South West Primary Care Alliance

Oxford Sub-region
April 5, 2018
6:00 p.m. - 7:30 p.m.

In attendance

Dr. Jitin Sondhi	Dr. Donald Miettinen	Christie Cook	Randy Peltz
Rachel Griffin	Dr. Howard Lamb	Dr. Joel Hamilton	Sue Tobin NP
Stacy Crown	Dr. Lisa Dalby	Dr. Rob Stern	Dr. Rachel Orchard
Dr. Ian Hons	Dr. Kim Baker	Dr. Elizabeth Allen	Dr. Aaron Bigham (Ortho)
Dr. Lori Bruce	Dr. Pongrac Kocsis	Andrea McInerney	Shirley Koch
Flo Cassaw	Nicole Seymour	Lindsay Bevan	

Minutes

Topic	Minutes/Actions
Welcome (Jitin Sondhi)	• Jitin welcomed the group and reviewed the agenda
Sub-region Integration Table (SRIT) Update	• Reviewed current state of Priority Scoping and summary of plans • PINOT and CHC: (Some excitement by members about increasing resources for the predominantly FHO environment). • Health Links (to come at next meeting)
Academic Detailing	• Academic Detailer was introduced with presentation provided Clarified that this service is already provided to FHT based practices by internal staff and Academic Detailer will focus on FHO/FHG practices where this resource is not available. NPs are currently not provided this service however this may change in the future as work is being reviewed by the NP college.
MSK Initiative	1. **Will the funding increase for total joint replacements as part of this strategy**? *No. As outlined in the Case for Change slide, this initiative isn't a silver bullet. Reducing wait times is complex and requires multiple initiatives to address – the LHIN has a broader Ortho wait times strategy and the MSK Initiative sits within that strategy and has included significant investment into additional surgeries, including more than $1.7Million for additional surgeries in 2017/18. The intent of this initiative is to provide equitable patient access across our LHIN as we currently see significant variation in wait times between hospitals and surgeons. The MSK Initiative will also ensure non-surgical patients are connected with community based resources within 2-4 weeks of referral from primary care.* **2. How do Primary Care Providers (PCP) refer outside the South West LHIN? We have experienced instances where South West LHIN patients have been refused, i.e. Psychiatry. Also, I'm curious to know what the surgical wait times are for other LHINs. Where is that data available?** *The South West LHIN Central Intake Office and local Assessors will coordinate cross-LHIN referrals with the patient following local assessment and education. Access to surgical wait times for the province are available on the Ontario Wait Time Report via the Health Quality Ontario website.* **3. Some surgeons are rejecting patients. Is that taken into consideration in wait**

times?

If there are surgeons in the South West LHIN who are rejecting patients, please let us know as we aren't aware of any Ortho practices who are refusing referrals today. Patients who aren't on electronic wait lists would be excluded from today's reporting of wait times.

4. **The expertise of a Spine surgeon may be required for a full assessment. What value will an Assessor add compared to the expertise of a Primary Care Provider?**

   Patients experiencing low back pain who are deemed surgical candidates will also receive an assessment from the Advanced Practice Leader (APL) who will have successfully completed provincially mandated spine education for the position. The APL will work very closely with Spine surgeons to ensure that ongoing teaching takes place as the MSK model evolves. This improvement opportunity is focused on equitable patient care across our vast geography and today, there are varying levels of non-surgical management taking place prior to referral for surgery across the South West LHIN's approximate 800 Primary Care Providers.

5. **How should patients (and any other AHPs), who insist on having an MRI be responded to?**

   We hear you! Continue doing what you are doing today and explain that best practice and a requirement to make a referral to an orthopedic surgeon is x-ray. Central Intake will complete the Assessment and if additional diagnostics are required, it will be determined at that time. The MSK standard referral indicates that MRI is not indicated prior to referral for surgical consultation.

6. **What is the incentive for PCPs to use the Assessment Model? Will PCP's have access to Central Intake? It feels like duplication in patient care.**

   The centralized intake and assessment model has been proven in other LHINs, for as long as 8 years, including those with similar geographies as ours. Based on patient feedback and success realized in other parts of the province, this new model of care is a Ministry mandated initiative, meaning in order to access surgical assessment for your low back pain and hip/knee osteoarthritis patients, you will need to refer to central intake for assessment, education and surgical consultation if indicated.

   PCP's will have access to the single Central Intake office for the South West LHIN where patients will be offered the next available appointment. A copy of the patient's care plan will be sent to the PCP following the assessment. What will be helpful for the project team to know is what information is needed by a PCP following assessment and education. An outline of roles and responsibilities between the Central Intake Office and health care providers will be published.

7. **How will conservative management be managed for patients, i.e. patients want to be seen by a surgeon right away. What patient criteria will be provided to PCPs so mild cases aren't addressed prematurely?**

   A copy of the patient's assessment/care plan will be provided to the patient as well as their PCP. The Assessment team will provide the expertise in assessment of osteoarthritis patients and when appropriate, refer the patient to the next available (or their preferred surgeon) for consultation. In cases where the assessment indicates conservative management, the patient will be connected with community based resources to support their shared care plan and the patient will be accountable to follow-through on the

recommendations and will liaise with their PCP for ongoing care as needed.

8. **I like the concept of Central Intake, i.e. centralized access to data, (i.e. surgical wait times), funding updates for orthopedic services and education. How will the exchange of information work? Also, I wonder if there are best practices that PCP's could benefit from to support the model.**

   That's a great question and one we'll take back to the Working Committee because it'll be critical to success that the continuum of patient care is engaged as Central Intake evolves. To date, the SouthWestHealthline.ca and Primary Care Alliance website have been identified as potential communication mechanisms with Primary Care.

9. **Tell me about the Referral Form. If the PCP has already exhausted all conservative management activities, i.e. therapies, how will the Central Intake office know?**

   The Referral Form will include an area where past medical and surgical treatments are to be included. It will be loaded on EMR and be available in paper format. It can be faxed and regardless of which communication vehicle is used for submitting the referral, the software used by the Central Intake office, will digitize all referrals received for tracking and routing.

10. **I don't think this Assessment and Education model will reduce MSK wait times. Tell me how it will**.

    There are multiple change initiatives needed to address wait times (see slide 7 in the presentation). The key areas this initiative will positively impact are referral patterns and wait list management across the South West LHIN which will also result in more equitable patient care. What we do expect to see is level loading of surgeon waitlists which carries significant variance today for the hip and knee population and a higher benefit to the low-back pain patients.

11. **Additional funding should be directed to orthopedic surgery where the gap in services really exists. Will additional funding for orthopedic surgery funding coming from LHIN?**

    Additional funding for orthopedic surgeries was provided last fiscal year and will be provided again in 2018/19. The rate of improvement in wait times needs to be carefully considered, so as to not negatively impact other patient populations or services (e.g. hospital surgical inpatient ward capacity to admit patients from the Emergency Department).

12. **What's to prevent a patient from self-referring to Central Intake and skipping Primary Care all together?**
    The MSK Initiative is intended to work closely with Primary Care to support shared plans of care. At this time there is no intention to accept self-referrals. Referrals to the Central Intake Office will be received from PCP's, including those from walk-in clinics.

13. **What is the fee schedule for the referral form?**
    The MSK Standard Referral form is very brief and like the majority of other specialty referrals, does not have a billing fee associated with its completion. The services of the Central Intake office are intended to provide patients with timely access to Ministry of Health and Long-Term Care Best Practices for low back pain and osteoarthritis assessment and education and support Primary Care Providers by enabling a single location for referrals and routing/scheduling of appointment for patients.

14. **With regards to conservative management, there are a number of patients who aren't covered for therapy and have limited discretionary funds. Also, there are long waiting lists for patients older than 65 for therapies. How will the patient whose been given an exercise prescription receive the treatment they need?**

Your concern is one that is shared with other Primary Care Alliances and allied health providers who have limited funding. This reality has been escalated to the Ministry. In the interim, we are conducting an environmental scan of Community resources as a means to inform all partners in the continuum of care of what is already publically funded in the community. We also meeting with larger resources, like the Arthritis Society who provides similar services and is funded through a separate arm of the Ministry.

15. **Who will provide prescriptions to the patient?**

The patient's PCP will provide medical prescriptions. Assessors will be Allied Health Professionals and prescribing is not within their scope of practice.

16. **Help me understand the problem we are trying to solve for hip and knee patients when statistics indicate app. 60% of that patient population requires surgery. Seems to me the focus should be increasing OR time.**

Keep in mind, app. 40% of the hip and knee osteoarthritis patients referred today are non-surgical. This population will benefit from Assessment, education, and connection to community based resources. All patients will receive more equitable and timely patient care. We do anticipate greater benefits to improving surgical consultation wait times for spine patients.

17. **What is the cost of the MSK Model and what does it include?**

The annual cost for the South West LHIN's MSK Model is approx. $1.6mil annually. The model includes approx. 10 new clinicians consisting of 2, Advanced Practice Leaders – one for Hip and Knee and another for Spine and 6-8 Assessors. It also covers the costs of Central Intake including technology infrastructure and salaries and benefits for app. 4 administrative staff.

18. **Explain Wait Time Reporting (i.e. Wait 1, Wait 2). There is a need to standardize Wait 2 reporting by Ortho Surgeons because the timeliness of their patient charting currently impacts waitlist management reporting.**

You are bang-on Dr. Bigham! The new reporting environment will create more transparency to wait *time reporting. Currently there isn't reporting available on the wait-time of patient referral from PCP to assessment for those patients who do not go on to have surgery.* Wait 1 reporting demonstrates the patient's wait time from referral to surgical consultation. If the *surgical consultation resulted in conservative management, i.e. no surgery, that data isn't available. It will be with Central Intake where the wait time for an initial assessment is 2-4 weeks. Orthopedic surgeons in the South West LHIN had previously been targeting an initial assessment within 3 months. Wait 2, or time from decision to treat to surgery is provincially set at 182 days.*

19. **If the patient requires an injection. Does that require a referral to Central Intake?**

An inventory of community based resources, including where to send patients for injections will be made available to Primary Care. If you do not believe you patient requires surgery, continue existing practices.

20. How will patients currently on wait lists be addressed in the new Central Intake model?

Patients currently on wait lists will receive an assessment before net new patient referrals. The actual number of patients on wait lists is unknown because a) the information isn't centrally monitored and b) some PCP's will send multiple referrals to orthopedic surgeons in hopes of their patients receiving the earliest appointment.

21. Who is coordinating the patient's appointment date/time in this new model?

The Central Intake Office will coordinate the assessment appointments with the patient. The method (i.e. phone, e-mail) and number of attempts to reach the patient are in the process of being finalized in the South West LHIN. Recognizing there is a small window of time to coordinate the appointment and complete the assessment (i.e. 2-4 weeks), the provincial process is to advise the PCP if the Central Intake office was unable to reach the patient.

22. Based on the estimate of 3,000 hip and knees done annually, how will the volume of required assessments are completed by app. 7 assessors? The estimated cost for the service is $325 per patient. Considering app. 60% of these patients, result in surgery, how practical is this solution?
It is frustrating to hear more dollars are going towards a process vs. patient care when needed.

A balanced, improvement approach (i.e. Institute for Healthcare Improvement's Quadruple AIM) is applied to Ministry funded initiatives that look at four dimensions for 1) Improvement to patient experiences of care (i.e. quality and satisfaction); 2) improving the health of populations (outcomes); 3) reducing per capita costs of health care (value for money); and 4) improving providers experiences
Patients are stating they are very satisfied with the level of care they are receiving with the MSK model of care in other LHINs and that they are better able to self-manage their non-surgical conditions. This model provides a full assessment (e.g. 45-60 minutes) for the patient by an advanced practice clinician in orthopedic care. What patient's consider Therapeutic and what some providers consider Therapeutic seem to be at odds for some.

As mentioned earlier, the MSK Initiative isn't intended to address all wait-time issues. It will though, give us a better understanding of our osteoarthritis patient population, quantify actual raw demand for service, and improve wait times for initial assessments and provide more equitable patient care.

23. **What evidence is available that physio-therapy (PT) reduces the need for surgery?**

Dr. Bigham advised evidence exists there is improved quality of life for mild to moderate arthritic patients. The patient's range of motion and functionality improves. If it is a severe case, the Assessor will refer the patient directly for surgical consultation versus going for PT before determining surgical requirements.

24. If a patient receives a non-surgical management plan, and comes back in 6 months saying what was offered hasn't resolved their needs, what is expected action a PCP should take?

A second referral to the Central Intake Office is encouraged. We haven't heard this to be an issue in other LHINs (Thunder Bay and GTA) who have adopted this model for many years. Criteria may be established that after a certain period of time (e.g. 6 or 12 months

a patients will require a re-referral) however if within the re-referral time frame, the patient reach out to central intake directly.

25. **An opinion was expressed that "patients aren't waiting in a queue for surgery to receive a longer assessment and education component and what they can do in advance of surgery".**

    A number of LHINS have implemented both models and are achieving very positive patient satisfaction. Assessments average 45-60 minutes. This is a definite benefit for the spine population because evidence has shown only 10% of those patients are surgical. Rather than waiting 200+ days for a surgical consultation, the patient is relieved to hear that surgery isn't needed and are there conservative management services or exercises they can do to relieve symptoms. Patients appreciate the thorough evaluation and 1:1 education, and if needed, will leave with an appointment to see a surgeon.

26. **Does the funding include a greater complement for patient coverage of Physio-Therapy?**

    The Ministry funding doesn't cover Physiotherapy services although we anticipate the assessors will be OT/PTs or other Allied Health Care Professionals. We agree, this is a gap in our health care system today. The Central Intake system will track all patient referrals and enable us to factually speak about the gaps in the continuum of orthopedic care needs both at a LHIN and provincial level. The current focus is on level-loading of wait times to provide equitable access and enable ethical use of existing resources as wait times across our South West LHIN vary between 224-800+ days total wait time today.

27. **Data collection may help adjust the variances once we understand where patients are coming from; where the demands for service exist. The intent is to keep patients within their local areas for care. The Funding model is app. 15-20 year old with huge variability across the South West LHIN. The 15 or so hip and knee surgeons do things differently today and can't get decent data that's needed.**

    Agreed.

28. **When will this start? I recommend you start with Spine where the greater benefits exist.**

    The plan is a small, staggered launch starting in Q2 (July – September, 2018) for both hip and knee and lower spine pathways. This is the current preference of the Clinical Advisory Board (core group of orthopedic surgeons across the South West LHIN).

29. **The Champlain LHIN is a comparable size to the South West LHIN; are they doing better with their hip and knee wait lists?**

    Yes they are. Their wait lists were also comparable to how ours sit today and they are now reduced following implementation of this model of care.

    I hear they received more funding to reduce their surgical time.

    That may be true; I can't speak on behalf of the Champlain LHIN. The South West LHIN invested in more orthopedic surgeries earlier this year and has ear-marked funds to further reduce surgical wait times but 400 surgeries will not address all surgical orthopedic needs.

30. **It doesn't make sense to me that patients have to have an assessment after I've examined them and want to refer to a surgeon. Why are we making patient have**

	another assessment? *All referrals must go through Central Intake; the referral ID is needed to move the referral forward to a surgeon. In future, we may be able to by-pass some referrals but it is currently mandatory based on provincial criteria and conditions of funding.* **31. Where will assessments be done pre and post-surgery?** *We haven't finalized where the 6 – 8 assessors will be based but do know they will be mobile as we want patients to receive an assessment as close to their community as possible. There will be assessments conducted at a minimum in each of the five sub-region areas (London Middlesex, Huron Perth, Oxford, Elgin, and Grey Bruce).* *Surgeries done outside of their local community will have follow-up appointments where the surgeon is located, as is today's practice (as many patients are currently travelling around the region for care in an attempt to find a lower wait time).* **32. I heard there is hospital funding to create in-house space or utilize Home and Community Care PT services. The concept is that the PT is paired to where the surgery occurred. For example, if an Owen Sound patient had surgery in Woodstock, Woodstock Hospital would release those funds to enable the patient to receive PT in their local community.** *That could be true; the province's intent is that funding follows the patient* **Comments: There was a general concern from the PCPs that there is a replication of their work and the perception of loss of value in their ability to evaluate a Knee or Hip for surgery. Many PCPs wondered if the Central Intake can function as a Central Referral process with only those patient's whose management has not yet been exhausted by the provider to enter the assessor. This would reduce replication of work and save money in an exhausted system ($325/ assessment by one of these assessors compared to 17 to 30 dollars from a Primary care Provider). The PCA implores the MSK to review this aspect and reconsider the cost impact this may have. It is still unclear how this will benefit patient care but it was illustrated that this will improve data collection to aid in the development of future policy.**
Future meetings	• June 7th at 1800 with location to be determined based on capacity