HSPN Health System Performance Network

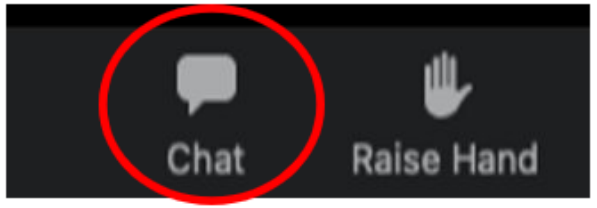
Integrated Care Pathways – Exploring the Building Blocks for Success

HSPN Monthly Webinar

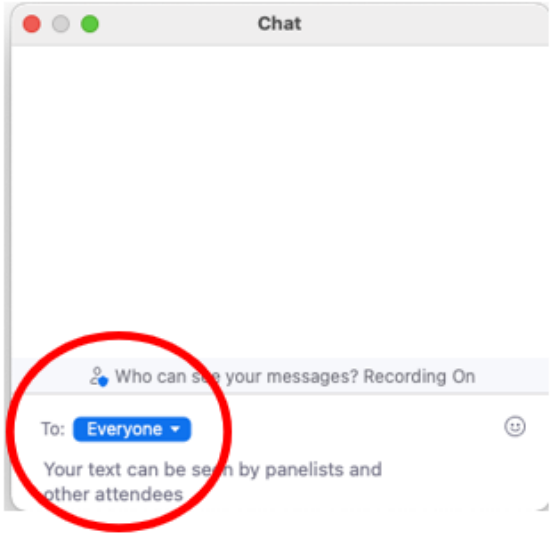
April 22, 2025

Welcome & thank you for joining us!

Please let us know who you are by introducing yourself (name & OHT or other org)



➢Open Chat



➢Set response to everyone in the chat box

Land Acknowledgement

We wish to acknowledge this land on which the University of Toronto operates. For thousands of years it has been the traditional land of the Huron-Wendat, the Seneca, and the Mississaugas of the Credit. Today, this meeting place is still the home to many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work on this land.

Poll 1

1. Have you joined us for an HSPN webinar previously? (Single choice)

67/67 (100%) answered

Yes. I have participated previously	(44/67) 66%
No. This is my first event	(23/67) 34%

HSPN Health System Performance Network

Today's event:

Integrated Care Pathways – Exploring the Building Blocks for Success

Co-Host

Dr. Kaileah McKellar
Co-Lead
Leading Project Evaluation HSPN

Dr. Gaya Embuldeniya
Cultural Anthropologist
HSPN Investigator

Presenters

Abhi Regmi
Manager of Digital Health, Information a Management and Projects at Burlington OHT

Dr. Reham Abdelhalim
Manager, Population Health and Evaluation with Burlington OHT

Dr. Jeff Powis
Medical Director, Integrated Care and Infection Prevention, Control, Michael Garon Hospital

Rishma Pradhan
Manager of Care Integration at East Toronto Health Partners

Melissa Chang
Sr. Director, Integrated Care, UHN Connected Care

Dendra Hiller
Project Manager, Integrated Care Pathways for Chronic Disease

Ali Somers
Digital Health Lead and Project Manager

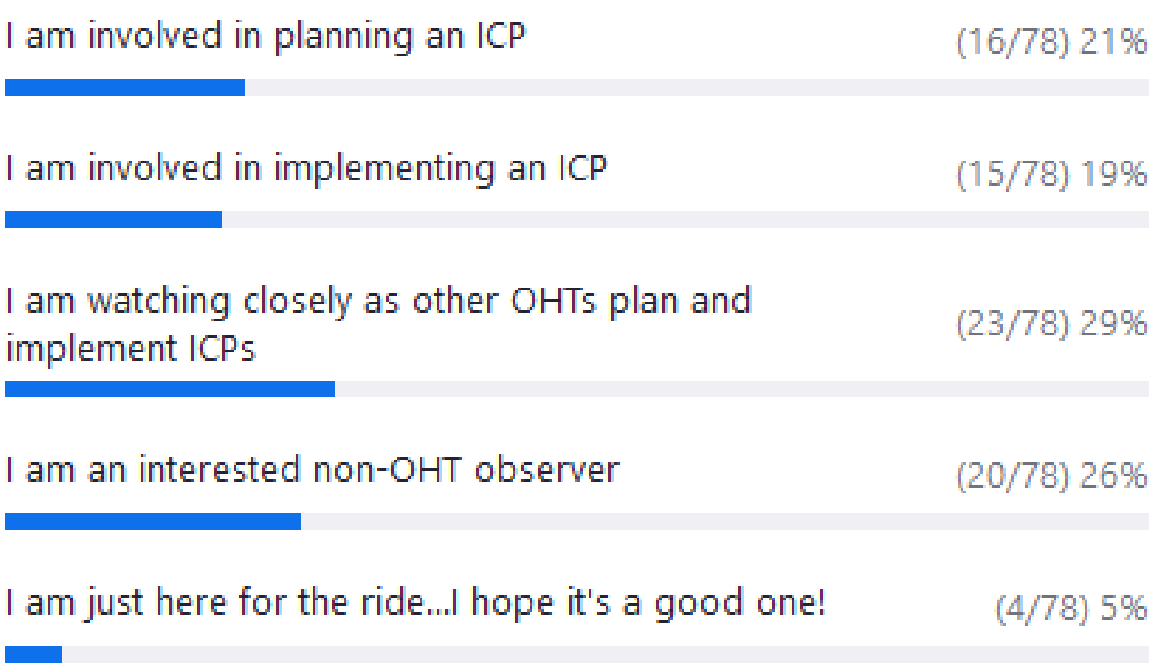
HSPN Monthly Webinar

April 22, 2025

Poll 2

1. What is your relationship with the Integrated Clinical Pathways?
(Single choice)

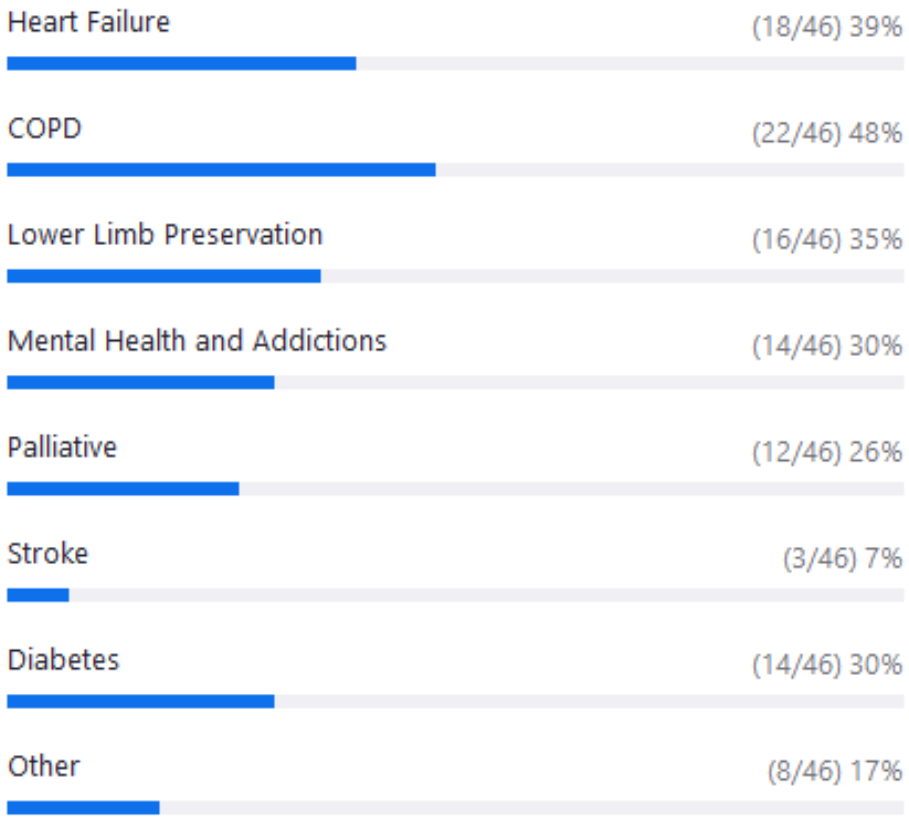
78/78 (100%) answered



Poll 3

1. For those of you who are planning or implementing an ICP, what is your focus? (Select all that apply) (Multiple choice)

46/46 (100%) answered



Agenda and Overview

1. Introductions
2. Learning from OHTs
   - East Toronto Health Partners
   - Burlington OHT
   - Frontenac, Lennex, & Addington OHT
3. Learning from an Integrated Care Program
4. Panel Discussion
   - Essential success factors
   - Key challenges and how these were addressed
   - ..And more

Integrated Care Pathways in Ontario

Jeff Powis and Rishma Pradhan

East Toronto Health Partners

Transforming Chronic Disease Management with Integrated Care Pathways

A Collaborative Co-Design Approach to Implementation

Jeff Powis

East Toronto Health Partners

Medical Co-Lead

Rishma Pradhan

East Toronto Health Partners

Manager, OHT Development and Care Integration

About East Toronto Health Partners

- **100+** community, primary care, home care, hospital and social services organizations
- **100+** patient, caregiver and community advisors and community health ambassadors
- **350,000+** people who live or get care here
- **21 neighbourhoods,** including five **high-priority, equity-deserving** communities

The Challenge

Why Integrated Care Pathways?

- Chronic diseases is the leading cause of poor quality of life & healthcare utilization
- System challenge: Fragmented care between hospitals, primary care, and community services
- Ontario Health Priorities:
  - ❑ COPD
  - ❑ CHF
  - ❑ Diabetes (Lower Limb Preservation)
  - ❑ Stroke
- Need for patient-centered, connected care across settings (integrated care)

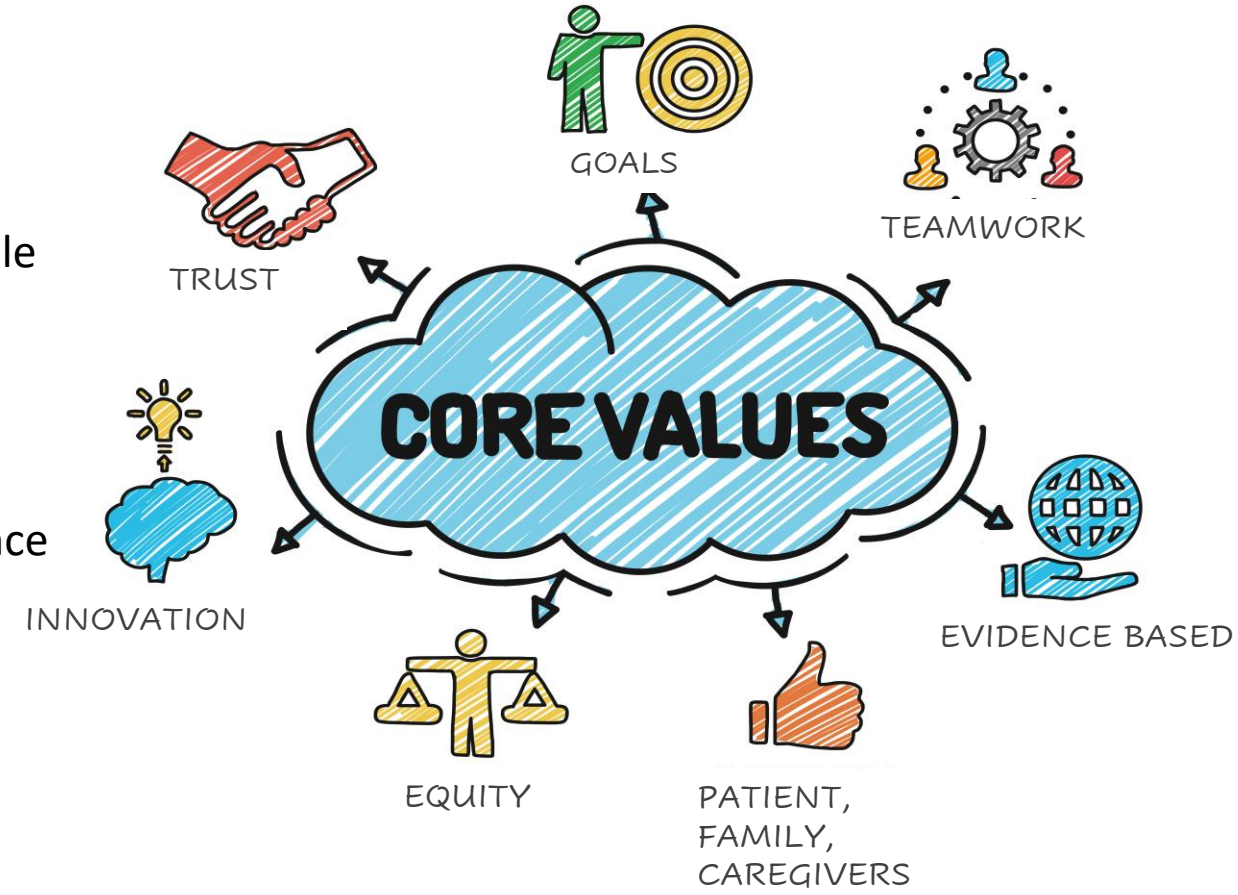
Our Approach

Guiding Principles:

- Patient-centered care
- Health equity lens
- Evidence-based standards (CTS guidelines, Treatable Traits Framework, Canadian Cariology Society)
- Focus on seamless transitions & self-management

Who Was Involved:

- Patients, Families & Caregivers with Lived Experience
- Primary Care & Specialists
- Home Care & Community Providers
- Technology & Digital Health Experts



East Toronto Health Partners

Engagement

- Specialist Clinical Leads
- Primary Care Clinical Leads
- Acute Care
- Community Health Centres and Family Health Teams
- Rehabilitation

- Clients, Caregivers and Community Members
- Home Care
- Community Support Services
- Mental Health
- Government

More than **150** individuals engaged!

Meaningful Co-Design

Partner Engagements

Design Workshops

Working Groups

Patient and caregiver (people) partnership in all engagements, specifically individuals with lived experience related to chronic disease management

Consensus Decision Making

Integrated Care Pathway Objectives:

- Reduce **Readmission Rates**
- Avoid **Emergency Department** Visits
- Improve **Self-Mastery** & **Confidence in Care**
- Enhance **Quality of Life**
- Empower **Clinical** and **Community Champions**
- Position our community Hospital as core partner and **leverage committed specialists** (respirology, cardiology, etc.)
- Leverage and strengthen **existing Programs & Services**
- Keep the focus on **Integrated, Connected Care**
- **Build an engine for multiple pathways**

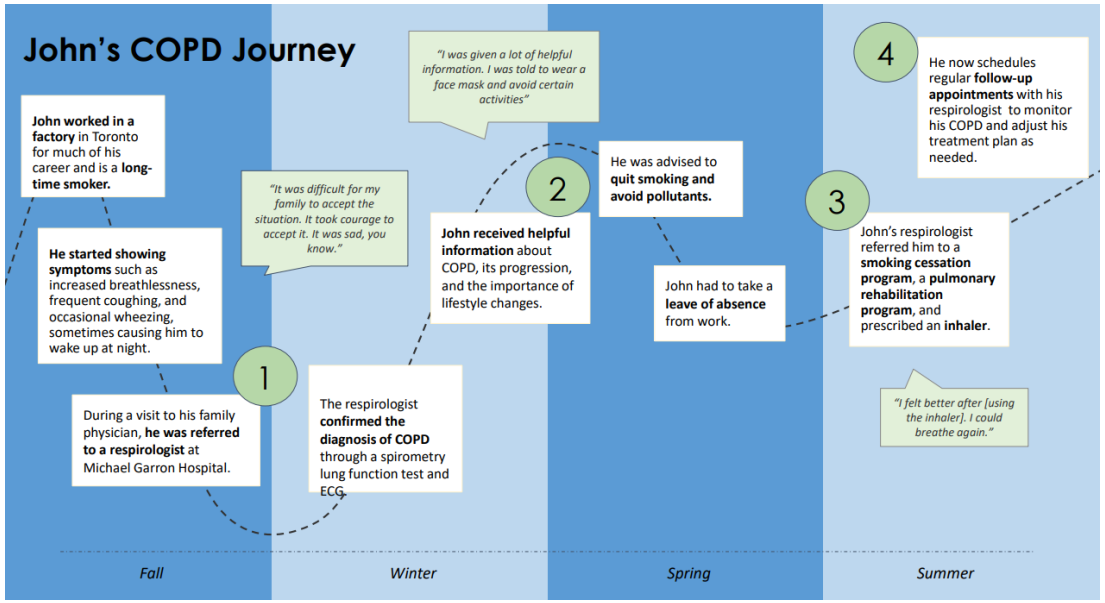
*We want to **build** a lasting impact of **integrated care**: **Sustainable, People-driven solutions** that **foster Internal Capacity** and **deliver Long-term Value**.*

East Toronto Health Partners

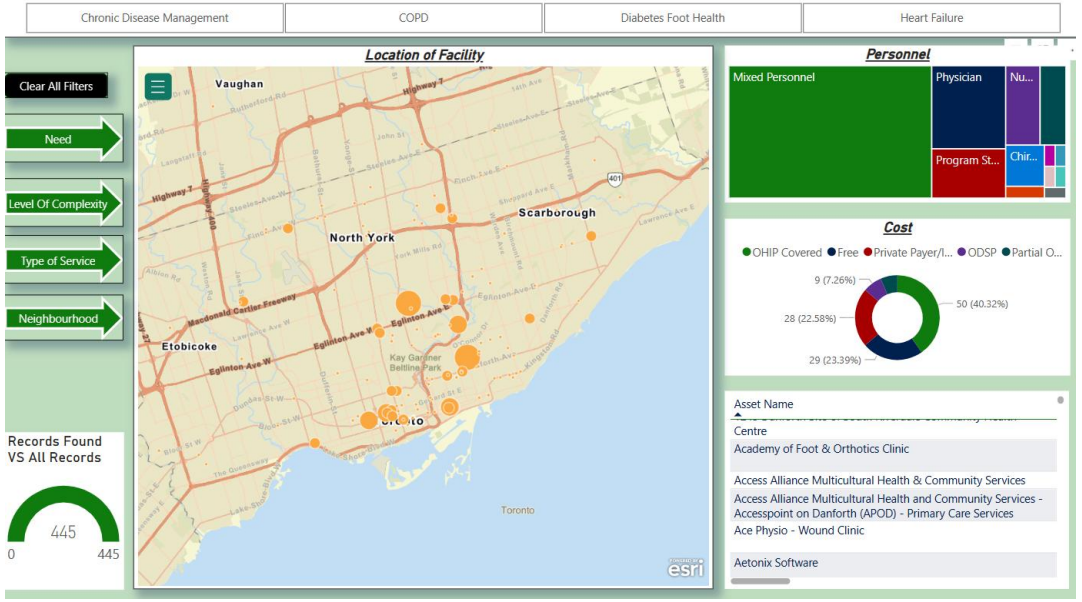
Meaningful Co-Development

East Toronto Health Partners

People Journey Mapping

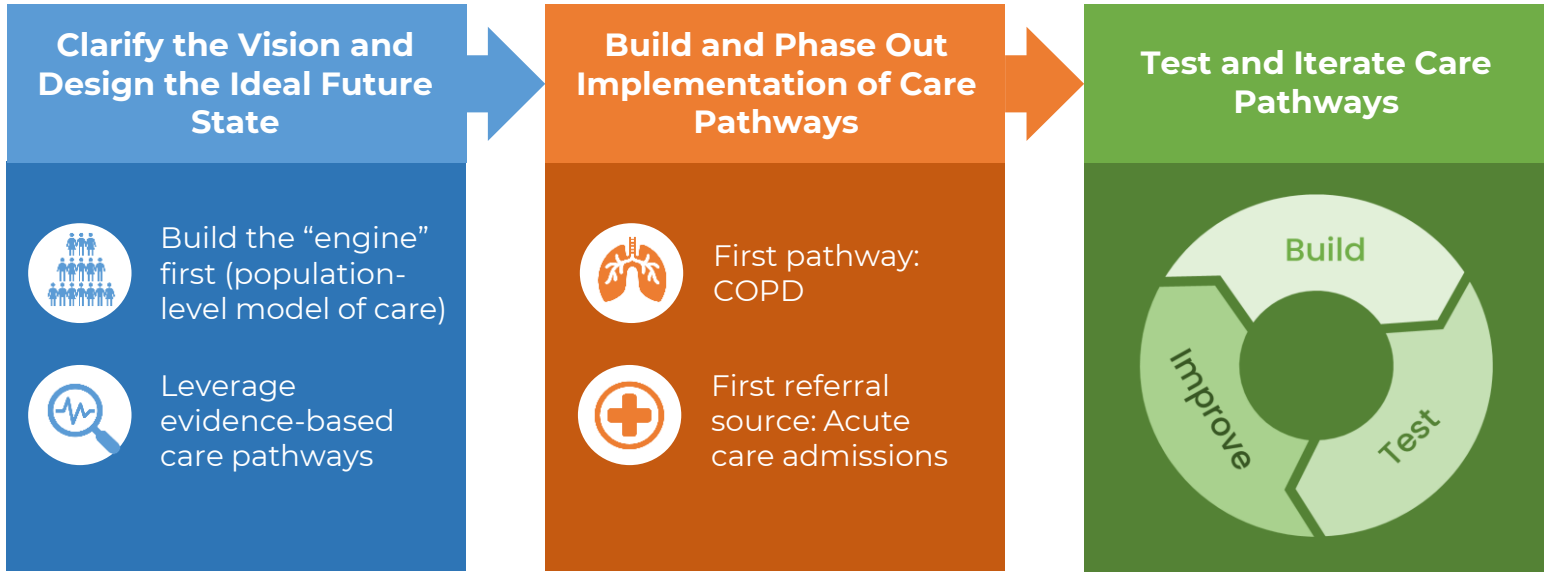


Partner Asset Mapping



Our Model: Key Features of the Program

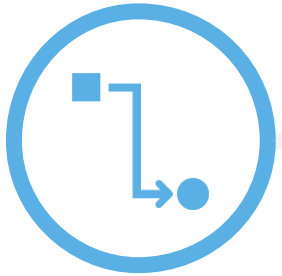
- ✓ Staffing
  - Clinical Care Facilitator
  - Access Administrator
- ✓ Remote Care Monitoring & Post-Discharge Support
- ✓ Individualized Holistic Self-Management Goals & Plans
- ✓ Case Management and Progress Reporting
- ✓ Digital Enablers
  - Electronic Medical Records
  - Shared Care Planning Platform
- ✓ Service Connections & Coordinated Team-Based Rounds
- ✓ Action plans, exacerbation management, follow ups
- ✓ Equipment & Patient Education Resources



East Toronto Health Partners

Build and Implementation

Processes



- ✓ Referral
- ✓ Enrollment
- ✓ Assessment(s)
- ✓ Care Planning
- ✓ Service Connections
- ✓ Remote Care Monitoring
- ✓ Primary Care Connections
- ✓ Rounding

Tools

- ✓ Registration Guide
- ✓ Schedule of Assessment(s)
- ✓ Action Plans
- ✓ Encounter Notes (goal planning, symptom management)
- ✓ Self-Management Progress Reports

Staffing

- ✓ Clinical Care Facilitators
- ✓ Access Administrator
- ✓ Clinical Specialists
- ✓ Primary Care
- ✓ Program Support

Technology

- ✓ ETHP Collaborate
- ✓ Electronic Medical Records
- ✓ eReaders (self management education)
- ✓ Equipment (scale, blood pressure cuff, oximeter)

Communications

- ✓ Patient-Facing One-Pager
- ✓ Provider-Facing One-Pager
- ✓ Website (client- and provider-facing sections)
- ✓ Communications and knowledge translation

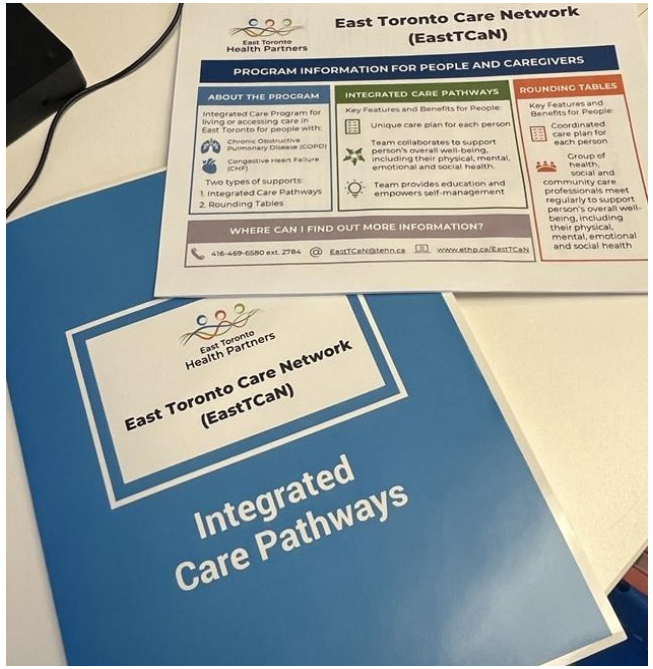
Change Management

- ✓ Change Management Plan
- ✓ Supported by processes, communications materials, and people

East Toronto Health Partners

East Toronto Care Network

East Toronto Health Partners launched East Toronto Care Network (EastTCaN) a scalable, multisector, patient-centered, integrated service delivery model that empowers individuals to "manage their chronic disease instead of the chronic disease managing them."
https://ethp.ca/our-work/east-toronto-care-network/

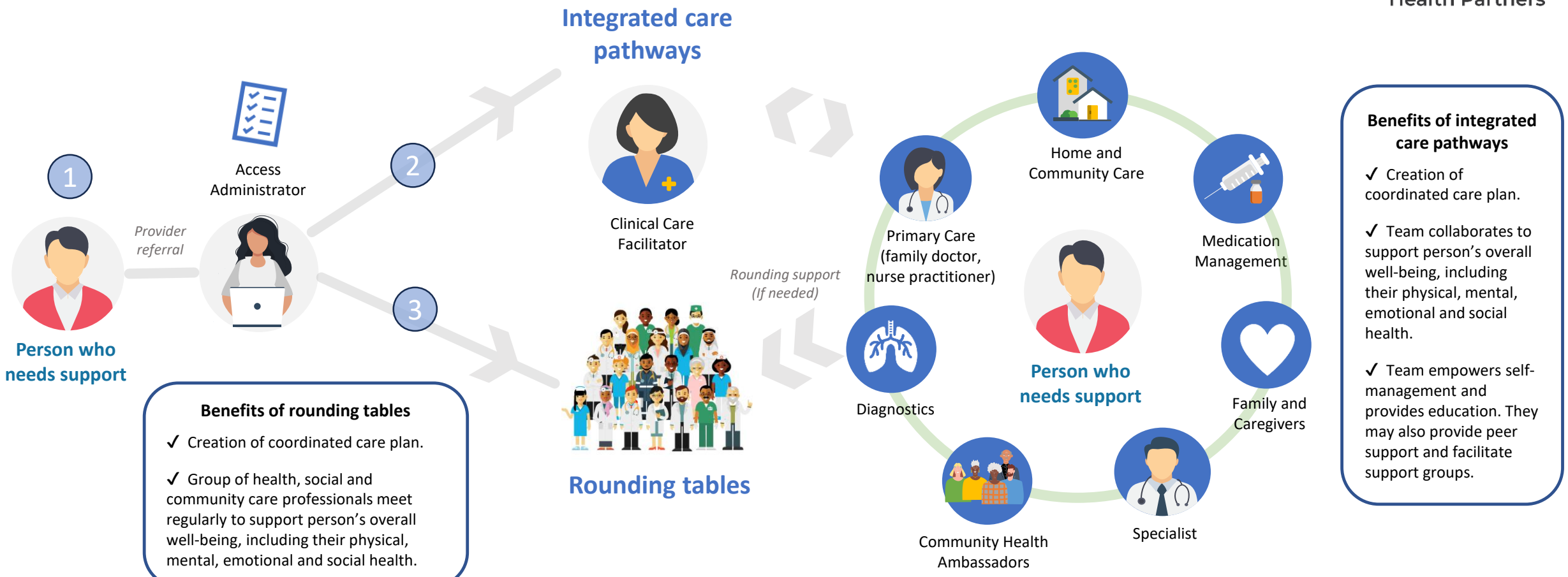


East Toronto Health Partners

East Toronto Care Network (EastTCaN)

This integrated care program offers two types of support: **Integrated care pathways** for people with chronic heart failure (CHF) or chronic obstructive pulmonary disease (COPD); and **rounding tables** for people aged 18+ who have unmet health and social needs. Learn more at ethp.ca/EastTCaN.

East Toronto Health Partners



Benefits of rounding tables

✓ Creation of coordinated care plan.

✓ Group of health, social and community care professionals meet regularly to support person's overall well-being, including their physical, mental, emotional and social health.

Benefits of integrated care pathways

✓ Creation of coordinated care plan.

✓ Team collaborates to support person's overall well-being, including their physical, mental, emotional and social health.

✓ Team empowers self-management and provides education. They may also provide peer support and facilitate support groups.

1 **A person is referred to EastTCaN's integrated care pathways or rounding tables,** depending on the person's eligibility and the support they need. An Access Administrator processes the referral and starts a coordinated care plan.

2 **If the person is referred to integrated care pathways,** they meet a Clinical Care Facilitator, who becomes the person's main point of contact in the program and:

- Meets the person regularly to ensure they have the support they need;
- Builds the coordinated care plan for the person; and
- Connects the person to a larger group of health, social and community care providers who work together to address needs and support well-being.

The person may also receive support from rounding tables as appropriate.

3 **If the person is referred to rounding tables,** their referring care team member discusses the person's needs with a larger group of health, social and community care providers who work together to support the person's well-being.

Last updated: April 14, 2025

East Toronto Care Network (EastTCaN) COPD Pathway

Health and Social Care: Building a healthier and more equitable East Toronto - enabling every person and neighbourhood to thrive

East Toronto Health Partners

Phase 1: Acute Care

Phase 2: Primary Care

Phase 3: Community

Remote Care Monitoring

RCM for Post Acute Care Admissions

★ *QS11-Follow-up after an acute exacerbation of COPD*

Access Administrators

Clinical Care Facilitators

★ *QS2- Comprehensive Assessment*

★ *QS3-Goals of Care and Individual Care Planning*

★ *QS10- Management of Acute Exacerbations*

★ *QS14-Long-Term Oxygen Therapy*

ETHP Collaborate

Shared Care Planning Tool for Collaborative, Coordinated Care Management

Primary Care

★ *QS7- Vaccinations*

Home and Community Care

★ *QS5-Promote Smoking Cessation*

Medication Management

★ *QS6-Pharmacological Management*

Person

★ *QS4-Education and Self-Management*

Family and Caregiver

Diagnostics

★ *QS1- Diagnosis confirmed with spirometry*

Community Health Ambassadors

Respirology

★ *QS8- Specialized Respiratory Care*

★ *QS13- Palliative Care*

★ *QS 9 & 12- Pulmonary Rehabilitation*

Key Program Features

- ✓ Guidance from the Canadian Thoracic Society, Treatable Traits and the Lung Foundation
- ✓ Holistic Case Management
- ✓ Medication Management
- ✓ Rounding Support
- ✓ Team-Based Care
- ✓ COPD Education

★ *Health Quality Ontario (HQO) Quality Statement*

Referral	Enrollment	Ongoing Assessments and Custom Care Planning	Outcomes
• Phased referral sources into program	• Patient/Client Profile: SDoH, Self-efficacy, Access to services (caregiver, virtual), care journey, etc.	• Evidence-based care management • Understanding care needs • Making service connections (person-centered care) • Self-management resources • Regular check-ins	✓ Reduced Acute Care Utilization (ED, Beds) ✓ Self-Mastery ✓ Better Quality of Life ✓ Quintuple Aim

East Toronto Health Partners

East Toronto Care Network (EastTCaN) CHF Pathway

Health and Social Care: Building a healthier and more equitable East Toronto - enabling every person and neighbourhood to thrive

East Toronto Health Partners

Phase 1: Acute Care

Phase 2: Primary Care

Phase 3: Community

Remote Care Monitoring

RCM for Post Acute Care Admissions

★ *QS9-Transition From Hospital to Community*

Access Administrators

Clinical Care Facilitators

★ *QS2- Individualized, Person-Centred, Comprehensive Care Plan*

★ *QS6- Worsening Symptoms of Heart Failure*

★ *QS7- Management of Non-cardiac Comorbidities*

ETHP Collaborate

Shared Care Planning Tool for Collaborative, Coordinated Care Management

★ *Health Quality Ontario (HQO) Quality Statement*

★ *QS5- Quadruple Therapy for People With Heart Failure Who Have a Reduced Ejection Fraction*

Medication Management

Primary Care

Home and Community Care

Person

★ *QS3- Empowering and Supporting People to Develop Self-Management Skills*

Family and Caregiver

Diagnostics

★ *QS1- Diagnosis confirmed: Labs & Echo*

★ *QS4- Physical Activity and Exercise*

Lifestyle and Behaviour Change

Heart Function Clinic/Cardiology

★ *QS8- Specialized Multidisciplinary Care*

★ *QS10- Palliative Care and heart failure*

Key Program Features

- ✓ CorHealth Ontario Spoke-Hub-Node Model for Integrated Heart Failure Care
- ✓ Holistic Case Management
- ✓ Medication Management
- ✓ Rounding Support
- ✓ Team-Based Care
- ✓ CHF Education

Referral	Enrollment	Ongoing Assessments and Personalized Care Planning	Outcomes
• Phased referral sources into program	• Patient/Client Profile: Social Determinants of Health, Self-efficacy, Access to service, Caregiver supports, Health and digital literacy, Care journey, etc.	• Evidence-based care management • Medication Management • Goals of care and service connections (person-centered care) • Self-management resources • Regular check-ins	✓ Reduced Acute Care Utilization ✓ Self-Mastery ✓ Better Quality of Life ✓ Quintuple Aim

East Toronto Health Partners

East Toronto Care Network (EastTCaN)

Integrated Care Pathways- Operational Dashboard

Empowering individuals to take control of their health, ICP supports people to manage their chronic disease—rather than their chronic disease managing them. Through integrated, person-centered care and proactive planning, we help individuals lead healthier, more independent lives.

Program Goals

- Reduce Acute Care Utilization
- Improve Self-Management
- Increased Quality of Life
- Quintuple Aim

Patients in Pathway

84

Care Plans Created

Crisis Encounters

58

27 Avoided ED Visits
2 Necessary Visits

Program Discharges

Program Total	9
Non-survival	3
Transferred to CHC or moved	3
Unreachable	3

NUMBER OF CARE PLANS CREATED
84

PROGRAM ENROLLMENT RATE
~75% (expected 20%)

ED AVOIDANCE
27

READMISSIONS (coming soon)
X

Two Week Review (April 7-18)

14 Patients Identified

13 Patients Offered

10 Patients Enrolled

Top Services Needed

Service	Opportunity
Mental Health/Social Work	• Developing partnerships with CCIS • TNO/FHC Integrated Mental Health • Working with MH/SU portfolios
Homecare	• Direct referral to homecare leading project (when eligible) • MGH2Home (when eligible) • Working with Ontariohealth@Home
Smoking Cessation	• MGH training and resources • Partnership with Bridgepoint
Rehab	• Partnerships with virtual providers

IMPACT STORIES

1. *Palliative COPD Patient Maintaining Functionality and Avoiding Hospitalization*

A palliative COPD patient, who remains highly functional, has successfully avoided hospital admissions since enrolling in the program. Through evidence-based COPD action plans, the patient has been effectively treated for multiple exacerbations. EastTCaN facilitated home oxygen setup and expedited respirology follow-ups when needed. Additionally, collaboration with the visiting respiratory therapist (RT) led to a transition to a more user-friendly inhaler, significantly improving the patient's symptom management.

2. *Coordinated Support for a Socially Complex Patient*

A patient with significant social complexities is receiving enhanced care coordination through EastTCaN. Working closely with the patient's case worker and case manager, we brought her situation to EastTCaN rounds, leading to the activation of multiple support pathways tailored to her needs. This multidisciplinary approach is ensuring she receives the necessary resources and care.

3. *Mental Health and Respiratory Support for an Anxious Patient*

A patient struggling with anxiety has been successfully connected to mental health support, which he reports as highly beneficial. Close collaboration with his primary care provider (PCP) enabled an expedited home visit during a recent exacerbation. Additionally, after his respirologist retired, the team arranged for a new specialist at MGH to ensure continuity of care for his complex lung condition.

4. *Transforming Care for a Patient Previously Bedbound*

An NP caring for a patient faced challenges in securing appropriate support. Initially, the patient was bedridden and unresponsive to calls. Through EastTCaN rounds, she was connected with the CCIST team, leading to a structured support plan. A multidisciplinary team—including the NP, CCF, and CCIST—has maintained regular communication to ensure ongoing care. The patient now attends follow-ups consistently, and her concerned roommate has expressed relief and satisfaction with her progress.

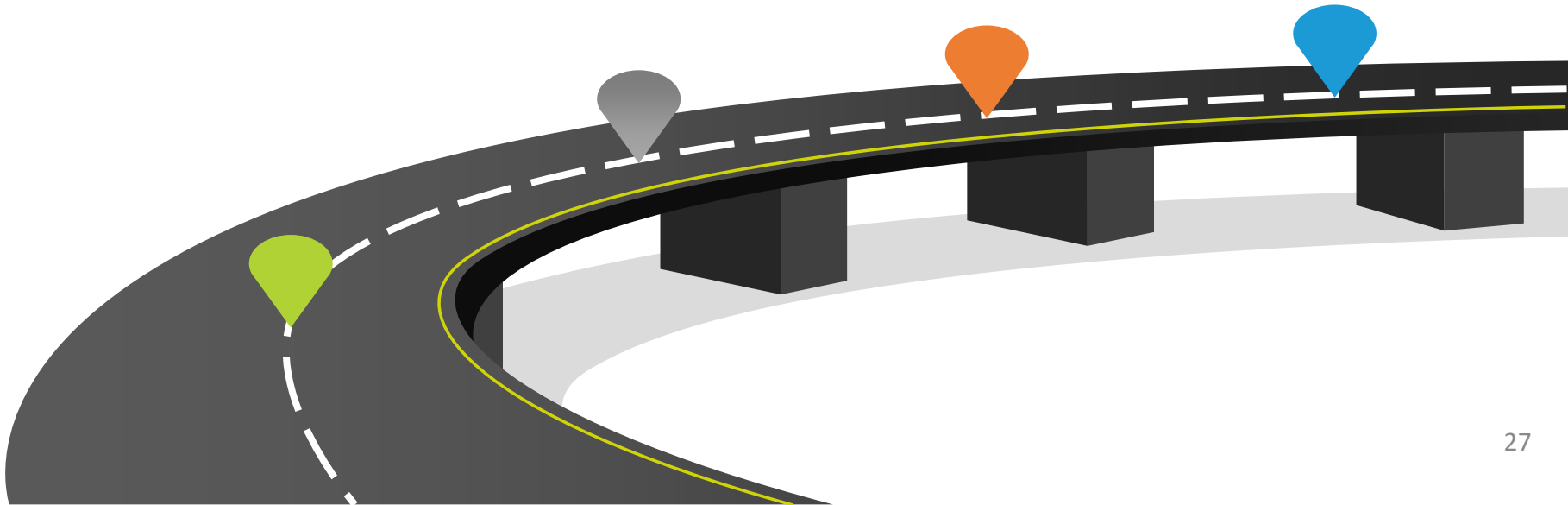
System Implications & Next Steps

Why This Matters:

- A scalable model for integrated care- we build the engine
- Digital enablers & team-based workflows embedded
- Strengthening East Toronto's system capacity
- Integrated care is not about connecting services, its about centering care around people and their needs

What's Next:

- Expand to more pathway; Post Ventilation (in progress), Diabetes Lower Limb, Mental Health
- Alignment with ETHP integrated care vision
- Evaluation
  - Provider & Patient journey maps
  - Healthcare utilization data (comparing pre- and post-program metrics to assess impact)



East Toronto Health Partners

Dr. Reham Abdelhalim & Abhi S. Regmi

Burlington OHT

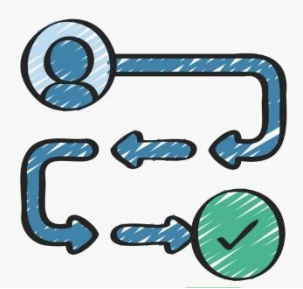
The Road Towards Evidence-based, Person-centered, Provider-friendly Integrated care Management of Chronic Conditions

Dr. Reham Abdelhalim
Manager, Population Health and Evaluation, BOHT

Abhi S. Regmi
Manager, *Information Management, Digital Health & Projects, BOHT*

BURLINGTON ONTARIO HEALTH TEAM

The beginning of the Journey



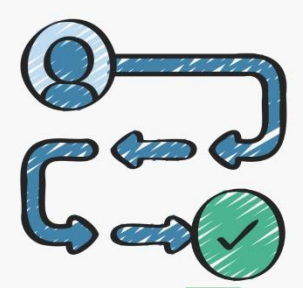
- The Burlington OHT was one of the initial OHTs to receive approval. In late 2023, the Burlington Ontario Health Team (BOHT) was identified as one of 12 OHTs who would be supported with additional resources to accelerate their journey to become a designated OHT.
- A designated OHT will be fiscally and clinically responsible for their attributed population. A new set of deliverables and tasks were assigned to the accelerated OHTs.
- The first of these tasks was to design and implement two clinical pathways for individuals living with Chronic Obstructive Pulmonary Disease (COPD) and Heart Failure (HF).
- The BOHT's approach to co-designing interventions with a population health perspective necessitated a redefinition of clinical pathways to better fit within an integrated care system.
- The goal was to create integrated care pathways that cover the entire disease trajectory, from prevention and early detection to palliation, and facilitates care across various health and social care settings.

What we did …

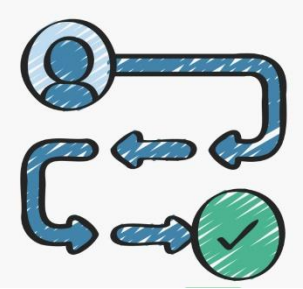
- BOHT launched an extensive community engagement process to understand the current state of care for both conditions and design the ideal future state
- The findings of this engagement process informed the BOHT plan
- About 70 Key informants
- About 100 hours of engagement
- We worked very closely with GHHN and MLOHT

BURLINGTON ONTARIO HEALTH TEAM

Outcome: Guiding Principles for Co-designing COPD and HF Care Pathways



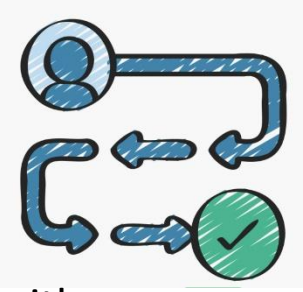
- We are building care pathways not clinical pathways*
- Our pathways are person-centered
- Our pathways are evidence-based
- Our pathways are standardized yet adaptable
- Our pathways are provider- friendly
- Our pathways are for all individuals living with COPD or HF in our community
- Our pathways are easy to adapt
- Our pathways are equitable
- Our pathways are sustainable



Care Pathways Vs Clinical Pathways

A Care Pathway	A Clinical Pathway
Focuses on the majority if not all of individuals living with the chronic disease	Focuses on the more complex segment of individuals living with the chronic disease
Pays special attention to upstream interventions looking at prevention and early detection as main components of the pathways	Centres more on management and reduction of acute care utilization
Addresses clinical and non-clinical needs of individuals living with the chronic disease	Clinical needs are prioritized
Recognises the intersection between concomitant chronic diseases whether physical, psychological or mental.	Focuses on one chronic condition

Findings Highlights



- Currently, many programs existed in the community to serve individuals living with COPD and HF. However, these programs remain siloed and awareness about these programs is equally challenging to providers and patients.
- Primary care providers lack access to consistent, evidence-based resources when it comes to diagnosing, managing and navigating their patients who live with COPD, HF and other chronic conditions.
- Standardized care that is based on updated evidence-based quality standards was an area of improvement identified by various stakeholders.
- Lack of coordination across various providers and care settings was another gap that was described by the participants
- Support to self-management and patient education was an area for improvement

An Integrated System For Chronic Disease Prevention And Management

Prevention Y2 onwards

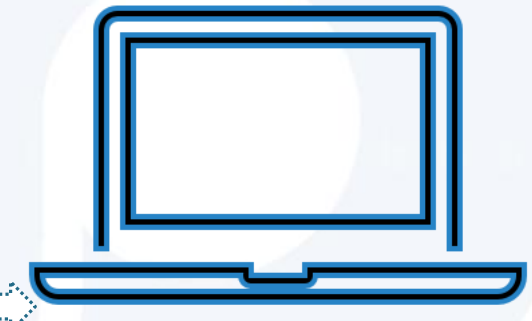
Palliation and End of Life Y2 onwards

Early ID & Management Y1 onwards

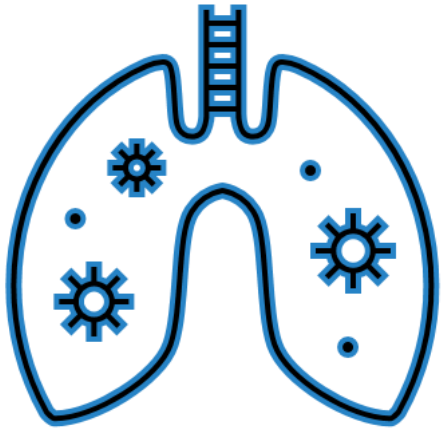
Digital Enabler

Interdisciplinary Team

Shared Digital Resource



Capacity Building for community Services and self-management

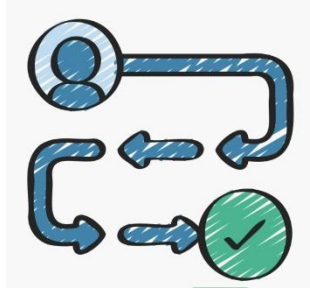


System Navigation

Remote Care Management

BURLINGTON ONTARIO HEALTH TEAM

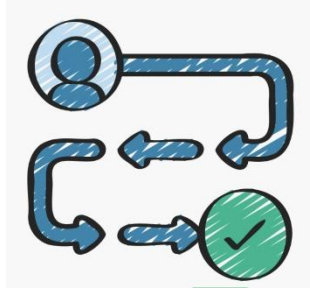
Collaborate



BURLINGTON ONTARIO HEALTH TEAM

MIDDLESEX LONDON Ontario Health Team

Greater Hamilton Health Network



We have a winner!

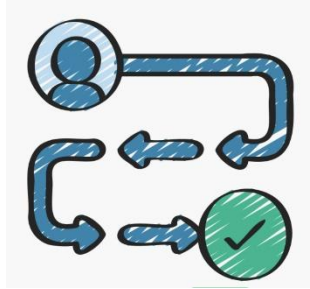
HealthPathways is a trusted, online, clinical guidance tool that provides healthcare professionals with instant access to hundreds of condition-specific, evidence-based guidelines and resources.

Each pathway has:

1. **clear and concise steps** for assessing, managing and referring patients within the local health system, and is
2. **designed for use at the point of care** by primary care providers (including family physicians, nurse practitioners and allied health professionals).

HealthPathways Community

Implementation



- Tri-OHT Teams
- Collaborative Governance
- Pathways Selection
- Communications and engagement
- Evaluation

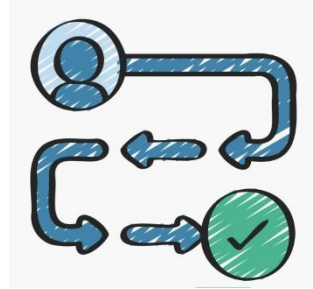
Implementation

It's about collaboration

- One of the main benefits of HealthPathways is that the process of developing content requires conversations between primary and secondary care. Every pathway represents local agreements that reflect "'how we do things around here today.'"
- Doctors and other health professionals with experience in the pathway condition are involved in compiling and adapting content.
- Technical writers provide support by guiding information design, focusing on the user, and ensuring standardisation across the site.

40-50 care pathways will be reviewed, localized, and published to our region by June 2025.

Value proposition



Platform is easy to use and designed for point-of-care use

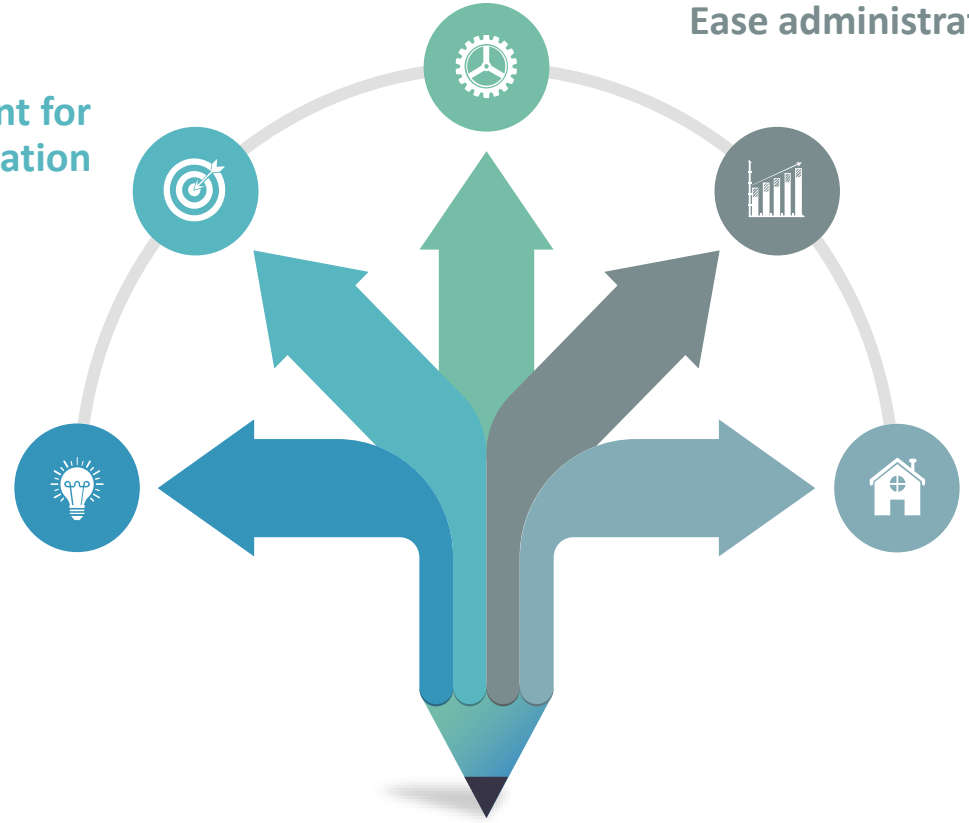
Ease administrative burden

Create one single access point for important care information

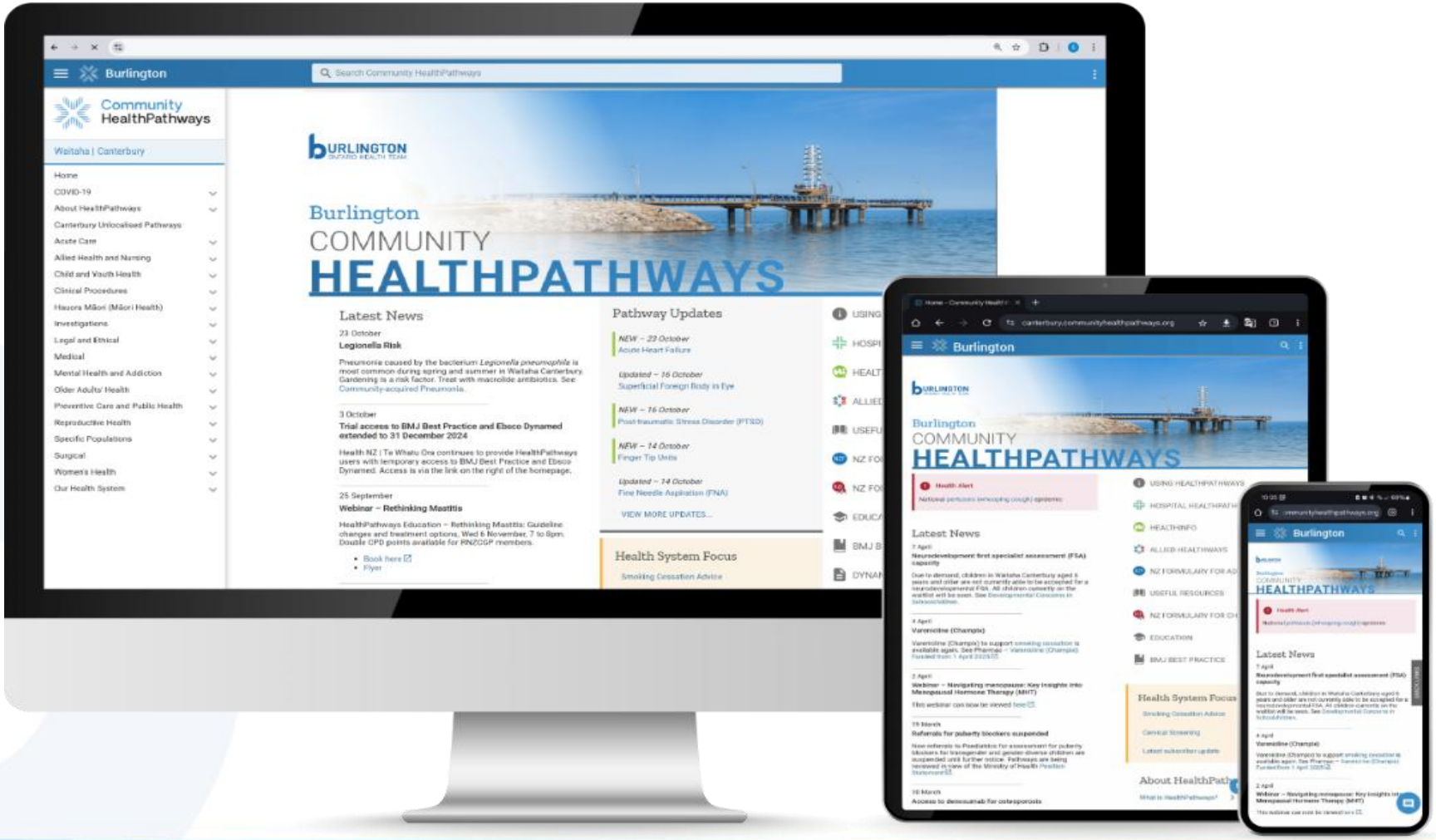
Foster collaboration across specialties, allowing more coordinated care and greater options in managing patients

Ensure simplified access to clinical guidance in real time

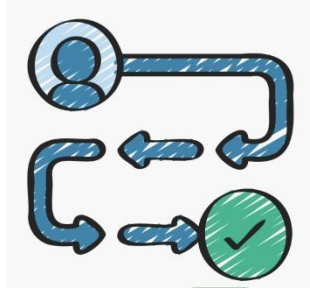
Reduce variation in care



Almost here…


Burlington
Community HealthPathways
Waitaha | Canterbury
Home
COVID-19
About HealthPathways
Canterbury Unlocalised Pathways
Acute Care
Allied Health and Nursing
Child and Youth Health
Clinical Procedures
Hauora Māori (Māori Health)
Investigations
Legal and Ethical
Medical
Mental Health and Addiction
Older Adults' Health
Preventive Care and Public Health
Reproductive Health
Specific Populations
Surgical
Women's Health
Our Health System
BURLINGTON
Burlington
COMMUNITY
HEALTHPATHWAYS
Latest News
23 October
Legionella Risk
3 October
Trial access to BMJ Best Practice and Ebsco Dynamed extended to 31 December 2024
25 September
Webinar – Rethinking Mastitis
Pathway Updates
NEW – 23 October
Acute Heart Failure
Updated – 16 October
Superficial Foreign Body in Eye
NEW – 16 October
Post traumatic Stress Disorder (PTSD)
NEW – 14 October
Finger Tip Units
Updated – 14 October
Fine Needle Aspiration (FNA)
VIEW MORE UPDATES...
Health System Focus
Smoking Cessation Advice

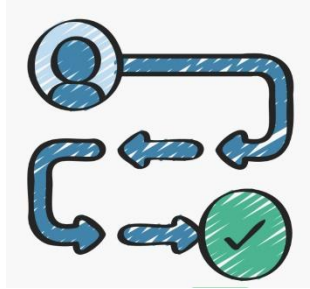
Take Home Messages



Engagement, engagement, engagement

Implementing best practices within integrated care systems requires tweaking, tailoring and adaptation

Collaborative approaches among integrated care networks can facilitate innovation and forward thinking



Thank you

Abhi Regmi

aregmi@burlingtonoht.ca

Reham Abdelhalim

rabdelhalim@burlingtonoht.ca

Dendra Hillier & Ali Somers

Frontenac, Lennox & Addington OHT

FLAOHT Frontenac Lennox & Addington Ontario Health Team | ÉSOFLA Équipe Santé Ontario de Frontenac, Lennox et Addington

Integrated Clinical Pathways CHF and COPD

Prepared for HSPN




FLAOHT | ÉSOFLA

3 Hospitals

160 Family doctors

Populatio n ~210,000

80+ Partners

May – Dec 2022

Strategic Plan Development

Jun 2022 – Feb 2023

KHSC CHF Pathway Development

Oct 2023

ICP Funding (CHF and COPD)

Oct 2023 – Mar 2024

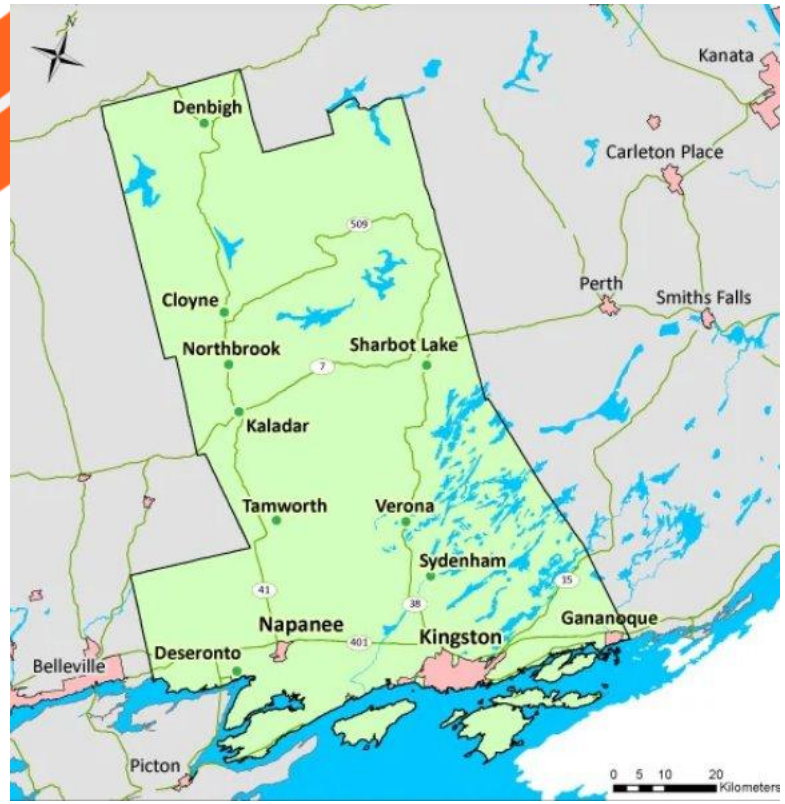
ICP Planning

April 2024

ICP Initiatives Launched

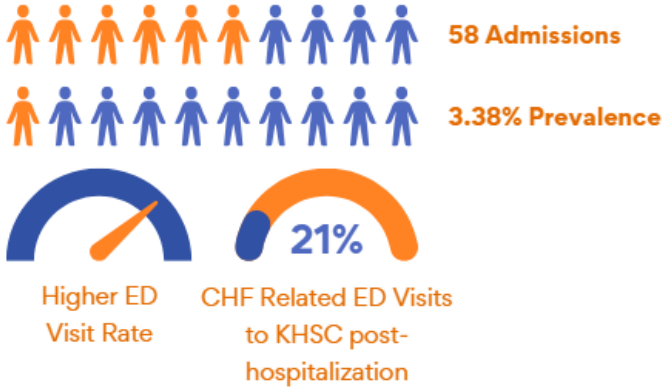
Apr - Sep 2024

Partner Organization



ICP Development

CHF

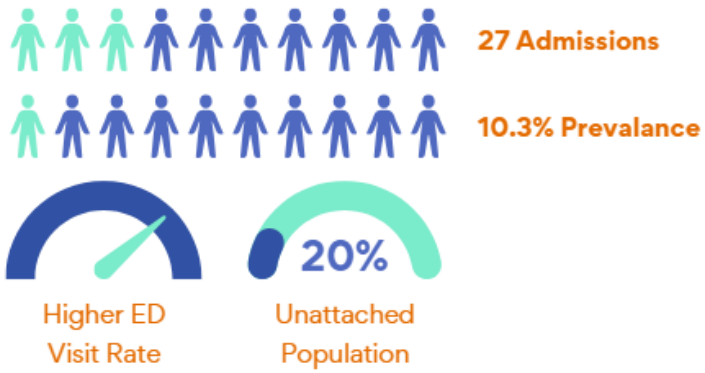


Opportunities for Change

- Coordination of care between spokes, hubs and nodes
- Primary Care assessments
- Existing local resources with a willingness to help

*Admissions per 100 affected patients

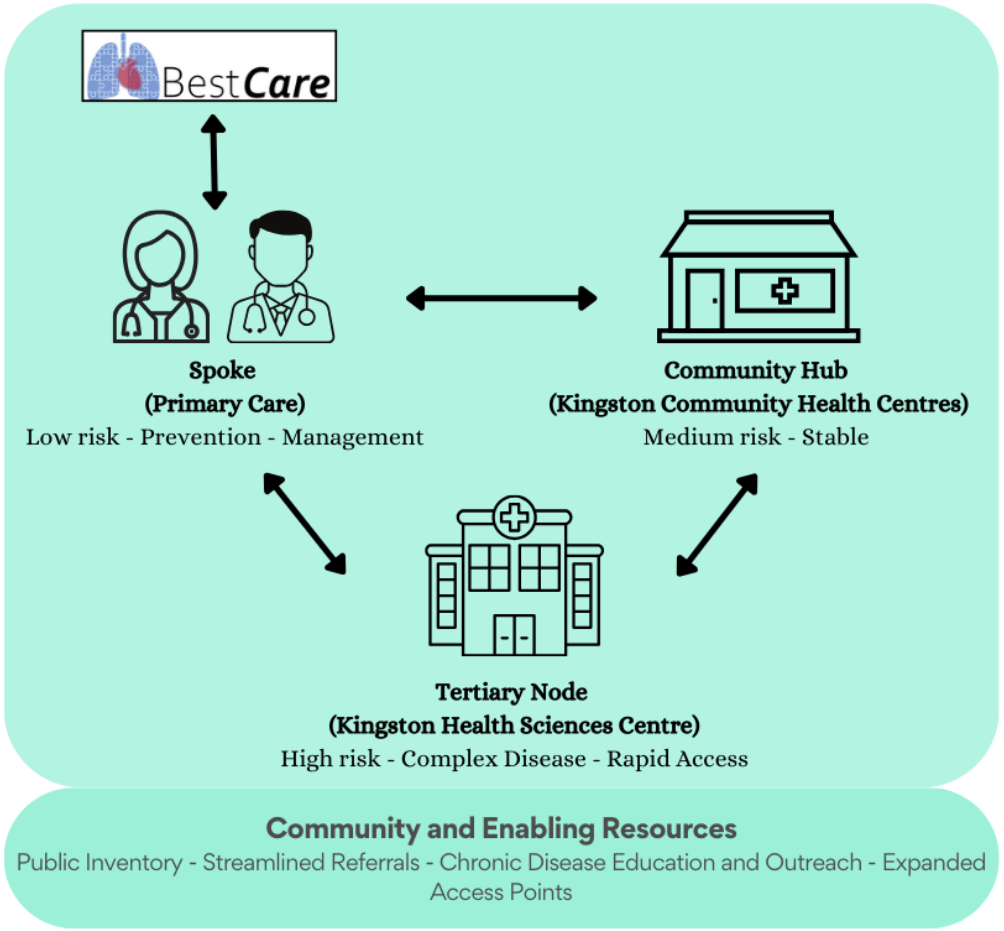
COPD



Opportunities for Change

- Bringing spirometry closer to home
- Primary Care assessments
- Virtual pulmonary rehabilitation

Model Overview



FLAOHT | ESOFLA

Initiatives

After mapping our regional system, key initiatives were identified to strengthen care for those with COPD and CHF in FLA.

Hiring Personnel

Personnel to support:

- COPD pathway navigation
- CHF clinical assessment
- Data review
- Project management

Reviewing ED Data

Review of KHSC ED Data to identify people with COPD and CHF who require follow up and medication optimization.

Training Healthcare Providers

Develop training on each pathway for healthcare personnel, including:

- Primary Care Providers
- Community Paramedics
- Transition Care Nurses
- OH@H Remote Care Monitoring Nurses

Unattached Patients

Identify a Primary Care Provider who is willing to take on patients who arrive to KHSC ED and design pathway to getting them attached.

Best Care Pilot

Embed Certified Integrated Disease Clinicians in Health Homes across the region to provide care to people with COPD and CHF.

Virtual Pulmonary Rehabilitation

Provide enhanced access to pulmonary rehabilitation for those with COPD.

Rapid Access Clinics

Develop and coordinate rapid access clinics across the region for those who visit the hospital for COPD and CHF.

Developing Protocols

Develop protocols for healthcare teams to streamline care transitions.

FLAOHT | ESOFLA

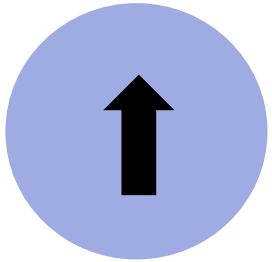
ICP Metrics

Integrated Care Pathways by the numbers for 2024-2025

7
Personnel Hired

86
Healthcare Providers Trained

50
Patients Attached


Increased HF Clinic capacity and access

12
Months of ED Data Reviewed

20
People completed virtual pulmonary rehabilitation

5
Protocols Developed

4
Rapid access clinics coordinated

FLAOHT | ÉSOFLA

ICP Metrics: Best Care

Integrated Care Pathways by the numbers for 2024-2025

250

Visits completed

96%

People seen have COPD Action Plan

More insights about our region, like pack years and Gold classification

25% → 49%

Increased Closed Triple Therapy for COPD

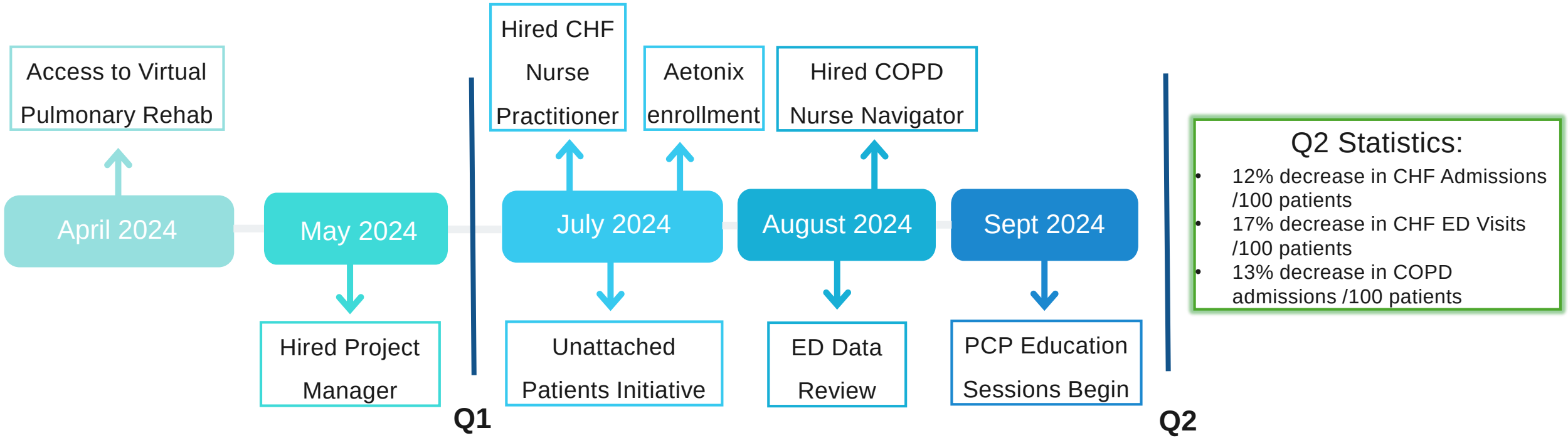
10% → 2%

Decreased % of people on no daily controller therapy for COPD

FLAOHT | ESOFLA

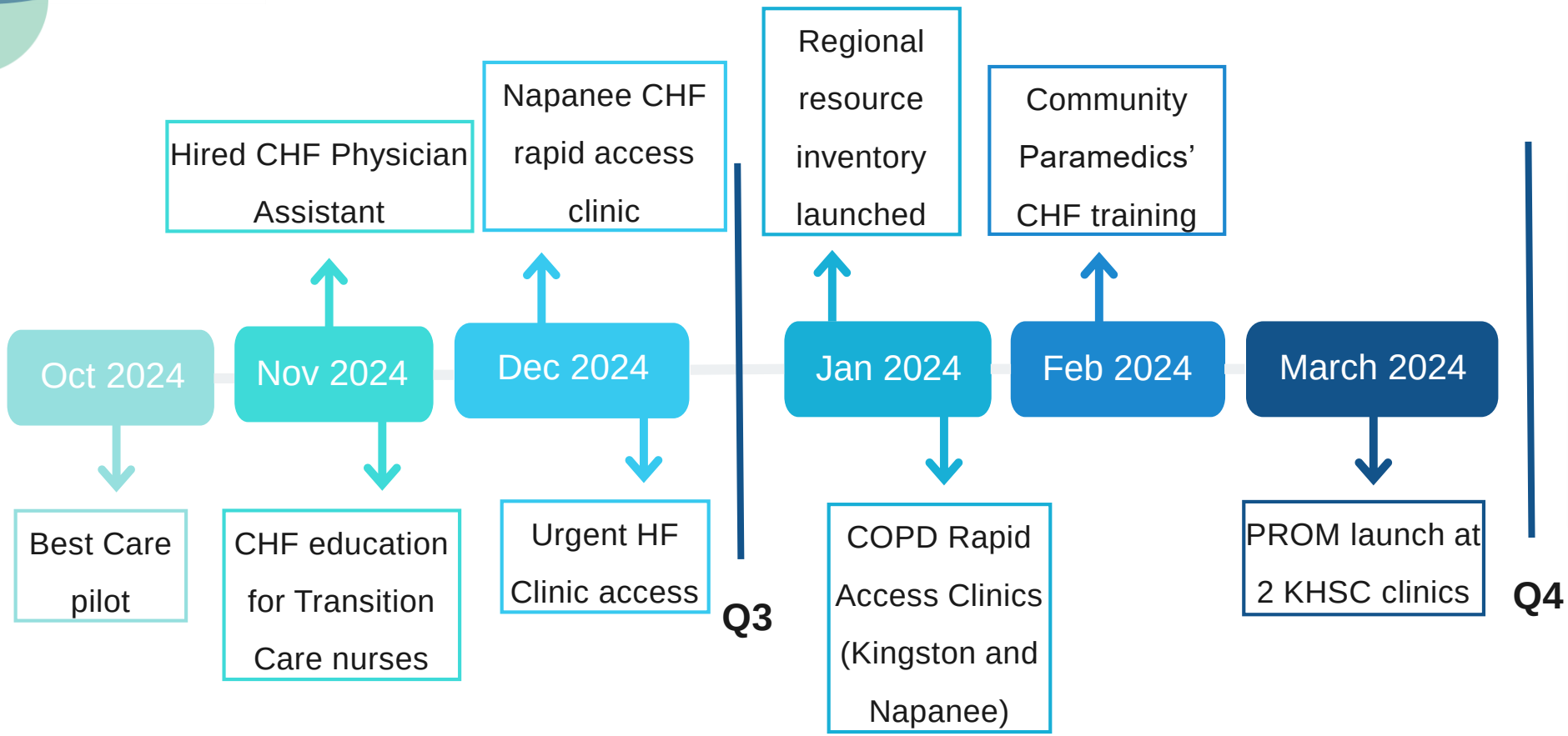
Q1-2

ICP Initiatives Timeline



Q3-4

ICP Initiatives Timeline

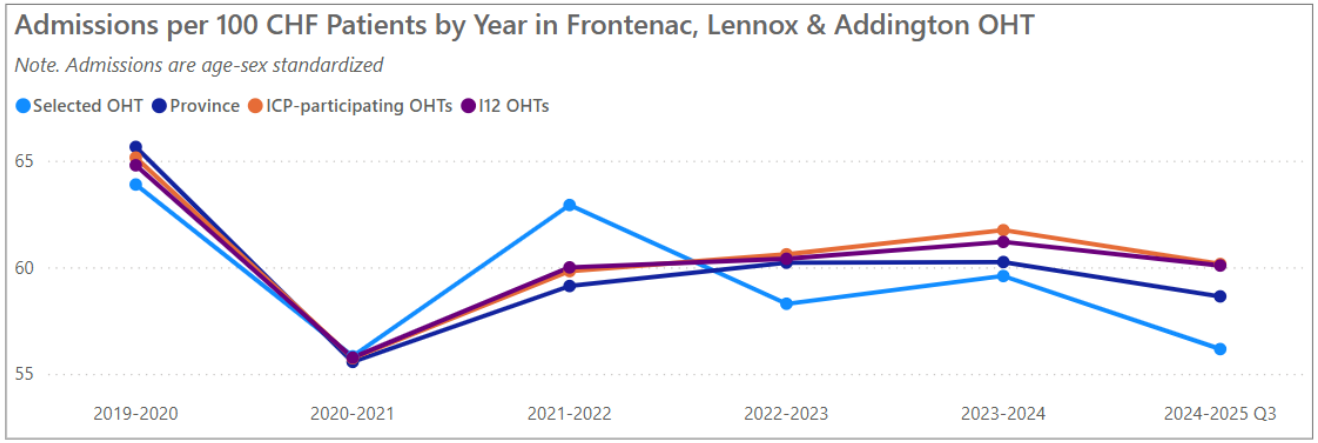


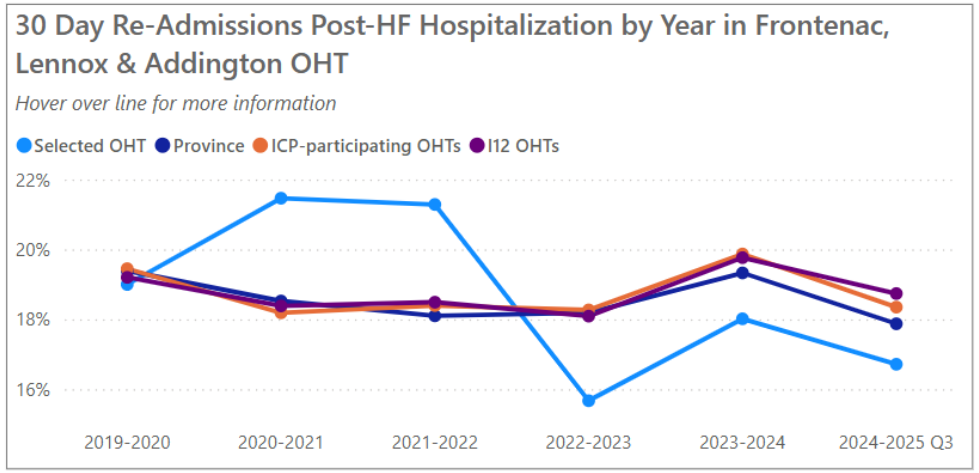
Q3 Statistics:

- 12% decrease in CHF Admissions
- 18% reduction in CHF ED Visits
- 17% reduction in COPD Admissions
- 4% reduction in 30-day readmissions for COPD (from 19% to 15%)
- Increased spirometry rates to 37.4%

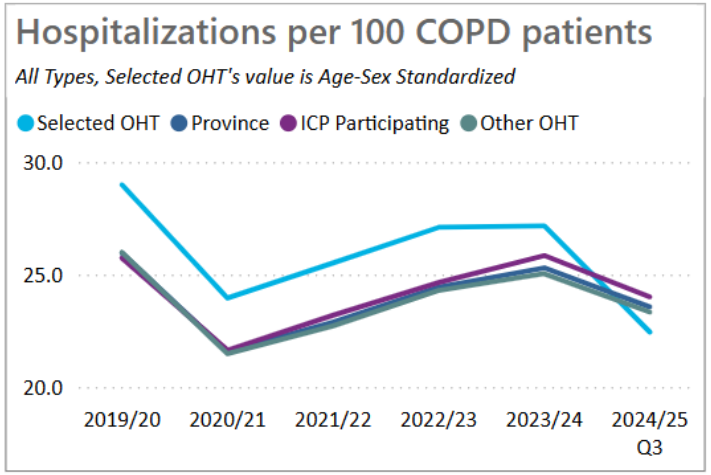
ICP Outcomes

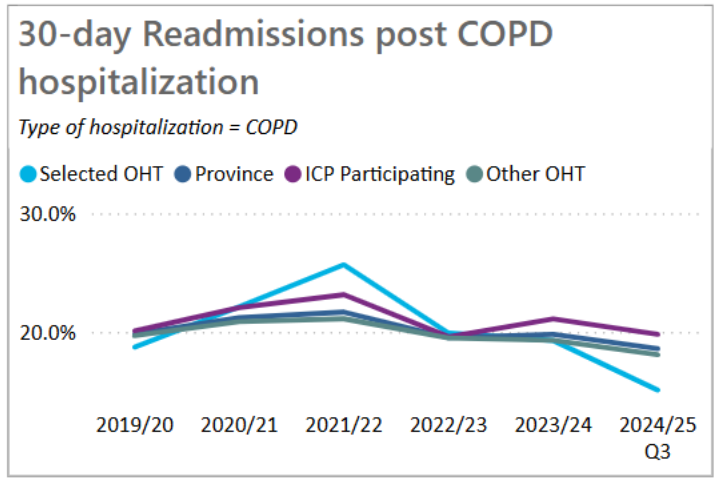
CHF





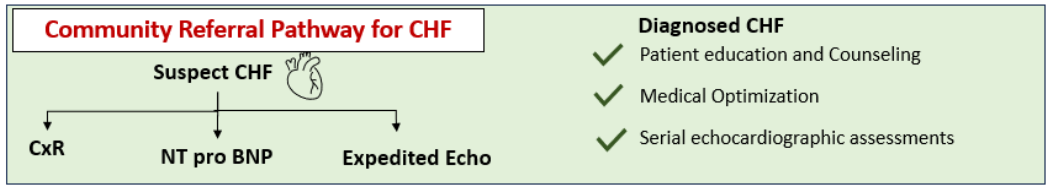
COPD

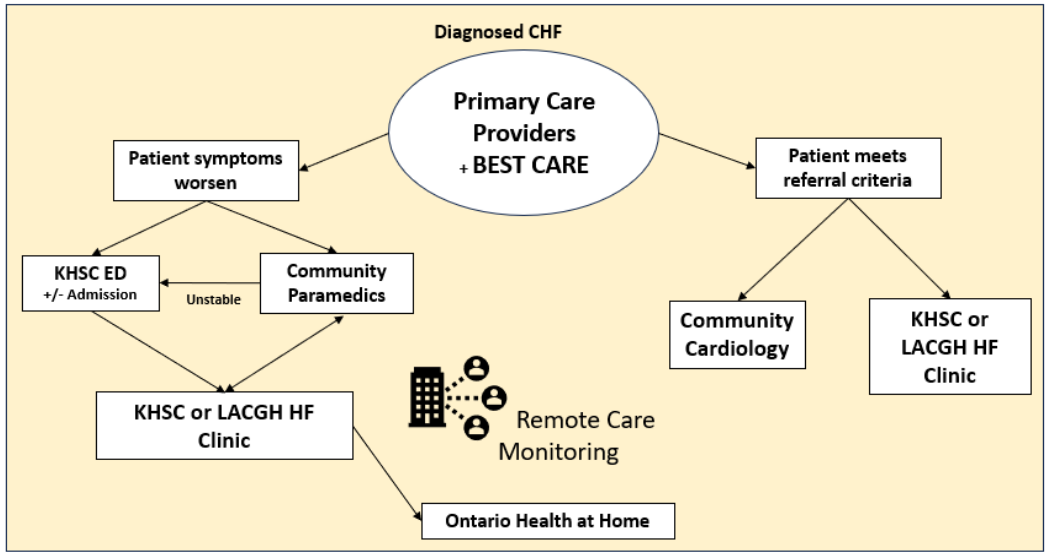




Detailed Workflows

CHF





Outpatient

KHSC HF Clinic
Supporting PCP and BEST CARE

E-consult OTN.ca

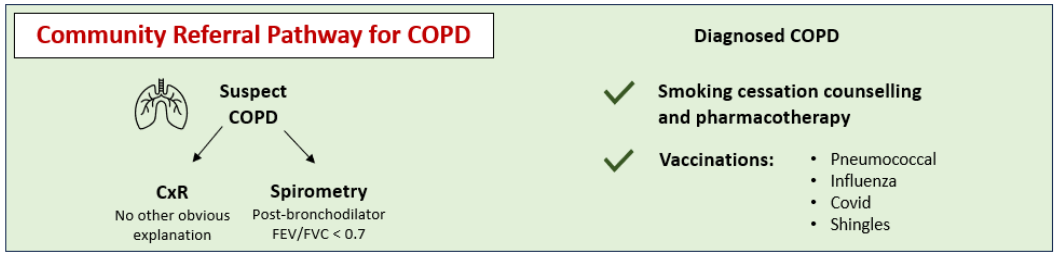
Heart Failure **Hotline**

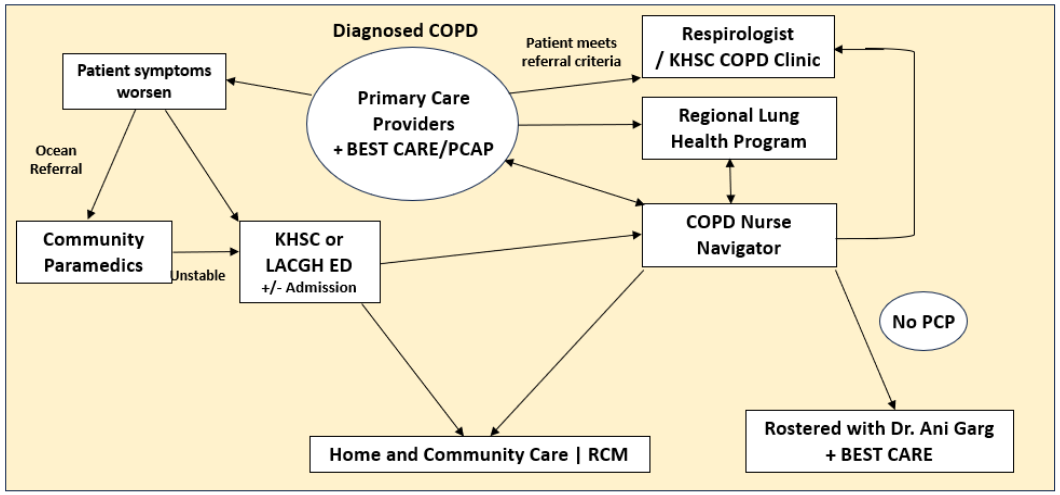
Calling HF Nurse Practitioners
613-449-2889
9 am -5 pm
Mon-Friday

HF Physician Assistant

In-patient

COPD



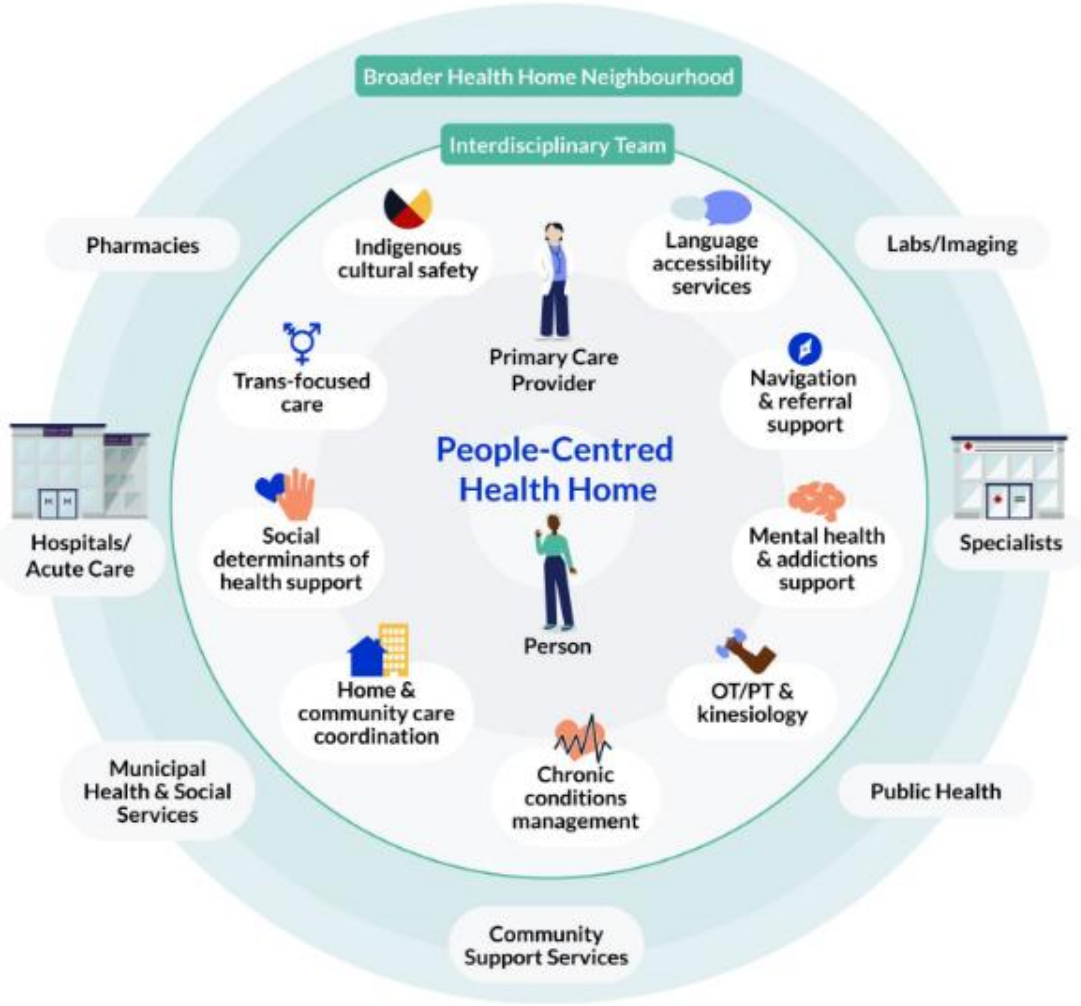


Health Home Overview

Geographic Health Homes with an interdisciplinary team-based approach are central to the FLA OHT strategy

How ICPs compliment the Health Home Model:

1. Unattached people entering the pathways can be connected to primary care through ICP integration with the Primary Care Network
2. Building capacity for chronic disease identification and management at the primary care level
3. Streamlining referrals to specialty care
4. Strengthening community partnerships and resource navigation



FLAOHT | ÉSOFLA

Summary

Enablers

- Recruit highly engaged and passionate leaders as Pathway Leads
- Create opportunities for connection and collaboration across different providers
- Pathway documents and maps allow for shared understanding across various providers

Lessons Learned

- Map your pathway early – identify siloes and overlaps in service
- Track as many local metrics as possible
- Understand each organization's priorities to estimate impacts on ICP implementation, especially partners tackling internal transitions (technical or structural)
- Establish MOUs and other agreements early in implementation to avoid delays and confirm collective objectives

Melissa Chang
UHN's Integrated Care Program

UHN Integrated Care

UHN's Integrated Care Program

Prepared for HSPN Integrated Care Pathways Webinar

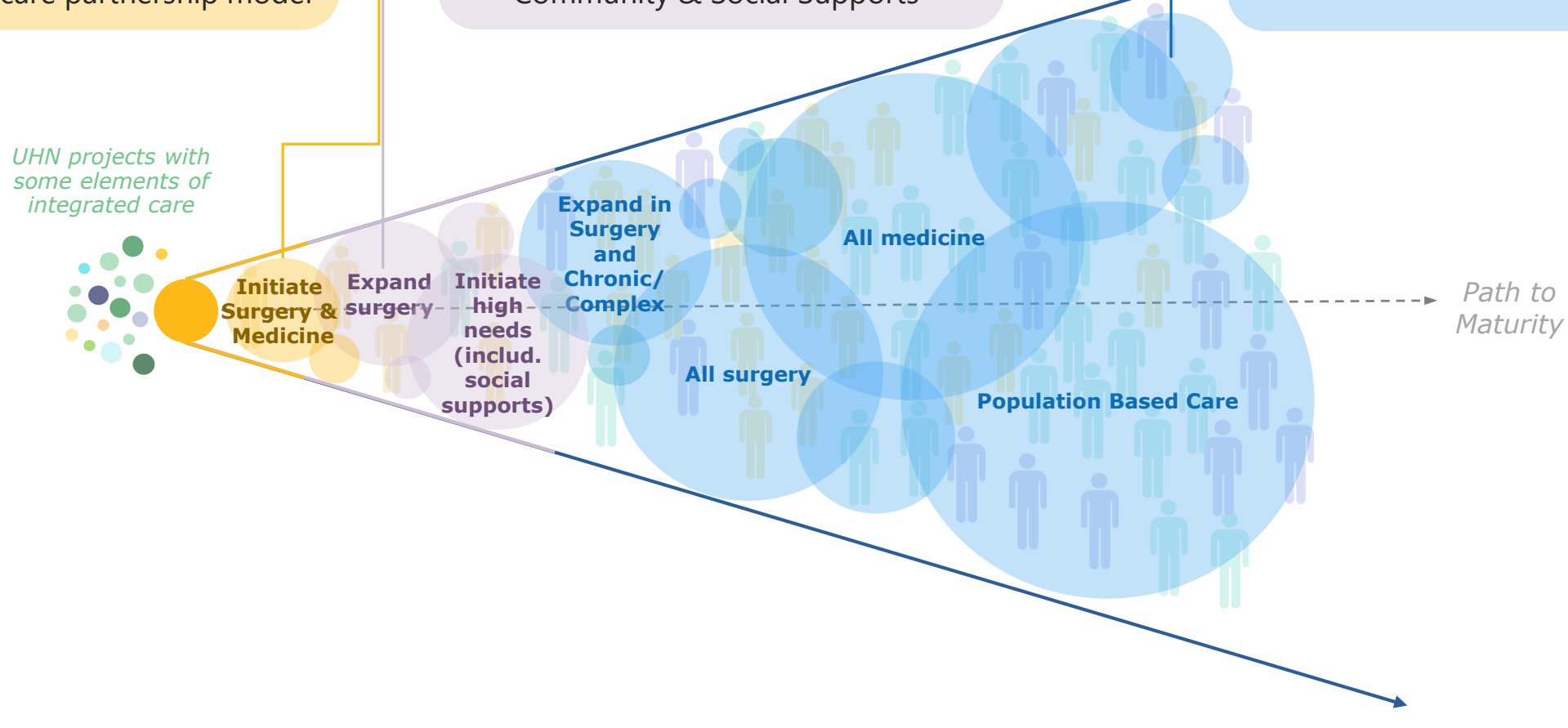
Melissa Chang
Sr. Director
Integrated Care,
UHN Connected Care

Driving Tomorrow's Care

PHASE 1
- Tests of Change in Surgery & Medicine
- Evaluation to Expand
- Establish homecare partnership model

PHASE 2
- Expand in Medicine and Surgery
- Digital Enabler strategy
- Integration with ED, Primary Care, Community & Social Supports

PHASE 3
- Population based approaches (Older Adults, Community-Enabled approaches)



The Integrated Care Experience

One Team

Care Coordination

One **consistent care team** with a **primary point of contact**

One Digital Record

Continuity of Care

One **story to tell**, enabled by a **shared digital record**

One Number to Call

Timely & Accessible

One **24/7 phone line** available to patients and caregivers

One Integrated Fund

Customizable

One **integrated fund** to support patient needs

Collective Commitments

Integrated Care at UHN is an evidence-based model of care that wraps care around patients, their essential care partners and care providers needs. We are creating a standard of care to advance Acute Care in the Home.

Following the principles below set by international best practice we target to be in the **best decile of health outcomes, length of stay, patient and care provider satisfaction.**

1. Provide **24/7 access** to reach a person at all times
2. **Respond in <30 min** when patients or care providers request clinical advice
3. Establish **clear patient action plans** including escalation paths with standing orders or medical directives for worsening symptoms where relevant
4. Enable **direct care or admissions** (not via the Emergency Department) wherever possible
5. Ensure **health equity** by having clear mechanisms for at risk and equity deserving populations to participate in program
6. Embed **continuous quality improvement** and evaluation

Traditional Health Care vs. Integrated Care

PATIENT JOURNEY	Arrival & Referral	Hospital Stay	Discharge Planning	Recovery @ Home
TRADITIONAL HEALTH CARE MODEL			• At point of discharge - eligibility assessment completed by **hospital care coordinator** • Timing and approved type(s) of home care services is unknown to the hospital team	• Transfer to **community care coordinator** • Multiple medical records, numbers to call, limited hours (8am-8pm) and multiple **care providers** • Limited bidirectional information sharing • No direct access back to hospital team
INTEGRATED CARE MODEL	• **IC Lead** at earliest point (ex: pre-op) in hospital admission • Reviews expectations for hospital stay • Early identification of barriers to discharge and flag to integrated **homecare team**	• **IC Lead** embedded within patient unit; links hospital and home care team; supports earliest return home	• Co-create care plan in collaboration • Simultaneous planning with **care providers**	• **IC Lead** remains point of contact • ONE medical record, number to call 24/7 and team • Relevant hospital information shared with home care team to facilitate care delivery • Timely documentation of home care visits accessible to the one team • Continued and timely access to the **hospital team**

Hospital Team
Hospital Care Coordinator
Community Care Coordinator & Multiple Providers
Hospital Funds
Home Care Funds

One Team: Enabled through IC Lead Role
Hospital Team
Integrated Homecare Team
ONE fund driving capacity and outcomes

Creating System Capacity

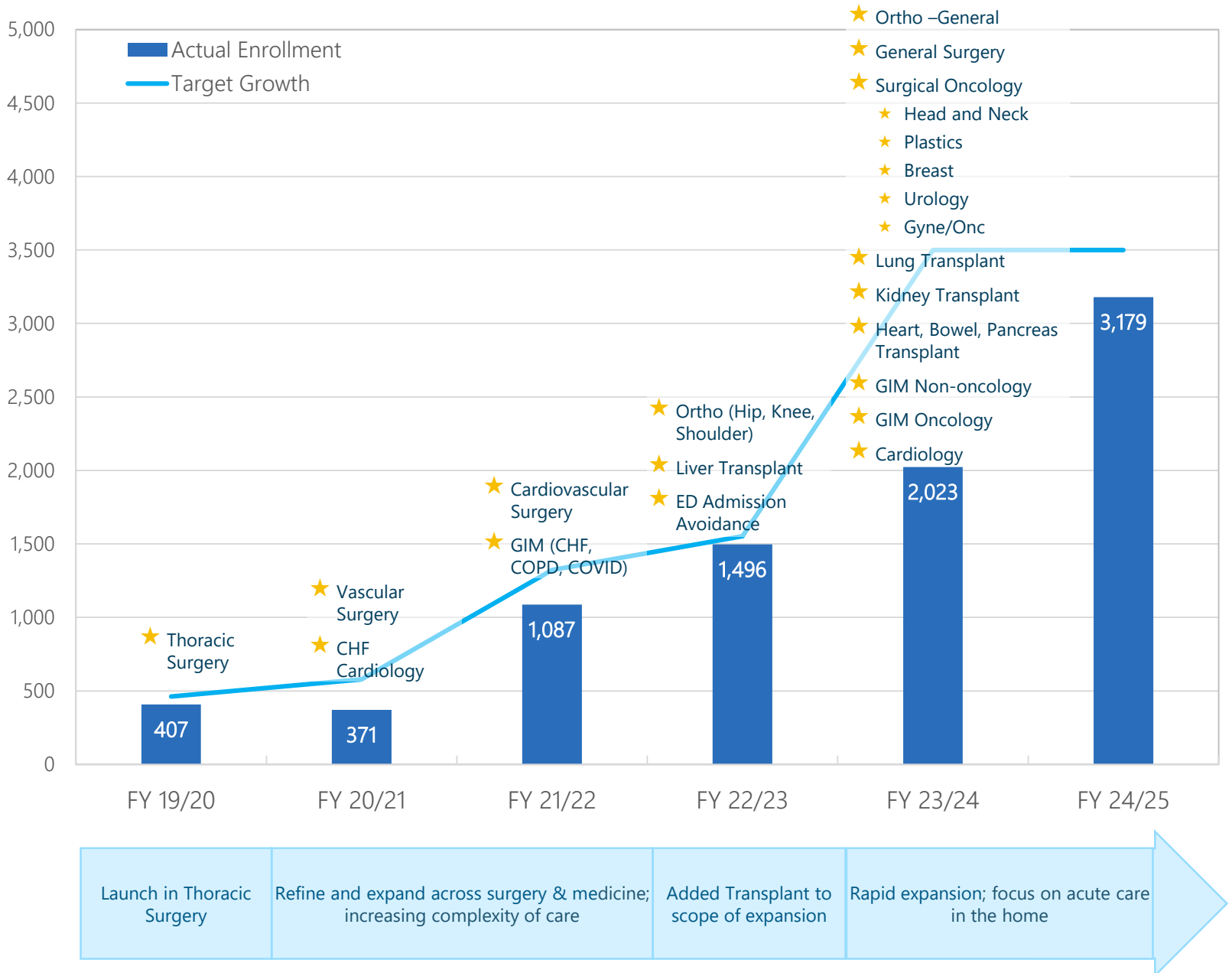
Example scenario of Program supports enabling improved care experience and outcomes

Traditional Care: 3 siloed admissions to the hospital

Integrated Care: ability to impact 90 day **TC LOS** activity

IC Supports:	***One point of contact (IC Lead)*** *across hospital and homecare team*	***One 24/7 line to call*** *with proactive check in calls*	***One dedicated homecare team*** *with close link back to IC Lead*	***One medical record*** *to ensure continuity of care*

Expanding Integrated Care at UHN



Impact To Date

+79 net promoter score
91.7% of patients rated the Program a 4 or higher

7,400 bed days saved
Estimated impact for 4,000 patients

↓ 90 day ED Revisits
Some pathways seeing relative reduction up to 43%

↓ 90 day Readmit Revisits
Some pathways seeing relative reduction up to 25%

Our Promise – Delivering a Better Care Experience

Sample of Integrated Care Program Interventions Supporting the Quintuple Aim

PATIENT EXPERIENCE

Timely patient access to expert care

A urology patient experienced difficulty urinating 24 hours after their urinary catheter was removed

The patient called the after-hours 1-833 number and a nurse on-call was **able to conduct a home visit within 30 minutes**, preventing an ED visit

Nurse (home care) escalated to on-call **urology physician**, new orders issued **to reinsert the catheter that evening** and scheduled a follow-up appointment in the clinic 5 days later

PROVIDER SATISFACTION

Increasing understanding & creating capacity in hospital

Outpatient follow-up clinicians **value comprehensive communication** especially when it includes sequential photos

Allows clinicians to have a better understanding of how patients are recovering at home and allows them to conduct consultations virtually, creating capacity in the outpatient clinic setting

HEALTH OUTCOMES

Streamlined & seamless care transitions

Delay in OHaH practice for **applying VAC dressings** (currently done in community & takes up to 5 days to initiate)

IC implemented a new process to apply the community VAC dressing directly on the unit before discharge **preventing unnecessary interruptions in treatment**

COST EFFICIENCY

Shifting care from hospital to home

To support patients with JP drains, the Thoracic Surgery department has **transitioned** VATS wedge resections from **inpatient procedures to same-day surgeries**

The Integrated Care homecare nurse is now responsible for **managing and removing the surgical drains in the community**, a task that was previously performed in the hospital

HEALTH EQUITY

Supporting failed discharge & health equity

Patient was readmitted 7 days post discharge due to "failure to thrive" (OHaH could not reach pt. by phone)

IC Lead enrolled patient, affixed the 1-833 number to the patient's phone,

An **assessment of the home environment prompted** the addition of a social worker to **assist with financial and food insecurity**. The patient was receptive to services and successfully remained out of hospital for the duration of the care bundle

Panel Discussion

Up Next

- HSPN webinar series
  - ‘Spring Break’: there will be no webinar in May
  - See you back on June 24th

THANK YOU!

@infohspn

hspn@utoronto.ca

The Health System Performance Network

hspn.ca

HSPN

HSPN Questions:

- **Given your progress to date, what has been an essential factor in your success?**

A shared vision with our partners has been critical. Success has also relied on having the right resources in place, strong leadership from our OHT medical lead and ICP lead, and the support of clinical champions across specialties and primary care. Continued alignment with the hospitals and partners strategic plan has further reinforced our efforts.

- **Could you talk about a key challenge you faced and how you went about tackling it?**

One major challenge has been operational staffing—particularly clinical capacity for enrollment and ongoing program delivery. We've had to navigate competing priorities, capacity constraints, and the need to keep diverse partners aligned and engaged. We addressed this through regular reinforcement of our shared vision, transparent communication, and creative solutions to funding uncertainty. Accessing consistent and meaningful data, especially data silos, has also been a significant hurdle.

- **Is there anything you know now that you wish you knew when you started this work?**

Yes—how crucial early HR planning is, especially in high-demand environments. We also learned the importance of distinguishing between evaluation planning and research frameworks from the outset. Finally, we underestimated how difficult it would be to access and integrate data across systems. Building a care-planning solution is challenging and resource intensive-focus efforts on those clients most likely to benefit.

- **If you have engaged in any other programs/ pathways (e.g. LP, IFM): What are some of the main differences you have experienced working with these different programs?**

Each program is at a different stage of development, with varying levels of resource capacity. Many are still in early phases, being built under tight timelines. It can be difficult to coordinate across overlapping criteria, especially with multiple pilots happening simultaneously. There's a need for clearer alignment and integration across programs to support cohesive implementation.

East Toronto Health Partners