Ontario Health

Collaborative Quality Improvement Plan Change Concepts and Change Ideas

Improve early detection, intervention, and outcomes for people with chronic diseases, specifically heart and lung disease

- Admissions per 100 heart failure (HF) patients
- Admissions per 100 chronic obstructive pulmonary disease (COPD) patients
- Hospitalizations for ambulatory care sensitive conditions (ACSCs)

Note: Additional change packages about improving access to preventative cancer screening and improving access to mental health and addictions care in the community are available through the Collaborative Quality Improvement Plan (cQIP) Community of Practice on the Ontario Health Team (OHT) Shared Space.

About the Indicators

Admissions per 100 HF patients and *Admissions per 100 COPD patients* measure the rate (per 100 cohort members) of inpatient admissions for people identified as being in the HF or COPD cohort, respectively. *Hospitalizations for ACSCs* measures the numeric rate (per 10,000) of hospitalizations for health conditions that may have been prevented or managed by appropriate primary health care.

One way to improve the quality of health care for people with HF, COPD, or other ACSCs is by providing appropriate, high-quality preventative services in the community and/or primary care setting. These indicators help track the outcome of services that people do or do not receive. Although there can be several factors outside the direct control of the health care system that result in hospitalization, this data can be used to provide insight on past performance, or to help identify where there are unmet community health care needs that would benefit from improvement interventions.

Approximately 1 in 4 adults over the age of 30 will be living with a major illness in 2040, requiring significant hospital care; this is an increase from approximately 1 in 8 individuals in 2002.[1] These

[1]Rosella LC, Buajitti E, Daniel I, Alexander M, Brown A. Projected patterns of illness in Ontario [Internet]. Toronto: Dalla Lana School of Public Health; 2024 [cited 11 Nov 2024]. Available from: https://www.oha.com/Documents/externalresources/Projected%20patterns%20of%20illness%20in%20Ontario.pdf

increases may disproportionately impact the individuals who are most affected by the social determinants of health.

The planning and programming of chronic disease prevention and management continue to evolve in alignment with Ontario Health priorities and needs within the sector. Key areas of focus will be for OHTs to implement chronic disease prevention and management models rooted in primary care and community care settings within OHTs, targeting patients with many risk factors and/or with chronic and complex conditions, to ensure strong connections between upstream and downstream elements of the pathway.

Key Resources

- *Heart Failure* quality standard
- *COPD* quality standard
- *Palliative Care* quality standard
- *Transitions Between Hospital and Home* quality standard
- *Diabetic Foot Ulcers* quality standard
- *Prediabetes and Type 2 Diabetes* quality standard

Getting Started: Review and analyze data to identify, understand, and explore variation within the patient population

When developing a pathway to improve outcomes for people with chronic disease, begin by clearly defining the patient population for which the pathway will be designed.

- Access your OHT Data Dashboard or email OHTanalytics@OntarioHealth.ca to request access
- Review data and look for trends related to higher admission rates or number of hospitalizations, or variability in the data (e.g., are rates higher in certain postal codes?)
- Consider any sociodemographic factors or attributes in the neighbourhood where the population of interest lives, and review the Public Health Ontario Snapshots
- Primary care providers can leverage data from their *MyPractice* Reports
- Engage your Rapid-Improvement Support and Exchange (RISE) coach for support with population-health management

Change concept 1: Collaborate with partners on early identification of needs and upstream care activities

- Use tools for early risk identification and preventative management
- Health care providers can leverage tools and resources, including academic detailing, from the Centre for Effective Practice:
  - COPD (English only)
  - Type 2 Diabetes (English only)
  - Preventative Care for Older People (English only)
  - Managing Patients with Heart Failure in Primary Care (English only)
  - Point-of-care testing (including glucometers, HbA1c, microalbumin, lipid panels, cardiac panels, and cluster testing as clinically appropriate)

Change concept 2: Provide education and training to health system planners, providers, patients, families, and care partners on best practices for care of patients with chronic diseases

- HF
  - Minimal requirements and key clinical services for heart failure programs within a spoke-hub-node model of care (English only)
  - *Heart Failure* quality standard pathway (English only)
  - Integrated Heart Failure Care Community of Practice
  - Heart and Stroke Foundation – Heart failure resources (English only)
  - Canadian Cardiovascular Society – Management of HF (English only)
  - HeartLife Foundation
- COPD
  - *COPD* quality standard pathway (English only)
  - *COPD* quality standard implementation toolkit
  - COPD Integrated Clinical Pathway Community of Practice
  - Academic detailing for primary care on the topic of COPD (English only)
- Diabetes
  - Diabetes Canada – Clinical Practice Guidelines
  - Public Health Ontario – Diabetes resources
  - Registered Nurses' Association of Ontario (RNAO) Best Practice Guidelines – Diabetic foot ulcers: Prevention, assessment and management (English only)
  - International Working Group on the Diabetic Foot – Guidelines and resources
  - Wounds Canada – Best Practice Recommendations for the Prevention and Management of Diabetic Foot Ulcers (English only)
- Palliative care
  - Ontario Palliative Care Network – Palliative Care Health Services Delivery Framework
  - Ontario Palliative Care Network – Tools to Support Earlier Identification for Palliative Care
  - Ontario Palliative Care Network – Palliative Care Toolkit
  - RISE brief 18: Resources to support population-health management for people who could benefit from a palliative approach to care
  - RISE brief 27: Ontario Palliative Care Network and how it can support OHTs as a health-system partner
- General preventative care
  - Support individuals working in health care or on health care teams to become prevention specialists through training in motivational interviewing, chronic disease self-management (choices and changes training may be offered in each former Local Health Integration Network (LHIN) through their self-management programs), smoking cessation counselling (English only), physical literacy, nutrition, food insecurity (English only), diabetes management training, and health promotion
- Chronic disease self-management and preventative care education for patients and care partners
  - Regional Chronic Disease Self-Management Programs

Change concept 3: Develop and implement a collaborative model for service delivery to patients with chronic diseases

- Leverage the quality standards and best practice guidelines listed above
- Create shared care models with multisector partnerships, informed by primary care leadership
    - CorHealth Ontario – Integrating Heart Failure Care (provincial road map and implementation support toolkit) (English only)
    - CorHealth Ontario – Lower-Limb Preservation Strategy (English only)
- Ensure that the pathways are co-designed with patients who have lived experience
- Ensure alignment with Ontario Health's Social Determinants of Health Framework and Equity, Inclusion, Diversity, and Anti-Racism Framework. Integrate principles from these frameworks into the pathway to address health disparities and promote equity
    - Social Determinants of Health: The Canadian Facts, 2nd Edition
    - National Collaborating Centre for Determinants of Health – Glossary of Essential Health Equity Terms
- Join the Integrated Clinical Pathway communities of practice (HF, COPD, Lower-Limb Preservation) to learn, develop skills, and access resources that can help you plan and implement clinical pathways for patients with chronic diseases

Change concept 4: Leverage digital and virtual solutions to improve processes and workflow

- Use digital health solutions and technology to support integration, documentation, and communication. Plan for integration and coordination across different sectors and care settings for the lifetime of a patient's condition
    - Ontario Health's Digital Health Programs
        - Includes Health811, eConsult and eReferral, Ontario Laboratories Information System (OLIS), ClinicalViewer, Health Report Manager (HRM), Ontario Telemedicine Network (OTN) Hub, and solutions for virtual visits
        - Provincially funded virtual care programs (remote care management for HF and COPD)
    - Evidence2Practice Ontario provides tools for HF, COPD, diabetes, and other conditions for use in acute care and primary care to assist with screening, diagnosis, decision-making, quality interventions, monitoring, connecting patients to self-management supports, and patient conversations (English only)
    - Project ECHO Skin and Wound features live online sessions, de-identified patient cases, and case discussions. Health care providers and specialists learn from each other, acquire knowledge and skills, increase competency, and build a strong community of practice. Project ECHO follows the hub-and-spoke model, in which an interprofessional specialist resource team forms the hub, and participants (supported by a community of practice) are the spokes (English only)

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