Inter-professional Spine Assessment and Education Clinics (ISAEC):
A New Model of Care

From self-management to surgery, integrating the continuum of care.

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Toronto Western Hospital, University Health Network (UHN)
Arthritis Program, UHN
ISAEC- Provincial Clinical Champion, MOHLTC
Objectives:

- Development, Implementation and Outcomes of an inter-professional, shared care model for the management of low back pain.
- Provincial Scale and Spread
Low Back Pain: The need for a paradigm shift!

- 70-80% of the population experiences low back pain at some point in time
- 40% annual prevalence
- One of the commonest reasons to see a physician
- High degree of inappropriate and ineffective healthcare utilization (e.g. imaging) and management

4 out of 5 adults will experience at least 1 episode of back pain at some time in their lives.
Societal Burden

- Number one cause of years lived with disability
- Increasing Burden
- 25% responsible for 75% of the cost!

Disability-adjusted life years (DALYs) for 291 diseases and injuries in 21 regions, 1990–2010: a systematic analysis for the Global Burden of Disease Study 2010

Vos et al, Lancet 2012

Y. Raja Rampersaud MD. FRCSC.
LBP Current Problems – Not addressed!

- Messaging is inconsistent with nature of LBP
  - “it will get better” …recurrence is the rule, not the exception
- One size fits all approach for initial management
  - Guidelines “keep active, keep working”, non-specific mgmt. of non-specific LBP
  - Guidelines don’t adequately address heterogenous chronic/recurrent LBP
- “Medicalization” of LBP
  - Too much focus on the BIO – Psycho – Social …imaging
  - Societal perception and expectation regarding LBP pain…fix it
  - Third party payers need a DIAGNOSIS to pay $…imaging / specialist
- Fragmented, often contradictory and episodic care
  - 10 providers…12 opinions
Current approach

- Perfect storm
  - maladaptive pain behaviours, coping, and cognitive processes
  - wide practice variation and poor effectiveness
  - system inefficiency
Malalignment: LBP and Current Practice is in the Brain

▪ Retrain the brain – Multi-stakeholder Issue
LBP Model of Care

- Best Practices
  - Efficiency
  - Appropriateness
- Provide Value / Sustainability
Key Planning and Development Steps

- Evidence / Best practice reviews
- Define key objectives of new MOC
- Understand needs of principle target audience
  - Patient and provider (primary care) surveys / focus groups
    - Access
    - Consistency in education / management across providers
    - Management support (patient and providers)
- Implementation / Scale and Sustainability strategy
Principle Practice Change

- Integrated and Sustainable Model of Care

**Shared Care Model:**
No one provider can do it all!

An approach to care which uses the skills and knowledge of a range of health professionals who share joint responsibility in relation to an individual’s care. (Moorehead 1995)
How do we pay for it?

- **Return On Investment**
  - Reduction of unnecessary health services
    - MOC - $25 million/year reduction in cost for unnecessary MRIs

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Acceptable Practice Change?

- Integrated and Sustainable Model of Care

Shared Care Model:
Has to be acceptable to all stakeholders.

ORIGINAL RESEARCH
Nurse practitioner-led surgical spine consultation clinic
Angela Sarro, Yoga Raja Rampersaud & Stephen Lewis
Accepted for publication 30 July 2010
Thank you to ISAEC’s advisors and sponsor

The secret to ISAEC’s success...
Inter-professional Spine Assessment and Education Clinics (ISAEC) Program

Rapid access
Thorough consultations
Personalized management plans

Empowering patients to better manage their low back pain.
ISAEC’s Objectives

Overarching objectives of the ISAEC program...

1. Improve outcomes and satisfaction with health care delivery for patients with persistent or unmanageable recurrent LBP-related symptoms
2. Decrease utilization of lumbar spine MRIs
3. Reduce unnecessary referrals to LBP-related specialists
4. Improve access to specialist care
5. Inform provincial roll-out of a model of care for all musculoskeletal conditions
ISAEC: General Overview

ISAEC’s value drivers

Scope of Services

Patient assessment

Patient education

Access and Referral Recommendations

Follow-ups

Education for Primary Care Providers (PCPs) in LBP assessment and management

Centralized referral pathway for PCPs and their patients within a shared-care management model

Specialized, evidence-based training for Advanced Practice Clinicians to execute standard program of care

Streamlined access to networked specialists, diagnostic services and spinal injections as indicated

Tailored patient treatment plans emphasizing self-management and health promotion strategies

Patient and PCP-centered resources to support ongoing patient self-management

ISAEC follow-ups for patients identified to be at highest risk (e.g., chronicity risk)

Assessment within 2-weeks of referral!
ISAEC’s Clinical Sponsors

Clinical sponsorship by local spine specialists
Strategic geographic location to ensure scalability

Clinical Sponsor (Toronto region)
/ Clinical Champion
Dr. Raj Rampersaud

Clinical Sponsor (Hamilton region)
Dr. Brian Drew

Clinical Sponsor (Thunder Bay region)
Dr. David Puskas
De-centralized (“Hub-Spoke”) Delivery of Care
Private – Public commitment (0.2 FTE)
ISAEC’s Model of Care

Regionally implemented but centrally managed...

PCP Portal/Clinic Management System: Provincial MSK Intake Office
- Automated referral management
- Automated matching of patient to APC based on condition and postal code
- Clinician recruitment, training and performance management (standardized assessment and protocols)
- Patient records management through shared IS
- Common patient/provider resources (e.g., isaec.org, ISAEC Newsletter, treatment plans, etc.)

LBP Patient

Primary Care Provider

(Granted referring privileges after LBP training)

Specially trained Advanced Practice Clinicians

FHT APC
APC located within a family health team

PCLBP APC
Utilizing current PCLBP clinicians (if applicable)

Community APC
(Assessment Based Compensation)

Practice Lead

Assess patients referred for surgical consult and order
- MRI/CT/X-Ray
- Spinal injections

✓ Recommendations for ancillary support (when indicated)

Community Providers

Community Programs, Physiotherapists, Chiropractors, Psych Counseling, Occupational Therapists, Registered Massage Therapists, Acupuncturists.

Surgeons

Radiology

✓ (Updated) Tailored Treatment Plan and resources for ongoing self-management

✓ (Updated) Consult Note and Patient Tx Plan and other resources

(Granted referring privileges after LBP training)
The ISAEC Process – Upstream Model of Care

ISAEC Referral - Patient inclusion/exclusion criteria

ISAEC Patients:

✓ Persistent LBRS 6 weeks to 12 months post onset
✓ Unmanageable recurrent LBRS

Non-ISAEC Patients:
- Patient with Red flags
- Initial LBRS <6 weeks
- Constant LBRS >12 months post onset
- <18 years of age
- Established pain disorder
- WSIB claim
- Motor vehicle accident patients
- Established narcotic dependency
- Involved in active litigation
- Pregnant/post-partum patients (<1-year)

LBRS: Low back related symptoms
### ISAEC's Toolkit – Individual risk stratification and MGMT

<table>
<thead>
<tr>
<th>Mechanical Stratification (Hamilton Hall Approach) – PLUS +</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Surgical</strong></td>
</tr>
<tr>
<td>![Red flag with an exclamation mark][]</td>
</tr>
<tr>
<td><strong>Inflammatory</strong></td>
</tr>
<tr>
<td>![Image of an inflamed person]</td>
</tr>
<tr>
<td><strong>Risk of Narcotic Dependency</strong></td>
</tr>
<tr>
<td>![Image of a medical form with checklist]</td>
</tr>
<tr>
<td><strong>Risk of Chronicity</strong></td>
</tr>
<tr>
<td><strong>STarT Back Screening Tool</strong></td>
</tr>
</tbody>
</table>

Alignment to Best Evidence Providers and Treatment
Interprofessional Spine Assessment and Education Clinics (ISAEC): Shared Care Model-of-Care for LBP (Primary-to-Tertiary Care)

Validated Intake Screening Questionnaires

- STarT Back
- Oswestry Disability Index
- EuroQol 5
- Connor-Davidson Resilience Scale
- Pain Catastrophizing Scale
- Patient Health Questionnaire 9
- Opioid Risk Tool
- Inflammatory Risk Tool

![Patient Intake Form](image_url)
Clinical Assessment and Treatment Protocols

ISAEC’s standardized clinical assessment - Patient stratification model

Eligibility Criteria
Primary Assessment (Back specific history and targeted physical exam)
Secondary Assessment (If indicated through Primary Assessment)

- Leg Dominant (Constant/Intermittent)
- Back Dominant (Extension/Flexion)
- Non-mechanical
- Possible Surgical
- Risk of Inflammatory Arthritis
- Risk of Chronicity
- Risk of Opioid Dependence

"Complex"
(Patient self-management plan with ISAEC follow-up and possible referral to specialist(s) and/or adjunct community support)

"non-complex"
(Patient self-management plan and possible referral to adjunct community support)
## ISAEC’s Process

### Standardized, evidenced-based treatment protocols (referral protocol for “Complex” patients)

<table>
<thead>
<tr>
<th>Presenting Condition</th>
<th>If Possible Surgical</th>
<th>If Risk of Inflammatory Arthritis</th>
<th>If Risk of Chronicity</th>
<th>If Risk of Opioid Dependence</th>
</tr>
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<tbody>
<tr>
<td></td>
<td></td>
<td>High</td>
<td>Moderate</td>
<td>High</td>
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<table>
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<tr>
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<th>Surgical Consultation (joint clinic)</th>
<th>Note to PCP</th>
<th>Note to PCP</th>
<th>Recommend Psych. Counseling</th>
<th>Note to PCP and Recommend Supported Exercise Therapy</th>
<th>Recommend Pain Clinic/ Physiatrist Consultation</th>
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<tr>
<td>ISAEC follow-up(s)</td>
<td>2-3</td>
<td>1*</td>
<td>1-2</td>
<td>1*</td>
<td>1-2</td>
<td>1*</td>
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<th>Back Dominant (Extension/ Flexion)</th>
<th>Surgical Consultation (joint clinic) (case by case)</th>
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**ISAEC follow-ups:**

- Surgical Consultations will be arranged though ISAEC’s Provincial Intake Office and take place via a joint Practice Leader and Clinical Sponsor clinic (~once per month) where surgical assessment and education will be provided to the patient.
- Follow-ups will be 60 minutes in duration and arranged through ISAEC’s Provincial Intake Office.
- Some follow-up appointments may be conducted in a group format.
- Follow-up intervals: 6-weeks, 12-weeks and 6-months depending on patient need.

*See note in margin*

*Surgical Consultation – Leg Dominant*

Patients will be referred for surgical consultation after undergoing a six week ISAEC self-management program with no evidence of improvement at follow-up or immediately if patients have functionally limiting intermittent leg dominant pain. Additionally, patients with prolonged unmanageable constant leg dominant pain that has not responded to a proper rehabilitation program at the time of referral to ISAEC will be referred directly for surgical consultation.
ISAEC Program

ISAEC Clinic / Case Management System

ISAEC’s Clinic Management System
- Patient scheduling and tracking
- PL/APC standardized assessment and documentation
- Patient stratification
- Autofaxing of consult notes and self-management plans to PCPs
- Report extraction for program evaluation
- Tablet/mobile friendly

ISAEC CMS

![Diagram of ISAEC CMS process including PCP, Community Partner, Specialist, Provincial Intake Office, and PL/APC connections with features such as Consult Note and Self-management Plan (auto-fax/online), Patient referral information, Follow-up instructions, Patient assessments, Self-Management Plan, Consult Note, Appointment scheduling (online), and Self-management Plan and progress tracking (online/mobile).]

Denotes functions/features already implemented.
Denotes functions/features in development roadmap.

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Positions of Relief, Stretches and Exercises

Here is a list of short videos that demonstrate specific positions of relief, stretches and exercises that may have been prescribed to you by your ISAEC clinician.

Your ISAEC Treatment Plan will indicate which specific positions of relief, stretches and exercises you should attempt. In addition, your ISAEC Treatment Plan will indicate the number of sets and repetitions for the stretches and exercises prescribed as well as when they should be attempted in your multi-week ISAEC Treatment Plan.

If you experience pain aggravated by FLEXION (sitting, bending, stooping and lifting) or Constant Leg Dominant Pain (sciatica) these exercises may benefit your condition.

<table>
<thead>
<tr>
<th>Positions of Relief</th>
<th>Extension Exercises</th>
<th>Stretches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prone Lie on Elbows</td>
<td>Sloppy Push-ups</td>
<td>Adductor Stretch - Lying</td>
</tr>
<tr>
<td>Prone Lie on Pillows</td>
<td>Standing Back Extensions</td>
<td>Hip Flexor Stretch</td>
</tr>
<tr>
<td>Supine Lie</td>
<td></td>
<td>Supine Twist - Advanced</td>
</tr>
<tr>
<td>Z-Lie</td>
<td></td>
<td>Supine Twist - Beginner</td>
</tr>
</tbody>
</table>

If you experience pain aggravated by EXTENSION (walking, standing) or Intermittent Leg Dominant Pain (neurogenic claudication) these exercises may benefit your condition.
Evaluation Results

Evaluation data confirms that LBP beyond the initial presentation to a PCP is “complex”

Despite a fairly upstream model of care we found that 68% are complex and represent the greatest challenge to primary and allied health care providers!

Simple: 563 (32% of all patients)
Complex: 1198 (68% of all patients) →
  • Possible Surgical: 295 (16.6% of all patients*)
  • H/M Risk of Inflammatory Arthritis: 197 (11.2% of all patients*)
  • H/M Risk of Chronicity: 920 (52.2% of all patients**)
  • H/M Risk of Opioid Dependence: 291 (16.5%**)

* Non-mutually exclusive: Complex patients may exhibit multiple risks
** Have identifiable psychosocial factors

Source: ISAEC Research Database (August 2014)
## Evaluation results

### Current statistics ... 25-35 referrals a week

<table>
<thead>
<tr>
<th>Primary Care Engagement</th>
<th>Patient Accessibility</th>
<th>Patient Satisfaction</th>
<th>Patient Health Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>✅ 97% of PCPs believe ISAEC services would be useful to all PCPs.</td>
<td>✅ Average wait time for ISAEC consultation: 12 days</td>
<td>✅ 99% of patients are satisfied with their ISAEC consultation</td>
<td>✅ ISAEC patients show an average 10 point improvement in ODI score</td>
</tr>
<tr>
<td>✅ 96% of PCPs feel ISAEC services have improved care for low back pain patients</td>
<td>✅ Average wait time for surgical consultation: &lt;6 weeks</td>
<td>✅ 95% patients understand their condition much better after seeing an ISAEC clinician.</td>
<td>✅ 48% of patients reported a perceived improvement in their symptoms</td>
</tr>
<tr>
<td></td>
<td>✅ 96% of patients are satisfied with the wait time for consultation.</td>
<td></td>
<td>✅ Reduction in patient chronicity risk, especially among patients at moderate risk of chronicity.</td>
</tr>
</tbody>
</table>

### Sources: ISAEC Research Database

>6,646 patient referrals to ISAEC since Nov. 2012!

#PCPs 220 to 540 since Nov. 2012, with approx. same operational budget!
Evaluation Results

Improved health outcomes for ISAEC patients 6-months post ISAEC consultation

Comparison of Chronicity Risk between first intake and at 6 months: \( n=811 \)

Comparison of Oswestry Disability Index (ODI) between first intake and at 6 months: \( n=820 \)

Comparison of Perception of Symptom Change between first intake and at 6 months: \( n=383 \)

Source: ISAEC Research Database
Evaluation Results
ISAEC Surgical Consultations as of September, 2016

✓ Greater than 96% of patients referred for ISAEC Surgical Consultation by their ISAEC APC were surgically appropriate!

✓ Less than 7% of ISAEC patients have gone on to imaging or specialist intervention!

n = 5663

Source: ISAEC Research Database
Evaluation Results

ISAEC is curbing LBP-related imagining utilization...

- "The overall annual costs for all LBP-related imaging tests ordered by physicians enrolled in the ISAEC pilot project fell by 27% compared with baseline."
- "Estimated savings in the first year after the start of the pilot project were approximately $500,000." (from 164 primary care MDs alone)

Source: ICES (August 2014)
Evaluation results

ISAEC continues to drive down imaging-related costs...

<table>
<thead>
<tr>
<th></th>
<th>Year 1</th>
<th></th>
<th>Year 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual cost avoidance</td>
<td>$517K</td>
<td></td>
<td>$685K</td>
</tr>
<tr>
<td>Annual cost avoidance per PCP</td>
<td>$3,150</td>
<td></td>
<td>$4,175</td>
</tr>
</tbody>
</table>

- “The overall annual costs for all LBP-related imaging tests ordered by physicians enrolled in the ISAEC pilot project fell by another 5% during year 2 of follow-up.”
- “Overall, it appears that the changes in test ordering among ISAEC physicians that were evident in the first year of follow-up have been maintained into the second year.”

A note about the costing methodology:
- The OHIP costs for x-ray include both professional and technical fees.
- Hospital cost estimates for CT and MRI were based on $850/MRI and $400/CT – figures which came from a survey of private lab prices and conversations with radiologists.
- The costs from year 2 of follow-up were up-weighted from 11 to 12 months to allow for comparison with year 1 of follow-up.

Source: ICES (May 2015)
Conclusion - ISAEC

- Utilizing patient specific multi-dimensional risk and symptom stratification to provide the right care, at the right time, by the right provider

- Supported by a network based interprofessional shared care model of care

- Provides value to all stakeholders

- Adaptable to regional needs / scalable
Standardized components for MSK models of care

- MSK model implementation will be modular and based off a common set of core requirements.
- The agreed upon core requirements will be put in Ministry-LHIN Accountability Agreement.
- The Ministry will work with LHINs/providers to have these core components in place at maturity.

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
</tr>
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<tbody>
<tr>
<td><strong>PATIENT PRESENTS TO PRIMARY CARE</strong></td>
<td>PCPs receive additional training and education in MSK assessment and management based on the specific needs of each clinical model (e.g. ISAEC, primary care imaging pathways).</td>
</tr>
</tbody>
</table>
| **REFERRAL AND INTAKE**                     | Central intake: one point of contact for all referrals  
  Triage that follows standardized risk assessment and prognostic protocols:  
  - Intelligent e-referral automatically matches the patient to the next most appropriate and available inter-professional care provider.  
  - Streamlined access to networked specialists and diagnostics when indicated. |
| **INTER-PROFESSIONAL ASSESSMENT & MANAGEMENT** | Secondary assessment by a specially-trained inter-professional care providers, functioning at full scope of practice.  
  Inter-professional care providers assess patients within 2 weeks of referral.  
  Standardized assessment tool used to determine patient care pathways, management and self-management plans (specific to each clinical area, e.g. spine). |
| **SURGICAL CHAMPIONS**                      | Surgical champion* identified and included as part of the inter-professional assessment and management team.  
  Surgeons accept and book procedures for patients that have gone through central intake.  
  Intelligent e-referral matches the patient to the next available surgeon (default); however, also allows for patient to select a surgeon of their choice. |
| **DATA COLLECTION AND PERFORMANCE**         | Electronic data capture and reporting of standardized indicators, including PROMs, that will facilitate performance monitoring and program improvement.  
  All LHINs commit to a wait time target (from referral to first consult). |

*Includes orthopaedic surgeons and neurosurgeons for spine.
Balancing provincially standardized clinical models with LHIN/local flexibility in service delivery

- Achieving provincial scale of MSK central intake and assessment models will be LHIN-led, guided by clinical advice
  - ...allowing for local flexibility in service delivery models and
  - ...ensuring fidelity through standardized components based on existing best practices

- Acknowledging LHIN priorities for 2017/18, implementation supports will be available (e.g. the Adopting Research to Improve Care (ARTIC) program).

- The ministry will meet with LHINs and their local partners to determine capacity and readiness to implement MSK central intake and assessment models. This assessment will inform appropriate phasing of implementation.
A LHIN readiness assessment will enable successful, phased implementation

The approach to assess LHIN readiness to implement MSK intake and assessment models has been vetted by LHIN ELT:

- **March 2017**
  - Launch
  - Presentation at LHIN ELT on planned implementation.
  - Develop LHIN Readiness Assessment Criteria.

- **April 2017**
  - LHIN Consultation
  - MSK Executive Committee and key informants advise on readiness assessment.
  - Share guidance on readiness criteria.

- **May-June 2017**
  - Plan Implementation
  - Discuss readiness for implementation with LHINs & clinical teams.
  - MSK Executive Committee advise on phasing of implementation based on LHIN readiness.

- **July 2017**
  - Funding and Waves
  - Determine funding.
  - Announce implementation waves.
**Proposed Approach to LHIN Readiness Assessment**

- LHIN-specific discussions will focus on the following themes:

<table>
<thead>
<tr>
<th>Proposed Readiness Criteria Themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. LHIN capacity to oversee implementation of an MSK central intake and assessment model.</td>
</tr>
<tr>
<td>2. Local health system (health service provider) capacity to implement an MSK central intake and assessment model including the ability to recruit and train inter-professional clinical resources.</td>
</tr>
<tr>
<td>3. Existing processes and systems to support centralized referrals (e.g. electronic or manual data capture/reporting methods).</td>
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<tr>
<td>4. Presence of known, or ability to identify a clinical and patient champions to support “system change”, lead implementation and engage colleagues (e.g., orthopaedic surgeon, neurosurgeon, radiologist, primary care, patients).</td>
</tr>
<tr>
<td>5. Providers and administrators commitment to functioning in shared care models and meeting wait times targets, including patient support for self-management across the continuum.</td>
</tr>
<tr>
<td>6. Capacity to link intake models with available programs, resources or networks to support non-surgical patients in the community.</td>
</tr>
<tr>
<td>7. Ability to leverage an existing regional orthopaedic strategy, leadership structure, or central intake model.</td>
</tr>
<tr>
<td>8. Commitment to require interprofessional education and knowledge transfer and exchange.</td>
</tr>
<tr>
<td>9. LHIN commitment to work with a defined project management team.</td>
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</tbody>
</table>

*NOTE: For ISAEC, specific additional readiness criteria exist*
# ISAEC – Provider Implementation Readiness

| PRIMARY CARE | • PCPs trained through a funded CME-accredited education module in low back pain assessment and management.  
• Trained in ISAEC referral process and criteria  
• Commitment to shared-care model and continuum of care (e.g. f/u 2 weeks after ISAEC assessment) including patient support for self-management of LBP |
| ---------------------------------- |
| REFERRAL AND INTAKE | • Centralized PCP referral portal with standardized referral form  
• Central / Provincial Intake Office provides one referral entry point and books patients for their community based ISAEC assessment |
| INTER-PROFESSIONAL TEAM | • Rapid low back pain assessment (< 2 weeks) provided by specially-trained Advanced Practice Clinicians (APCs)*, which are either chiropractors or physiotherapists  
• Funded training for APC to learn standardized, evidenced-based management and referral protocols  
• Hybrid models for service delivery locations (i.e. where will patient's be seen etc)  
• Accountability of APCs to program quality and KTE  
• Additional training of Practice Leader* (PL) with directive powers from surgeons and co-location (i.e. space/location for assessment), regional education and quality assurance; reporting to centralized network for performance management, program improvement, and KTE |
| SURGICAL CHAMPION | • A local surgical champion(s) who commits to seeing patients referred from PL within 6 weeks, providing case management support for complex cases, regional program education and quality assurance |
| DATA COLLECTION | • Agreement for PROMS and case management data to be reported into a centralize case management database used for performance management, program improvement, and KTE |

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*Specialized, evidence-based ISAEC training for PL and APCs provided  
** Self management tools include online video exercise modules, as well as downloadable illustrated exercise pamphlets for patients  

Courtesy of MOHLTC
Expand ISAEC Operations: 5 LHINS 2017/18
Region 1: Champlain LHIN

Improve LBP management in the Champlain LHIN by:
1. Providing LBP patients with timely access to assessment and a shared-care management
2. Providing LBP patients with streamlined access to specialists and DI services when indicated

Implementation priorities...

- Mentor ISAEC Clinic Sponsor located at The Ottawa Hospital (TOH) on ISAEC processes and model of care
- Recruit and train remaining dedicated spine surgeons at TOH (up to 6 spine surgeons)
- Streamline ISAEC PCP referral and patient/APC matching process
- Recruit ISAEC Practice Leader(s) in Ottawa
- Leverage local support to recruit up to 1600 PCPs across the Champlain LHIN (MDs and NPs)
- Select clinic locations and recruit new regional Advanced Practice Clinicians (as needed) leveraging existing infrastructure
- Deliver PL (and APC) onboarding/training
- Deliver PCP onboarding and training
- Scale ISAEC infrastructure to enable opening of ISAEC clinics across the Champlain LHIN

Clinical Sponsorship:
Dr. Eugene Wai, Spine Surgeon (QBP panelist)
ISAEC’s Champlain LHIN Network

Community-based and FHT-based APCs in regional networks to service PCPs

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Internal referral to hospital-based Practice Leader (PL) when indicated—for surgical assessment, diagnostic imaging and advanced conservative management (if indicated)

Patient referral to ISAEC by PCP—LBP assessment, education and follow-up by a specially trained, community-based and FHT-based Advanced Practice Clinicians (APC)

APC providing ISAEC services from a Family Health Team (FHT)
ISAEC’s Clinical Sponsors

Clinical sponsorship by local spine specialists

Clinical Sponsor (HNHB LHIN)
Dr. Brian Drew

Clinical Sponsor (TC LHIN) / Clinical Champion
Dr. Raj Rampersaud

Clinical Sponsor (NW LHIN)
Dr. David Puskas

Clinical Sponsor (Champlain LHIN)
Dr. Eugene Wai
Standardized, best practices and processes to bridge between 1\(^0\), 2\(^0\), 3\(^0\) care.

Box 1. Patient
Acute / Sub-Acute presentation of MSK pain:
Web-based portal for Education and Self-Management, Screening Flags

Box 2. Patient Self-referral

Box 3. Community-based health care
3a. Primary care practitioner[PCP]
- Assessment
- Management
- Patient education and goal-setting

3b. Focused MSK Care by:
1. Focused Practice Family physician
2. Extended role the Allied health
   ISAEC - MSK
- Assessment
- Management
- Patient education and goal-setting

Box 4. Referral when indicated by assessment

Box 5. Specialist-based health care
DI*
- Box 5a. Surgery
- Box 5b. Rheumatology
- Box 5c. Psychology/Psychiatry
- Box 5d. Physical Medicine/Rehab
- Box 5e. Pain Specialist
- Box 5f. Osteoporosis Specialist

Box 5. Specialist-based health care

Informatic Support / Integration

ISAEC – stakeholder value
Patient:
Access, education, self-mgmt., appropriate care
Primary Care:
Access, education, shared-care
Specialist:
Access to shared care, appropriate and timely referrals, practice improvement
System:
Standardization, quality (incl. patient level metrics) appropriate health care utilization, cost-avoidance


* Diagnostic Imaging / ER was not in scope for the QBP discussion, but a key opportunity for MSK reform
Thank you
Questions?