Summary of Proposed Future Vision for Complex Frail Vulnerable – Hip Fractures Patient Population

A regional evidence-based pathway for hip fractures will improve the patient experience by making care easy to access with smooth transitions at every step in the patient journey. It will improve patient outcomes, as well as patient and provider satisfaction, while helping us make the best use of our resources.

Current state

Most hip fractures happen in elderly people as a result of a simple fall. The average age of people who experience hip fractures is approximately eighty. Seventy per cent of those are women. In 2012/13 there were 12,307 patients admitted to hospital for hip fracture surgery in Ontario. Of this patient population:

- 608 of these patients were in the SE LHIN;
- 77.1 per cent received surgery within 48 hours of initial presentation to Ontario hospitals against a target of 90 per cent as recommended by an expert panel;
- 33 per cent were discharged to rehabilitation following hip fracture surgery however hospital level results across the province ranged from a low of 6 per cent to a high of 71 per cent.

There is room for improvement.

A hip fracture is a very serious event that can cause permanent disability, loss of independence and, for many, premature mortality. Complex, Frail Vulnerable patients are at greater risk and our obligation is to improve their experience and outcomes.

Recent Ontario data on the care of hip fracture patients shows wide variability on the time it takes to get their surgery, length of stay in the hospital, ability to access timely rehabilitative care and the number of patients who are able to return to their homes following the incident. There are many opportunities to improve clinical practices by standardizing hip fracture care maps. In Canada there is a good understanding of best practices in hip fracture care, which we can leverage in the SE LHIN to ensure patients receive the best possible care.

Opportunities considered

As part of the Hip Fracture Clinical Steering Team's deliberations, the Quality Based Procedures Clinical Handbook on Hip Fractures from Health Quality Ontario and MOHLTC

were reviewed for opportunities to implement provincially endorsed evidence-based guidelines consistently across all hospitals in the SE LHIN. For more information on this topic, see *OBP Clinical Handbook Hip Fracture*

Working group process and engagement

A Regional Hip Fracture Clinical Steering Team was launched in January 2016 with regional representation from medicine, nursing and allied professions from the seven hospitals, CCAC and community.

- *See the Appendix for a list of team members.*

We have consulted with team members from a multi-disciplinary perspective as the content experts. The team reviewed best practice and local patient journey maps to identify the gaps, opportunities and challenges with respect to how hip fracture patients are currently managed across each hospital site.

An overall engagement plan for Phase 2 of the Health Care Tomorrow – Hospital Services project created opportunities to gather meaningful input from all stakeholders between October 2015 and May 2016. This engagement included two broader surveys for staff and physicians, followed by a targeted clinical stakeholder engagement from May 16th to 26th, 2016 to solicit specific feedback on the recommendations to inform a report to hospital executives and board members and further planning.

Analysis undertaken

The Hip Fracture Clinical Steering Team conducted a best practice review and local patient journey mapping of the process from a patient's initial presentation with a hip fracture to their eventual discharge into rehabilitation, their home or other community setting. A summary of gaps in practice, process, access and resources was completed. This analysis was compared against provincial standard and a set of recommendations were created that leverage best practices while addressing the gaps and opportunities identified within our region.

Proposed future state

The Hip Fracture Clinical Steering Team is developing a plan to move to a regional best-practice patient journey that includes regional communities of practice and accountability mechanisms to ensure compliance with the recommendations and guidelines. Once the plan has been implemented and we have consolidated our accomplishments and lessons learned, our aim is to build on this work as a template for future regional initiatives within other clinical service areas.

The recommendations

Patient Focus:

- Each patient admitted to an emergency room or hospital bed in the SELHIN with hip fracture shall receive treatment based on an identical evidence-based hip fracture care pathway.
- The care pathway shall include management of the acute assessment, planning for surgery and the conduct of the surgical repair of the hip fracture that meet the needs of the patient.
- A plan for the post-operative or post-non-operative transition of care between the acute phase of the journey and the rehabilitation phase will be critical to the success of the final outcome for the patient.
- The care plan will include empowering the patient and family members with a care map that will outline evidence based post- operative and rehabilitation care to regain mobility and independence to the extent possible. The care plan will include any identified gaps in care for the individual patient, and a follow-up appointment coordinated with the patient's primary care practitioner, continuing rehabilitation as needed upon discharge from hospital.
- Individual hospital sites in the SELHIN will implement the hip fracture care pathway in ways that are most practical, efficient and effective at that site. Each hospital site will audit and report on utilization of the evidence-based care map after implementation.

Provider Focus:

- To establish a community of practice framework with the specific focus on post traumatic hip fracture care. This network will develop common goals, shared metrics and oversight of outcomes as a region.
- That all providers/facilities in the SELHIN adopt the standardized and evidenced based fractured hip pathways for each phase of care enabled through common order sets and protocols that will lead to effective transitions of care from emergency room to primary /geriatric care as well as the appropriate destination for the patients.
- As a region, develop a capacity plan and improved processes to achieve a re-stated goal of 24 hours as time to surgery.
- Adopt a common decision support model for rehabilitation care using consistent and evidenced based processes of assessment found in leading practice rehabilitation readiness tools.
- Patients experiencing a hip fracture at home will have a defined discharge destination on day five with transfer on day six to the most appropriate rehabilitation services or to complex long or short term medical geriatric care. In situations where access to rehabilitation is delayed following the acute phase, the patient's care is transferred from the orthopaedic consultant to a model of care provision and provider that will continue to incorporate the expected outcomes of hip fracture rehabilitation and management of geriatric/primary care.

Key benefits of proposed future state

- Patients with hip fractures will have access to a standardized, evidence-based, patient- and family centred care pathway that uses the SELHIN's specialized clinical resources and professionals in the most effective and efficient manner.
- Patients and their families will be empowered with an individualized care pathway that addresses treatment gaps while meeting their specific needs.
- Clinicians who manage hip fractures in the SELHIN will form a cohesive community of practice dedicated to continuous care-process improvement with a centralized registry of cases, interventions and outcomes.
- Patient will experience smooth transitions in care between hospital, rehabilitative services, the Community Care Access Centre and other community settings.
- The hip fracture rate will be reduced through fragility fracture intervention and follow up for patients presenting at any SE LHIN access point. Health care providers will participate in risk assessment/education and escalation fall prevention initiatives developed by community partners.
- The risk of mortality will be reduced for hip fracture patients.
- Inter-professional care will be the norm and focus on caring for the whole patient, not just the hip fracture.
- Health-care resources in the SELHIN will be used efficiently through a hospital-community of practice environment that follows best practices and continuously improves processes to deliver the perfect patient experience.

Appendix

Complex Frail Vulnerable –Hip Fractures Clinical Steering Team Members	
Michele Bellows	VP, Patient Care Services, PSFDH
Dr Dick Zoutman	COS, QHC
Janet Baragar,	Director Surgery Program, QHC
Dr David Birchard	Orthopedic Surgeon, QHC
Derk Damron,	Manager Rehabilitation Therapies, QHC
Katie Clement	Physiotherapist , LACGH
Susan Lambert,	Manager, Kidd 4 (ortho) KGH
Patricia Lunt	NP, Orthopaedic Surgery, KGH
Cynthia Phillips,	Mgr, Interprofessional Collaborative Practice & Education, KGH
Dr Gavin Wood	Orthopedic Surgeon, KGH
Colwell, Kathi	RN, Program Manager-Inpatient Rehabilitation, Prov Care
Julie Evoy	Physiotherapist, Prov Care
John Hope	Advanced Physiotherapist, HDH
Sherry Anderson	Director of Medical Inpatients, Palliative and Rehab-BGH
Dr Jay Gambrel	Orthopedic Surgeon, BGH
Michelle St. Pierre	Quality Improvement, BGH
Dr Mark Roberts	Orthopedic Surgeon, PSFDH
Susan Roberts	Patient Care Manager, PSFDH
Dr Adina Birenbaum	Bone Health Program, FHT Kingston
Marianne Hunter	Care Coordinator, SE CCAC
Laurie French,	Senior Manager, Clinical Support & Utilization , SE CCAC
Sabrina Martin,	Health System Design & Implementation Lead, SE LHIN
Megan Jaquith	Health Planner, SE LHIN
Kristen Spring	Regional Patient Advisor
Richard Stillwell	Regional Patient Advisor

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