Ontario Health

Chronic Obstructive Pulmonary Disease Integrated Clinical Pathway

Action Plan Template

October 16, 2023

Ontario Health

Contents

1.0 Background

Chronic obstructive pulmonary disease (COPD) is a progressive lung condition characterized by irreversible airflow obstruction and progressive shortness of breath, hindering the ability to carry out daily activities and reducing quality of life. More than 1 in 10 people in Ontario have COPD and spirometry is the only way to confirm a diagnosis. However, spirometry testing has been declining, with only 40% of people living with COPD in Ontario receiving testing in 2021/22, down from 45% in 2016/17. COPD has significant implications for health care costs and system utilization. As the disease progresses, many people living with COPD have more frequent or severe acute exacerbations, which can lead to emergency department visits and hospital admissions. Income status is linked to COPD prevalence and health care utilization, with higher rates observed in lower-income neighbourhoods. Primary and community care settings are crucial for delivering well-coordinated and high-quality COPD care.

In November 2022, the Ministry of Health (ministry) released "The Path Forward" noting the opportunity for improvement in patient quality of life and disease management for people living with COPD (and other chronic conditions) through proactive, coordinated, and integrated care. Early identification and testing of symptomatic individuals is critical to ensure they receive the most appropriate level of care. Early intervention and management in combination with specialized respiratory care and pulmonary rehabilitation (as appropriate) can reduce the risk of acute exacerbations and associated emergency department (ED) visits and hospitalizations.

In 2019, Ontario Health Teams (OHTs) were established to integrate population-level care across regions. Supported by the ministry, a cross-functional team at Ontario Health has secured funding to implement an integrated clinical pathway (ICP) for COPD, focusing on three key priorities:

- Diagnosis confirmed with spirometry
- Appropriate referral to specialized respiratory care
- Appropriate referral and access to pulmonary rehabilitation

These priority areas align with the COPD Care in the Community for Adults quality standard, which encompasses 14 quality statements for diagnosis, management, and treatment of COPD in community-based settings. The focus on quality statements 1, 8, and 9 are a starting point given their potential to improve patient experience and outcomes (including acute care utilization). OHTs will be expected to **leverage the entire COPD quality standard** to strengthen care in primary and community care settings. There are key dependencies between the quality statements that OHTs will need to consider when developing and operationalizing their approach to integrated care for people living with COPD. Teams will be expected to implement a COPD ICP to improve care for people living with COPD and track patient outcomes and experience over time. Learnings from this project are expected to inform future decisions around integrated approaches to the design and delivery of care models/services for people living with COPD.

Ontario Health Teams

In collaboration with Ontario Health regions and the Ontario Health provincial COPD project team, OHTs will assess existing COPD health care and community services and identify gaps in care. OHTs typically involve interprofessional teams of primary, home, community, and specialized health care providers,

including patients and family members. They are expected to identify, plan, and implement change initiatives aligned with the COPD quality standard. Active engagement and collaboration between OHT partners from across the care continuum is the foundation for the effective design and successful implementation of an integrated approach to COPD care.

Action Plan

The purpose of this **Action Plan** is to:

- Guide OHTs on the critical pieces for building and implementing an Integrated Clinical Pathway (ICP) for COPD that aligns with the COPD quality standard and can be launched in fiscal year (FY) 2024/25,
- Provide OHTs with insight into the roles and responsibilities for participating as a demonstration program for an ICP for COPD

The Action Plan will be reviewed to ensure that the proposed change initiatives are aligned with best evidence. The assessment approach will also help the Ontario Health provincial team to better tailor additional supports for OHTs to enable the successful implementation of their ICPs.

Each OHT's Action Plan should describe initiatives aligned with the COPD quality standard, with the goal of strengthening COPD management in primary and community care settings, to improve patient experience and outcomes and ultimately reduce acute care utilization. The completion of the Action Plan should involve relevant OHT partner organizations and Ontario Health regional partners. The Ontario Health provincial team can help answer questions and provide guidance to teams during the completion of the Action Plan.

Funding

Participating OHTs will receive seed funding through a deliverables-based Transfer Payment Agreement (TPA) to plan and implement comprehensive coordinated care for people living with COPD. In addition to seed funding, it is expected that a temporary "no-loss provision" will be granted specifically for participating COPD-Quality Based Procedure (QBP) hospitals for two consecutive years (2024/25-2025/26) as teams implement their change initiatives. Ontario Health continues to work with the ministry to confirm the extension of the no-loss provision to sites that will implement the COPD ICP. As per the approach applied to current in-flight pathway projects, if approved, there will not be any recovery of funds for COPD-QBP volumes completed below baseline over two fiscal years (2024/25 and 2025/26) for the OHTs involved in the COPD ICP. The no-loss provision is intended to ensure that as OHTs work to reducing avoidable acute care utilization, that they will not be subject to recoveries for COPD-QBP volumes not performed.

2.0 Participation Requirements

The following requirements are expectations of teams working to deliver an ICP for people living with COPD successfully. Demonstration programs who have concerns about the scope of these expectations are encouraged to contact OHT Support at OHTSupport@ontariohealth.ca.

Several key participation requirements have been identified for this ICP. Please review and assess your capacity to fulfill these requirements. OHTs (and partner organizations) must:

- Have reviewed the 2023 COPD Care in the Community for Adults quality standard and developed this Action Plan in alignment with it
- Partner with at least one hospital site that currently performs COPD-QBP volumes and receives associated funding

Case for Change

- Have submitted an Action Plan focused on change initiatives that align with key priorities for action (quality statements 1, 8, and 9) with consideration given to the entire COPD quality standard and have the potential to improve patient experience and enable reductions in acute care utilization
- Proposed change initiative(s) described in this Action Plan should:
  - Represent an improvement/enhancement in patient care and/or fill a care gap through better coordination and connectivity between providers and care settings along the care continuum
  - Involve co-design with the OHT Primary Care Network or similar structure within the OHT, if one exists
  - Leverage **existing** remote care management programs and/or other digital/virtual care programming/assets where applicable
- Propose an integrated COPD clinical pathway involving active cross-sector collaboration between OHT members, endorsement by OHT governance structures (as per the Collaborative Decision Making Agreement (CDMA) requirements) and have the mandatory participation of a COPD-QBP hospital as well as primary care, community partners (e.g., community paramedicine, pulmonary rehabilitation, home and community care), and specialized COPD care providers

Collaboration/Involvement

- Collaborate with the primary care sector in the co-design and implementation of the change initiatives identified within the Action Plan, including the identification and integration of a Primary Care Lead[1]

[1] *Demonstration programs are required to identify a Primary Care Lead who is a primary care clinician (e.g., family physician, primary care nurse practitioner, traditional healer).*

- *If the OHT has a Primary Care Network (or similar structure) representing primary care clinicians within the OHT, and/or has an existing Primary Care Lead (or Clinical Lead who is a PC clinician), the Primary Care Network and/or existing Lead should identify a Primary Care Lead for the demonstration program (can be the existing Lead themselves, or a different PC Clinician).*
- *If the OHT does not have a Primary Care Lead or Primary Care Network (or similar structure) that can support in the identification of a Primary Care Lead for the demonstration program, the demonstration program should contact their Ontario*

- Identify and integrate a clinical leader with specialized knowledge in COPD and best practice care for people living with COPD to support implementation of change initiative(s)*

  **NOTE: the individual(s) with specialized COPD knowledge are not required to be within or part of the OHT and can act as an external expert to support the implementation of change initiatives*

- Involve active cross-sector and interorganizational collaboration, including connecting pertinent social services to ensure patients are cared for across the care continuum
- Participate in continuous engagement and team capacity building, including a provincial community of practice that will be supported by Ontario Health

Co-Design/Equity

- Complete the Action Plan, which incorporates co-design principles for the development and implementation of the of change initiative(s). The co-design should include OHT partners, people with lived experience, members of equity-deserving populations (including but not limited to First Nations, Inuit, Métis, and Urban Indigenous (FNIMUI), Francophone communities, members of 2SLGBTQIA+ communities, individuals experiencing housing instability, underrepresented groups, and newcomers to Canada), care partners, and care providers
- Collaborate with Ontario Health region (Clinical, SSPDI, Equity (Indigenous) and French Language Service leads) on an ongoing basis to develop, endorse, and implement the Action Plan [2]
- Embed equity considerations into proposed change initiatives described within the Action Plan to ensure that the needs of equity-deserving populations are met

Measurement and Evaluation

- Collect local performance indicators described in the measurement and evaluation framework (Appendix A) and share data and lessons learned with Ontario Health for Ontario Health-led evaluation of program success (e.g., identify, measure, and report indicators, knowledge sharing, funding/cost components)
- Participate in the collection of patient reported outcome/experience measures (PROMs/PREMs) through an Ontario Health validated digital tool(s) and use data to inform opportunities to improve patient care experiences and outcomes. Sites that have already implemented an alternative electronic platform to collect PROMs/PREMs, must be able to send data to Ontario Health's provincial database, with adherence to all applicable standards (e.g., data standards, privacy)

3.0 Description of Change Initiatives

Health Regions and Ontario Health Regional Primary Care Clinical Lead to help identify an appropriate Primary Care Lead for the demonstration program.

[2] In Ontario, the French Language Services Act (FLSA) guarantees that Francophones have access to services in their language within 27 designated areas across the province. The FLSA requires health service providers to actively offer and deliver services in French, ensuring the needs of Francophone communities are considered during the development and implementation of health programs, policies, and procedures. Additional information to support FLS:

- French language services supports for Ontario Health Teams
- The Active Offer of French Language Health Services online training

Collaborate with OHT partners and Ontario Health regions to complete the following sections of this document. Additional information with increased detail may be requested as a TPA deliverable.

- **Parts 1-2**: These sections provide OHTs with an opportunity to describe the current state of COPD care in their communities. A vision for the ideal future-state for COPD care and services through the identification and implementation of change initiatives that are aligned with the COPD Care in the Community for Adults quality standard should be articulated.
- **Part 3**: This section is used to identify all partners actively collaborating to design and implement the change initiatives outlined within the Action Plan.
- **Part 4**: Demonstration programs are asked to outline how seed funding will be used to support the proposed change initiative(s) over FY 2023/24 and FY 2024/25 based on guidelines around the use of seed funding.
- **Part 5**: Demonstration programs should indicate compliance with the participation requirements, including a confirmation that they have specific leads/individuals from across key sectors and a proposed transfer payment recipient in place to support the implementation of the Action Plan.

Part 1: Describe the Current State of COPD Care

Based on knowledge of the **current model of care** for people living with COPD within the OHT, please answer the following questions:

1. In 1-2 pages, describe the **current state** of the COPD model of care (visuals, flow charts, diagrams and/or appendices can be attached to your submission) from COPD diagnosis (for people clinically suspected of having COPD) to end of life.

   A current state assessment

Quality Standard	**Current State**
Diagnosis confirmed with spirometry: People clinically suspected of having COPD have spirometry testing to confirm diagnosis within 3 months of developing respiratory symptoms.	COPD is diagnosed for some patients based on ability to access spirometry at Ajax Pickering or Oshawa hospitals, and a small handful of other locations in Durham Region.
Comprehensive Assessment People with COPD have a comprehensive assessment to determine the degree of disability, risk of acute exacerbation, and presence of comorbidities near the time of diagnosis and on an annual basis. The severity of airflow limitation, as initially determined by spirometry testing to confirm diagnosis, is reassessed when people's health status changes.	Primary care does this but would appreciate education on standardized tools for their EMRs. Evidence to Practice (E2P) coming early next year and should help.
Goals of Care and Individualized Care Planning People with COPD discuss their goals of care with their future substitute decision-maker, their primary care provider, and other members of their interprofessional care team. These discussions inform individualized care planning, which is reviewed and updated regularly.	Goals of care and cross-sector care coordination is currently done through notes sharing, EPICCare Link, emails and verbal discussions. A cross-sector care coordination tool is an area of opportunity for Durham (i.e. Shared Health Integrated Information Portal- SHIIP)
Education and Self-Management People with COPD and their caregivers receive verbal and written information about COPD from their health care professional and participate in interventions to support self-management, including the development of a written self-management plan.	Patients referred to the current HCCSS telehomecare program receive education from telehomecare RNs Patients referred to respiratory rehab receive education LH, inpatients at LHAP receive education and a COPD action plan from our NP stewardship NP. Additionally, EPIC has education materials and documentation built in.

	Port Perry Medical Associates have a lung health program available which provides education
Promoting Smoking Cessation People with COPD are asked about their tobacco-smoking status at every opportunity. Those who continue to smoke are offered pharmacological and nonpharmacological smoking-cessation interventions.	Telehomecare, respiratory rehab and the Port Perry lung health program provide this. Smoking cessation guidance also occurs during admissions through pharmacists and Ajax COPD stewardship NP.
Pharmacological Management of Stable COPD People with a confirmed diagnosis of COPD are offered individualized pharmacotherapy to improve symptoms and prevent acute exacerbations. Their medications are reviewed at least annually.	Prior to discharge for inpatients our pharmacists review meds Flags in primary care EMRs to review medications regularly E2P (evidence to practice)- developing evidence based EMR tools
Vaccinations People with COPD are offered influenza, pneumococcal, and other vaccinations, as appropriate.	Flags in primary care EMRs to review vaccinations Vaccinations reviewed during admissions
Specialized Respiratory Care People with a confirmed diagnosis of COPD are referred to specialized respiratory care when clinically indicated, after receiving a comprehensive assessment and being offered treatment in primary care. This consultation occurs in accordance with the urgency of their health status.	Specialized respiratory care availability is currently limited in Durham Region in relation to the need.
Pulmonary Rehabilitation People with moderate to severe, stable COPD are referred to a pulmonary rehabilitation program if they have activity or exercise limitations and breathlessness despite appropriate pharmacological management. Available within 1 month of discharge and runs for at least 6-8 weeks. Available at Lakeridge Health Whitby – in-person exercise classes and an 8-week virtual education classes	Average wait time for LH respiratory rehab is 78 days, which is well above the 1-month standard. Geographically, patients close to the physical location of respiratory rehab are served more, with those farther away facing access challenges. It is estimated that of 1100 COPD patients admitted annually, only 200 are referred to respiratory rehab.
Management of Acute Exacerbations of COPD People with COPD have access to their primary care provider or a health care	This is limited and challenging currently. No data, but primary care feel it is a need.

professional in their care team within 24 hours of the onset of an acute exacerbation.	Durham CHC has a virtual resource available.
Follow-up after hospitalization for an Acute Exacerbation of COPD People who have been admitted to hospital for an acute exacerbation of COPD are considered for pulmonary rehabilitation at the time of discharge. Those who are referred to a pulmonary rehabilitation program start the program within 1 month of hospital discharge. In-person follow up with primary care within 7 days of discharge. Specialist, if needed, within 30 days of discharge...sometimes faster.	This is limited in Durham and is a need. Approx 37% receive follow up assessment with a physician within 7 days of discharge. Telehomecare program- RN follow up currently available. New NP virtual remote care monitoring referrals started as of November 14th
Palliative Care People with COPD and their caregivers are offered palliative care support to meet their needs	Early discussions around goals of care are an opportunity for this population. Conversations tend to occur later in disease progression. This is limited and seen as a need in Durham.
Long-Term Oxygen Therapy People with stable COPD who have clinical indications of hypoxemia receive an assessment for and, if needed, treatment with long-term oxygen therapy	It is felt that home oxygen programming in Durham is well accessed and is not a gap.

2. To help us understand the gaps between the current state of your COPD model of care and the COPD Care in the Community for Adults quality standard, please complete the table below. Prior to completing the table, review the quality standard, including:

    - **Each quality statement** and the corresponding **What This Quality Statement Means For People With COPD sections**, which outline the goal for the care that each person living with COPD should be receiving
    - **Definitions**, which provide more detail about terms used within the quality statement (usually to provide clarification about key components of care)
    - **What This Quality Statement Means for Clinicians sections**, which describe how clinicians can support the implementation of the quality statement
    - **What This Quality Statement Means for Organizations and Health Services Planners sections**, which describe how health care organizations, such as OHTs, can support the implementation of the quality statement

    In collaboration with primary, community, specialized, and acute care settings, and people with lived experience, assess the current COPD model of care and answer the questions outlined in the table below for each quality statement. Please provide answers for as many quality statements as possible (bullet points can be used); however, at minimum, responses are

mandatory for the three key priorities for action (bolded below). *If your OHT is uncertain or are unable to answer for a particular quality statement, please explain why (i.e., limited data, lack of funding etc.) (maximum 300 words for each)*

COPD Quality Statement	1. From the perspective of the person with COPD, what are the gaps between care currently being provided through your model of care and each of the quality statements?	2. What barriers make it challenging to bridge each gap you identified or prevent you from providing the care outlined in the quality statement?
***1: Diagnosis Confirmed with Spirometry**	COPD diagnosis with spirometry only occurs for approximately 39% of people with COPD. There are a limited number of pulmonary labs in the Durham region that conduct spirometry, and therefore longer wait times	Additional spirometry equipment and RRT human resources are needed to increase access to PFTs. Primary care providers need a clear list of all available pulmonary labs in the region.
2: Comprehensive Assessment	Primary care providers provide assessment of COPD patients within their expertise and volume capacity. When patients are diagnosed in hospital, spirometry is sometimes available, but is not ideal during an exacerbation. Patients are then referred to their PCP.	Evidence based Tools such as E2P are awaited Access to repeat spirometry is subject to wait times PCPs would value education from Respirologists in Durham
3: Goals of Care and Individualized Care Planning	Patients are receiving the benefits of care providers across sectors giving their best effort to coordinate care, however the full benefit is not realized in one coordinated platform. Patients are introduced to a booklet with a physical “My COPD Action Plan” which can be shared across some sectors as long as the patient does not misplace it	Use of a care coordination platform such as SHIIP- Shared Health Integrated Information Portal would be of benefit to patients and care providers. Ensure consistency of using My COPD Action Plan with the patient and various Health care providers
4: Education and Self-Management	Patients may be able to access educational materials through the internet, a COPD booklet provided to them, the HCCSS telehomecare program and/or the Port Perry Medical Associates	Access to education materials from from the MyChart portal would be of benefit to patients. Increased access to pulmonary rehabilitation and to referrals to

	lung health program, however there are opportunities to enhance this.	HCCSS's telehomecare program would be of benefit.
5: Promoting Smoking Cessation	Patients are able to access smoking cessation resources such as those listed below: Durham Regional Cancer Centre's Smoking Cessation Program, Health811, Primary Care Providers Pharmacies, Public Health, Smoking Treatment for Ontario Patients (STOP) Program, Smoker's Helpline, Talk Tobacco, Cancer Care Ontario, Canadian Cancer Society, Lung Health Foundation, The Canadian Lung Association	Ensuring resources reach the patient to promote awareness of and/or access to smoking cessation programs in region
6: Pharmacological Management of Stable COPD	Patients can benefit from treatment plans and medications guided by the most up-dated Canadian Thoracic Society and GOLD guidelines, however access is often a challenge	Continuation of the Nurse Practitioner led COPD remote care monitoring program Access to an in-person COPD outpatient specialty clinic, with ability to do outreach and enhance care accessibility.
7: Vaccinations	Patients are able to receive vaccines at PCPs and community pharmacies Some patients face financial, mobility and/or transportation challenges to get to these locations. Prevalence of COPD is significantly higher in lower-income neighborhoods (~ 8% in highest income locations versus 14% in lowest income locations)	Availability of free, accessible transportation Ensuring patients are aware of where and when vaccines are available and have the tools to track their immunization
***8: (Appropriate Referral to) Specialized Respiratory Care**	Patients are often referred but waiting for 3-4 months for an appointment with a respirologist or other provider with COPD expertise. There are a small number of respirologists in Durham Region	Continuation of the Nurse Practitioner led COPD remote care monitoring program Access to an in person COPD outpatient specialty clinic, with ability to do outreach and enhance care accessibility.

	A new NP stream of the COPD telehomecare program has begun in November showing some promise to increasing access to specialized monitoring and care virtually.	
***9: (Appropriate Referral and Access to) Pulmonary Rehabilitation**	Patients are referred to pulmonary rehab by a variety of HCPs, however the referral rate is low and clinics are only in person at one Lakeridge Health site. Wait times are high at approximately 78 days, which is below the standard.	Access and wait times for pulmonary rehabilitation can be improved with the provision of virtual classes and satellite site offerings.
10: Management of Acute Exacerbations of COPD	Patients are able to access a number of locations for AECOPD. However ready access to a service to avoid admission is often lacking and subject to capacity. Patients have HCCSS, virtual COPD clinic, Paramedicine Services, walk-in clinics, emergency services, and the local Emergency Departments available for when acute exacerbations are not manageable at home Patients are introduced to the My COPD Action Plan and educated regarding what to do in the event of an acute exacerbation	Continuation of the Nurse Practitioner led COPD remote care monitoring program Access to an in person COPD outpatient specialty clinic, with ability to do outreach and enhance care accessibility. Consistent reinforcement of the use of the My COPD Action Plan for acute exacerbations Ensure education provided during various patient-HCP encounters (i.e., appointments, pulmonary rehab classes, etc.)
11: Follow-Up After Hospitalization for an Acute Exacerbation of COPD	Patients are sometimes able to follow up quickly with a primary care provider, and ideally has been referred to the NP COPD RCM program.	Continuation of the Nurse Practitioner led COPD remote care monitoring program Access to an in person COPD outpatient specialty clinic, with ability to do outreach and enhance care accessibility. Increasing capacity and accessibility to pulmonary rehab.
12: Pulmonary Rehabilitation After Hospitalization for an Acute Exacerbation of COPD	Some patients are referred to the pulmonary rehabilitation program after hospitalization, but the rate is low, and patients tend to come from the municipalities closest to the physical	Limited amount of physical space in pulmonary rehab exercise room

	clinic (which resides at Lakeridge Health Whitby)	Location of pulmonary rehab (difficult for some patients to have transportation to LHW) Increase capacity by offering virtual and satellite classes for patients who have access issues
13: Palliative Care	Patients do not often experience early conversations about palliative goals of care with their health care provider	Education for primary care providers and co-run clinics for COPD and palliative care would be of benefit. Increase ability and comfort for HCPs to have discussions with patients about palliative care via education
14: Long-Term Oxygen Therapy	Readily available via Community Respiratory Services (perform home oxygen assessment and supply necessary equipment) - 24/7 support available to patients	Increase awareness of this service amongst HCPs

*** Key priorities for action**

Part 2: Proposed Change Initiatives

1. The COPD quality standard outlines what high-quality care looks like related to the diagnosis, management, and treatment of COPD in community-based settings. This quality standard has been summarized into a pathway (available on Quorum), which describes key components of each quality statement and a collaborative approach across settings (including primary care, community care, specialized respiratory care, and acute care), emphasizing the foundational and central role of primary care.

   The COPD quality standard pathway should be used to help you envision an **ideal future-state model of care** for people living with COPD in your OHT. Refer to this pathway and consider what COPD care needs to look like within your OHT to achieve this ideal future-state.

   Please answer the following questions to help you envision your future-state for COPD care and identify change initiatives. In your answers to the questions below, please describe how existing remote care management programs and/or other digital/virtual care programming/assets (eConsult, eReferral, virtual visits, telemedicine) will be leveraged.

   a) **Identification of people living with COPD:**

   - How will people with suspected COPD be identified across the integrated clinical pathway (e.g., in primary care, at hospital discharge, people who are unattached, sub-populations that may be disproportionately affected by social determinants of health [e.g., FNIMUI communities, individuals in lower-income quintiles, etc.])? *(maximum 300 words)*

     Patients with suspected COPD will be identified through visits to primary care provider offices, emergency department visits, hospital admissions, community paramedicine visits, pulmonary rehabilitation, the North Durham lung health program or visits to community health centres. From there patients will be referred on to spirometry testing or have it completed in hospital.

     Discussions with nurses in the Mississaugas of Scugog Island First Nation (MSIFN) have raised awareness of this initiative, and they will work within their Health Centre and their lead physician to identify patients.

   - Where will people with suspected COPD go to receive a spirometry test (including the interpretation of spirometry results)? *(maximum 300 words)*

     Patients will receive spirometry testing in one of Durham's pre-existing locations* or can be referred through e-Referral to our expanded capacity spirometry services, which will be available through our in-person COPD clinic, respiratory rehabilitation and to patients who are being discharged from hospital. Spirometry equipment will be mobile to ensure ability to perform the test in various locations, increasing efficiency of use. Additionally, consultation with MSIFN nurses and lead physician have indicated that expanded spirometry testing hours can be made available in north Durham through education for nurses working in conjunction with a current respiratory therapist in the lung health program.
     * Patients can have spirometry testing and interpretation of spirometry results

performed at the following Durham locations: Lakeridge Health Oshawa and Ajax-Pickering Pulmonary Function Lab, the Oshawa Clinic pulmonary function lab, Durham Pulmonary and Sleep Services (Ajax), Port Perry Medical Associates, and Pickering Pulmonary Function Lab.

b) **Management of people living with COPD in primary and community care settings:**

- How can primary and community care be better supported to provide COPD care in alignment with the COPD quality standard pathway? *(maximum 300 words)*

The Durham primary care advisory council have expressed a desire for ongoing education from our Durham Respirologists group. This was discussed to take place in town hall format allowing for information-sharing, and question/answer format. E2P resources were also eagerly awaited to support care.

An ongoing NP led telehomecare remote care monitoring program, along with the addition of an in-person COPD clinic is also seen as a supportive factor to primary care and the community.

Two other suggestions made were 1) a bookable timeslot for primary care to consult with a COPD specialist virtually, and 2) the ability to eRefer patients to a centralized referral model, such as the current Health Care Connect service for Mental Health patients. The first suggestion is not currently feasible due to lack of specialist resources however specialist respirology physicians are planned to partner with the North Durham lung health program to add expert consultation and clinic offerings there. The centralized eReferral model is proposed within this submission as an above $400K budget option.

- What digital, virtual, and/or remote care management tools or programs will be leveraged to support people living with COPD in primary and community care settings (e.g., remote care monitoring, the Evidence2Practice program when available for COPD in January 2024, etc.)? *(maximum 300 words)*

  - Several digital, virtual and remote care monitoring tools will be leveraged to support people living with COPD. These include:
  - Aetonix remote care monitoring platform: The RN and NP streams of the telehomecare program leverage Aetonix, which allows patients to take biometric readings (vital signs, oxygen saturations, etc) and to submit them via an app to be reviewed by an RN or Nurse Practitioner.
  - COPD E2P tools for primary care EMRs and Lakeridge Health's CIS.
  - Ocean eReferral will be utilized to receive referrals to the in-person COPD clinic, Pulmonary rehab and for spirometry.

- EPICCare Link currently provides access to community partners and primary care to view our patient care records for care continuity.
- EPIC's MyChart will also be used to provide patient education and other information to patients
- Finally iPADs will be used to collect patient reported outcome measures (PROMS) for the ISAAC platform

- How can people living with COPD be followed up with and managed in primary and community care following an acute exacerbation of COPD and/or an acute care visit? *(maximum 300 words)*

  It is proposed that patients who have an ED visit or are admitted to hospital will be referred through the HCCSS telehomecare program. Moderate to severe COPD patients will be streamed to the Nurse Practitioner remote care monitoring stream. Through this stream the NP will work with Community Paramedicine to complete home visits for a patient who needs assessment and/or intervention.

  In addition eReferrals will be opened up for an in-person COPD clinic where patients can be seen post admit/ED visit for follow up with an NP, respirologist, respiratory therapist and pharmacist.

  Finally, a respirologist physician will partner with Port Perry Medical Associates' lung health program to offer COPD clinics there a few times per month.

c) **Appropriate referral to specialized respiratory care:**

- How can primary and community care be better supported to make appropriate referrals to specialized respiratory care (when clinically indicated, as per the definition in quality statement #8)? *(maximum 300 words)*

  Through the use of Ocean eReferral, primary care and community care will be able to see the referral criteria. Education sessions offered regularly will help to reinforce those criteria.

  However, if additionally approved, the primary care advisory council have expressed that knowing where to refer is sometimes overwhelming. With referrals for telehomecare, an in-person clinic, spirometry and respiratory rehab, this is understandable. To enhance the patient and provider experience, a centralized eReferral process is recommended and proposed.

- What digital, virtual, and/or remote care management tools or programs will be leveraged to support appropriate referral to specialized respiratory care (e.g., eConsult, eReferral, virtual visits, telemedicine)? *(maximum 300 words)*

  The in-person COPD clinic, spirometry and respiratory rehabilitation will all be accessed through Ocean e-Referral. Criteria will be fully visible in Ocean.

Referral to the HCCSS telehomecare program remains as a faxing process at this time, however it is well-engrained in practice.

d) **Appropriate referral to pulmonary rehabilitation:**

- When people living with COPD are referred to pulmonary rehabilitation, what can be done to support people in enrolling and participating (e.g., where there are limitations around availability of pulmonary rehabilitation, will virtual options be leveraged)? *(maximum 300 words)*

  As all COPD patients who are hospitalized today are not being referred to pulmonary rehabilitation, this will be promoted and potentially auto-referred, if possible. Our current pulmonary rehabilitation service has longer wait times of over 2 months and are located at one hospital site in Whitby. Human resources for pulmonary rehabilitation will be increased and classes will be offered in a more geographically-accessible format.

  Through the use of Microsoft teams, exercise classes will be offered virtually to patients in their homes, which offers the ability provide some hearing and language accessibility options. Patients will not require specialized exercise equipment in their home and can participate through any phone, tablet or computer.

  In addition, classes will be offered at satellite in-person locations with support from Community Care Durham's accessible transportation service Home at Last.

  Input from MSIFN was that a satellite location at Lakeridge Health Port Perry, with available transportation support will meet needs for accessible care for their community within an existing familiar environment.

2. Based on the identified gaps and barriers (Part 1) and your answers to the questions above, please identify and describe change initiatives that you will implement as part of the COPD ICP below. *(maximum 300 words for each)*

Description of Change Initiative • Please describe in detail the key components of the initiative and how resources will be used to improve care for people living with COPD.	**Relevant quality statement(s)**	**How will the change initiative reduce the likelihood of acute care visits by improving COPD management in primary and community care settings?**	**How will the change initiative facilitate integration across settings? Clearly describe the relative roles of primary care, community care, specialized respiratory care, and acute care in developing and implementing the change initiative.**
1. Increase access to diagnostic spirometry at Lakeridge Health (outpatient areas) by increasing respiratory	QS 1	Earlier identification of patients with COPD with subsequent referrals to appropriate care for the individual patient.	Primary and community care: early identification of COPD and referrals to specialized respiratory care made as soon as possible

therapy human resource and mobile spirometry equipment.			Outpatient/community care: provide access and interpretation of spirometry
2. Increase capacity for in-person and virtual pulmonary rehabilitation by increasing exercise therapist human resourcing, equipment to allow the offering of virtual exercise classes and securement of satellite locations in locations across Durham that will encourage participation of all populations (i.e. churches, community centres, Lakeridge Health Port Perry, Community Care Durham locations or other)	QS 3, 4, 5, 9, 12,	Offers patients another opportunity for education and self-management to assist in mitigating COPD exacerbations. Exercise therapy also improves quality of life and reduces breathlessness.	Primary care: Provide referrals to respiratory rehab to COPD patients Acute care: At discharge from an acute setting, HCPs will be able to refer to the in-person and virtual pulmonary rehabilitation sessions to assist patients with managing their COPD at home Hospital site-located community rehab care: Offer accessible respiratory rehabilitation services
3. Create, provide, and maintain an in-person COPD clinic at Lakeridge Health. Clinic will be staffed with an NP, Respirologist, Respiratory therapist and Pharmacist. Clinic visits will include review of an eHOMR score for consideration of co-visits with palliative care services. Additionally, add a COPD clinic to North Durham through partnership	Q 2, 3, 4, 5, 6, 7, 8, 10, 11, 13	In-person clinics will add timely, expert post discharge follow up. The clinic will be supported by a respirologist and pharmacist to ensure spirometry, health teaching and medication reviews are all offered. Having an in-person clinic can also offer an alternative to an ED visit if a patient needs an in-person treatment or assessment that can be done clinic rather than in the ED.	Hospital site-located community clinic: This clinic will assist with providing timely follow up post discharge and diverting visits from the ED. The clinic will be able to streamline services/tests provided to patients at a “one stop shop” in-person COPD clinic Primary care: Collaborate/communicate with COPD clinic as needed Acute care/ED: Provide referrals at discharge to COPD clinic. See patients who require emergent or acute care that

between LH respirologist and Port Perry Medical Associates			cannot be managed appropriately in a clinic
4. COPD Telehomecare remote care monitoring- NP stream	QS 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14	Patients will be supported immediately post-discharge from hospital. They will receive education re: managing COPD flare up, use of the medications, etc. Current literature indicates that patients have less readmission rates/return visits to ED when involved with a virtual COPD clinic.	Acute care: Provide referrals at discharge to COPD telehomecare NP stream Hospital site-located NP RCM stream: Patients with moderate to severe illness will be streamed to the NP monitoring stream. The NP will reinforce patient education for managing COPD at home as well as make appropriate adjustments to medications and order appropriate bloodwork/tests. The NP will work with the patient's health care team to support the patient at home. Referrals to be made to appropriate services/programs/healthcare providers. Primary care: Collaborate/communicate with COPD clinic as needed
5. Increase capacity for primary care to provide COPD care via education sessions	QS 2, 3, 4, 5, 6, 7, 9, 10, 11, 12, 13, 14	COPD patients can be identified and referred earlier when presenting to their primary HCP. Enhances primary HCP comfort in caring for patients with COPD.	Primary care: Partner to provide insight into learning needs, and regularly meet with DOHT COPD team to review plans to meet those needs. Specialist respiratory care: Provide education sessions in a town hall format regularly to Durham primary care providers through partnership with the primary care council.
If additionally funded: Implementation of a centralized eReferral service for COPD. Clinicals	QS 1, 4, 6, 8, 9, 11, 12, 13, 14	By supporting coordination of referrals to the appropriate services, patients will receive more	Primary care: refer patients centrally through eReferral

and clerical staff will intake referrals, touch base with patients, and then ensure coordination of all service referrals required (e.g. spirometry, in-person COPD clinic, rehab, etc.)		comprehensive, coordinated care, therefore contributing to ED avoidance.	Hospital based team: oversee a centralized referral management service that assists with ensuring a connection to other available services Primary care providers have expressed being confused with the various services and referral options for chronic conditions such as COPD. By centralizing the referrals, care will be better coordinated for patients. An added benefit is that ongoing support for such a service may allow for expansion to other chronic conditions in Durham, provided capacity allows.

3. In the context of administrative functions (e.g. project management resourcing, governance, overall leadership), please elaborate on how you will plan to leverage synergies and lessons learned (from past ICPs where applicable) to enable concurrent implementation of multiple ICPs (heart failure and COPD). *(maximum 300 words)*

   Having implemented the CHF integrated care pathway already, we have already been able to leverage some lessons learned in the preparation of this proposal. Community partnerships have strengthened and allowed a stronger base of input. Our CHF telehomecare RCM leadership team has been key to the action planning for our COPD RCM leadership team. The implementation leads at Lakeridge Health, Community paramedicine and Home and Community Care have much overlap, and the project management, data, and information technology professionals are the same across projects.

4. In the context of operational functions (e.g. clinical leaders, decision support and data, technology enablers, communication), please elaborate on how you plan to leverage synergies and lessons learned (from past ICPs where applicable) to support patient populations that may have both heart failure and COPD. *(maximum 300 words)*

   Through implementation of the CHF initiative we have learned the interconnectedness of referral pathways and the need for bi-directionality. It is anticipated that we will see the same between CHF and COPD, and will need to map new pathways as they occur.

   We anticipate some lessons will be learned from our COPD implementation that will allow ongoing improvement of our CHF pathway as well. In particular, the enhanced engagement of our primary care advisory council has been fulsome and rewarding this time around.

5. In the context of the proposed change initiatives, please describe past and planned future efforts (e.g., patient centered co-design, social supports, and community partnerships if applicable), to better serve priority populations (including but not limited to First Nations, Inuit, Métis, and Urban Indigenous (FNIMUI), Francophone communities, members of 2SLGBTQIA+ communities, individuals experiencing housing instability, underrepresented groups, and newcomers to Canada). For additional information on social determinants of health, see Appendix B. *(maximum 300 words)*

   The Durham OHT and partners involved in the planning for the COPD Integrated Care Pathway (ICP) have proven to be very successful in the engagement efforts achieved to date. The planning team (consisting of partners from Lakeridge Health, Home and Community Care Support Services, Acute and Community Respirologists, and Community Paramedicine have lead thoughtful conversations with the Durham OHT Executive Leadership Table, Primary Care Advisory Council, the DOHT Patient Family and Care Partner Advisory Council and the Durham OHT Partnership, Innovation and Strategic Forum. Discussions were also completed with the MSIFN health care centre nurses and lead physician. Through engagement with our partners and patients that we serve, the team has been able to learn of innovative options, capacity and support for the COPD ICP. Results of these engaging discussions has further developed the scope of services to provide to the Region. It has also provided insight to possible siloed and individual partners which will assist in developing a robust inventory of respiratory services such as spirometry.

Part 3: Partner Engagement Plan

1. The Partner Engagement Plan identifies all of the partners who are actively collaborating to design and implement the change initiatives outlined in the Action Plan. The Partner Engagement Plan will allow demonstration programs to identify how key partners will support the selection of high-value activities in alignment with the priorities for action and the implementation of the Action Plan. Additional rows may be added as required.

Partners at a minimum must be representative of local and/or regional health service providers across the care continuum, inclusive of persons with lived experience, such as:

- Primary care providers (including interprofessional primary care teams, if applicable);
- Home and community care providers (HCCSS and Service Provider Organizations);
- Specialized health care providers and leaders

It is recommended to consider social service and community care partners that may support upstream care that would be beneficial to include in the ICP.

Partner Details		**Role: Which of the following activities will partner(s) be involved in?**					
Name of Organization **(and lead contact if applicable)**	**Is this organization an OHT member and/or partner (direct core partners, enabling core partners etc.)**	*Planning*	*Consulting/ Informing*	*Implementation*	*Operations – PM, Analytics etc.*	*Other (please describe)*	**Has this partner been formally engaged in the development of this Action Plan**
Lakeridge Health	Yes	X	X	X	X		Yes
HCCSS	No	X	X	X	X		Yes
Paramedicine Services	Yes	X	X	X	x		Yes
Home Oxygen Services	No	X	X				Yes
PCP providers	Yes	X	X	x			Yes
Patient/Family Rep	Yes	x	x				Yes

2. **Describe how you plan to engage with primary care partners in the implementation of the COPD ICP:** *(maximum 300 words)*

In discussion with the primary care advisory council we will continue to have a couple of representatives on our direct implementation group. Then we will plan to re-engage the primary care advisory council regularly to check in on how we are doing with meeting the COPD quality standard and what challenges remain. Finally, as expressed by the primary care advisory council, we will engage the group to plan and offer town hall style education events on COPD care standards.

On a patient care level, we will engage with primary care through electronic and verbal means regarding the care of their patients when in our collective care. We are also continuing to engage in discussions with the broader DOHT regarding electronic care coordinator (SHIIP) a primary care shared EMR and other methods to enhance integration and sharing. The COPD, and CHF groups, will remain a stakeholder in that ongoing work.

Part 4: Forecasted Costs

Teams will be granted up to **$200k for FY 2023/24** to support planning deliverables and early implementation of the change initiatives. Ontario Health will collaborate with demonstration programs relative to how funds will be allocated and spent in FY 2023/24 to support planning efforts, through the Transfer Payment Agreement process.

Additional funds may be approved in exceptional circumstances, with sufficient justification.

Describe how the $200k will be utilized to support planning efforts in the table below:

Description of Investment Administrative supports, project management, health human resources, technology supports, etc.	**Estimated cost**	**How investment will support planning**
Respiratory Rehabilitation exercise classes (Exercise equipment, IT set up for virtual classes and Community Care Durham/Home at Last partnership and transportation)	$43300 $57500 (in kind for kinesiology FTEs)	All of these investments will support the start-up of virtual exercise classes, as well as satellite location classes, along with patient transportation
Spirometry Equipment Respiratory therapy FTE 1.0	$31000 $23700	This investment will allow us to set up and pilot logistics of offering stationary and mobile spirometry, and providing training to North Durham nurses for spirometry
Project start-up costs Project manager- 1 FTE	$40000	This investment will support the project workplan and deliverables, meeting structure and agenda, establishing a key performance indicators plan and OH reporting structure.
PROMs preparation & clinic set up IT equipment IT project manager- 1 FTE	$2600 $40000	This will provide the human resource and equipment required to set up for PROMS collection in the in-person COPD clinic
In-person/Virtual clinic Pharmacist 0.6 FTE Clerk 1.0 FTE Medications	$8000 $7000 $4400	This investment will allow for start up and training for key in person/virtual clinic support roles, as well as stock of medications for clinic and community paramedicine
TOTAL	**$200000**	

Based on the proposed change initiatives outlined within this Action Plan, please describe:

How the demonstration program will use up to $400k **for FY 2024/25** [pending approval of the Action Plan from Ontario Health and funding from the Ontario Ministry of Health] to support full implementation of your proposed change initiatives (see Appendix C for guidelines on the use of seed funding).

Higher seed funding may be approved in exceptional circumstances, with sufficient justification.

Description of Investment (e.g., 1 FTE care navigator, 0.5 FTE project manager, digital tools)	Care Setting (if applicable)	Estimated cost	Estimated in-kind contributions (if applicable)	Link to specific change initiative
Telehomecare RCM: Telehomecare RN 1.0 Telehomecare NP 0.5 Community paramedicine 1.0	 HCCSS LH Community	 $89956	 $460 000 $90 000	#4
In person clinic & spirometry: NP 0.5 RRT 1.0 Pharmacist 1.0 Clinic Clerk 0.6 Clinic supplies	 Lakeridge Health	 $89956 $141108 $160 000 $50575 $4860		#1 & #3
Respiratory Rehab: Kinesiology 2.0 Home at Last transportation	Lakeridge Health	 $23545	$345 000	#2
Total		**$560000**	See note immediately below regarding increased requested funding.	

Note: A higher funding amount is requested to allow support for all critical roles for this population and to meet the highest priority standards. It was not possible to sustain a pharmacist role for the CHF integrated care pathway work, so efficiencies would be found if a pharmacist is supported within this proposal. The role would become cross functional to CHF and COPD. Pharmacists are highly important to medication management and teaching, however if the increased amount cannot be supported, it will be removed from this proposal and from its support for the CHF clinic as of April 1st. Note: a part time (0.6 FTE) pharmacist was considered, however the clinics are likely to be at two different sites due to space constraints and this may pose a challenge of splitting that FTE between sites.

ADD on to consider: Chronic Care Centralized eReferral

There was strong feedback and opinion about the need for a centralized eReferral system to which primary care could submit referrals and trust that the central service would additionally connect the patient to other services beneficial to the chronic population. A service like this could be expanded to allow a centralized chronic care eReferral service that can be built upon for all integrated care pathways.

Even if not possible at this time, the idea is worthy of consideration for future major primary care/ patient care enhancement. Lean costing to trial this in a format similar to our Mental Health “central connect” service are below.

COPD Central eReferral: Project Manager- 1 FTE (6 months) Clerical- 1 FTE Clinical Staff- 2.6 FTE IT PM- 1 FTE (6 months) Ocean costs IT Equipment **TOTAL**	Lakeridge Health	$70 000 $85 000 $475 800 $70 000 $3 000 $10 000 **$711 000**		#5

Notes about funding:

- Any requests for clinical staffing expenses should be matched with in-kind resources from partners. This will help to build capacity within the OHT to ensure sustainability of the model without relying on one-time funding for staffing in the longer term.
- Action Plans will be reviewed in detail by the Ontario Health provincial team with the following considerations:
    - Appropriateness of scope
    - Adherence to guidance on the use of seed funding (see Appendix C)
    - Expected impact of dollars spent (i.e., patient outcomes, value for money)

Part 5: Declaration of OHT Collaboration

OHTs must complete and submit this Action Plan Proposal to be reviewed and assessed by Ontario Health. The completion of the Action Plan must be a collaborative effort including relevant OHT partner organizations and Ontario Health regions. It is the expectation that before this document is submitted it has been reviewed by appropriate regional partners and where possible, endorsed through the OHTs collaborative decision-making structure.

By completing this section, the OHT is attesting that the following positions as part of the core team have been involved in the completion of the Action Plan and will be part of the implementation of the pathway. The role of the "Lead" will be responsible for collaborating, planning, monitoring, executing, and reporting on the COPD ICP. Leads will be responsible for ensuring all teams (and members) are meeting deadlines and supporting efficient communication and collaboration across teams.

Submission of this Action Plan confirms intent to participate in Ontario Health's Chronic Obstructive Pulmonary Disease Integrated Clinical Pathway program.

Please e-mail the review team at OHTSupport@ontariohealth.ca for guidance, clarification, and/or interpretation of the Action Plan Proposal Template and to submit your completed Action Plan Proposal by no later than December 7th, 2023.

OHT Name: __Durham OHT_____

POSITION*	NAME	TITLE/ROLE, ORGANIZATION	CONTACT INFORMATION
PM/Project Lead	**Michael Jeffreys**	Title/Role: CQSL Org: **Lakeridge Health**	e-mail: mjeffreys@lh.ca Tel:
OHT COPD ICP Lead	**Colleen Wilkinson**	Title/Role: Medicine Director Org: **Lakeridge Health**	e-mail: cwilkinson@lh.ca Tel: 905 435-8855
COPD-QBP Hospital Lead(s)	**Barbara Amah** **Jennifer Rizan-NP**	Title/Role: Patent Care Manager / NP Org: **Lakeridge Health**	e-mail: bamah@lh.ca, jrizan@lh.ca Tel:
Primary Care Lead[3]	**Dr Lubna Tirmizi** **Dr Rebecca Wray**	Title/Role: Org: **Durham Ontario Health Team / LH**	e-mail: v.ltirmizi@doht.ca , rwray@lh.ca Tel:

[3] *OHTs are required to identify a Primary Care Lead who is a primary care clinician (e.g., family physician, primary care nurse practitioner, traditional healer).*

- *If the OHT has a Primary Care Network (or similar structure) representing primary care clinicians within the OHT, and/or has an existing Primary Care Lead (or Clinical Lead who is a PC clinician), the Primary Care Network and/or existing Lead should identify a Primary Care Lead for the demonstration program (can be the existing Lead themselves, or a different PC Clinician).*
- *If the OHT does not have a Primary Care Lead or Primary Care Network (or similar structure) that can support in the identification of a Primary Care Lead for the demonstration program, the demonstration program should contact their Ontario Health regions and Ontario Health Regional Primary Care Clinical Lead to help identify an appropriate Primary Care Lead for the demonstration program.*

**Multiple Lead roles may be filled by the same person*

Clinical Lead with COPD expertise	**Dr Sean O'Loghlen**	Title/Role: Respirologist Org: **Lakeridge Health**	e-mail: sologhlen@lh.ca Tel:
Data/Reporting Lead	**Jake Tennant**	Title/Role: Data analyst Org: **Lakeridge Health**	e-mail: jtennant@lh.ca Tel:
Ontario Health Region Lead	**Laurel Hoard**	Title/Role: Director Org:	e-mail: Laurel.Hoard@ontariohealth.ca Tel:
Ontario Health Chief Regional Officer (or delegate)	**Anna Greenberg**	Title/Role: Chief Regional Officer Toronto and East Org: **Ontario Health**	e-mail: anna.greenberg@ontariohealth.ca Tel:
Contract funding management Lead	**Chris Squire**	Title/Role: CFO Org:	e-mail: csquire@lh.ca Tel: ext 34232

The OHT is required to identify a **health service provider organization sponsor** (i.e., the transfer payment recipient) that the Ontario Health region deems suitable to manage the initiative and to whom the funding can be flowed from Ontario Health according to existing financial processes.* The funding recipient may be the existing OHT fund holder or an appropriate designate. The health service provider organization identified below is agreeing to enter into a deliverables-based agreement with Ontario Health and to manage and flow the funds to any other organizations and vendors involved in this initiative. Any vendor agreements will be between the health service provider organization and the vendor.

Legal Name of Transfer Payment Recipient:	Lakeridge Health

**NOTE: organizations may be required to provide constating documentation to confirm their legal name.*

Executive Contact at Sponsoring Organization to be named in the Notice of the Funding Agreement: *	Cynthia Davis
Name, Position:	Cynthia Davis – Chief Executive Officer
Email Address:	cynthiadavis@lh.ca
Telephone:	Ext 34421

**NOTE: This individual must have the ability to legally bind the organization*

Senior Financial Contact (CFO, CAO) at Sponsoring Organization to respond to required requests related to the funding agreement*:	Chris Squire
Name, Position:	Chris Squire – Health System Executive, Chief Financial Officer
Email Address:	csquire@lh.ca
Telephone:	Ext 34232

**NOTE: This individual could also be the contract funding management lead*

Appendix A - Measurement and Evaluation Framework

Key priorities for action will be mapped onto a range of system Key Performance Indicators (KPIs) and process indicators, supplemented with site-specific measurement to ensure ongoing tracking of the success of the COPD ICP. Results will be used to adjust future cohorts and support the spread and scale of the COPD ICP at a provincial level.

Part A: Patient Profiles (by OHT)

- COPD incidence and prevalence in the fiscal year
- Age group
- Rural vs. urban
- Neighbourhood level equity stratifiers
- % attached to OHT

Part B: Proposed system, process, and balance indicators

System/Provincial KPIs	Process Indicators	Balance Indicators

• % of people living with COPD with one or more unplanned acute-care visits for COPD in each year:
  ○ Emergency department visits (Quality statement [QS] 1 + 8)
  ○ Nonelective hospitalizations (QS 1 + 8)
• 30-day and 90-day readmissions after COPD hospitalization (QS 11)
• 30-day ED visits after COPD hospitalization (QS 11)
	• % COPD Confirmation via spirometry (QS 1)
	• 7-day in-person assessment following discharge (QS 11)
	• % of people living with COPD seen by a respirologist (QS 1 + 8)
	• % of people living with COPD who begin an inpatient pulmonary rehabilitation program and complete the program (QS 9)
		• Average and median length of stay
		• 30-day mortality after COPD hospitalization*
		**Only in-hospital deaths are recorded in a timely manner – outside of hospital incurs data lags*

The indicators presented above are measurable using provincial data. It is not an exhaustive list of indicators that could be used to track the progress of the change initiatives. See Part C on measurement of local/site-specific data.

Part C: Local/Site-specific Measurement Template

Teams will be given a template to collect and report on a quarterly basis based on the change initiatives they are implementing at a local level (Example: % of people living with COPD referred to specialized respiratory care when clinically indicated, referrals/access to community-based pulmonary rehabilitation programs – to address quality statements 8 and 9).

Appendix B - SDOH Supplementary Resources

- The Social Determinants of Health: THE CANADIAN FACTS. 2nd Edition: https://thecanadianfacts.org/The_Canadian_Facts-2nd_ed.pdf
- National Collaborating Centre for Determinants of Health: Glossary of essential health equity terms - https://nccdh.ca/images/uploads/comments/English_Glossary_Nov17_FINAL.pdf

Appendix C - Guidelines for eligible/ineligible use of seed funding

Seed funding provided to participating OHTs is subject to eligibility and ineligibility criteria to ensure funds are appropriately utilized to advance the implementation of the COPD ICP in alignment with the three priorities for action.

Guidelines for proposed budgets: eligible expenses

- Project lead/management resources dedicated to as the lead the project design and implementation
- Decision support resource to support project reporting and evaluation
- Innovative use, or use in an innovative context, of data, digital and/or virtual tools to support care pathways, communication and data analytics
- Technical/licensing costs for technology with remote monitoring functionality
- Clinical resources for new/expanded roles to support the new care pathways and integration of care across health and non-health care sectors, matched in-kind
- Physicians can be funded to support program development/operations, not for on-call/clinical care
- Resources to support project communications and/or resources for patients, referral sources, OHT members
- Technical and/or administrative support
- Eligible virtual care technology:
    - Any funding requested for technology, including infrastructure, solution licenses, set-up or configuration costs, devices, voice or data plans, must support the delivery of health care resources and services to patients
    - Eligible virtual care tools include patient navigation and screening, eReferral for social services, online appointment booking, videoconferencing, phone, asynchronous messaging, and remote care management solutions that support care pathways and the collection and exchange of patient biometric or self-reported data
    - Digital self-care tools that support health promotion, disease prevention and chronic disease management and provider-to-provider messaging tools may also be eligible if they are part of a broader program that supports the delivery of virtual care services to patients
    - Proposals for device lending programs, with or without data plans, must be cost-effective, targeted at individuals who face barriers to accessing care, and include a sustainability plan
- Eligible PROMs/PREMs implementation expenses:
    - Hardware to support collection, including tablets, kiosks, etc.
    - Software (e.g., HL7 bridge for EMR integration for the implementation of PROMs collection using an electronic platform)

Guidelines for proposed budgets: <u>ineligible</u> expenses

- The Project shall <u>not</u> include developing or acquiring digital enablers or services that:
    - would duplicate in functionality or purpose requiring provincial digital enablers; or
    - would require the development of new registries, data repositories, or other digital health solutions that are available in whole or part from the Ministry of Health, Ontario Health or other delivery partners;
    - would duplicate digital health solutions or services for which existing pilot programs are in place provincially (e.g., digital identity services), and remote care management