Central East **LHIN**
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Central East LHIN

Board Meeting

Integrated Orthopaedic Capacity Plan

March 27, 2013

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Integrated Orthopaedic Capacity Plan (IOCP) – Guidelines (Ministry of Health, 2012)

The IOCP will ….

- create more efficient and effective patient-centered continuums of care – considering new care models as well as demographics and utilization;
- support the transition from traditional capacity planning to a more integrated approach which incorporates quality;
- support Ministry and LHIN planning for utilization (initially for hip and knee replacements) including resources, capacity, access, quality and introduction of future QBPs (Quality Based Procedures);
- identify opportunities for improving quality and standardization and in reducing practice variations; and
- Facilitate volume management decision making at the LHIN and Ministry.

Orthopaedic Surgery Task Group

Mandate:

Prepare an Integrated Orthopaedic Capacity Plan (IOCP) that considers and recommends a regional delivery model for orthopaedic surgical procedures.

Considerations:

- LHIN-wide and cluster based access;
- Current and future capacity and demand;
- Emerging changes in clinical practices, care pathways, quality and performance standards;
- Standardization;
- Health human resources; and
- Fidelity to the Central East LHIN Hospital Clinical Services Plan (CSP) 2009.

Overarching Principles and Foundational Themes (CSP, 2009)

Overarching Principles

- Improving **quality** and **safety** by **grouping** together clinical or medical/surgical specialists, their teams and appropriate physical resources.
- **Expanding** or **creating new** programs that would not be **viable** or **sustainable** at multiple sites.
- Creating **operational and clinical efficiencies** that would allow hospitals to focus on, and improve, their **core programs**.
- Create new **"centres of excellence"** to allow CE LHIN residents to receive services within the LHIN and as **close-to-home** as possible.

Foundational Themes

- Adopt a **"systems" focus** that respects **local access and local governance**
- Uses **evidence** to determine "appropriateness" of **local access versus regional & provincial access**
- Promote **innovation** and with a relentless focus on **quality**
- Advance the concept of **mutuality of support** between CE LHIN providers
- Promote the **sustainability** of the public health system.

Clinical Program Service Delivery Models (CSP, 2009)

ROLE 1: LOCAL CENTRE

- **Services needed by the local population, access through the Local facility and utilization of resources and expertise pertinent to the patient needs.**
- **Ability to provide core, emergency-driven services as they relate to the respective clinical programs.**

Role 2: Cluster Centre

- **Services are located at one institute for populations with several or many surrounding communities.**
- **Hospitals will capture a large proportion of residents who may require certain types of subspecialty programs, yet do not need to travel to a LHIN-wide Centre.**

Role 3: LHIN-wide Centre

- **Specialized services that will promote access LHIN-wide.**
- **Programs may be located at 1 or 2 sites.**
- **These site(s) will have the critical mass required to sustain quality standards of care and clinical efficiencies.**

The Process

- Administrative and physician membership from each hospital and CECCAC
- Facilitated Task Group discussions – 9 x 2 hour meetings
- Consultant support
  - Project management and report writing
  - Identify best practices and standard work
  - Report on provincial processes and lessons from other jurisdictions
- Leadership and counsel from Dr. James Waddell
- Data analysis – Central East LHIN and Hospitals
- Application of a decision making framework
- Hospital and physician stakeholder engagement through TG members
- Ongoing information sharing and input to decisions and report
- Feedback on final draft

LHIN Priority Setting &Decision Making Framework Toolkit (LHIN Collaborative, 2010)

Step 1: Compliance screen for services

- The compliance issues identified for a hospital to host a program were:
  - Clinical skills
  - Hospital interest
  - Sufficient Volumes

To be completed as appropriate:

Step 2: Decision making priorities for allocation

Step 3: Costing

Step 4: System readiness

Planning Assumptions

1. Build on existing clinical expertise.
2. Consider hospital roles at local, cluster and LHIN-wide levels.
3. Facilitate implementation of best practices standards.
4. Consider patient demand/need.
5. Agreement that a coordinated approach to patient care is in the best interests of the patients.
6. Prevention of future fractures is important for all fracture patients.
7. A governance structure with appropriate administrative and clinical leadership will oversee the move to the future state.
8. Recommendations were made independent of the ministry funding allocation. Volume allocation will be considered as part of implementation planning to ensure success of the model.
9. An allocation methodology will be developed for the LHIN to allocate elective volumes to the individual hospitals which reflect the findings of this report.

Recommendation Groupings

Recommendations on key system changes fall under the following four groupings:

1. Siting and sizing of orthopaedic procedures.
2. Standardization of practice.
3. Rehabilitation.
4. Optimization of health human resources including physician integration.

Key System Changes

1. Siting and Sizing	
Key system change #1	Align surgical services using a LHIN-wide/cluster/ local framework which ensures optimal use of Central East LHIN capacity and quality care while keeping the patient as close to home as possible.
Key System change #2	Develop a systems approach to trauma access and repatriation
2. Standardization of Practice	
Key system change #3	Standardize care for orthopaedics, including hip and knee replacement and hip fracture, throughout the LHIN through coordinated care plans for inpatient care and rehabilitation.
Key System change #4	Identify a performance measurement system which includes outcomes for orthopaedics.
Key System change #5	Complete a review and develop a plan for a coordinated intake system and an interdisciplinary assessment program if it is identified that they will assist in promoting access and standardization in care.
3. Rehabilitation	
Key System change #6	Align rehabilitation services to patients' need and within their local community.
4. Optimization of Health Human Resources including Physician Integration	
Key System change #7	Complete a review and develop a plan for a coordinated staffing model which supports physician integration including coordinated coverage to maximize efficiencies. This may include LHIN-wide Credentialing, LHIN-wide On-Call; and LHIN-wide Operating Room Efficiency and Scheduling.

Key System Changes

- Action Items (32)
  - Responsible
  - Timeframe (short-term ≤ 1 year; medium = 1 to 2 years; long ≥ 2 years)
  - Rationale

- Risks (35)
  - Likelihood
  - Impact
  - Mitigation strategy

Key System Change #1. - Siting and Sizing of Orthopaedic Procedures

Patient population	Recommendation
Non elective and Trauma	Local Centres Cluster or LHIN-wide Centres providing equitable access to specialized surgical services
Hip and Knee Replacement	Local Centres
Hip and Knee Revision	Cluster Centres LHIN-wide Centre for complex patients including infection
Ankle and Foot	Cluster Centres
Arm, Elbow, Forearm, Hand and Wrist	Local Centres aligned with plastic surgery and hand units
Knee (excluding replacement and revision)	Local Centres
Shoulder	Cluster Centres
Spine	LHIN-wide Centre

Orthopaedic Surgical Task Group Member feedback on final draft

Consensus but not unanimous

Procedure	Recommendation	Hospital	Preference
Shoulder	Cluster	RMH	Local with coordinated referral for complex
		LHC	Local
Foot and Ankle (lower leg)	Cluster	RMH	Local with coordinated referral for complex

Achieving the Future State

1. Prioritize Action Steps
   - Impact vs. Effort
   - Identification of responsibilities
2. Select sites for cluster-based and LHIN-wide services
3. Develop an Implementation Structure for future state
   1. Advisory Committee (OSTG extension)
   2. Working Group
   - Systems approach to trauma access and repatriation (#2)
   - Standardize care for orthopaedics (#3)
   - Identify a performance measurement system (#4)
   - Plan for coordinated intake and assessment (#5)
   - Align rehab services to patient need in their community (Rehab Services TG) (#6)
4. Address Risks – extensive list of potential risks (including Likelihood and Impact) and mitigation strategies outlined in report

Summary of Risks identified by OSTG

- Insufficient funding or change in direction of future funding;
- Inability for hospitals to work together;
- Lack of resource support where necessary to support the change;
- Lack of physician buy-in;
- Procedures considered as groups rather than individual procedures;
- Consensus but not unanimous for cluster recommendations for shoulder and ankle and foot;

Risks Identified as Either High Likelihood (L) or High Impact (I)

Risk	L	I	Mitigation strategy
Future funding rates may not be sufficient for service	H	M	Develop the future vision for orthopaedics to support best practice minimizing the reliance on ministry activity
Inability of hospitals to work together	M	H	Ensure leadership is prepared to oversee and facilitate change
Potential loss of funding to hospitals that have built specialties within their hospitals	M	M	Overall impact of funding changes need to be considered as a component of planning and implementation
Differing referral protocols for different procedures may create confusion in primary care	H	M	Planning process needs to consider long term strategy and support primary care
Lack of resource support where necessary to support the change	M	H	Appropriate budget allocation for orthopaedic surgical services
Lack of Health Human Resources	M	H	Ensure planning includes a review of staff availability
Most Responsible Physician (MRP) issues to manage post-operative care	H	H	Ensure system developed considered MRP

Next Steps

March 27, 2013:

- Final Draft IOCP including Future State and Implementation Strategies presented to the LHIN Board for review and endorsement.

March 31, 2013:

- Final IOCP submitted to MOH.

April 2013:

- IOCP shared with appropriate HSP Boards for endorsement.
- Continued Stakeholder Engagement process.
- Continued planning and Implementation.

Board Motion

Be it resolved that the Central East LHIN Board of Directors endorse the Central East LHIN Integrated Orthopaedic Capacity Plan and the recommendations contained therein and furthermore that staff be directed to initiate implementation of the action steps.