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HNHB LHIN Hip Fracture & TJR

Self-Assessment Analysis Report Findings

January 9, 2019

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Presentation Overview

- Overview of the Self-Assessment Process
- Provincial and HNHB LHIN Self-Assessment Participation
- Provincial and HNHB LHIN Self-Assessment High Performers
- HNHB LHIN Self-Assessment Data Analysis
- Analysis Summary
- Best Practice Implementation Strategies

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RCA Vision

Patient and system outcomes are optimized through the integration of rehabilitative care at all levels of health services policy, planning and delivery.

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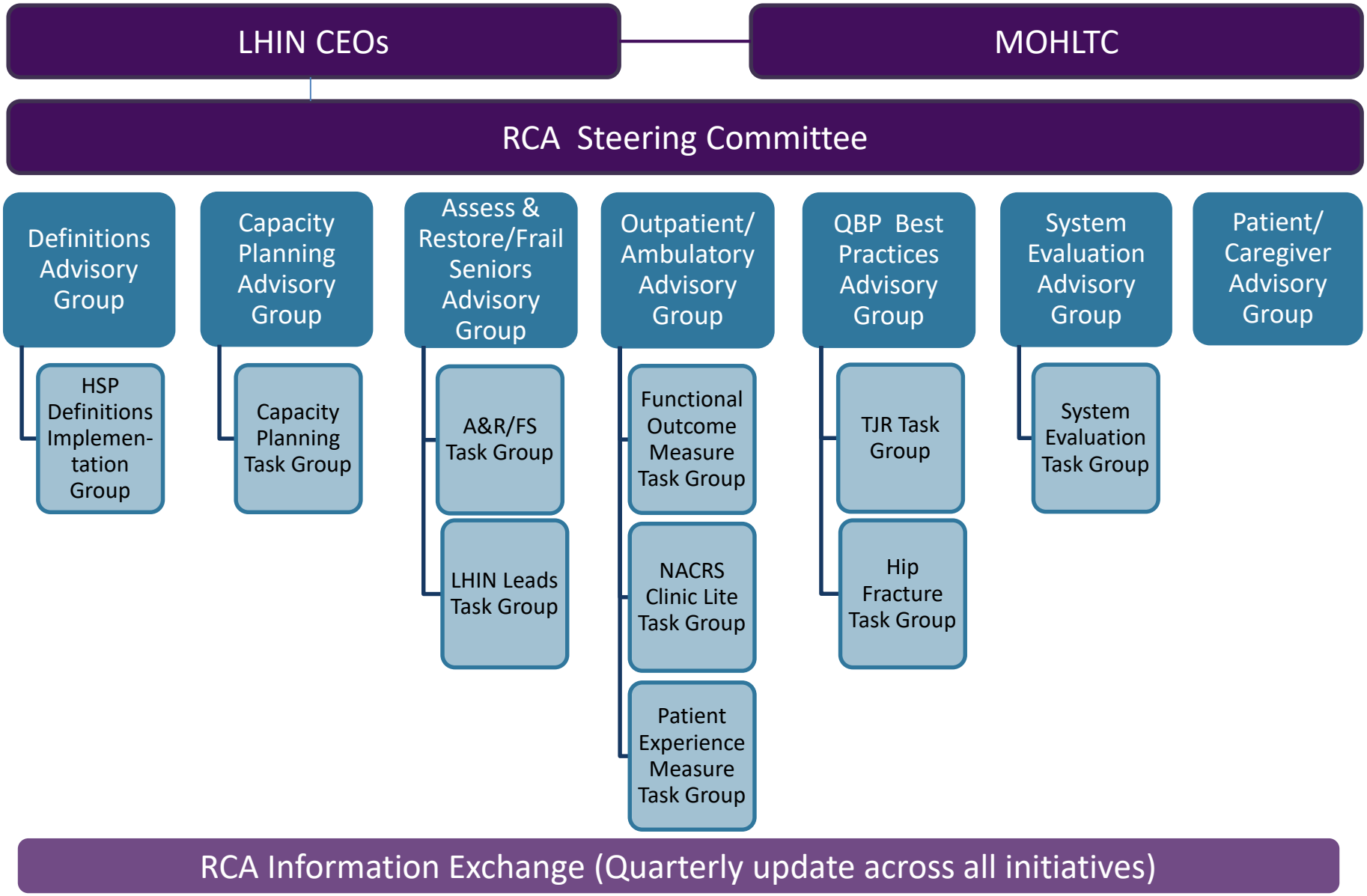
RCA Mandate

- Work with LHINs, provincial stakeholders, client and caregiver representatives to strengthen and standardize rehabilitative care in Ontario, through:
  - Better planning
  - Improved performance management and evaluation
  - Increased integration of best practices across the care continuum



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Overview of Self-Assessment Process

- The Rehabilitative Care Alliance (RCA) released two best practice frameworks in 2017:
  - *Rehabilitative Care Best Practices Framework for Patients with Hip Fractures*
  - *Rehabilitative Care Best Practices Framework for Patients with Primary Hip and Knee Replacements*
- The frameworks support implementation of QBPs with detailed best practices for rehabilitative care across all care settings: pre-operative (TJR), bedded, ambulatory, in-home and long-term care (hip). Quick reference guides for each setting provide a concise summary of best practices to guide clinical practice.

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Overview of Self-Assessment Process (2)

- The Rehabilitative Care Alliance undertook a provincial self-assessment process which allowed health service providers to determine how well their current care aligns with best practices set out in the RCA's rehabilitative care best practice frameworks for hip fracture and primary hip and knee replacements.
- Self-assessment tools were released in January to health service providers with a deadline of May 4, 2018. This deadline was extended to ensure that all organizations had the opportunity to complete their self-assessments. Final self-assessments were received July 13, 2018.
- The RCA received 247 self-assessments (116 Hip Fracture/131 TJR) from 104 organizations across all 14 LHINs.

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Self-Assessment Participation

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Number of organizations by LHIN

Central	3	Erie St. Clair	2
Central East	4	Waterloo Wellington	7
Toronto Central	10	Champlain	9
Central West	2	North Simcoe Muskoka	2
South West	10	**HNHB**	**19**
North East	5	Mississauga Halton	4
North West	17	South East	7
MultiLHIN	3	**TOTAL**	**104**

Data received as of July 17, 2018

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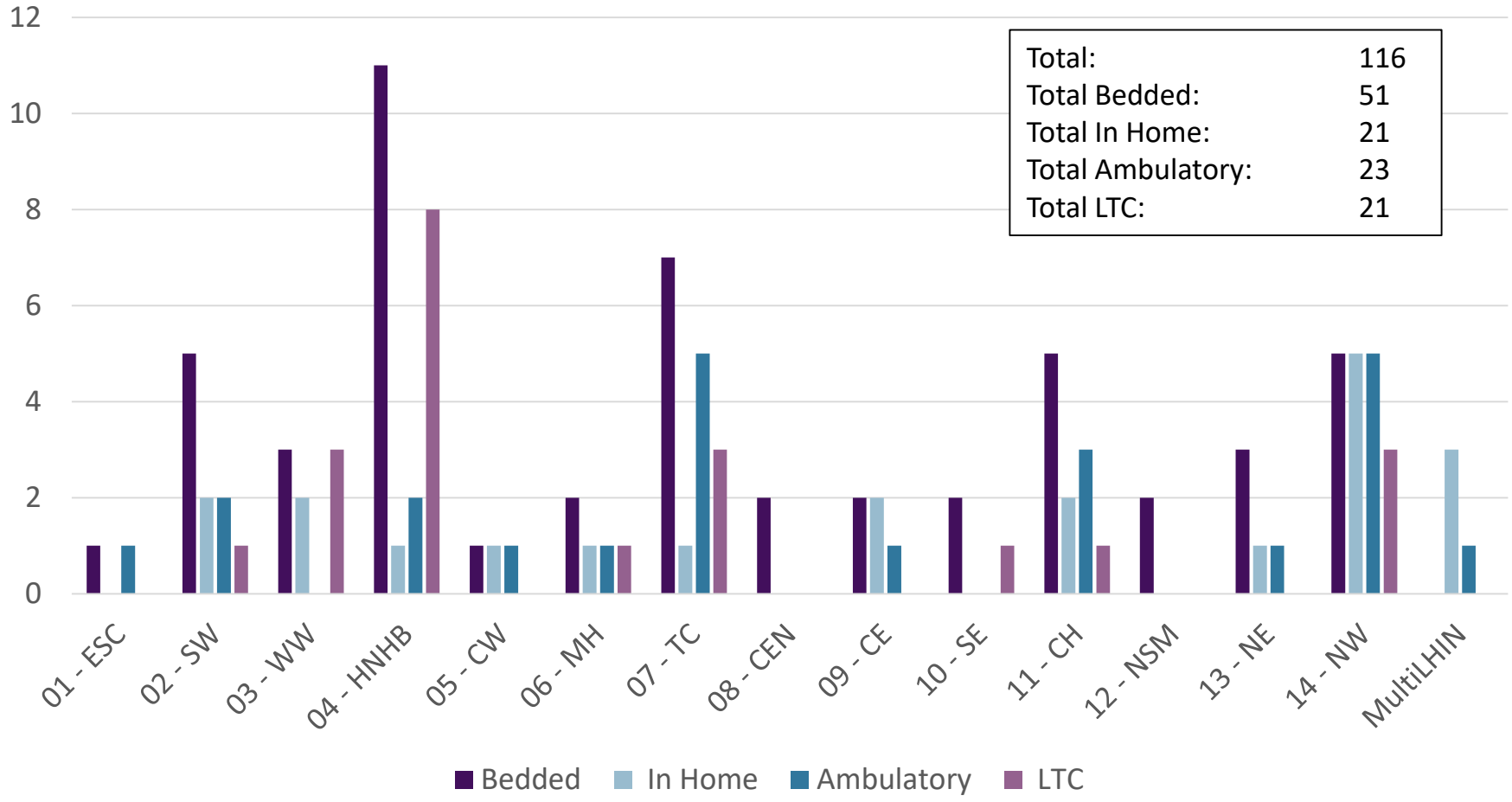
Number of Hip Fracture Self-Assessments by LHIN



Data received as of July 17, 2018

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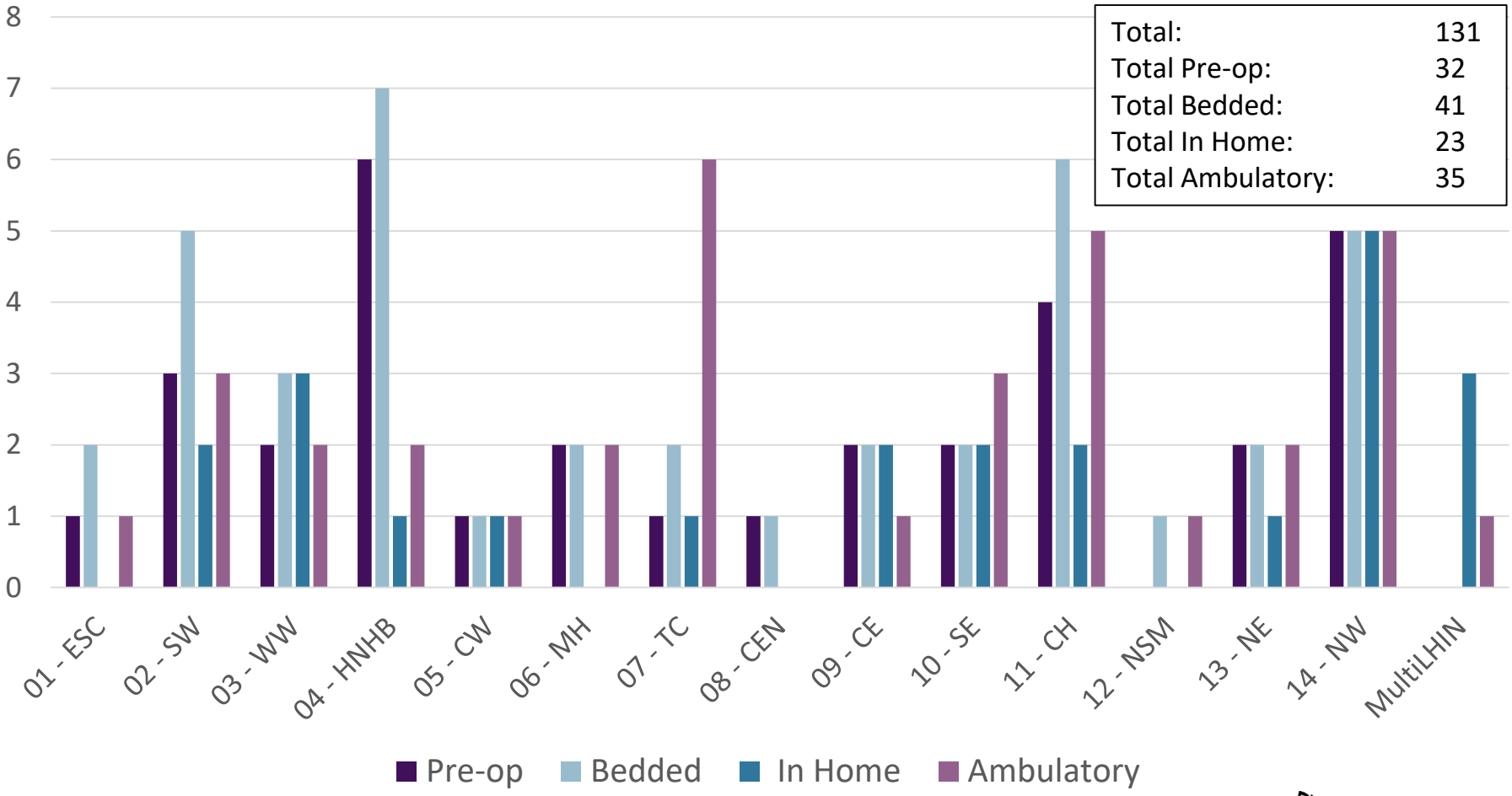
Number of TJR Self-Assessments by LHIN



Total:	131
Total Pre-op:	32
Total Bedded:	41
Total In Home:	23
Total Ambulatory:	35

Data received as of July 17, 2018

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Self-Assessment High Performers

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Self-Assessment High Performers

- Those who were named high performers were all or mostly aligned with hip fracture or total joint replacement best practices on their self-assessments

- Best practice implementation strategies from the high performing programs in each sector are shared to promote knowledge exchange

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High Performers – All or Mostly Aligned

Hip Fracture

- Bedded
  - Halton Healthcare
  - Grand River Hospital
- Ambulatory
  - Halton Healthcare
- In-Home
  - Mississauga-Halton St. Elizabeth
- LTC
  - Heidehof
  - Radiant Care Pleasant Manor

Total Joint Replacement

- Pre-operative Care
  - St. Joseph's Healthcare Hamilton
  - Halton Healthcare
  - Sunnybrook Health Sciences
  - Peterborough Regional
  - Queensway-Carleton
- Bedded
  - Cambridge Memorial
  - Grand River Hospital
  - Brant Community Healthcare
  - Dundurn Place
  - Peterborough Regional
  - Providence Care
  - Queensway-Carleton
- Ambulatory
  - Grand River Hospital
  - Providence Healthcare
  - Sunnybrook Health Sciences
  - Pembroke Regional
- In-Home
  - Waterloo-Wellington LHIN

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Self-Assessment Data Analysis

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Analysis Overview

- Heat Map:
  - Priorities for Improvement highlighted based on organizational best practice ratings of aligned, partially aligned or not aligned
- Provincial Data Analysis
  - Goal Summary Analysis based on Short-Term, Mid-range and Long-Term Goals outlined by each organization
  - Resources Analysis based on resources requested by each organization
  - See Appendix A for Pareto Diagrams
- LHIN specific goals and resources requested
- Strengths
  - Provincial and LHIN specific best practices that are all or mostly aligned
- Opportunities
  - Provincial and LHIN specific best practices that are least aligned

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Pareto Analysis

Pareto Analysis is a method that helps to determine the most important factors that significantly affect processes

- Prioritizes which issues, processes, products or services to work on first
- Identifies the most significant factors (LEAN 80/20 rule – 80% of problems are caused by 20% of contributors)
- In this case, we used frequency of occurrence as our unit of comparison (number of sites who identified similar factors). We could also prioritize categories based on cost, severity and timing.

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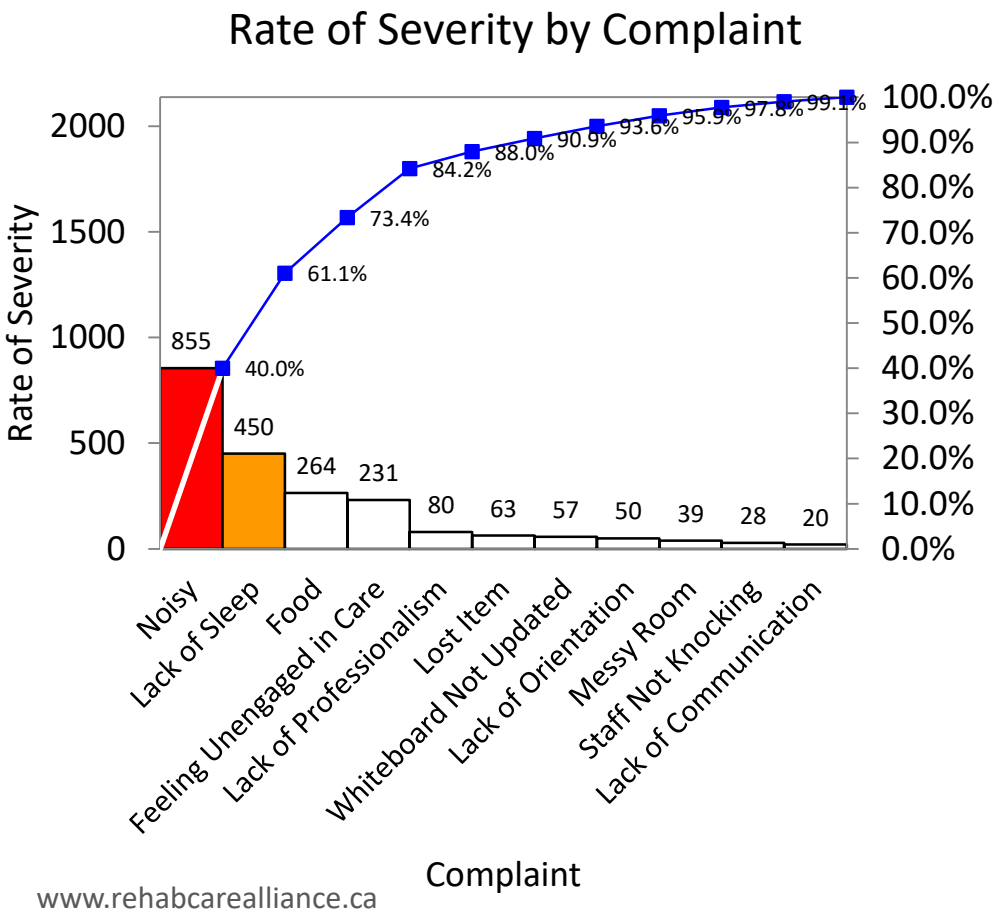
Overview of a Pareto Diagram

Pareto Diagram Example:



The Bar Chart shows the impact of the individual categories to the overall effect

The Cumulative Line shows how the individual categories add up to the total overall effect.

The Vital Few – the contributors that will make the greatest impact on the process

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Hip Fracture Bedded: Provincial Priorities for Improvement

LHIN	ESC (1	SW (n=5)					WW (n=3)			HNHB (n=11)										
Assessment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Delirium/ Dementia/ Depression	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned
Interprofessional Intervention	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned

LHIN	CW (1	MH n=2		TC (n=5)					CEN n=2		CE n=2		SE n=2	
Assessment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Delirium/ Dementia/ Depression	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Interprofessional Intervention	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned

LHIN	CH (n=6)						NSM n=2		NE (n=3)			NW (n=5)				
Assessment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Delirium/ Dementia/ Depression	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement
Interprofessional Intervention	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned

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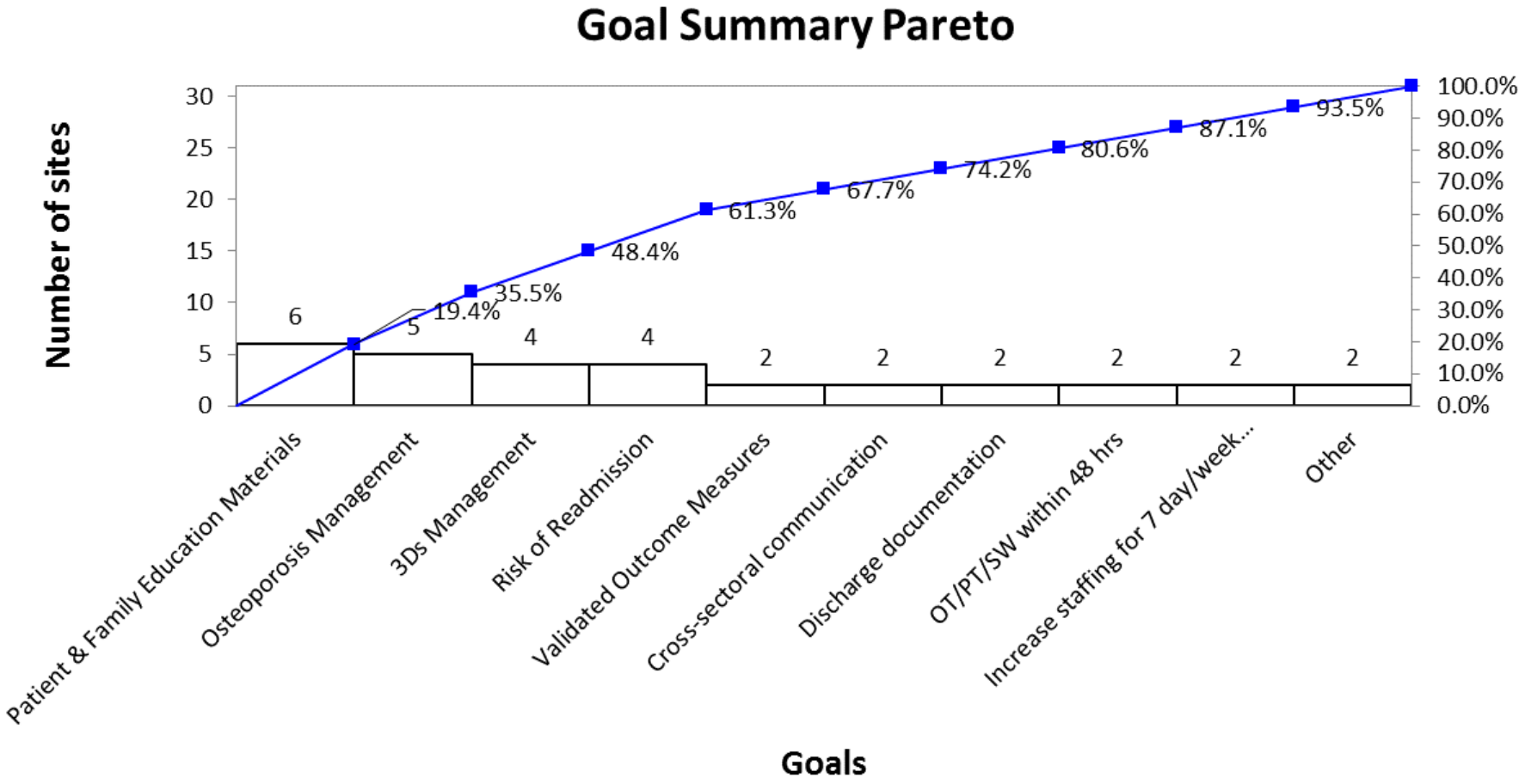
HNHB LHIN Hip Fracture Bedded



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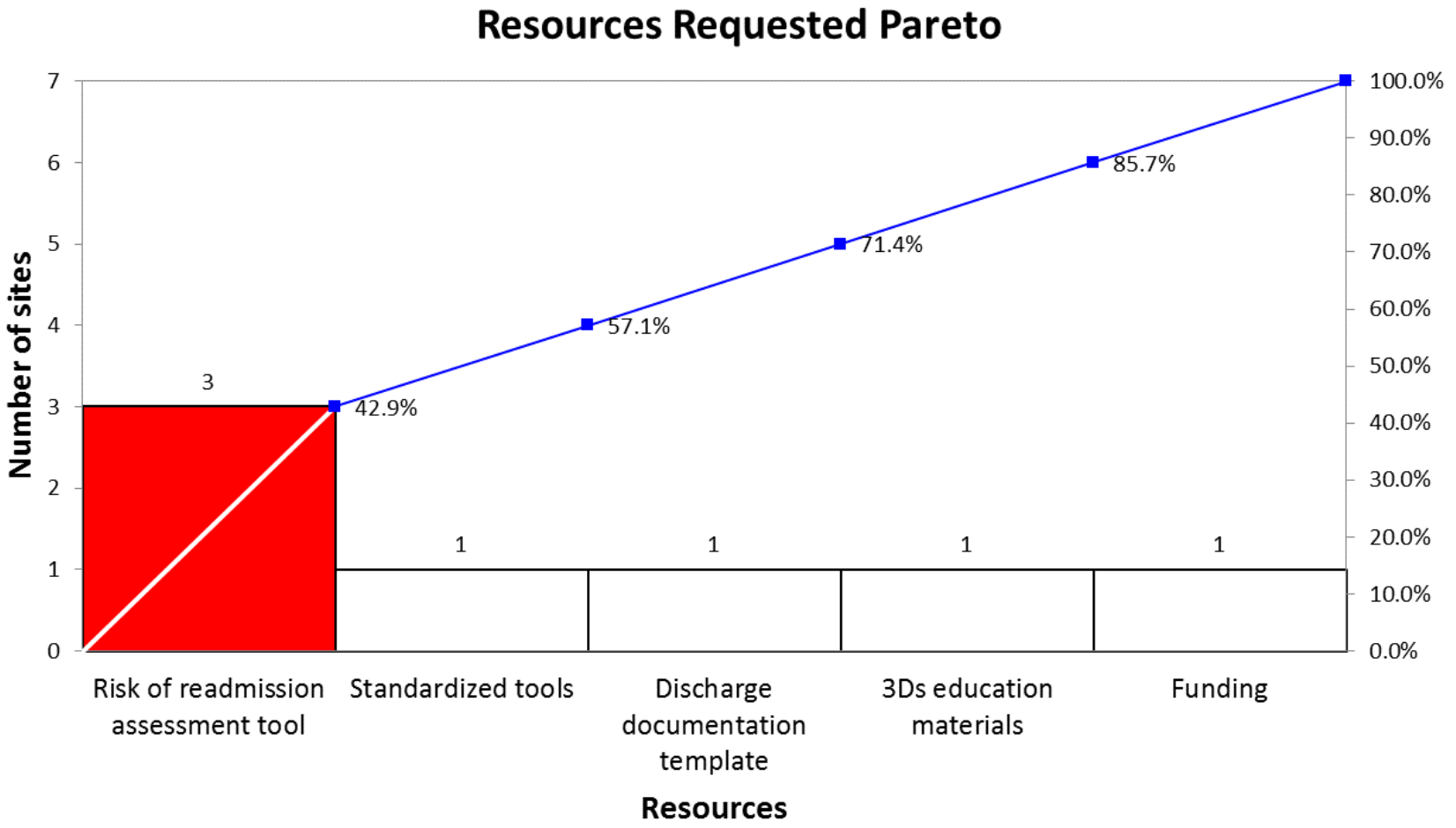
HNHB LHIN Hip Fracture Bedded



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Hip Fracture Bedded: HNHB LHIN Pareto Analysis Summary

- Goal Summary Pareto
  - None of the goals contributed to >20% of the cumulative total
  - The vital few goals that emerged were: Patient & Family Materials, Osteoporosis and 3Ds Management and Risk of Readmission (61.3% of cumulative total)

- Resources Pareto
  - The highest resource requested was Risk of Readmission assessment tool (42.9% of the cumulative total)

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Hip Fracture Bedded: HNHB LHIN Strengths

- Nursing assessments are completed within 24 hours of admission. Skin and wound assessment is completed, using a standardized tool. Preventative strategies are identified and implemented. Falls risk assessment on admission. Assessments are completed to determine behavioural, cognitive, and functional status.
- Rehab goals are established and documented with patient and family.
- Dietary intake is monitored and dietary consults are initiated when warranted
- Multifactorial, individualized falls prevention strategies are utilized
- Treatment including range of motion/strengthening and balance exercise programs and mobility, gait and stairs training
- Referrals to home care and/or outpatient providers are made as soon as needs are identified

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Hip Fracture Bedded: HNHB LHIN Opportunities

Least aligned best practices

- Provide family with standardized education material on delirium, depression and dementia
- Patients receive muscle strengthening, balance and posture exercises for Osteoporosis management, as per BONEFIT principles. Patient/Family are provided with Osteoporosis education materials education
- Patients and families are provided with information regarding osteoporosis management
- Patients' risk of readmission is assessed, using a standardized tool; care and discharge plans are revised required

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Hip Fracture Ambulatory: Provincial Priorities for Improvement

LHIN	ESC (n=1)	SW (n=2)		HNHB (n=2)		CW n=1	MH n=1	TC (n=5)					CE n=1	CH (n=3)			NE n=1	NW (n=4)				Multi n=1
Assessment	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Delirium/ Dementia/ Depression	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned
Interprofessional Intervention	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned

*MultiLHIN organization providing services in HNHB LHIN included in analysis

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Hip Fracture Ambulatory: HNHB LHIN Goals and Resources Requested

- Short Term Goals
  - BONEFIT and Osteoporosis Management
  - Awareness of community fall prevention programs
  - Patient & family education materials
  - Cognitive assessment
- Mid-Range Goals
  - General education program for hip fracture population
  - Osteoporosis patient & family education
  - Delirium/Dementia/Depression management
- Long Term Goals
  - Funding to increase services
  - Referral management with Home & Community Care
- Resources
  - Standardized patient & family education materials
  - Risk of readmission screening
  - Delirium/Dementia/Depression education and tools

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Hip Fracture Ambulatory: HNHB LHIN Strengths

- A function assessment is completed, using standardized outcomes measures
- Suspicion of delirium is recognized and treated as a medical emergency; urgent intervention is provided.
- Clinicians contribute a comprehensive clinical assessment of cognition, based on standardized assessments, ongoing observations, and expressed concerns from the patient, family, and interdisciplinary team. Assessment findings trigger referral to geriatrician, geriatric psychiatry, or social worker, as appropriate
- If depression is suspected, a member of the clinical team completes a valid and reliable assessment for depression
- Pain is assessed using a validated pain scale. Multi-modal pain management strategies are utilized.

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Hip Fracture Ambulatory: HNHB LHIN Strengths (continued)

- Patients with pressure ulcers or at risk for developing pressure ulcers receive an individualized plan of care
- Falls risk is assessed and multifactorial, individualized falls prevention strategies are utilized
- Interventions to improve independence and balance and strength training exercise programs and safe outdoor mobility
- Driving: educate clients and family that changes in medication/cognition/decrease function increase risk of MVAs.
- Patient/caregiver communication and education to review care and treatment programs
- Clients discharge based on achievement of goals. Face to face discharge conversations are held and client and family are aware of referrals for community services/consultations/medical follow-up.

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Hip Fracture Ambulatory: HNHB LHIN Opportunities

Least aligned best practices

- Rehabilitation commences no later than one week following discharge from acute care and last an average of 8 weeks, depending on clinical needs
- As all individuals with a fragility fracture of the hip should be considered as high risk for osteoporotic fractures; patients receive muscle strengthening, balance and posture exercises for Osteoporosis management, as per BONEFIT principles. Patient/Family are provided with Osteoporosis education materials education.
- Patient education materials have been developed using plain language and are compliant with the Accessibility for Ontarians with Disabilities Act (AODA) requirements for accessibility
- Patients and families are provided with information regarding osteoporosis management.

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Hip Fracture In-Home: Provincial Priorities for Improvement

LHIN	SW (n=2)		WW (n=2)		HNHB (n=1)	CW (n=1)	MH (n=1)	TC (n=1)	CE (n=2)		CH (n=2)		NE (n=1)	NW (n=5)					MultiLHIN (n=2)	
Assessment	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned
Delirium/ Dementia/ Depression	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement
Interprofessional Intervention	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned

*MultiLHIN organization providing services in HNHB LHIN included in analysis

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Hip Fracture In-Home: HNHB LHIN Goals and Resources Requested

- Short Term Goals
  - Education resources for osteoporosis and delirium/dementia/depression
  - BONEFIT certification
- Mid-Range Goals
  - AODA compliant patient and family education materials
- Long Term Goals
  - Build stronger LHIN & stakeholder relationships
- Resources
  - Clinician best practice framework resources
  - Patient & family education materials
  - Delirium/Dementia/Depression education and tools

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Hip Fracture In-Home: HNHB LHIN Strengths

- Delirium/Dementia/Depression screening/assessment and prevention/management
- Patients receive interprofessional rehabilitation, in accordance with the principles of geriatric care
- Pain is assessed using a validated pain scale. Multi-modal pain management strategies are utilized.
- Patients with pressure ulcers or at risk for developing pressure ulcers receive an individualized plan of care, based on identified intrinsic and extrinsic risk factors and those identified by a risk assessment tool
- Falls risk is assessed and multifactorial, individualized falls prevention strategies are utilized together with an appropriate exercise program

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Hip Fracture In-Home: HNHB LHIN Strengths (continued)

- Validated outcomes measures are utilized (e.g., TUG/Barthel) on admission and discharge to track progress in function and mobility
- Interventions to promote independence, muscle and bone strengthening, driving and safe outdoor mobility are provided
- Patients/caregivers are engaged in regular communication to review care and treatment programs, discharge plans and falls risk status
- Principles of healthy lifestyles are incorporated into the rehab program. Prior to discharge, patients are linked to appropriate community supports and/or exercise programs. Patients have the date and time of their next health care provider appointment.

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Hip Fracture In-Home: HNHB LHIN Opportunities

Least aligned best practices

- Assessment is completed within 48 hours of discharge from acute care
- Rehabilitation course lasts an average of 8 weeks; 2-3 times per week, depending on clinical needs and tolerance

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Hip Fracture LTC: Provincial Priorities for Improvement

LHIN	SW (n=2)		WW (n=3)			HNHB (n=8)								MH n=1	TC (n=3)			SE n=1	CH n=1	NW (n=3)		
Assessment	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned
Delirium/ Dementia/ Depression	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned
Interprofessional Intervention	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority Improvement	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned

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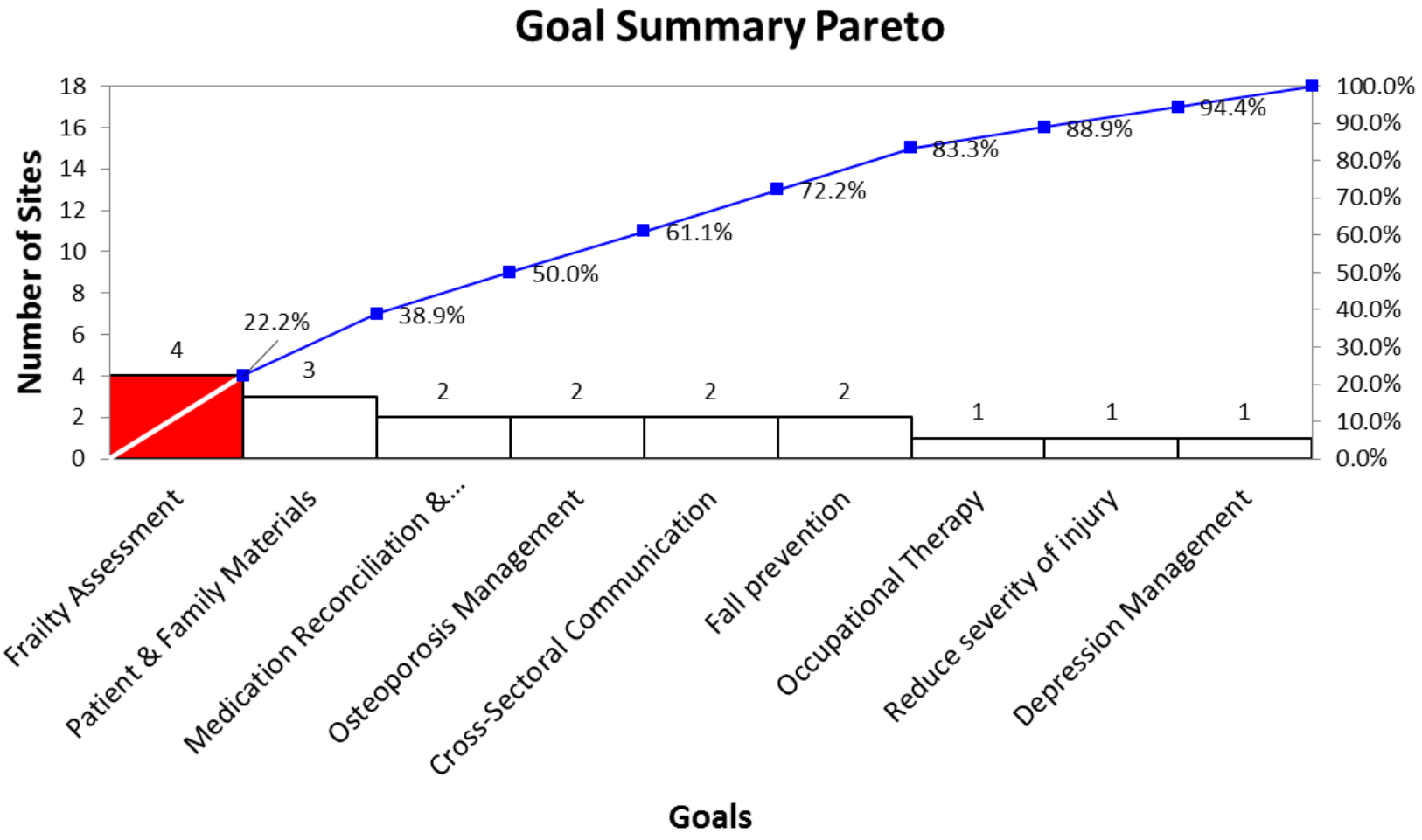
HNHB LHIN Hip Fracture LTC



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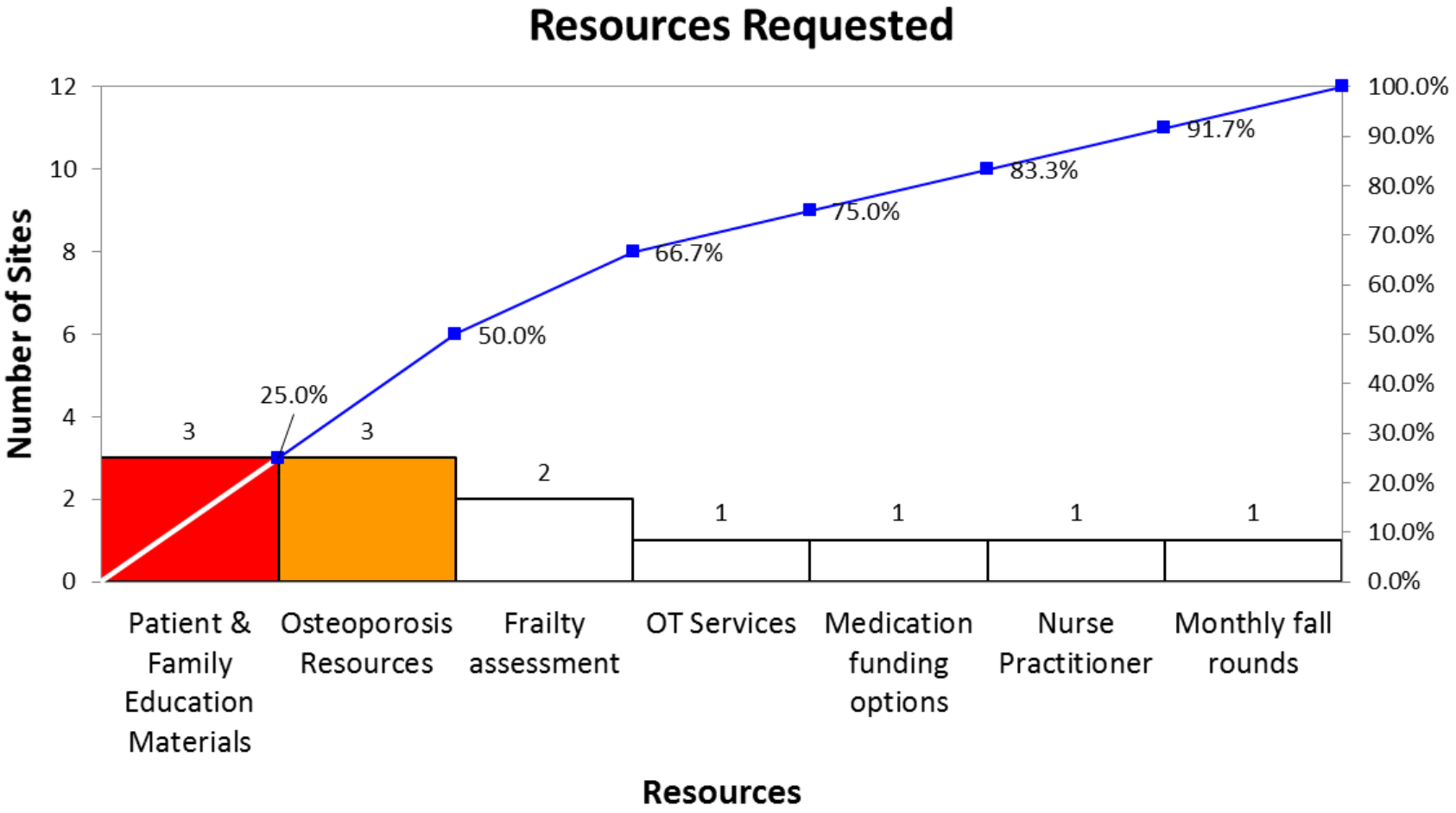
HNHB LHIN Hip Fracture LTC



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Hip Fracture LTC: HNHB LHIN Pareto Analysis Summary

- Goal Summary Pareto
  - Frailty Assessment was the most cited goal (25% of cumulative total)

- Resources Pareto
  - The highest resources requested were Patient & Family Education Materials and Osteoporosis Management (50% of the cumulative total)

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Hip Fracture LTC: HNHB LHIN Strengths

- A function assessment is completed, using standardized outcomes measures
- As appropriate, patients are screen for dementia using, a standardized screening assessment tool
- If depression is suspected, a member of the clinical team completes a valid and reliable assessment for depression
- Interprofessional rehabilitation, in accordance with the principles of geriatric care
- Pain is assessed using a validated pain scale. Multi-modal pain management strategies are utilized.

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Hip Fracture LTC: HNHB LHIN Strengths (continued)

- Patients' risk for pressure ulcer development is determined through multi-disciplinary clinical judgement and the use of a valid reliable risk assessment tool. Individualized plan of care is developed.
- Patients receive muscle strengthening, balance and posture exercises for Osteoporosis management, as per BONEFIT principles. Patient/Family are provided with Osteoporosis education materials education
- Falls risk is assessed and multifactorial, individualized falls prevention strategies are together with an appropriate exercise program.
- Intervention includes progression of functional abilities, assistive devices and physical activities to improve balance and prevent falls
- Ongoing communication with residents and families, including concerns identified and addressed

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Hip Fracture LTC: HNHB LHIN Opportunities

Least aligned best practices

- Frailty assessment is completed to inform interventions to minimize frailty
- As all individuals with a fragility fracture of the hip should be considered as high risk for osteoporotic fractures; patients receive muscle strengthening, balance and posture exercises for Osteoporosis management, as per BONEFIT principles. Patient/Family are provided with Osteoporosis education

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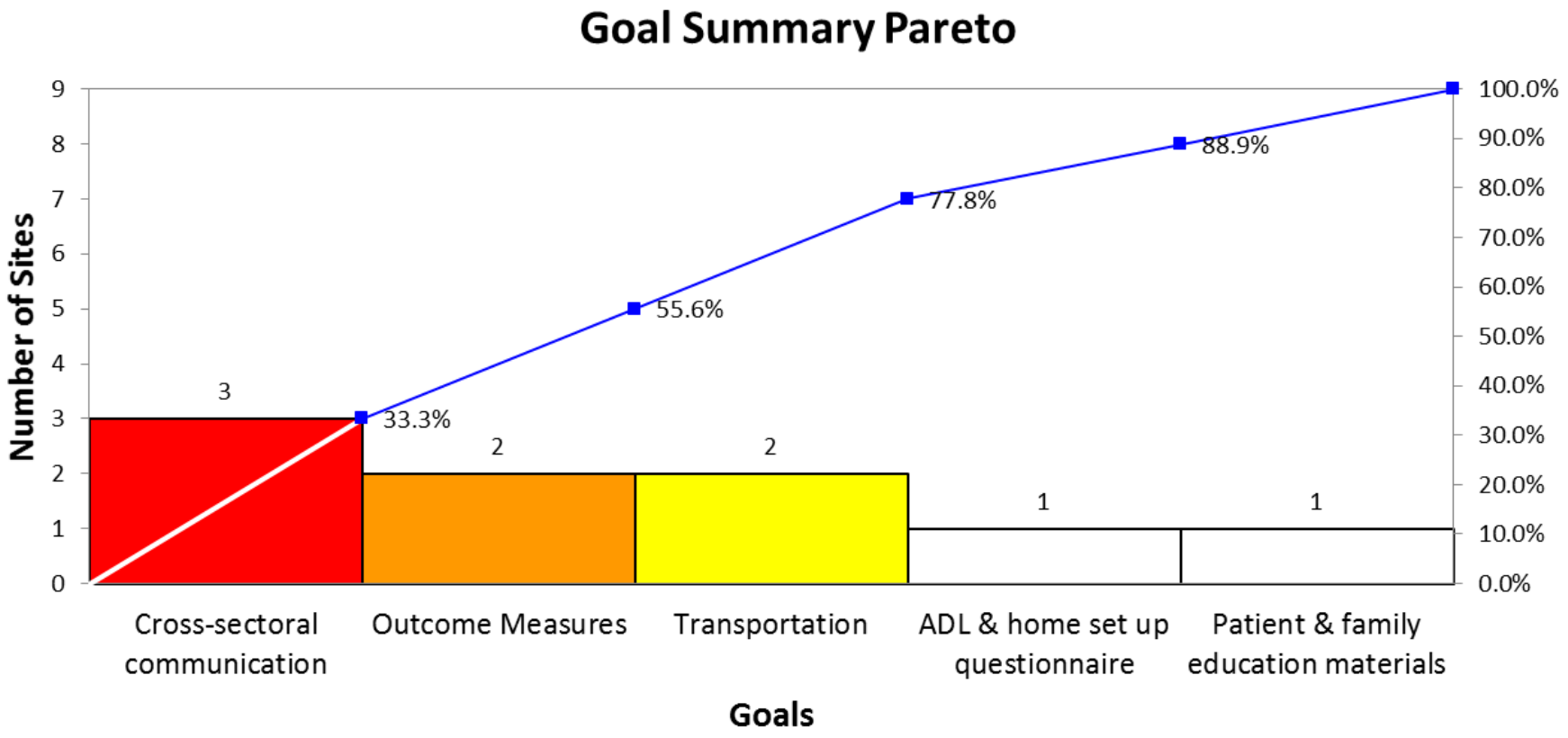
TJR Pre-operative Care: Provincial Priorities for Improvement

LHIN	ESC n=1	SW (n=3)			WW (n=2)		HNHB (n=5)					CW	MH (n=2)		TC n=1	C n=1	CE (n=2)		SE (n=2)		CH (n=4)				NE (n=2)		NW (n=5)				
Screening	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Assessment	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Treatment	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement	Priority for Improvement	Well Aligned

Ontario Local Health Integration Network

Rehabilitative Care Alliance

HNHB LHIN TJR Pre-op



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Rehabilitative Care Alliance

TJR Pre-op: HNHB LHIN Goals & Resources Requested

- Goal Summary Pareto
  - The most cited goals were cross-sectoral communication, outcome measures and transportation (77.8% of the cumulative total)

- Resources Requested:
  - Social support outcome measures
  - Standardized assessment tools to determine post-surgical destination

Rehabilitative Care Alliance

TJR Pre-Op: HNHB LHIN Strengths

- Patients' functional ability is assessed to determine level of disability and urgency rating.
- Physiotherapy and/or Occupational Therapy Assessment(s) completed to determine equipment needs post-surgery
- Patients are provided with information regarding equipment, assistive devices, gait aid, and home modification requirements prior to surgery
- Patients/caregivers are provided a standardized consolidated patient information package that is AODA compliant and includes expected length of stay; precautions and joint protection; energy conservation and pain management techniques; information on assistive devices; planning for the procurement of equipment, preparing the home, and arranging for help with meal planning/other IADLs; exercise, functional activities, ADLs
- Patients are provided with contact information for patients in the event that they have any follow-up questions

Rehabilitative Care Alliance

TJR Pre-Op: HNHB LHIN Opportunities

Least aligned best practices

- Patients are screened pre-operatively in order to predict post-operative discharge needs, and to identify whether the patient would benefit from a preoperative in-home OT or PT visit
- Assessments are completed to confirm post-surgery discharge destination o (i.e., home care, outpatient rehab, bedded rehab)
- Pre-operative outcome measure(s) are completed, to establish a benchmark for patient progress and achievement of functional outcomes
- Patients are referred to preoperative strengthening/range of motion programs, when appropriate

Rehabilitative Care Alliance

TJR Bedded: Provincial Priorities for Improvement

LHIN	ESC (n=2)		SW (n-5)					WW (n=3)			HNHB (n=7)							CW (1)	MH (n=2)		TC (n=2)		C (1)	CE (n=2)		SE (n=2)		CH (n=5)					NSM (1)	NE (n=2)		NW (n=4)			
Assessment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Treatment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned

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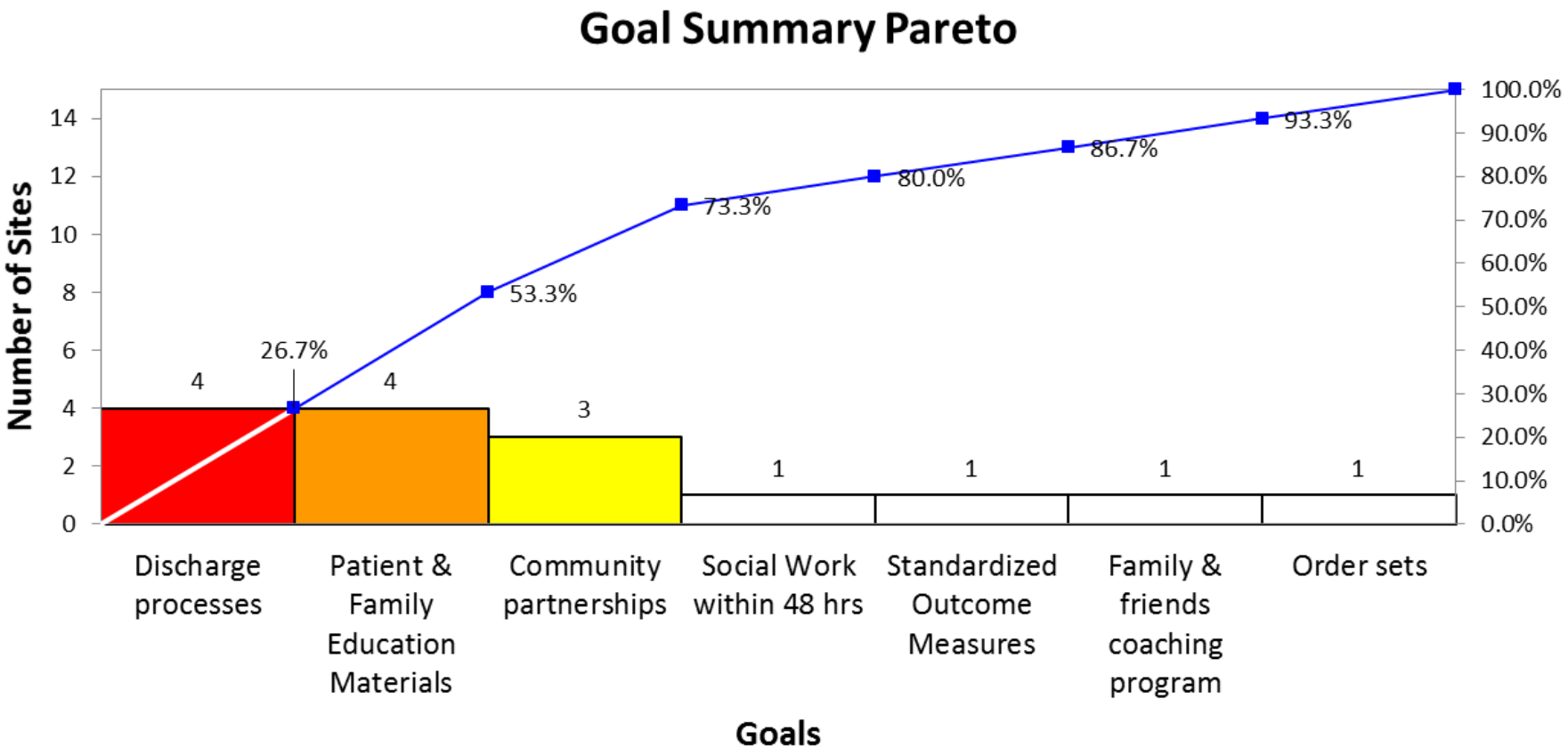
HNHB LHIN TJR Bedded



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Rehabilitative Care Alliance

TJR Bedded: HNHB LHIN Goals and Resources Requested

- Goal Summary Pareto
  - The most cited goals were Discharge Processes, Patient & Family Education Materials and Community Partnerships (73.3% of the cumulative total)

- Resources Requested
  - Coaching program information
  - Standardized discharge documentation
  - Patient education resources
  - Time with the LHIN

Rehabilitative Care Alliance

TJR Bedded: HNHB LHIN Strengths

- Patients received individualized assessment and development of an individualized therapy plan
- Goals are established in partnership with the client and their family/caregivers
- Interventions include exercises to improve active range of motion and strength and functional training
- Treatment is provided by a dedicated interprofessional team with general knowledge about TJR assessment and treatment processes
- Pain is assesses with a validated pain measurement tool and treatment is coordinated with pain management
- Any TJR precautions are discussed with patient and family
- Expected date of discharge is anticipated and discussed with patient and family

Rehabilitative Care Alliance

TJR Bedded: HNHB LHIN Opportunities

Least aligned best practices

- Outcome measures include both performance measures and patient report measures
- Where appropriate, education focused on health promotion, disease prevention and lifestyle changes is provided, or referrals are made to appropriate, available community resources.
- Referrals for ongoing rehabilitative care are made, and appointment confirmed, prior to discharge

Rehabilitative Care Alliance

TJR Ambulatory: Provincial Priorities for Improvement

LHIN	ESC (1)	SW (1)	WW (n=2)		HNHB (n=2)		CW	MH (n=2)		TC (n=6)						CE (1)	SE (n=5)					CH (n=5)					NSM (1)	NE (n=2)		NW (n=4)				Multi (1)
Assessment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Treatment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Priority for Improvement	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned

*MultiLHIN organization providing services in HNHB LHIN included in analysis

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR Ambulatory: HNHB LHIN Goals and Resources Requested

- Short Term Goals
  - Falls programs and BONEFIT staff education
  - Patient & family education materials
  - Standardized patient report measures
- Mid-Range Goals
  - AODA compliant patient & family education materials and program
  - Lifestyle modification education
  - Progressive resistance exercise programs
- Long Term Goals
  - Funding
  - Partnership with Home & Community Care
- Resources
  - Exercise prescription with sufficient intensity

Rehabilitative Care Alliance

TJR Ambulatory: HNHB LHIN Strengths

- Validated measurement tools are used to complete individualized assessment of safety at home, physical and functional abilities and ADL/IADL management
- Goals are established in partnership with the client and their family/caregivers
- Interventions include exercises to improve active range of motion and strength and functional training
- Pain is assessed using a validated pain measurement tool
- Rehab is provided by or supervised by a regulated health professional with clinical experience in TJR rehab
- Patients are provided exercises and functional activities which can be completed at home
- Expected date of discharge is anticipated and discussed, patients are discharged when they have achieved their discharge goals and referrals to community resources/programs are completed

Rehabilitative Care Alliance

TJR Ambulatory: HNHB LHIN Opportunities

Least aligned best practices

- Rehab for total knee replacement should commence within 7 days of discharge from acute care
- Rehab for total hip replacement should commence approximately 2 - 6 weeks following discharge from acute care
- Outcome measures include both performance measures and patient report measures
- Patient education materials have been developed using plain language and are compliant with the Accessibility for Ontarians with Disabilities Act (AODA) requirements for accessibility
- When appropriate, education focused on health promotion, disease prevention and lifestyle changes is provided, or referrals are made to appropriate, available community resources.

Rehabilitative Care Alliance

TJR In Home: Provincial Priorities for Improvement

LHIN	SW (n=2)		WW (n=3)			HNHB (n=1)	CW (n=1)	TC (n=1)	CE (n=2)		SE (n=2)		CH (n=2)		NE (n=1)	NW (n=5)					Multi (n=3)		
Assessment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Treatment	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Patient & Family Education	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned
Transition Planning	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned	Well Aligned

*MultiLHIN organizations providing services in HNHB LHIN included in analysis

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR In-Home: HNHB LHIN Goals and Resources Requested

- Short Term Goals
  - Staff education
  - Performance and patient reported outcome measures
- Mid-Range Goals
  - AODA compliant patient & family education materials
  - Lifestyle factors education resources
- Long Term Goals
  - Advocate for home therapy with funders
  - Develop electronic tool kit
- Resources
  - Performance and patient reported outcome measures

Rehabilitative Care Alliance

TJR In-Home: HNHB LHIN Strengths

- Validated measurement tools are used to complete individualized assessment
- Goals are established in partnership with the client and their family/caregivers
- Direct OT and/or PT services should commence within 7 days of discharge from acute care
- Treatment includes hands-on & manual therapy techniques, self-management, prescription of equipment and/or assistive devices
- Pain is assessed using a validated pain measurement tool and is integrated into patient care
- Patients and family are provided with education on safe activity resumption, mobility, precautions, expected progress, pain management and community supports

Rehabilitative Care Alliance

TJR In-Home: HNHB LHIN Strengths (continued)

- A self-management component should be included in the treatment plan to empower patients to continue exercise post-discharge; patient education includes information regarding the benefits of ongoing independent participation in exercise
- Expected date of discharge is anticipated and discussed with patient and family
- If patient's personal goals exceed the those of a the rehab program and a home exercise program, patients are supported in exploring community resources/exercise programs that best meet his/her needs
- Referrals to community resources/programs, as appropriate

Rehabilitative Care Alliance

TJR In-Home: HNHB LHIN Opportunities

Least aligned best practices

- For total knee replacement, rehab is more frequent for the first few weeks (2-3/week) in order to prevent contracture and loss of range of motion
- Outcome measures include both performance measures (e.g. TUG; BERG) and patient report measures (Western Ontario and McMaster Universities Osteoarthritis Index [WOMAC]; Lower Extremity Functional Scale [LEFS])
- Patient education materials have been developed using plain language and are compliant with the Accessibility for Ontarians with Disabilities Act (AODA) requirements for accessibility

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Ontario Local Health Integration Network

Summary

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Overall Provincial Summary

- Analysis based on 247 Self-Assessment Submissions
- Common Areas of Strength:
  - Individualized treatment interventions
  - Patient and caregiver engagement
  - Dedicated inter-professional team in pre-op, bedded, in-home and LTC sectors
  - Goal-directed plan of care
- Common Opportunities for Improvement:
  - Patient and family education materials
  - Communication across the continuum of care
  - Use of validated outcome measures and risk assessment tools
  - **Hip Fracture:** Addressing dementia, delirium and depression
  - **TJR:** Addressing pre-operative supports

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HNHB LHIN Summary

- A total of 43 self-assessments were received from 21 organizations in the HNHB LHIN (including 2 MultiLHIN organizations)
- All health care sectors were assessed
- Common Areas of Strength:
  - Individualized treatment interventions
  - Patient and caregiver engagement
  - **Hip Fracture:** Fall prevention & management
  - **TJR:** Pain assessment & management and goal directed care
- Common Opportunities for Improvement:
  - **Hip Fracture:** Osteoporosis Management
  - **TJR:** Performance & patient report outcome measures

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Best Practice Implementation Strategies

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Hip Fracture Bedded: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Co-locate hip fracture patients on 1 unit with a dedicated, interdisciplinary team[2]
- Unique interdisciplinary team members:
  - Professional Practice Clinician dedicated to Safe Elder Care practices[2]
  - Early access to Geriatrician[1]
  - Internal Medicine Reviews[1]
  - Osteoporosis Canada Fracture Prevention Coordinator[1]
  - Surgeon Best Practice Champions[1]
- Geriatric Hip Fracture Pre and Post-op Order Sets[2]
  - Automatic orders for delirium prevention
  - Care path for delirium includes no night sedation, non-pharmacological sleep protocol, re-orientation
  - Healthy Bone Treatment
  - Pharmacy assessment within 48 hours

[1]Grand River Hospital
[2]Halton Healthcare

Ontario Local Health Integration Network

Rehabilitative Care Alliance

Hip Fracture Bedded: Best Practice Implementation Strategies (continued)

- HELP Program (Hospital Elder Life Program) – (delirium prevention) a multicomponent intervention strategy utilizing a targeted interdisciplinary geriatric assessment and an innovative volunteer model with a structured curriculum, including daily orientation, early mobilization, feeding assistance, therapeutic activities, non-pharmacological sleep protocol and hearing/vision adaptations www.hospitalelderlifeprogram.org [1, 2]
- Music & Memory Program – (dementia care) taps deep emotional recall which improves relationship building, eases transitions, avoids challenging behaviours and saves time. www.musicandmemory.org[2]
- Staff training in Gentle Persuasive Approach (dementia care) [2]

[1]Grand River Hospital
[2]Halton Healthcare

Rehabilitative Care Alliance

Hip Fracture Bedded: Best Practice Implementation Strategies (continued)

- Therapists are BONEFIT certified (osteoporosis management)[2]
- Patient & Family Advisors assist with the development of all patient materials and videos[2]
- Patient entertainment arms have research modules for patients and families to search medical information. For example, diagnoses and medications. [2]
- Transfer of accountability provided to next health care provider and linkages to community resources[2]
- Therapy coverage during off hours. For example, changing a physiotherapist's work day to 1400-2200 to provide evening coverage and PT/OT weekend coverage[1]

[1]Grand River Hospital
[2]Halton Healthcare

Rehabilitative Care Alliance

Hip Fracture Ambulatory: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Transfer of Accountability from Bedded Sector
- Involvement of families and caregivers, including information regarding “what to watch for” for delirium
- Staff training in Gentle Persuasive Approach
- Motivational Interviewing techniques utilized
- Interdisciplinary teams from multiple ambulatory clinics are co-located to allow for team rounding/huddles to develop best strategies for individual patient care
- Interdisciplinary teams include PT, OT, SLP, Nursing, Nurse Practitioner, Social Work and Geriatrician

Halton Healthcare

Rehabilitative Care Alliance

Hip Fracture In-Home: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Delirium/Dementia/Depression strategies:
  - Embedded in therapy initial assessment form
  - 3Ds Standardized Outcome Measures: SIGECAPS, Geriatric Depression Scale, Mini-Cog, MoCA, Confusion Assessment Method (CAM)
- Rehabilitation treatment sessions average 8 weeks 2-3 visits/week using a PT-PTA care model
- BONEFIT certified therapists act as Osteoporosis Practice Champions
- Team meetings are focused on reflective clinical practice, peer to peer collaboration, case reviews and coaching to implement best practice

SE Health – Mississauga-Halton LHIN

Rehabilitative Care Alliance

TJR Pre-operative Care: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Prehab Program
  - Mandatory attendance (utilizing bundled funding)[1]
  - In person prehab classes or prehab video 2-3 months prior to surgery[1, 2]
  - Early screening for transition planning[1, 2, 3, 4]
  - High risk patients are immediately engaged by Social Work, Discharge Planning and/or Inpatient Rehabilitation Manager[1, 2]
  - Individual meetings with PT, OT, Fracture Clinic Nurse to assist with planning for equipment, care concerns and special needs[1, 2, 3, 4]
  - Special needs communicated with managers on inpatient, OR, PACU, Day Surgery and Pre-op Clinic[3]

[1] Halton Healthcare
[2]Peterborough Regional Health Centre
[3]St. Joseph's Healthcare Hamilton
[4]Sunnybrook Health Sciences Centre

Ontario Local Health Integration Network

TJR Pre-operative Care: Best Practice Implementation Strategies (continued)

- Advanced Practice Physiotherapist/Intake Clinic screens surgical versus conservative treatment[2, 3, 4]
  - Those exploring conservative measures are offered GLA:D program and other osteoarthritis best practice treatments[4]
  - Outcome measures: Sit-stand chair test, Timed Up & Go, 40 Metre Walk Test, LEFS[4]
- Mobile app provides pre-op education, reminders for pre-op preparation and post-op self-management[1, 4]
  - Families are included to assist with the use of the app (with the senior population)
  - Example app: CoHealth

[1] Halton Healthcare
[2]Peterborough Regional Health Centre
[3]St. Joseph's Healthcare Hamilton
[4]Sunnybrook Health Sciences Centre

Rehabilitative Care Alliance

TJR Bedded: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Patient & family education
  - Align Engage Program in Convalescent Care – lectures and materials include lifestyle modification information[1]
  - Lifestyle modification education provided in Intake Clinic or by surgeon[3, 5]
  - Videos providing education reviewed with patients and available on website for patients/families[5]
  - Ortho Surgical Passport Booklet/ Admission package and discharge summary provided[5, 6]
- Early mobilization
  - Abductor canal blocks allowing mobilization Day 0[2]
  - Anterior approach THR allowing potential discharge Day 1[2]
  - Patients not catheterized intraoperatively. Ambulation to washroom Day 0.[3]
  - Physiotherapy Day 0[3]

[1]Dundurn Place Convalescent Care
[2]Brant Community Health Centre
[3]Cambridge Memorial Hospital
[4]Grand River Hospital
[5]Peterborough Regional Health Centre
[6]Providence Care

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR Bedded: Best Practice Implementation Strategies (continued)

- Multimodal pain management led by Department of Anesthesia and support by a Nurse Practitioner[3]
- Total Joint Replacement Clinical Nurse Specialist[4]
- Therapy coverage during off hours. For example, changing a physiotherapist's work day to 1400-2200 to provide evening coverage and PT/OT weekend coverage[2, 4]
- Transition planning
  - LHIN Home & Community Care contacts patient prior to surgery to advise on equipment and physiotherapy follow up[3]
  - Blaylock score in pre-op identifies previous functional status and potential barriers for discharge[4]

[1]Dundurn Place Convalescent Care
[2]Brant Community Health Centre
[3]Cambridge Memorial Hospital
[4]Grand River Hospital
[5]Peterborough Regional Health Centre
[6]Providence Care

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR Ambulatory: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Patient & family education:
  - Provided via classes, 1:1, patient guide, post-op exercise booklet and mobile app[1, 2, 3]
  - Education includes managing meaningful tasks while adhering to hip precautions and lifestyle modification[2]
  - Education is reviewed and updated regularly with changes in practice and evidence[3]
  - Comprehensive fall prevention screening initiative – all patients 65+ years complete the "Staying Independent Checklist". Those who score at risk receive education from the health practitioner and are encouraged to see their primary care practitioner[1]

[1]Pembroke Regional Hospital
[2]Providence Healthcare
[3]Sunnybrook Health Science Centre

Rehabilitative Care Alliance

TJR Ambulatory: Best Practice Implementation Strategies (continued)

- Outcome measures utilized[1, 2, 3]:
  - LEFS
  - TUG
  - COPM
  - Numeric Pain Scale
  - 2 minute walk test
  - 1 RM leg press
  - Stair test
  - P4
  - PSFS
- Therapists are BONEFIT certified[2]
- Process in place to maintain consensus among surgeons regarding post-surgical care to create consistent evidence-based care[3]

[1]Pembroke Regional Hospital
[2]Providence Healthcare
[3]Sunnybrook Health Science Centre

Ontario Local Health Integration Network

Rehabilitative Care Alliance

TJR In-Home: Best Practice Implementation Strategies

Addressing Provincial Opportunities for Improvement: High Performer Strategies

- Patient & family education:
  - LHIN-wide regional education booklet for hip and knee surgery (http://regionalhealthprogramsww.com/PatientEducationMaterial?deptID=2)
  - CoHealth App in process to provide patients with information and planning for surgery
  - Best practice standard document for all aspects of the care pathway (http://regionalhealthprogramsww.com/HealthCareProviders/CarePathways/TotalJointArthroplasty?deptID=2)
- Outcome measures (http://regionalhealthprogramsww.com/HealthCareProviders?deptID=2)
- Transition planning:
  - Patients are seen in home and clinic by the same physiotherapist
  - LHIN Home & Community Care team calls patients 6 weeks prior to surgery to facilitate transition planning and preparations

Waterloo-Wellington LHIN Home & Community Care

Rehabilitative Care Alliance

Contact Information

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