Primary Arthroplasty
Hip and Knee
BUNDLED CARE
AMBULATORY BASED
REHAB REFERRALS PROVIDER INFORMATION

THIS PACKAGE IS TO BE FAX'D WITH THE REFERRAL TO THE NON-QHC REHABILITATION CLINICS THAT WILL FOLLOW THE PATIENT UPON DISCHARGE FROM HOSPITAL. IN MOST CASES THE CLINIC HAS RECEIVED PRIOR NOTICE DURING THE PRE SURGICAL PREPARATION AND IS EXPECTING TO RECEIVE THE PACKAGE AND REFERRAL AS CONFIRMATION THAT SURGERY HAS BEEN COMPLETED.

THE PURPOSE OF THIS DOCUMENT IS TO INTRODUCE THE PATIENT TO THE CLINIC AS A BUNDLED CARE PATIENT AND TO PROVIDE THE CLINIC THE SERVICE REQUIREMENTS AND INVOICING PROTOCOLS FOR PAYMENT AND OUTCOME MEASUREMENTS

****THE PATIENT IS TO RECEIVE A COPY OF THE REFERRAL TO CONFIRM THE NAME AND CONTACT INFORMATION FOR THE CLINIC THEY ARE BEING REFERRED TO

Physical Rehabilitation Planning for Discharge from Hospital

Providers: as a Public Funded Community or Hospital Rehabilitative Clinic you are receiving this package along with the introduction and referral of a patient in the QUINTE HEALTH CARE Bundled Care Program who has under gone surgery at our hospital:

☐ Primary Unilateral Hip Arthroplasty or	☐ Primary Unilateral Knee Arthroplasty

The clinical directive of the orthopedic surgeon is that the patient may be referred to attend physiotherapy in the clinic setting within the timelines provided in the attached detailed protocols with staples in situ. Any exceptions or restrictions will be found on the referral document.

By accepting the referral for rehabilitative care of the patient your clinic agrees to provide quality rehabilitative care consistent with the guidelines and best practices in accordance with *The Rehabilitative Care Best Practice Framework for Patients with Primary Hip and Knee Replacements*, developed by the Rehabilitative Care Alliance, and the *Quality Based Procedures (QBP) Clinical handbook for* Primary Hip and Knee Replacement developed by Health Quality Ontario and MOHLTC. The number, frequency and duration of visits offered for post-operative rehabilitation must be necessary and reasonable for the treatment of the primary joint replacement post-surgical condition as determined by the treating practitioner based on the patient's individual need and evidence-based best practices (see attached guidelines). Please note: Patients are able to access publicly funded services for their rehab care post arthroplasty surgery however if their choice is to attend a 'private' rehabilitation clinic, the cost of these services are not covered in the Bundled Care Program.

The patient may have up to **5** physiotherapy sessions for Total Hip Replacement (THR) up to a fixed cost of $300 per patient and up to **8** physiotherapy sessions for Total Knee Replacement TKR up to a fixed cost of $250 with a community based or hospital based Bundled Care rehab provider facility. The patient's rehabilitation program duration is dependent on achieving the discharge criteria and meeting the therapeutic objectives of a treatment plan as outlined in the attached protocol. Once goals and discharge criteria are met, the patient can be discharged and transitioned from treatment with a comprehensive home exercise program. Patient goals above and beyond the discharge criteria or are unlikely to be achieved from continuing rehabilitation services offered will not be covered within the bundle. Patients will be discharged once the therapeutic objectives identified in the treatment plan have been achieved, or when any reasonably equivalent gains could be achieved through exercise or similar program, or when no further gains are likely to be achieved from continuing the rehabilitation services offered. It is expected that a patient will not exceed a rehab length of stay>120 days. If the patient requires additional treatment to return to reasonable functional goals following surgery the clinic should contact the referring hospital.

If the patient would like to obtain additional therapy outside of the scope of the care required by best practices, the patient and the clinic may enter into their own payment arrangements for that care. If the

patient has been discharged from the bundled care program, QHC is no longer responsible for paying or providing further care using bundled care funding.

Please Note: in the circumstance where a patient who is discharged from acute care as a Bundled Care patient but who then requires a re-admission to hospital for any reason, the patient exits the bundle and the rest of their care would be provided using non-bundled funds such are the clinic's global budget or Episode of Care funding (OHIP).

If transferring or transitioning a patient to another rehab provider for completion of the arthroplasty pathway this additional information must be noted on the invoice.

All patients who have had primary hip or knee arthroplasty surgery are participating in the Patient Reported Outcomes Measures (PROMs) and will have entered their information prior to surgery and have been instructed that they must enter their progress within 90-120 days following surgery and again at one year. Their access to the provincial which has been provided to them or they can visit the QHC web site https://qhc.on.ca/bundled-care-in-surgery.php

We are asking all providers of rehabilitation services to remind the patients to complete their information at these key milestones when discharged from the rehabilitation pathway.

*Important

Re: Invoice and Discharge Summary Forms

Electronic PDF versions available on the QHC website https://qhc.on.ca/bundled-care-in-surgery.php

***These forms must be completed to process payment**

Hip/Knee Bundled Care
Post-Acute Rehabilitation
PROTOCOL GUIDELINES FOR SERVICE PROVISION

Total Knee Replacement

1. Initiation	Outpatient rehab should begin within 1 week of inpatient discharge from acute care
2. Duration	• Typical duration is 5-6 weeks with some patients requiring additional treatments dependent on progress • The greatest improvement in knee flexion occurs within the first 6-7 weeks postoperatively • Duration is based on the achievement of functional goals of independence or plateau in progression. • Each patient receiving a minimum of 6 treatment sessions.
3. Frequency	• Overall frequency of rehabilitation is important for optimal patient outcomes. • Treatments should be offered 1-2 times per week and are based on goal achievement and ROM. If ROM of 0-110 has been achieved and other goals are still outstanding frequency can be 1 time per week. • Emphasis placed on performance of self-directed home exercise program 3-4 times per day.
4. Format	• Assessment and progression of care is to be provided by a regulated health professional and ongoing treatment can be provided by a registered kinesiologist, therapy assistants/rehab assistants/PTA/OTA • Hands-on treatment & manual therapy techniques may be required to assist • Both 1:1 and individualized group-based exercise programs can be beneficial • Triage into class model vs. 1:1 treatment is based on the assessment of the PT • Focus on patient accountability and self-management – home exercise program 2-3 times daily for TOM and basic strengthening • For the patients who require community based rehabilitative care best Practice Guidelines include: ✓ Group based format provided to approximately 90% of TKR patients based on initial assessment by PT ✓ 1:1 individual treatments may be required for approximately 10% of TKR patients however this is based on an initial assessment by PT (i.e. increased stiffness, poor pain management and coping, language barrier, inability to follow in a group setting, multiple comorbidities that require additional attention
5. Discharge Criteria	Functional Active ROM (consider pre-op status and lifestyle) • 0-5 degrees Knee Extension • 110 degrees Knee Flexion

	Functional Strength (consider pre-op status and lifestyle) • Knee: Grade 4/5 or functional control of the knee • Quadriceps strength without lag in straight leg raise (SLR) and short arch quadriceps (SAQ) (sitting) Pain (consider pre-op status and co-morbidities) • Managed pain with functional activities of daily living Independent ambulation (indoors and outdoors, with/without ambulation aid as required in consideration of pre-op status) Normalized gait (consider pre-op status and co-morbidities) Safe transfers as required (home, vehicle) Safe use of stairs is required Swelling resolved or self-managed; wound healed or self-managed; pain self-managed with/without medications Patients are discharged when they have achieved their discharge goals or they have reached a plateau (showing no improvement for 2 weeks) rather than based on a maximum number of visits. If client's personal goals exceed the program goals above, a home exercise program or referral to a private clinic may be arranged. Upon discharge a home exercise program is to be provided Patient Reported Outcome Measures (PROMS): upon discharge from your rehab clinic the patient is to be reminded to complete their 3 month and 1 ear PROMS survey on line.

Total Hip Replacement

1. Initiation	Class or 1:1 session scheduled at approximately 1-2 weeks post inpatient discharge
2. Duration	• Duration is based on the achievement of functional goals of independence or plateau in progression • Duration to be 2-6 weeks, with 2 sessions prior to 6 week mark
3. Frequency	• Frequency of treatment depends on achievement goals, typically once every 2 weeks. • Each patient receives a minimum of 4 treatment sessions.
4. Format	• Triaged into group model vs. 1:1 treatment is based on the assessment of the PT • Both 1:1 and individualized group-based exercise programs can be beneficial. 1:1 individual treatments may be required for approximately 10% of TKR patients based on initial assessment by PT (i.e. Poor post op range of motion, poor pain management and coping, language barrier, inability to follow in a group setting, multiple comorbidities that require additional attention. • Empower patients to self-manage their care. Encourage a daily home exercise regime of 2-3 x/day with daily walking and step up program.
5. Discharge Criteria	Functional active ROM (consider pre-op status and lifestyle) • Flexion minimum 90 degrees (hip) Functional Strength (consider pre-op status and lifestyle) • Hip: Grade 4/5 hip flexion and extension • Grade 4/5 hip abduction Pain (consider pre-op status and co-morbidities) • Managed pain with functional activities of daily living Independent ambulation (indoors and outdoors, with/without ambulation aid as required – in consideration of pre-op status). Normalized gait (consider pre-op status and co-morbidities) Safe transfers as required (home, vehicle) Safe use of stairs if required Swelling resolved or self-managed; wound healed or self-managed; pain self-managed with/without medications Patients are discharged when they have achieved their discharge goals or they have reached a plateau (showing no improvement for 2 weeks) rather than based on a

	maximum number of visits. If client's personal goals exceed the program goals and bundled care provisions as above, a home exercise program or a referral to a private clinic may be arranged. Upon discharge, a home exercise program is to be provided. Patient Reported Outcome Measures (PROMS): upon discharge from your rehab clinic the patient is to be reminded to complete their 3 month and 1 year PROMS survey on line.

References:

1. Hip & Knee Bundled QBP Health System Quality and Funding Division Ministry of Health and Long-Term Care Overview https://www.oha.com/Documents/Bundled%20Care%20Expansion%20Oct%2013,%202017.pdf

2. Rehab Care Alliance- Rehabilitative Care Best Practices for Patients with Primary Hip & Knee Replacement March 2017 / Revised January 2018
http://www.rehabcarealliance.ca/uploads/File/Initiatives_and_Toolkits/QBP/UPDATED_January_2018_TJR_QBP_Rehabilitative_Best_Practices
Framework.pdf

3. GTA Network Outpatient Rehab Process Maps for Total Knee and Total Hip Replacements
https://drive.google.com/file/d/0By4k4zop-0eOYng4QlNoVFBCcEk/view?pref=2&pli=1