**MODULE 2: Determining FLS’s clinical setting and optimizing the local FLS team**

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| **IMPORTANT: Resources to review** |
| Essential Elements | [**Essential Elements**](https://fls.osteoporosis.ca/wp-content/uploads/Osteoporosis-Canada-Essential-Elements-FINAL-April-2021.pdf) |
| Webinar | [**The Effective Model of Care to Close the Care Gap**](https://www.youtube.com/watch?v=2kY2Y03VGEQ&feature=youtu.be)Presented by: Dr. Sonia Singh, MD, MHSc |
| Appendix H of OC’s FLS toolkit | [FLS-TOOLKIT-App-H.pdf (osteoporosis.ca)](https://fls.osteoporosis.ca/wp-content/uploads/FLS-TOOLKIT-App-H.pdf) |

In Canada and internationally, all FLSs have started within orthopaedic settings:

* inpatient orthopaedic ward only **OR**
* outpatient orthopaedic clinics only **OR**
* both inpatient and outpatient ortho settings

In most jurisdictions, the usual path to full access to FLS for all fragility fracture patients includes:

1. A united team of FLS champions supports the implementation of the region’s first FLS “pilot” (for lack of a better term). This will require the hiring of a dedicated FLS coordinator (typically a nurse).
2. The FLS pilot is implemented in orthopaedic setting (inpatient only, OPD only or both inpatient and OPD) and data is collected to demonstrate the clinical effectiveness of the new prototype. It is often helpful to start small rather than taking on too much with the initial pilot.
3. The FLS prototype proven effective for that region is gradually expanded to other orthopaedic hospitals.
4. If the initial FLS pilot is limited to only inpatients or only outpatient setting, the FLS prototype will need to be expanded to the other clinical setting at some point.

Whether your FLS pilot will reach orthopaedic inpatients only, OPD only or both inpatient and outpatient will depend on:

* your budget
* the volume of fracture patients seen at your hospital. As a rule of thumb, you can estimate 1 FTE will be needed for your FLS coordinator for approximately 500 fracture patients seen at your hospital. This estimate is dependent on:
	+ the intensity of your FLS model (e.g. 2i vs 3i)
	+ how well supported your FLS coordinator will be (e.g. an FLS coordinator who has access to clerical support will be able to devote their time exclusively to their clinical tasks whereas an FLS coordinator without any clerical assistance will need to spend part of their time doing any needed clerical work).

Knowing the setting where your FLS will be located will be helpful to help determine the optimal membership for your FLS team.

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| **Possible FLS options considered by your team** |
| **FLS model A** | **Assets/Opportunities/Drawbacks from the local FLS team’s perspective** |
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| **FLS model B** | **Assets/Opportunities/Drawbacks from the local FLS team’s perspective** |
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| **FLS model C** | **Assets/Opportunities/Drawbacks from the local FLS team’s perspective** |
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| **The FLS model selected by your initial FLS team (this decision may be revisited later if your situation changes)** |  |
| A very important prerequisite to the implementation of an FLS is a committed local FLS team. The most effective FLS teams are multidisciplinary in nature and typically consist of:1. at least one physician with expertise in osteoporosis (typically a general internist, endocrinologist, rheumatologist, geriatrician or family physician with interest in osteoporosis). This physician will typically serve as the new FLS’s Medical Lead.
2. one or more orthopaedic surgeons receptive to the implementation of an FLS at their hospital
3. other stakeholders who might include ortho nurses, ortho managers, allied health care professionals, healthcare administrators, local family physicians, patient partners, etc. For patient partners, you might consider contacting Osteoporosis Canada’s COPN (Canadian Osteoporosis Patient Network) at copn@osteoporosis.ca.

The importance of having members on your FLS team who are in a position to influence decisions related to the implementation of a new program/service cannot be overemphasized. Deliberately seek out passionate individuals who might have leadership roles within your healthcare system, at all levels of the organization (local hospital, district health authority and provincial Ministry or Department of Health). Engage decision makers early and often. Invite them to partner with you to champion FLS.You might consider broadening out your reach to include stakeholders with responsibilities beyond just orthopaedics and osteoporosis care. Consider individuals who sit on committees where the post-fracture care gap and/or FLS might become a topic of discussion such as quality improvement committees, patient safety committees, etc. There may be a need for you to offer a formal presentation on FLS to some groups or committees. OC may be able to provide assistance. Contact us at FLS@osteoporosis.ca. |
| **Other stakeholders who should be invited to participate in our local FLS team and their anticipated role**  | **Plan or person responsible for connecting with this stakeholder** |
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| **General FLS staffing details – it will be particularly helpful to have the input of the FLS’s medical lead in the below decisions.** |
| **Who will your FLS hire to be the FLS coordinator? Registered/licensed practical nurse? RN? Nurse practitioner?****Annual salary (with benefits included) for 1.0 FTE for your selected FLS coordinator. Please adjust to the specific FTE allocation for your FLS:\_\_\_\_\_\_\_\_\_\_\_\_** *NOTE: There is no need to cover replacement costs for the position. The FLS will not incur any replacement costs whenever the FLS coordinator is absent, e.g., for vacation.* **Annual salary (with benefits included) for 1.0 FTE clerical support position for the FLS. Please adjust to the specific FTE allocation for your FLS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_****How do you anticipate that the remuneration for the FLS medical lead might be covered?** **Have you identified a work space, preferably close to the orthopaedic services, for your FLS coordinator to work from, including the necessary accessories (computer, phone, etc.)? They will need a space to meet with patients and to do follow-up phone calls with them.** |

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| **General roles and responsibilities within the FLS** |
| **Task?** | **Who’s responsible?** | **General details** |
| **Identification** |  |  |
| **Investigation** |  |  |
| **Initiation of treatment** |  |  |
| **Monitoring of the patient** |  |  |
| **Monitoring of the FLS** |  |  |

The above may change once the more detailed FLS design is completed with input from the FLS’s medical lead (Module 3).

OC may be able to provide assistance, please contact: FLS@osteoporosis.ca .