MIDDLESEX LONDON
Ontario Health Team

COPD Townhall

February 25, 2025

Housekeeping

To ensure everyone has a good meeting experience:

- Please stay on mute if you're not speaking
- Use the 'raise hand' feature to ask a question
- Chat available to everyone
- If you're signed in as "iPhone", please rename yourself so we can send you Mainpro+ certificate shortly
- Sign up for MLPCN newsletter to learn of future events and practical information

Meeting is being recorded; recording and slides will be available at **https://mlpcn.ca/**

MLPCN Value Proposition

The Middlesex London Primary Care Network (MLPCN) is a **legitimate and powerful advocate** in the healthcare system. Formally funded by Ontario Health through the Middlesex London Ontario Health Team, we represent **family physicians, nurse practitioners**, and all those who have a stake in our primary care network.

Empowering Primary Care through Unity, Support, and Connection:

- We speak as a strong, unified voice to improve patient and provider experience.
- We provide a ‘home’ for the primary care sector to foster community, camaraderie and connection
- We support your practice with tools to increase knowledge, reduce burdens, and enhance practice

Join the movement: www.mlpcn.ca

Middlesex London PRIMARY CARE NETWORK

Disclosure of Financial Support

This program has received in-kind financial support from TVFHT and MLOHT in regard to administrative and logistical support.

- **Potential for Conflict(s) of Interest**
  - None

This 1-credit-per-hour Group Learning program has been certified by the College of Family Physicians of Canada. The program is part of a series that has been certified for Mainpro+ credits.

Speaker Disclosures

- Name: **Dr. Michael Nicholson**
- Relationships with financial sponsors: AstraZeneca, GSK, Vertex
- Grants/Research Support: AstraZeneca
- Speakers Bureau/Honoraria: N/A
- Others: N/A

- Name: **Dr. Aatika Imran**
- Relationships with financial sponsors: MLOHT
- Grants/Research Support: N/A
- Speakers Bureau/Honoraria: N/A
- Others: N/A

- Name: **Allyson Kellar**
- Relationships with financial sponsors:
- Grants/Research Support: N/A
- Speakers Bureau/Honoraria: N/A
- Others: N/A

- Name: **Renee Primeau**
- Relationships with financial sponsors: LIHC
- Grants/Research Support: N/A
- Speakers Bureau/Honoraria: N/A
- Others: N/A

- Name: **Jessica Law**
- Relationships with financial sponsors: N/A
- Grants/Research Support: N/A
- Speakers Bureau/Honoraria: N/A
- Others: N/A

- Name: **Sidra Jamal**
- Relationships with financial sponsors: MLOHT
- Grants/Research Support: N/A
- Speakers Bureau/Honoraria: N/A
- Others: N/A

Agenda for Townhall

	Time	Topic	Discussion	Lead
1	7:00 - 7:05	Welcome	• MLPCN Value Proposition • Conflict of Interest Disclosures	Michelle Pierce Dr. Vineet Nair
2	7:05 - 7:15	COPD Diagnosis	• Spirometry Referrals • Specialist Referrals • Action Plans	Dr. Nicholson
4	7:15 - 7:50	Community Hub Organizations	• Community Paramedicine • Best Care • Team Care • Ontario Health at Home	Sidra Jamla Alyson Kellar Renée Primeau Jessica Law
6	7:55 - 800	Center for Effective Practice COPD Supports	• COPD Supports	Nicole Seymour
7	8:00 - 8:10	Health Pathways	• Introduction to HealthPathways • Palliative approach to COPD	Dr. Imran
8	8:10 – 8:15	COPD Supports and Resources	• Resources Overview	Dr. Imran
9	8:15 - 8:25	Questions	Questions from the Audience	Speakers
10	8:25 – 8:30	Adjournment		Sidra Jamal

Objectives for Townhall for Primary Care

Practical tips to manage COPD patients

- Diagnosing suspected cases
- Referring to community organizations
- Implementing action Plans

Programs and resources available within the region

Educational resources for COPD

- Palliative support
- Shared Digital Resource

COPD Patients on Hospital Discharge

Discharge notes from the hospital can indicate if patient has been booked for spirometry

People with COPD who have been hospitalized for an acute exacerbation have an in-person follow-up assessment within seven days after discharge

OH Quality Statement

Suspected case of COPD: Spirometry Referrals

People clinically suspected of having COPD have spirometry testing to confirm diagnosis within three months of developing respiratory symptoms.

OH Quality Statement

Ideally book Spirometry test 4-6 weeks post exacerbation and not before

Confirming suspected COPD diagnosis via Spirometry

- Spirometry is categorized as a partial pulmonary test but is the easiest and quickest test
- Ordering spirometry can mean shorter wait times than full PFT tests
- Provides much relevant information
- Spirometry testing is available in multiple locations in the region.
- Referral forms are included in the resource packet

When to refer your patient to a specialist

Severe or very severe COPD

Recurrent exacerbations

Severe symptoms

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.

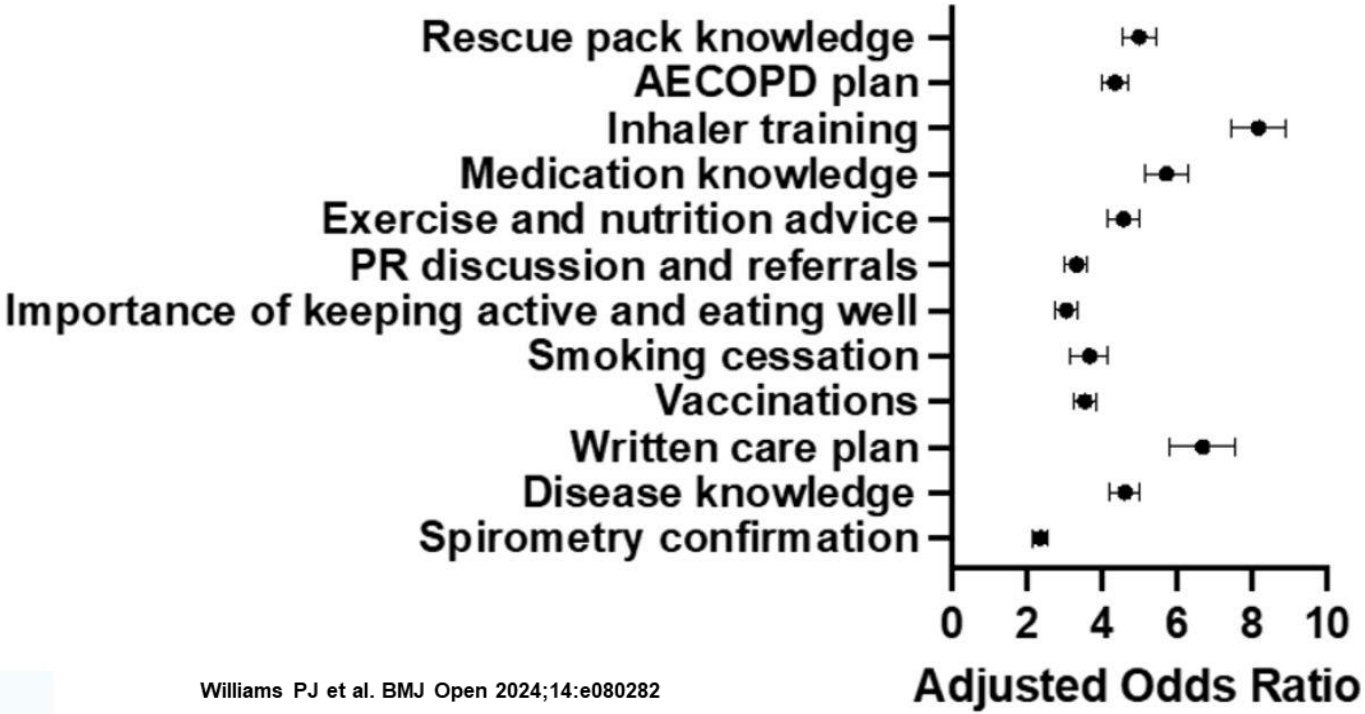
OH Quality Statement

Using a *written* COPD Action plan with directions on when to connect with a healthcare provider and listing medications can help with patient compliance.

Several Action plans are included in the COPD resource packet, including academic detailing supports

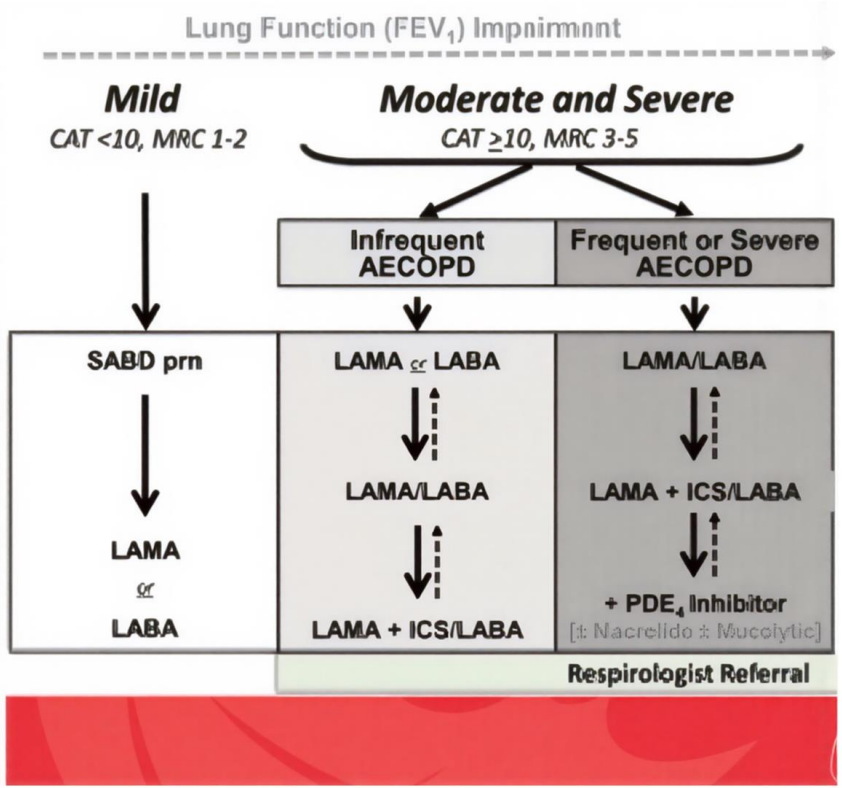
Providers can work with their patients to decide on an action plan that best suits their needs

Goals of Care and Individualized Care Planning



Williams PJ et al. BMJ Open 2024;14:e080282

Goals of Care and Individualized Care Planning



Referring Patients to Community Hub Organizations

Community Paramedicine	• Sidra Jamal
Best Care	• Alyson Kellar
Ontario Health at Home	• Jessica Law
Team Care	• Renée Primeau

Community Paramedicine

- Community paramedicine is a non-emergent mobile response team with specialized training designed to work in collaboration with a patient's primary care providers to provide a range of community-based primary care services in the comfort of a patient's home.

- Hours of Operations: 24/7

When to contact Community Paramedicine

- If patients are experiencing an early onset to acute COPD flare up and are not able to access their primary health care provider on site, they can choose to contact Community Paramedicine for non-emergent response.

- If patients have an appointment with their primary health care provider but are experiencing an early onset to acute COPD flare up in the interim, they can choose to self-refer to Community Paramedicine.

- Community paramedic services is *not* a replacement for primary care or 911

Community Paramedicine helping COPD patients

- Medical management of acute COPD flare up.
- This includes palliative acute care, pain and symptom management.
- Motivational coaching, education, and self-management guidelines.
- Collaborative care coordination with health-care providers.
- Referrals to community resources and programs.

Community Paramedicine helping COPD patients

- Symptom Relief Management / Treatment Plan Options:
  - Provide treatment prescribed in the Community Paramedic Patient Care Standards (CPPCS);
  - Consult with the Primary Care Provider prior to administration of treatment; OR
  - Consult with the Community Paramedic On-Call Primary Care Support Team prior to administration of treatment

Community Paramedicine helping COPD patients

- Monitor and follow-up
- Transport to ED where appropriate, and in alignment with the patient goals of care
- Community Paramedic's are required to notify the Primary Care Provider where treatment is provided without direct orders
- Community Paramedic are required to follow-up with the patient at 24, 48 & 72 hours when treatment is provided

Medications carried by Community Paramedicine

A Community Paramedic may provide the treatment prescribed in the MLPS CPPCS COPDE Medical Directive if authorized, or in collaboration with the Primary Care Provider.

- Ipratropium
- Salbutamol
- Amoxicillin
- Clarithromycin
- Doxycycline
- Co-Amoxiclav
- Prednisone

The Community Paramedic can provide the patient up to a 3-day supply of medication.

BEST CARE PROGRAMME IN PRIMARY CARE

A PROVEN AND MEASURABLE VALUE-BASED CHRONIC DISEASE MANAGEMENT MODEL

BestCare

Best Care in Primary Care

is a front-line clinical program

operated by a
not-for-profit corporation

lead by a
community board of governors
since 2003

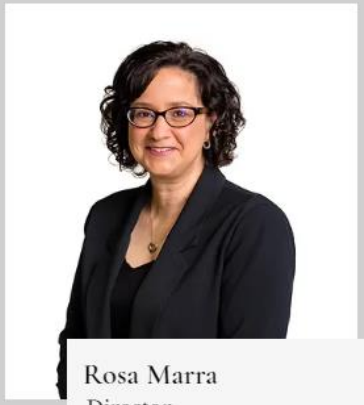
funded by the
Ontario Ministry of Health

at
>300 sites across Ontario

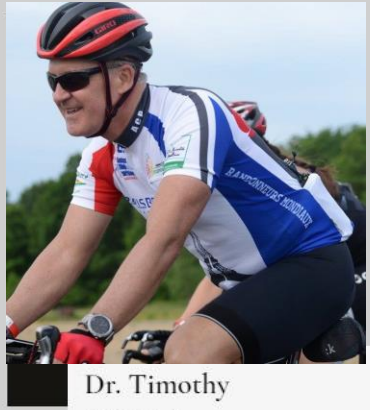
Dr. Cathy Faulds
Chair Director

Ian McIntosh
Director

Paul Huras
Director



Rosa Marra
Director



Dr. Timothy
O'Callahan
Director

Glenn Lanteigne
Director

OUR APPROACH AND HOW WE ACHIEVED IT

BEST CARE

An effective model of care for chronic disease management

A repeatable platform for multiple chronic diseases

An instrument of healthcare system transformation that empowers primary care

- A complete knowledge translation, interdisciplinary programme
- In person, evidenced-based care
- Embeds educators / case managers / guideline experts in the patient's medical home
- Proven, upstream, preventative care aiming to reduce hospitalisations and ED visits
- Supports system transformation building, with primary care as the foundation

ED, emergency department

Statements reflect the personal clinical opinion of the speaker

BestCare

BEST CARE EMPOWERS AND RESOURCES PRIMARY CARE PRACTITIONERS TO DELIVER COMPLEX GUIDELINES TO THEIR SICKEST PATIENTS – IN A 7 MINUTE ENCOUNTER?

- Do pre and post spirometry to Dx COPD
- Differentiate COPD from asthma
- Initiate inhaler treatment based on guidelines
- Know proper inhaler technique and do device instruction on every visit
- Monitor adherence
- Teach patients about COPD
- Write an action plan and support self-efficacy
- Support smoking cessation
- Manage exacerbations – see urgently when needed
- Ensure proactive identification and follow-up

HOW DOES IT WORK IN MY CLINIC? THE CLINIC WORK FLOW

- Designed to work in a primary care practice
- RRT/CRE in your practice seeing your patients
- RRT/CRE seeing 5-7 patients per day
- Need 5 - 7 minutes of physician time per patient
- Patient leaves with **all** elements of evidence based care (Diagnosis, Rx, education, action plan, case management)
- 3 visits year 1 – Continuing Care Relationship

A COMPLETE KT PROGRAM DELIVERING ALL ELEMENTS OF CARE

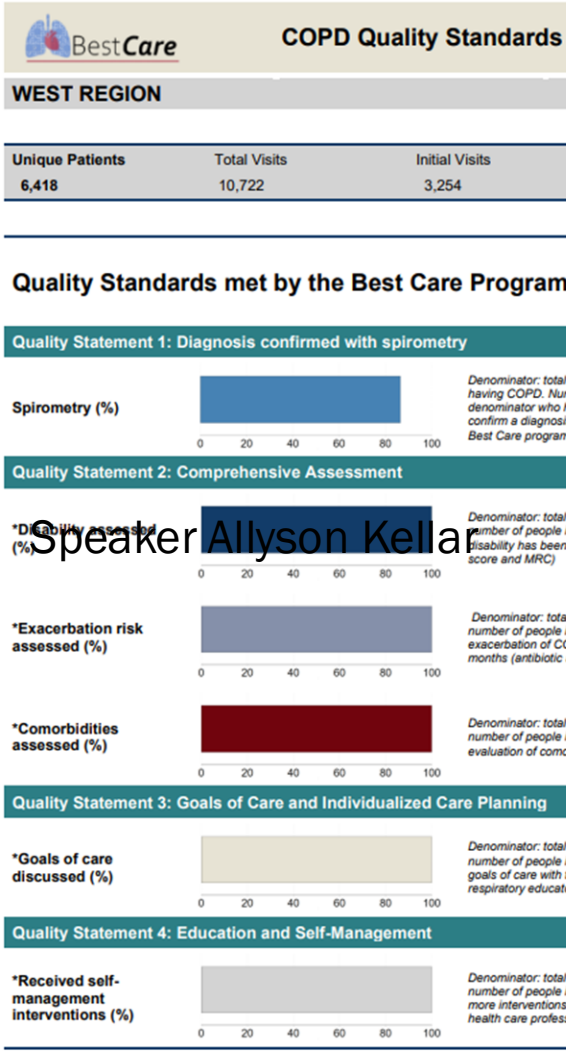
PHARMACOLOGIC AND NON - PHARMACOLOGIC

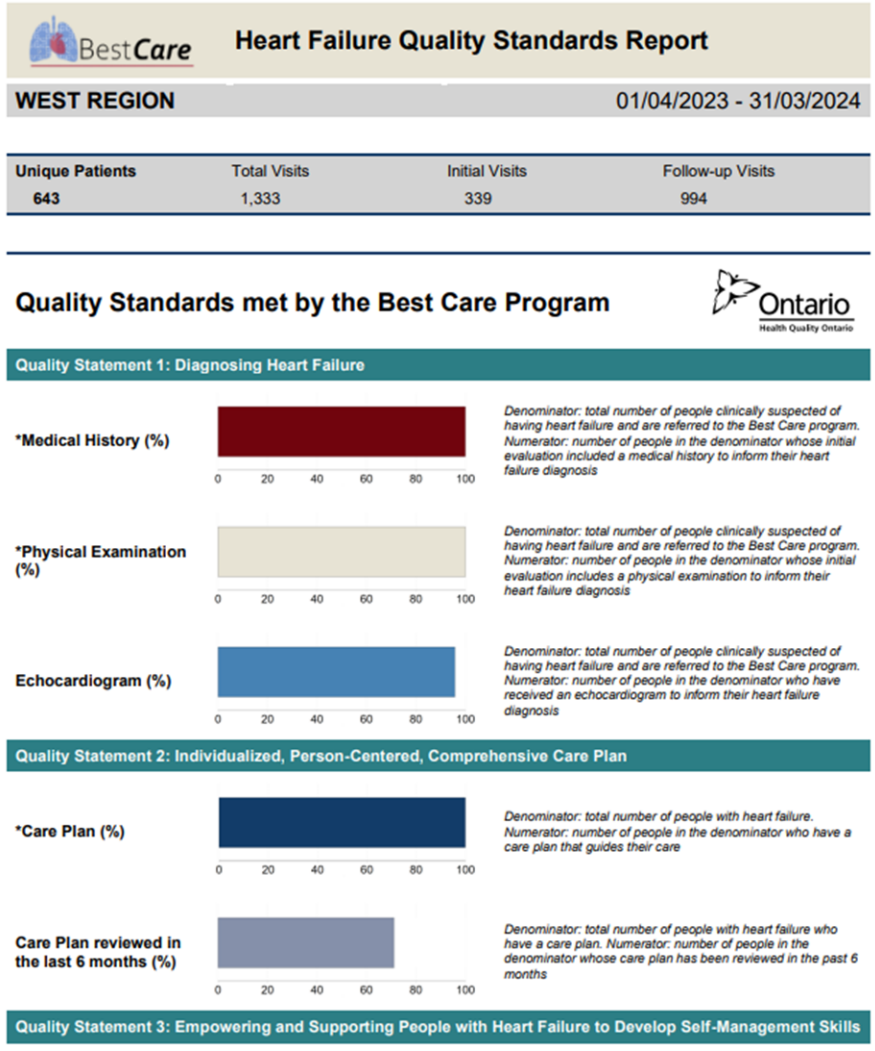
STANDARDIZED PROGRAMMING

ROBUST QUALITY ASSURANCE

ONTARIO HEALTH QUALITY STANDARDS

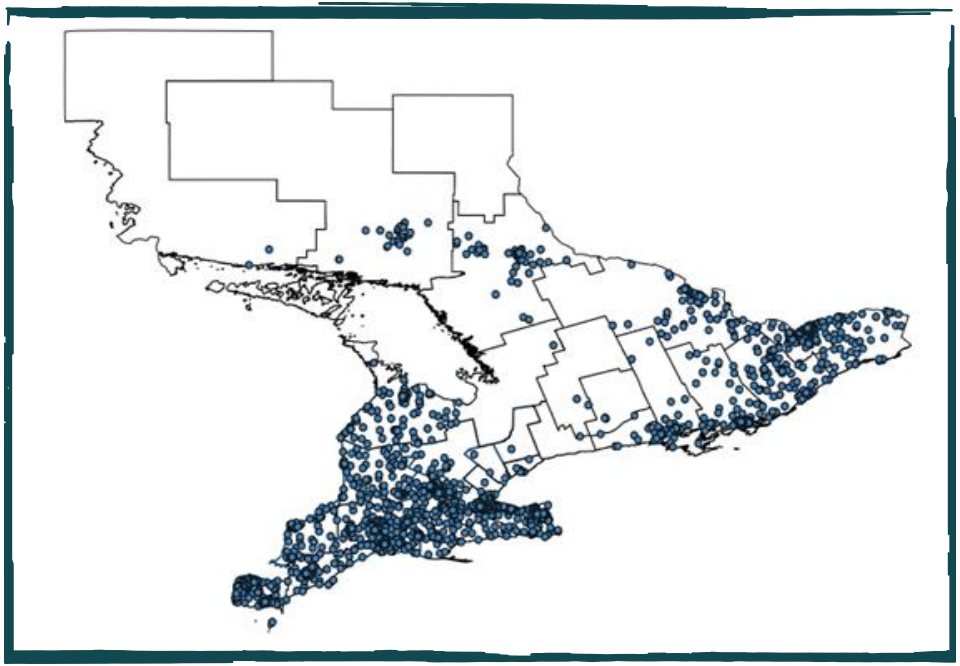
PERFORMANCE MEASURED IN EVERY VISIT





Speaker Allyson Kellar

COLLECTIVE ACTION TO TRANSFORM THE HEALTH SYSTEM WITH PRIMARY CARE AS THE FOUNDATION



- Is scalable at a health system level
- Exponential growth
- 100% of providers say yes
- 300 primary care clinics
- 1600 primary care practitioners
- High-risk COPD cohort = 8800
- Spirometry in Primary Care = 19,000

OHT, Ontario Health Team; PHU, Public Health Unit
Information provided by speaker from unpublished Best Care in Primary Care Program data

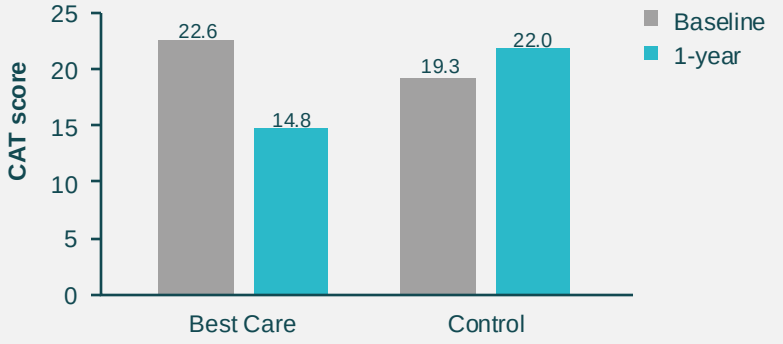
MEASURING THE IMPACT OF BEST CARE COPD

BestCare

BEST CARE COPD IMPROVES QUALITY OF LIFE AND INCREASES HOSPITAL AND EMERGENCY DEPARTMENT CAPACITY

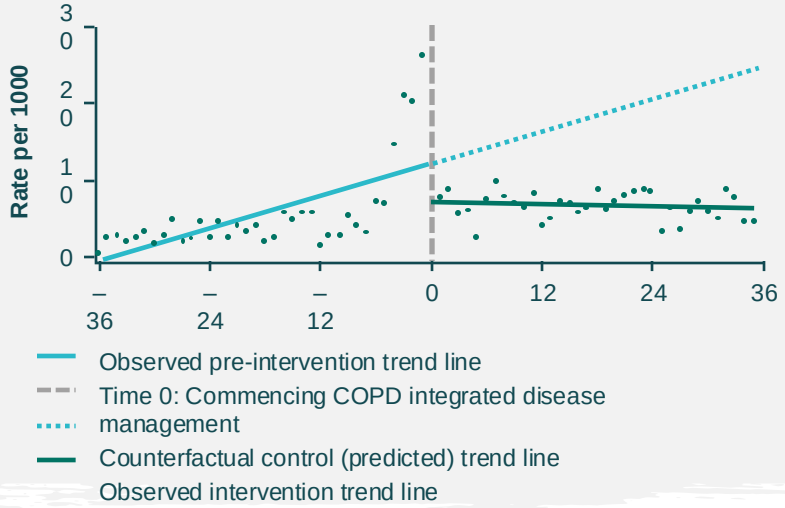
87% had an improved quality of life mean difference of > 9 on the CAT score

Quality of life: CAT score Best Care vs usual care (*n* = 72)[1]



51% reduction in COPD-related hospital admissions achieved at 12 months and up to 72% at 36 months

COPD-related hospital admissions[2]



CAT, COPD Assessment Test; ED, emergency department

1. Ferrone, M. NPJ Prim Care Respir Med 2019;29:8; 2. Licskai C, Hussey A, et al. Thorax 2024;79:725–734

BestCare

Ontario Health atHome

Ontario Health atHome Telehomecare and Connecting Care to Home (CC2H) Programs

Exceptional care –

wherever you call home

February 25, 2025| Jessica Law & Lori Elder

We are Ontario Health atHome

We are ready to serve every person in Ontario. We partner with patients, caregivers, primary care providers, hospitals, long-term care and retirement homes, service providers and Ontario Health Teams, to deliver responsive, accessible, integrated, patient-centred care.

Ontario Health atHome

Specialized Program – Telehomecare

What is Telehomecare?

- Helps people living with congestive heart failure (CHF) and/or chronic obstructive pulmonary disease (COPD) achieve the best possible quality of life through a virtual only program.
- Helps patients manage their condition through remote monitoring and regular health coaching sessions.
- Specially trained nurses guide patients virtually and provide coaching and support to patient and their caregivers to understand factors that affect the way they feel.
- Goal is to support patients and their caregivers to take actions and steps to improve their symptoms, reduce exacerbations, prevent ED and hospital admissions.

Telehomecare Pathways

COPD

- Four to six month self-management program designed to empower, support and teach patients to better manage their chronic conditions

Heart Failure

Covid

- Two-week monitoring program designed to support patient with symptom management and monitoring

How it works

- Patients use technology to self monitor and manage their condition in the comfort of their own home with the support a registered nurse.
- With the use of the loaned equipment, the patient is asked key questions about their symptoms to better manage their chronic conditions.
- Patients receive guidance how on checking their own blood pressure, weight, heart rate and oxygen levels.

Testimonials

‘We would like to acknowledge what a rock [our nurse]has been through [this] difficult journey she has a compassionate, yet professional way of explaining things to us. I honestly don’t know how we would have managed some of [these] challenges without her help’

‘In a convoluted system, [the Telehomecare nurse] was my saving grace. I knew she cared and she was only a call away’

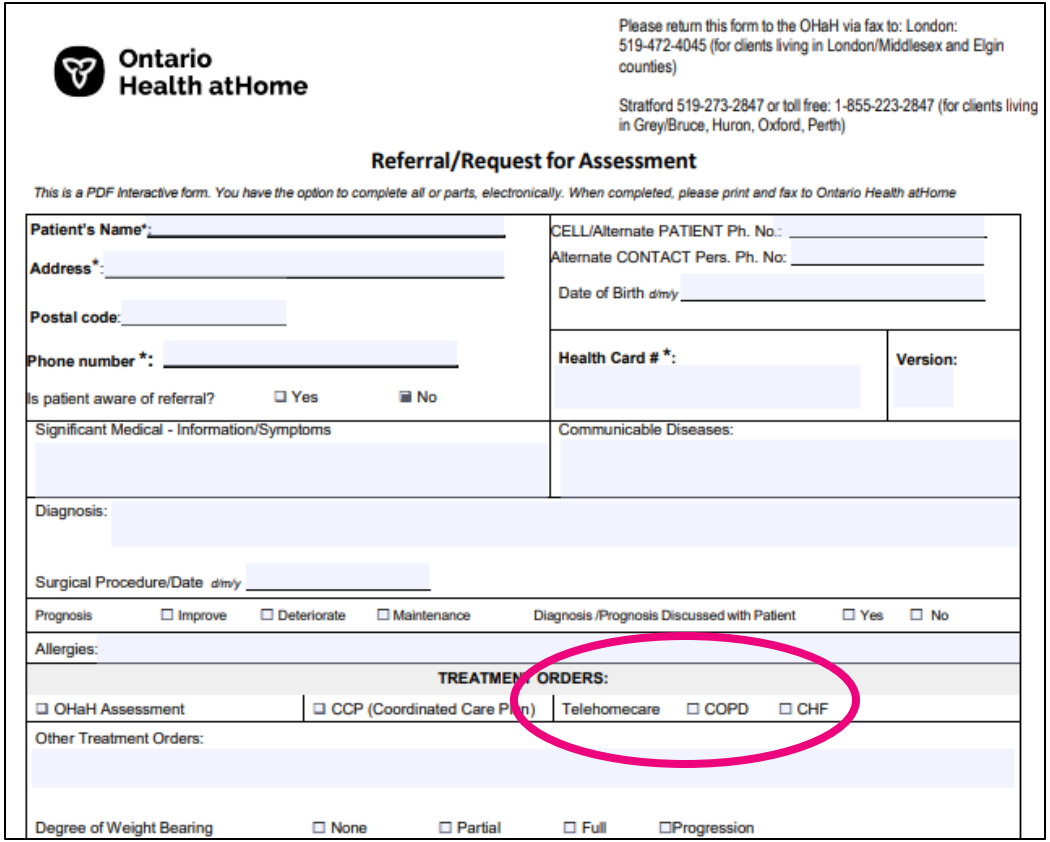
‘She definitely kept me out of the dreaded emergency room at least on three occasions…I don’t have enough superlatives to describe the knowledgeable, easily understandable and so effective advice and direction… I feel very privileged to be able to take advantage of this superb service’

Who is eligible?

- Adult patients aged 18 years and older
- Confirmed diagnosis of COPD and/or CHF and:
  - Willing and capable of partnering in their own health care or have a caregiver who is willing to assist
  - Willing and capable of operating the in-home monitoring equipment or have a consistent and engaged caregiver to provider support
  - Treatment pathway is aligned with and focused on meeting care goals

How to Refer

- Mark off COPD and/or CHF on the South West Ontario Health atHome referral form found on the Ontario Health atHome website: Ontario Health atHome
- Anyone can self refer by calling 310-2222



Ontario Health atHome

Please return this form to the OHaH via fax to: London: 519-472-4045 (for clients living in London/Middlesex and Elgin counties)

Stratford 519-273-2847 or toll free: 1-855-223-2847 (for clients living in Grey/Bruce, Huron, Oxford, Perth)

Referral/Request for Assessment

This is a PDF Interactive form. You have the option to complete all or parts, electronically. When completed, please print and fax to Ontario Health atHome

Patient's Name*:

Address*:

Postal code:

Phone number *:

Is patient aware of referral? ☐ Yes ☒ No

CELL/Alternate PATIENT Ph. No.:

Alternate CONTACT Pers. Ph. No:

Date of Birth d/m/y

Health Card # *:

Version:

Significant Medical - Information/Symptoms

Communicable Diseases:

Diagnosis:

Surgical Procedure/Date d/m/y

Prognosis ☐ Improve ☐ Deteriorate ☐ Maintenance Diagnosis /Prognosis Discussed with Patient ☐ Yes ☐ No

Allergies:

TREATMENT ORDERS:

☐ OHaH Assessment | ☐ CCP (Coordinated Care Plan) | Telehomecare ☐ COPD ☐ CHF

Other Treatment Orders:

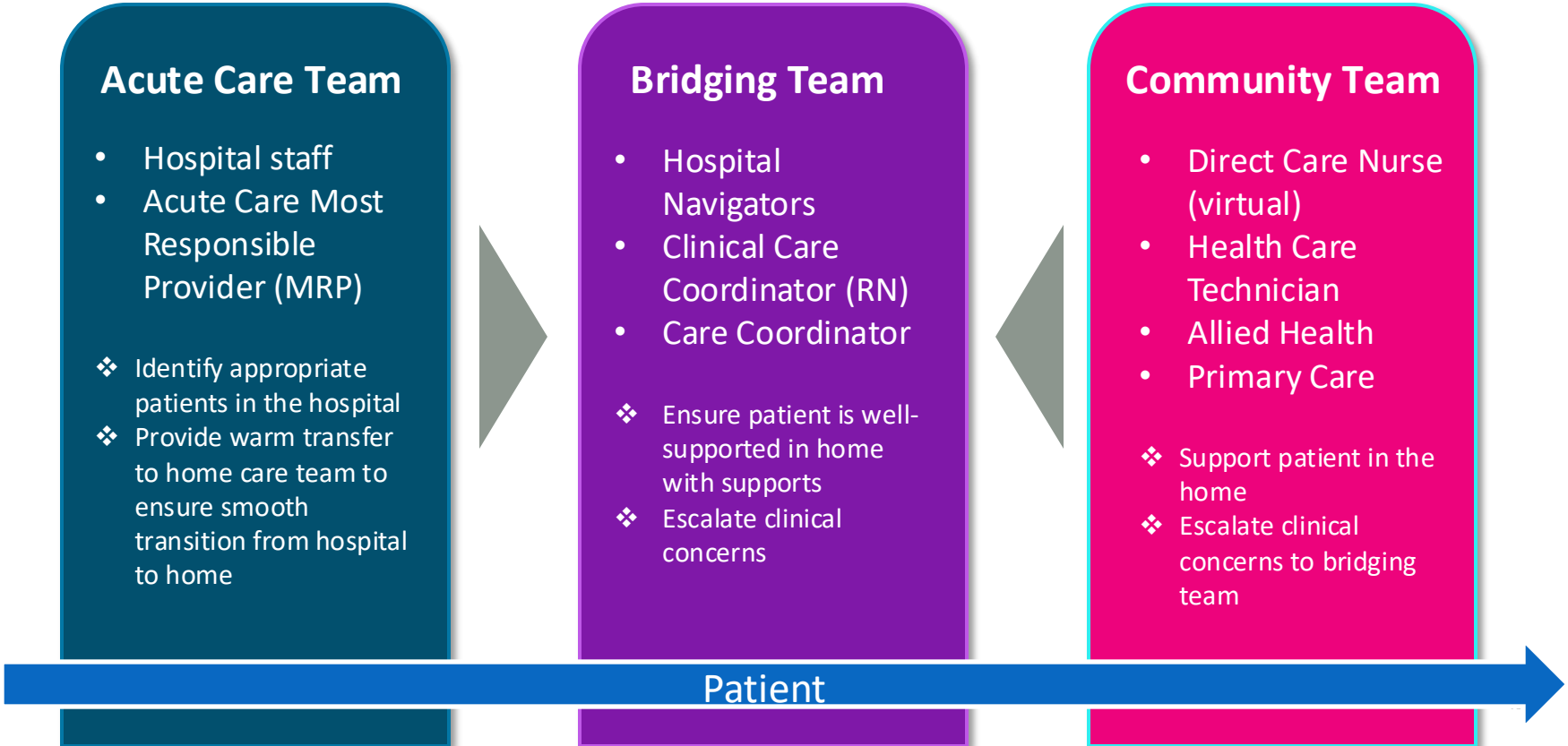
Degree of Weight Bearing ☐ None ☐ Partial ☐ Full ☐Progression

Specialized Program – CC2H (Connecting Care to Home)

What is CC2H?

- A partnership between hospital and community to improve care and transitions for patients with COPD and Heart Failure
- Exclusive to those residing in the Middlesex and London area
- Up to 60 day program to support COPD and Congestive Heart Failure (CHF) patients transitioning from hospital to home
- Patients provided with increased home care supports with staff trained to support chronic disease management
- Collaborative team approach in decreasing length of stay in hospital and preventing readmission to hospital

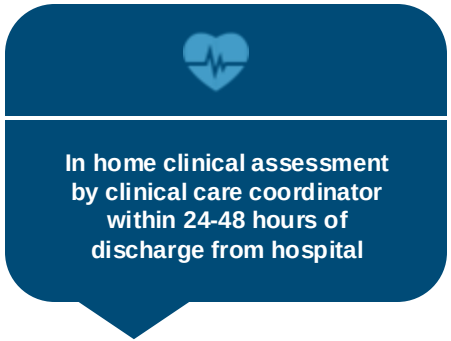
CC2H Team


Acute Care Team
• Hospital staff
• Acute Care Most Responsible Provider (MRP)
❖ Identify appropriate patients in the hospital
❖ Provide warm transfer to home care team to ensure smooth transition from hospital to home
Bridging Team
• Hospital Navigators
• Clinical Care Coordinator (RN)
• Care Coordinator
❖ Ensure patient is well-supported in home with supports
❖ Escalate clinical concerns
Community Team
• Direct Care Nurse (virtual)
• Health Care Technician
• Allied Health
• Primary Care
❖ Support patient in the home
❖ Escalate clinical concerns to bridging team
Patient

How patients are supported at home

- Manage COPD/CHF related symptoms through shared technology in home that require nursing interventions such as oxygen therapy and titration, diuretic therapy, nebulizer treatments, and medication reconciliation.
- Teach patients how to prevent flare-ups or exacerbations.
- Help patients identify what their warning signs and symptoms are for an exacerbation.
- Prepare patients with COPD action plans for exacerbation management: for steroid and antibiotic therapy as required.
- Access therapies such as RD, RT, PT and OT for additional patient education and support.

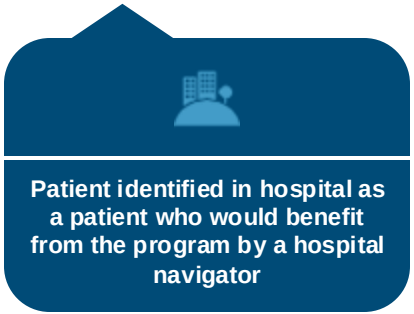
CC2H Pathway



Discharge from hospital

One to eight weeks

End of CC2H Program



Patients considered for the program

- Patients with a diagnosis of COPD and/or CHF
- Patients transitioning from hospital to home from an acute exacerbation of their COPD and/or CHF
- Patients who may benefit from the face to face assessment and education/teaching of a nurse specialized in chronic disease management
- Patients with a stable, safe treatment location (home or community setting)
- Patients with confirmed self-management goals and willingness to learn
- Living in London-Middlesex
- Has an acute care Most Responsible Primary Care Provider (MRP) who is willing to support patient on the CC2H program (hospital specialist/NP/Primary Care)

Ontario Health atHome

MISSION

Helping everyone to be healthier at home through connected, accessible, patient-centred care.

VISION

Exceptional care – wherever you call home.

VALUES

Collaboration. Respect. Integrity. Excellence.

Thank you

ontariohealthathome.ca

310-2222

Team Based Care at London Intercommunity Health Centre

London InterCommunity Health Centre

Objectives of this Presentation

1. Learn about LIHC
2. Learn the flow of Team Based Care (TBC) Referral
3. Gather essential contacts

London InterCommunity Health Centre

LIHC – What is a CHC?

- Non-profit, community-governed organizations using interdisciplinary teams to offer health and social services
- CHCs offer care to populations that have traditionally faced barriers accessing health care
- CHCs offer programs and services that address the needs and preferences of the communities they serve

London InterCommunity Health Centre

LIHC Sites

LIHC has 3 locations:

659 Dundas St

1355 Huron St

1700 Dundas St

London InterCommunity Health Centre

What is Team Based Care (TBC)?

- Team Care provides health supports to the patients of physicians not affiliated with an interprofessional team
- With Team Care, everyone works together to better the health and well-being of each patient

London InterCommunity Health Centre

Eligibility

- Lowest income quintile (20%), and may identify with some of the following considerations:
  - We prioritize those living in East London
  - Has no private health insurance or has exhausted all EAP/benefits services
  - Experiences barriers in accessing services due to the social determinants of health

London InterCommunity Health Centre

Team Care History in 30 Seconds

- TBC Previously called “PINOT”
  - ‘People in Need of Teams”
- Primary Contact: Renée Primeau
- Catchment previously all of London
- Based on “SPIN” from Toronto
  - “Solo Practitioners in Need”

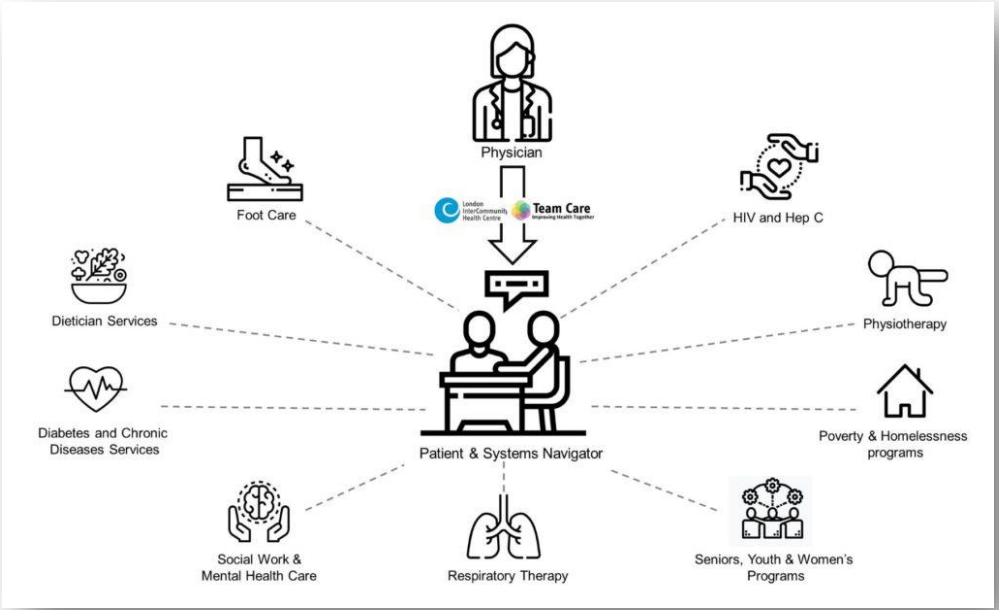
London InterCommunity Health Centre

TBC Process

London InterCommunity Health Centre

Every One Matters.

Services Available



London InterCommunity Health Centre

Contacts

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Anne-Marie Sanchez, Director: Strategy, Planning, and Health Systems Integration asanchez@lihc.on.ca

519 660 0875 x: 298

London InterCommunity Health Centre

If you haven’t already, register with us. We are here to help.

REGISTER HERE

lihc.on.ca/teamcare

London InterCommunity Health Centre

CEP's COPD Supports

Nicole Seymour, PharmD
CEP Academic Detailing Service
February 25, 2025

CEP Centre for Effective Practice

Established in **2004**, the **Centre for Effective Practice (CEP)** is one of the largest independent, **not-for-profit** knowledge translation organizations for primary care in Canada.

CEP Centre for Effective Practice

CEP

Research & evaluation

WE REVIEW LITERATURE AND USE EVIDENCE TO IDENTIFY SOLUTIONS FOR SPECIFIC CONTEXTS IN HEALTH CARE.

Clinical tools and digitization

WE DEVELOP PRACTICAL TOOLS FOR PRIMARY CARE AND OTHER PROVIDERS TO ADDRESS KEY HEALTHCARE TOPICS.

Education programs

WE BRING EVIDENCE TO PROVIDERS THROUGH SUITABLE EDUCATIONAL OUTREACH METHODS.

Engagement & communication

WE ENGAGE CLINICAL EXPERTS IN EVERY PHASE OF OUR WORK AND PARTNER WITH KEY ORGANIZATIONS TO ENSURE WE REACH THE INTENDED AUDIENCE.

A partner of choice

- 100+ stakeholder organizations engaged

CEP's tools and resources: www.cep.health

- ADHD
- Alcohol use disorder
- Antipsychotics and dementia
- Anxiety & depression
- Benzodiazepine use
- Childhood obesity
- Chronic insomnia
- Chronic non-cancer pain
- Concussion
- **COPD**
- **CORE back tool**
- **COVID-19 Resource Centre**
- Early Lyme disease
- Falls prevention
- Heart failure
- Manual therapy for MSK pain
- Medical assistance in dying
- Neck pain and headache
- Non-medical cannabis
- Opioid manager
- Opioid tapering
- Opioid use disorder
- Osteoarthritis
- **Poverty**
- Preconception
- PPI use
- **Social Prescribing**
- Type 2 diabetes
- Urinary incontinence
- Women-centred HIV care
- Youth Mental Health

CEP | Centre for Effective Practice

Provincial primary care academic detailing service

Health care providers…

working together to discuss…

objective, balanced, evidence-informed information about best practices…

based on the clinician's expressed needs…

at a location and time that is convenient for the provider.

CEP Centre for Effective Practice

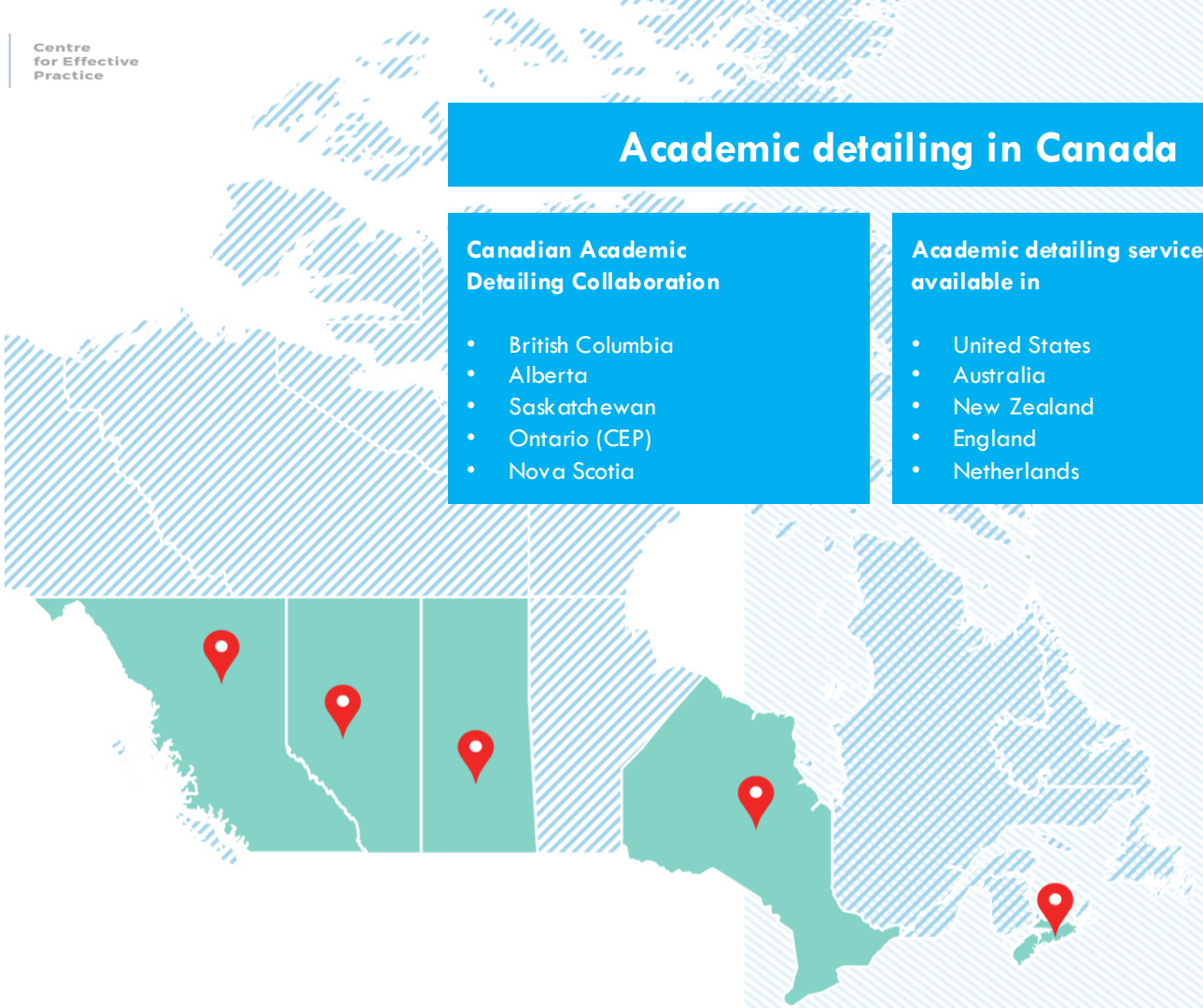
Academic detailing in Canada

Canadian Academic Detailing Collaboration

- British Columbia
- Alberta
- Saskatchewan
- Ontario (CEP)
- Nova Scotia

Academic detailing services are also available in

- United States
- Australia
- New Zealand
- England
- Netherlands



Service reach since 2018

1600 physicians & NPs across Ontario receive 1:1 support

Funded by the Ontario Ministry of Health for:

- ✓ Family physicians
- ✓ Primary care nurse practitioners
- ✓ Family medicine residents

> Academic Detailing is simply the most effective method of changing clinical practice to best practice. **– Dr. Paul Preston, North Bay**

Academic detailers

- Clinical pharmacists
- Strong foundational experience in:
  - Pharmacotherapy
  - Clinical evidence appraisal
- Free of commercial interest
- Extensive, on-going training on emerging/evolving evidence and local and provincial resources

Nicole Seymour

Academic Detailing Pharmacist, CEP

Hospital Pharmacist at St. Thomas Elgin General Hospital

Relationships with commercial interests: None

Grants/Research Support: None

Speakers Bureau/Honoraria: None

Consulting Fees: None

Other: Employee of RxFiles & the National Resource Centre for Academic Detailing (NaRCAD)

Academic detailing training ("upskilling")

- Physician Clinical Lead:
  - **Pain/Opioids:** Dr. Arun Radhakrishnan
  - **Benzos/Falls:** Dr. Felicia Presenza, Dr. Winyan Chung
  - **Diabetes:** Dr. Risa Bordman
  - **Heart Failure:** Dr. Rahul Jain
  - **Anxiety & Depression:** Dr. Sharon Bal
  - **COPD:** Dr. Tony D'Urzo
  - **Pharmacotherapy for Obesity:** Dr. Sonja Reichert
  - **ADHD in Adults:** Dr. Devon Shewfelt

Visit flow

- Needs assessment
  - **"What do you see in your practice?"**
  - **"What are you hoping to discuss?"**
  - **Some providers do EMR search ahead of time to generate questions**
  - **Option to frame discussion around a patient case (case-based learning)**
- Discuss key messages: **provide information/tools/resources**
  - I.e., Handouts, education, services, specialist supports, QI/EMR resources, etc
- **Check in & address any barriers** to applying information
- Closing and wrap-up:
  - Reinforce key points
  - Ask about planned practice changes
  - Arrange next visit
- **Ongoing availability** through email or follow-up visits if needed.

CEP's academic detailing service

- **Free for family physicians, primary care NPs and family medicine residents**
- **Convenient virtual or in-person** appointments with flexible timing
- **Sessions usually last 30-60 minutes (minimum 15 minutes)**
- **Mainpro+ accredited**
- **No industry** funding
- Interaction and individualized approach **enables practice change**

Supported by funding from the Ontario Ministry of Health.

CEP Centre for Effective Practice

Academic detailing results

- **98%** of detailed family physicians indicated that the academic detailing service increased their ability to practically translate evidence into patient care.
- Physicians who had an academic detailing visit about opioid tapering had a **37% reduction in opioid prescribing at 18 months** when compared to matched controls.
- Among detailed family physicians, the highest 25% of prescribers had a **reduction in benzodiazepine prescriptions that was 5x greater** than their matched control peers over a 12-month period.

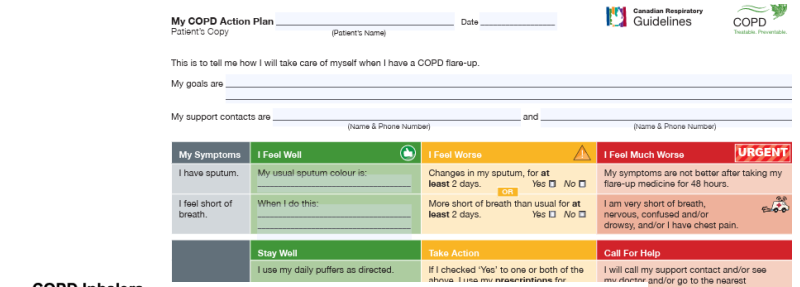
	Presentations (conference, webinar, etc.)	Online Module	Academic Detailing
Format	Didactic	Variable	Interactive discussion
Goal	Convey information to a large group	Convey information to a general group	Best practice facilitation (inspire/enable change)
Personalized?	May have Q&A	No	Yes
Industry involvement	Sometimes	Sometimes	No
Booked according to participant schedule?	No	Yes	Yes
Follow-up support?	No	No	Yes (email, follow-up appts)
Relationship based?	No	No	Yes
Resource focus?	Sometimes	Sometimes	Yes

Academic Detailing Topics

- **COPD**
- Pharmacotherapy for Obesity
- Anxiety & Depression
- Type 2 Diabetes: Insulin
- Type 2 Diabetes: Non-Insulin Pharmacotherapy
- Heart Failure
- ADHD in Adults [April 2025]
- 2 New Topics Each Year

Academic Detailing Subtopics for COPD

- Assessments
- Approach to treatment
- **Inhaler comparison**
- Self-management
- **COPD Action Plans**
- **Resources**



My COPD Action Plan _____ Date _____
Patient's Copy (Patient's Name)

Canadian Respiratory Guidelines — COPD Treatable. Preventable.

This is to tell me how I will take care of myself when I have a COPD flare-up.

My goals are _____

My support contacts are _____ (Name & Phone Number) and _____ (Name & Phone Number)

My Symptoms	I Feel Well	I Feel Worse	I Feel Much Worse URGENT
I have sputum.	My usual sputum colour is: _____	Changes in my sputum, for **at least** 2 days. Yes ☐ No ☐ OR	My symptoms are not better after taking my flare-up medicine for 48 hours.
I feel short of breath.	When I do this: _____	More short of breath than usual for **at least** 2 days. Yes ☐ No ☐	I am very short of breath, nervous, confused and/or drowsy, and/or I have chest pain.
	Stay Well	**Take Action**	**Call For Help**
	I use my daily puffers as directed.	If I checked 'Yes' to one or both of the above, I use my prescriptions for	I will call my support contact and/or see my doctor and/or go to the nearest department.
			911.

information: I will tell my doctor, / educator, or case manager **ays** if I had to use any of my **escriptions**. I will also make **appointments** to review my **ion Plan** twice a year.

i Asthma Network of Alberta (CANA), owledges the past contributions of ician Airways Group of Canada. PART 1 OF

COPD Inhalers

Device	Type	Inhalation Notes	Usable if weak lungs	Usable if weak hands	Convenience	LAMA	LABA/LAMA (or LAMA/LABA)	ICS/LABA/LAMA
Aerosphere®	MDI (env)	Low inspiratory flow required (slow, deep breath) Use with Aerochamber	✓	✗	BID	--	--	Breztri® budesonide/ glycopyrronium/ formoterol LU 638
Breezhaler	Dry Powder (capsule)	Adequate inspiratory flow needed (quick, forceful breath) Can repeat	✓	✗	capsule	Seebri® glycopyrronium	Ultibro® indacaterol/ glycopyrronium LU 459	Enerzair® mometasone/ indacaterol/ glycopyrronium [asthma LU 627]
Ellipta®	Dry Powder (pre-loaded)	Adequate inspiratory flow needed (quick, forceful breath)	✗	✓		Incruse® umeclidinium	Anoro® umeclidinium/ vilanterol LU 459	Trelegy® fluticasone/ umeclidinium/ vilanterol LU 567
Genuair®	Dry Powder (pre-loaded)	Adequate inspiratory flow needed (quick, forceful breath) Feedback window	✓	✓	BID	Tudorza® aclidinium	Duaklir® aclidinium/ formoterol LU 459	--
Handihaler	Dry Powder (capsule)	Adequate inspiratory flow needed (quick, forceful breath) Can repeat	✓	✗	capsule	Spiriva® tiotropium	--	--
Respimat®	soft-mist	Low inspiratory flow required (slow, deep breath)	✓	✓*		Spiriva® tiotropium	Inspiolto® tiotropium/ olodaterol LU 459	--

*Respimat can be used with weaker hands if cannister pre-loaded for patient

Adapted from RxFiles Hands vs Lungs Approach 2023

Academic Detailing

To learn more: https://cep.health/academic-detailing/

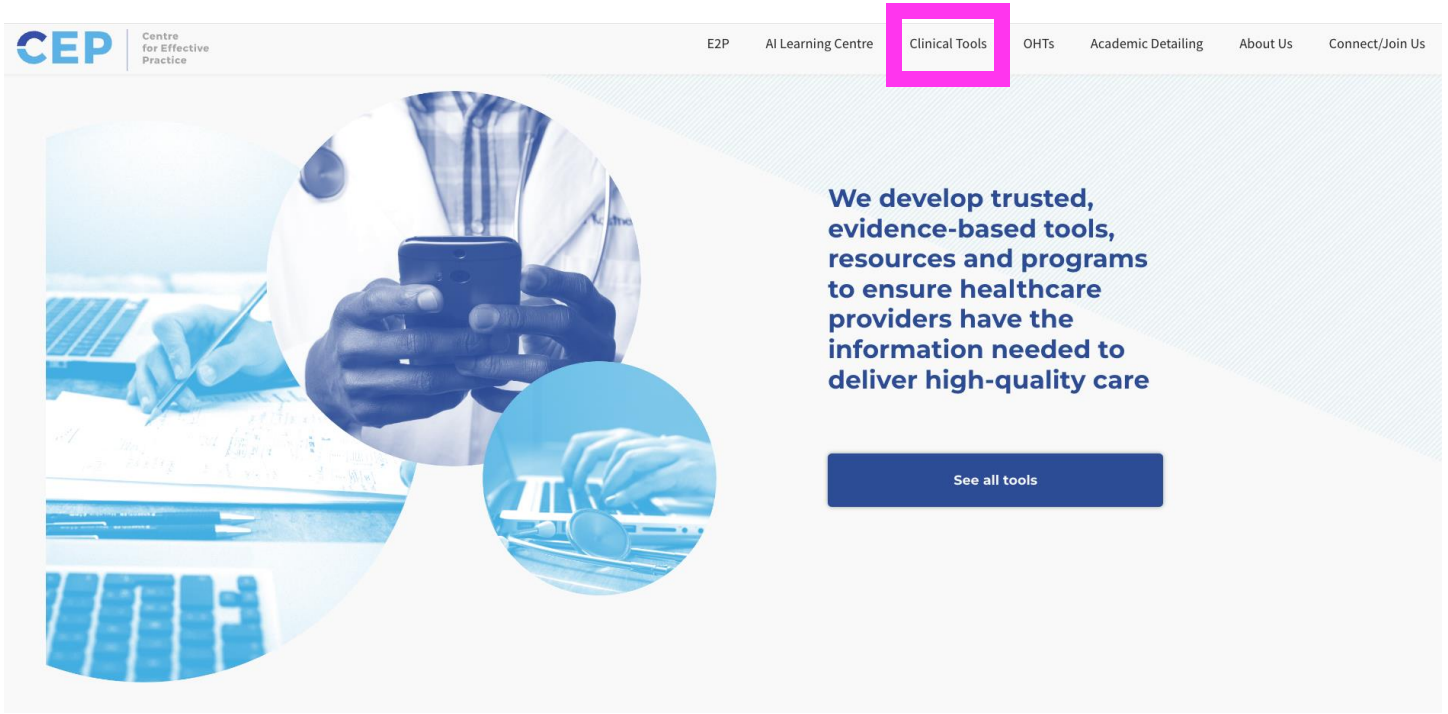
Sites supported by Thames Valley FHT:

- Sign-up through your FHT pharmacist

All other sites:

- Scan this QR Code →
- Sign-up through CEP's website
- Contact: Nicole Seymour (nicole.seymour@cep.health)

CEP's tools and resources: www.cep.health



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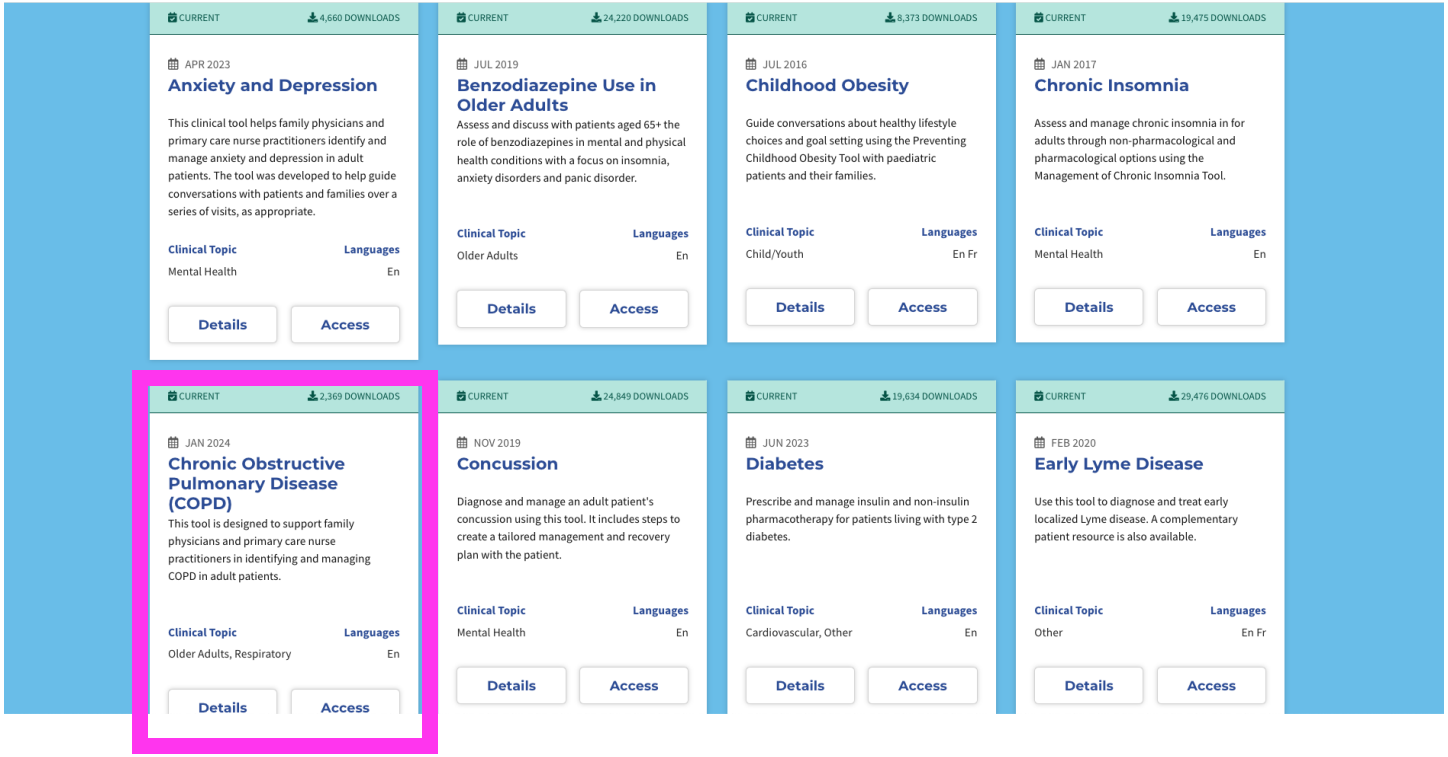
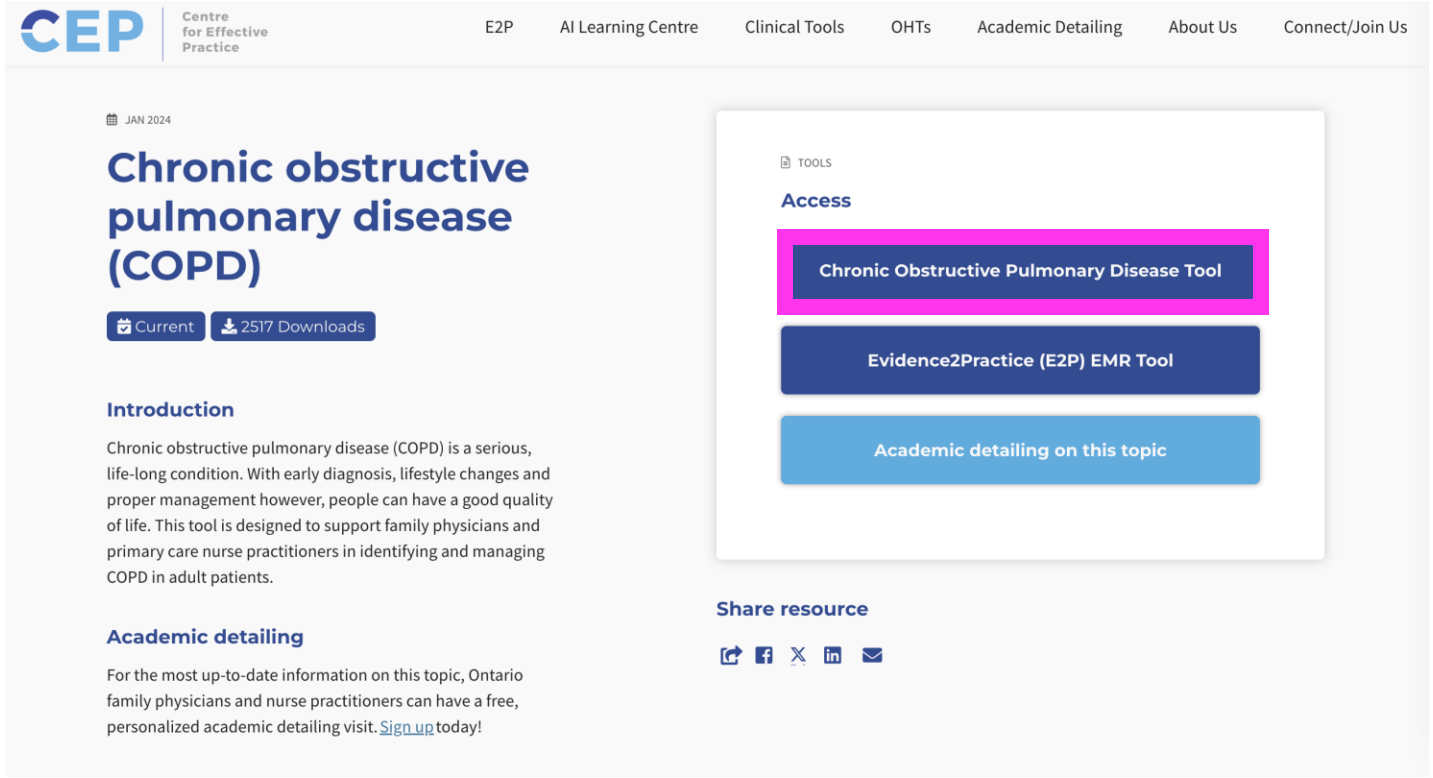
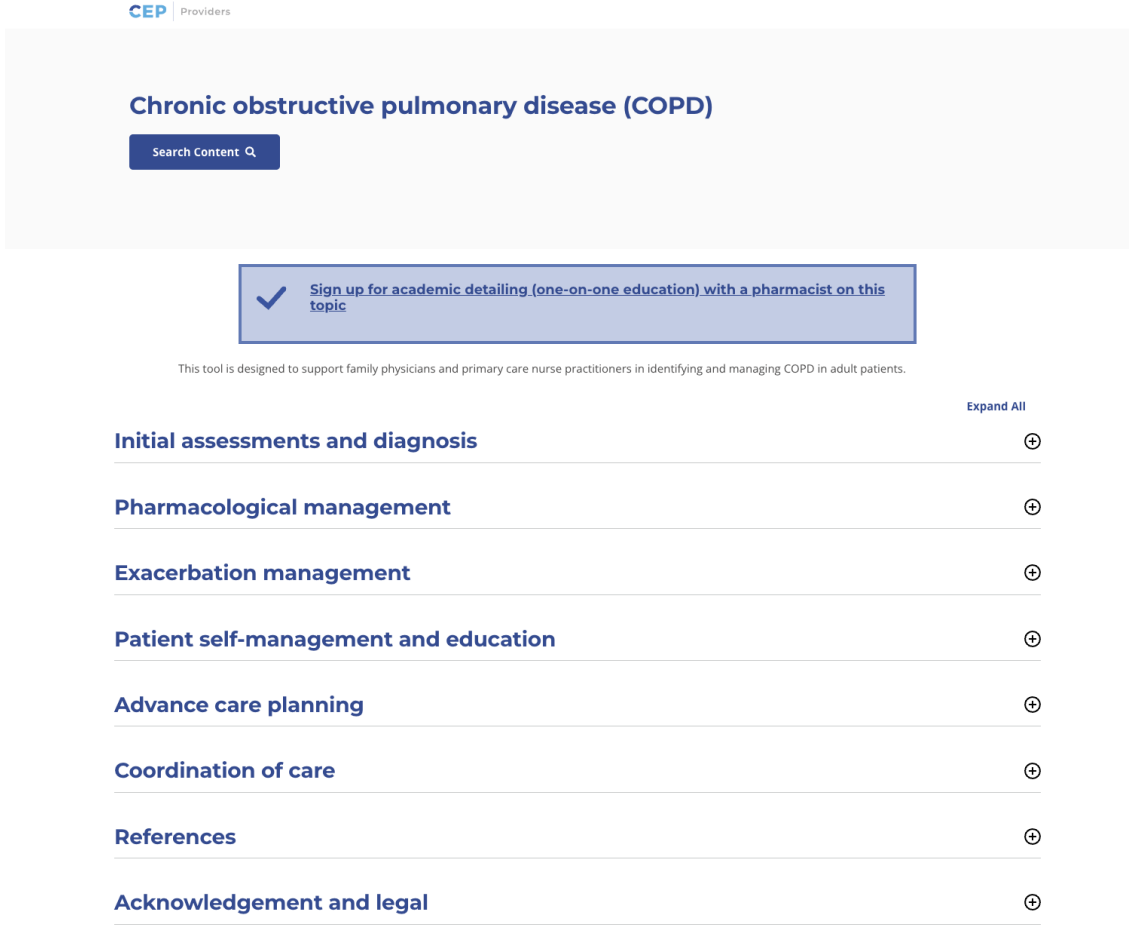


CEP Centre for Effective Practice



CEP COPD Tool

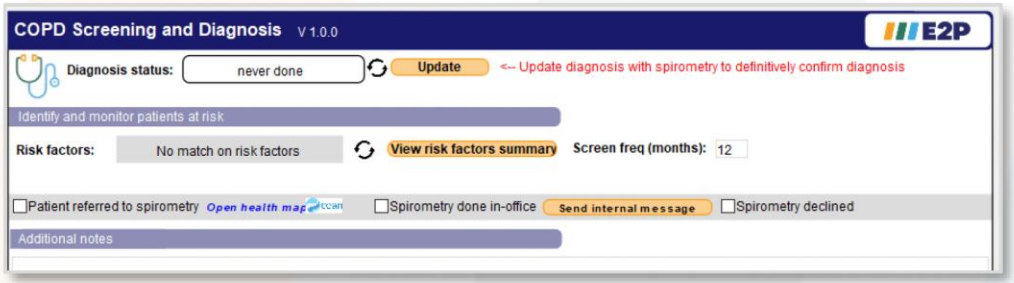


CEP COPD Tool

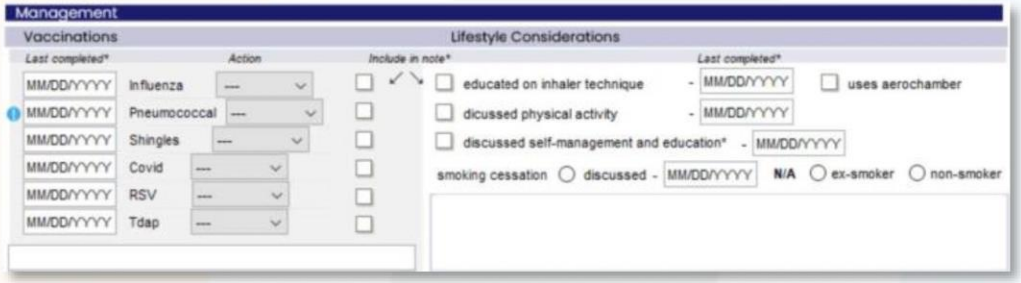
Evidence2Practice (E2P)

- EMR-Integrated COPD Tool ← based off CEP's HTML tool
- Collaboration between CEP, eHealth Centre for Excellence (eCE) & North York General Hospital

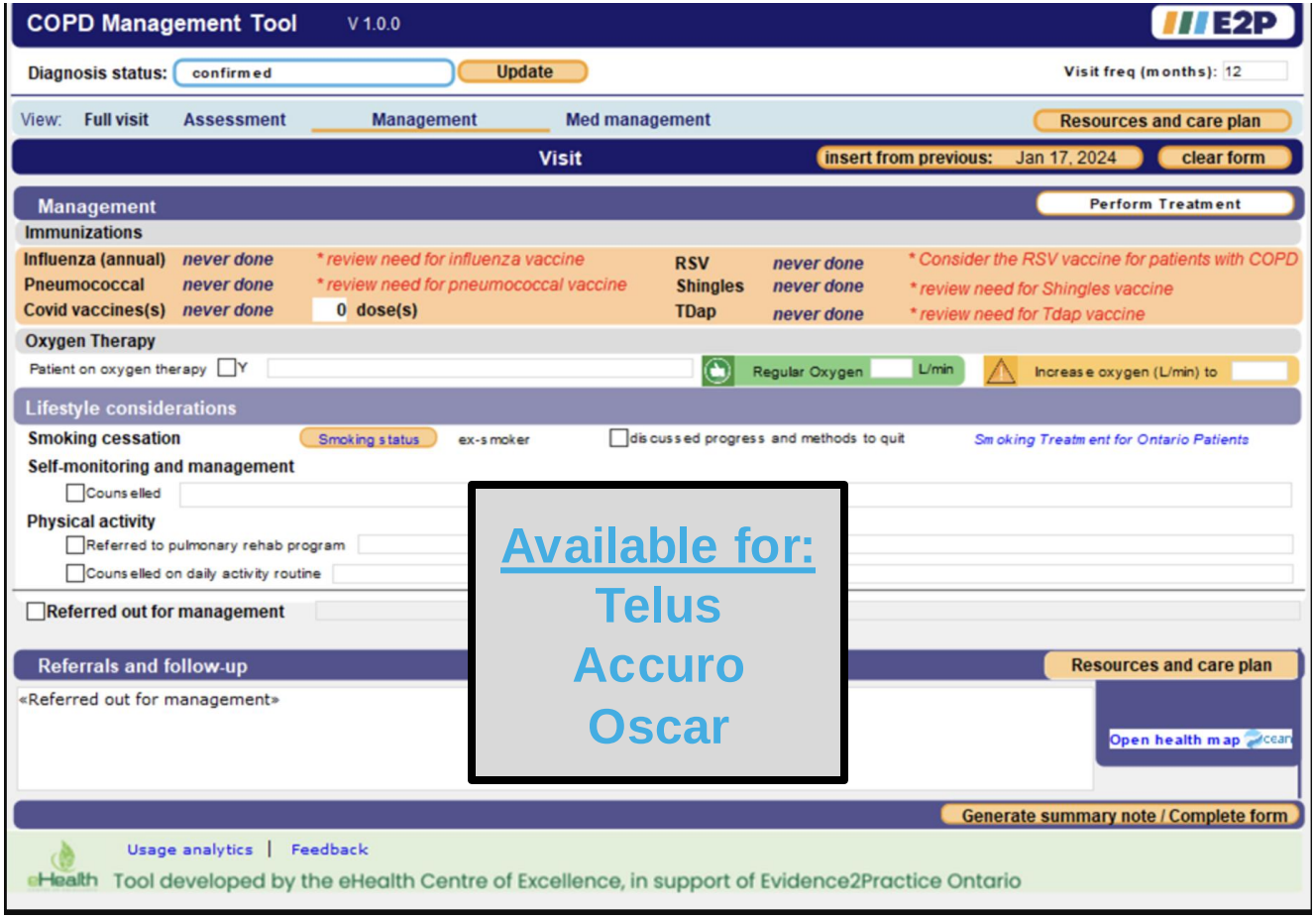
Screening and diagnosis module in TELUS PS Suite



Management plan module in Accuro QHR



Centre for Effective Practice



Available for:

Telus

Accuro

Oscar

CEP Centre for Effective Practice

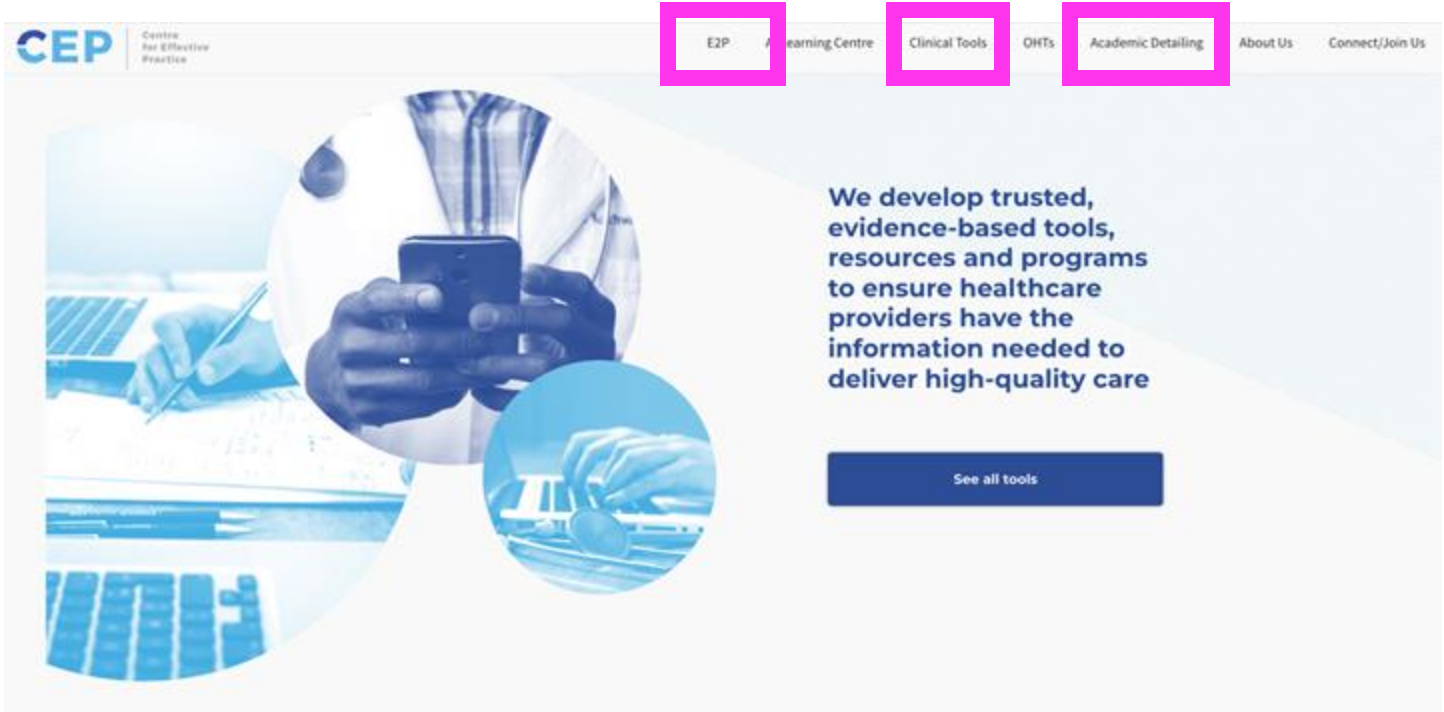
E2P EMR Tools

To learn more or sign-up: https://cep.health/e2p/

eCE change management specialists:

- Demo the tool
- Support install
- Answer questions

CEP's tools and resources: www.cep.health



MLOHT's HealthPathways Platform

- Web-based platform developed in New Zealand and spread to NZ, Australia, and the U.K.
- The MLOHT is collaborating with Burlington and Hamilton OHTs to bring HealthPathways to the three regions.
- A single source of truth for primary care providers, free of charge

HealthPathways

HealthPathways Platform

- Online platform that will be accessible by all primary care providers within their regions that include:
  - Clinical guidance
  - System navigation designed for point of care use.

HealthPathways Platform

COPD Pathway will include:

- Guidance on diagnosis
- Medical management
- Other clinical aspects of pathway
- Programs and services available
- Referral information

HealthPathways Platform

Information on HealthPathways will be kept up to date

Feedback button will allow any user to send feedback on any of the information

HealthPathways Platform

Middlesex London will be launching in June 2025

50 pathways localized to the Middlesex London context

Over 700 pathways will be localized in the next few years

HealthPathways

Receive Updates on HealthPathways

"Stay Informed: HealthPathways Operations Updates"

HealthPathways

End Stage COPD and Palliative Care for COPD

- Information and Resources on a Palliative Care approach to COPD can be accessed via HelathPathways.

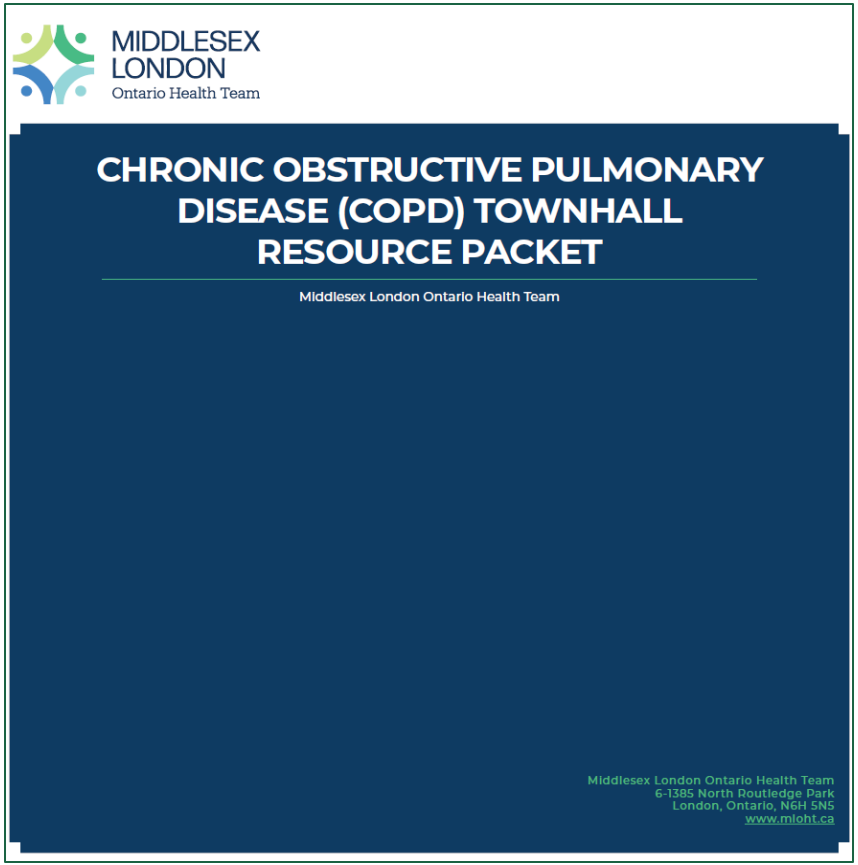
- Palliative Care and resources are also available are included in a resource packet which will be mailed to the audience.

COPD Supports and Services

- OH Quality Statement on 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.”

- Resource package containing supports for patient and providers will be mailed to audience and become available on the MLPCN website.



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Ontario Health Team

Questions?

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Thank you!

For more information,
Visit our website: mloht.ca

Email at info@mloht.ca