860
- Pr = 1.0

Counts and proportions from Discharge Abstract Database (2011/12) and Hip Fracture Scorecard (Q1Q2 FY2011-12)

Most responsible diagnosis or comorbidity diagnosis of S72.0*, S72.1* or S72.2*, excluding S72.00*

Legend
- Care module
- Assessment node
- Pathway endpoint

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Summary

Demonstrate the need for a model of care that can be implemented in all hospitals
Summary

Build a consensus group that shares the goal of improved patient outcome and best practices
Summary

Build a straw model that demonstrates the patient care pathway
Summary

Develop (or modify existing) reporting structure to document the affect of implementation of the model
AVERAGE LENGTH OF STAY (ALOS) IN ACUTE CARE ORGANIZATIONS

![Graph showing ALOS for All Discharges and ALOS for Rehab Discharges over four fiscal years (2010/11 to 2013/14). The ALOS for All Discharges decreases from 17.2 days in 2010/11 to 13.7 days in 2013/14. The ALOS for Rehab Discharges decreases from 15.0 days in 2010/11 to 11.0 days in 2013/14.](image_url)
PERCENTAGE OF PATIENTS DISCHARGED HOME FROM REHAB AND LTLD REHAB PROGRAMS

- 2010/11 FY*: 79%
- 2011/12 FY: 84%
- 2012/13 FY: 89%
- 2013/14 FY: 93%

- FHRAT Target for Rehab Discharges (75%)

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THANK YOU