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

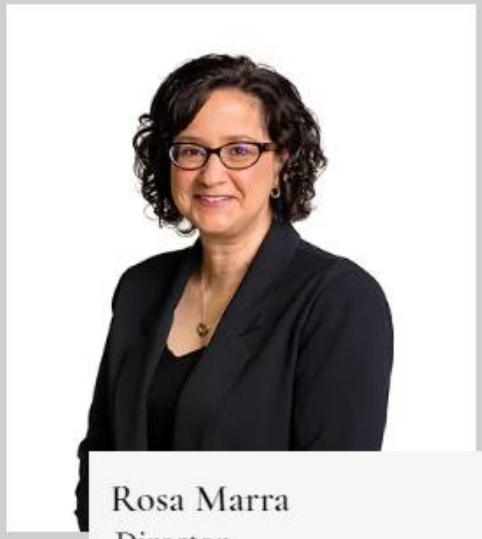
funded by the
Ontario Ministry of Health

at
270 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

BEST CARE VISION STATEMENT

To **develop, implement, and evaluate** standardized, world-leading, culturally acceptable chronic disease management programs that improve the lives of people living with chronic disease and **support the transformation of health systems** globally toward a **more resilient and sustainable future**

Achieved through an integrated disease management team-based model of care

THE CURRENT STATE OF THE HEALTH SYSTEM

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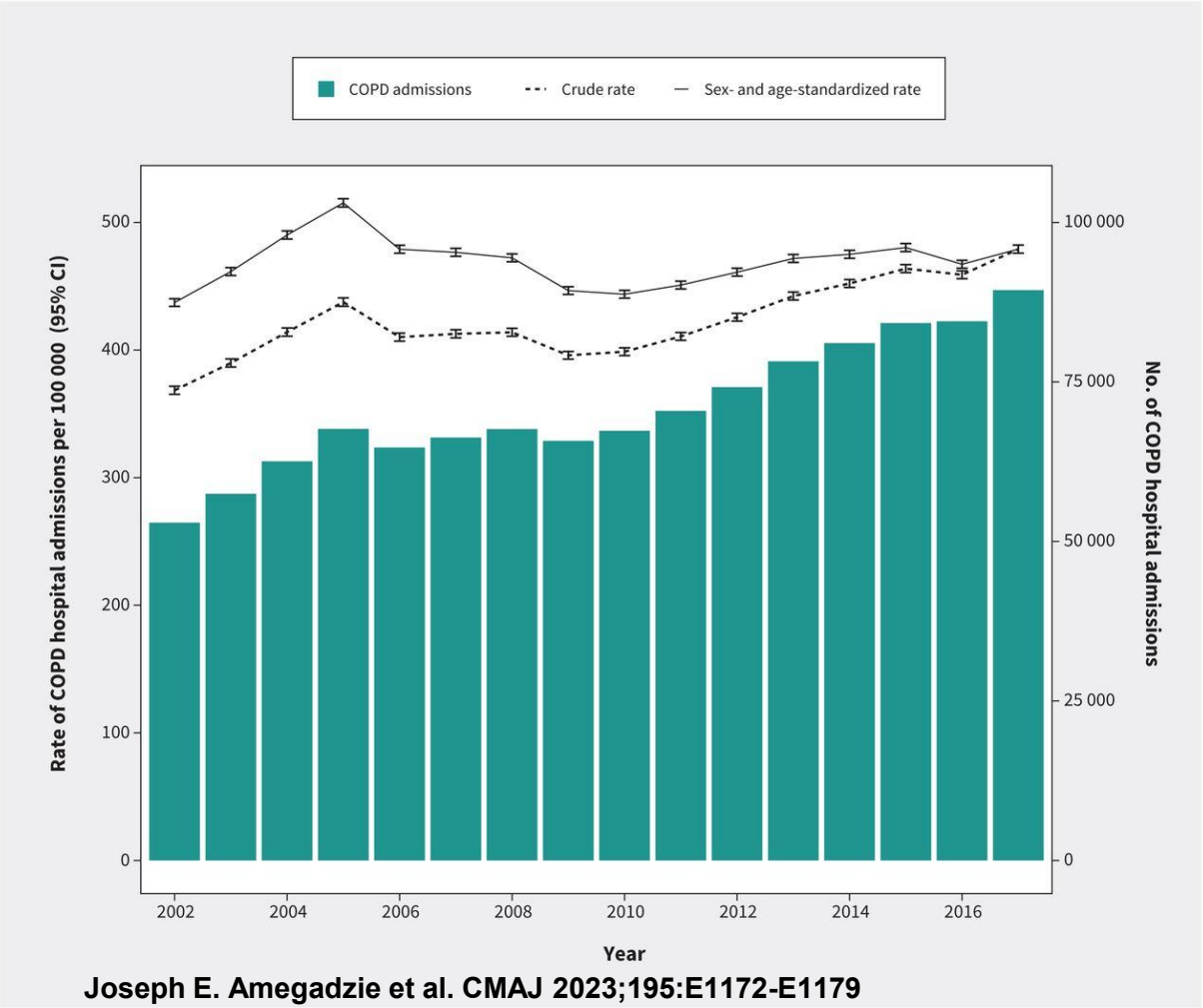
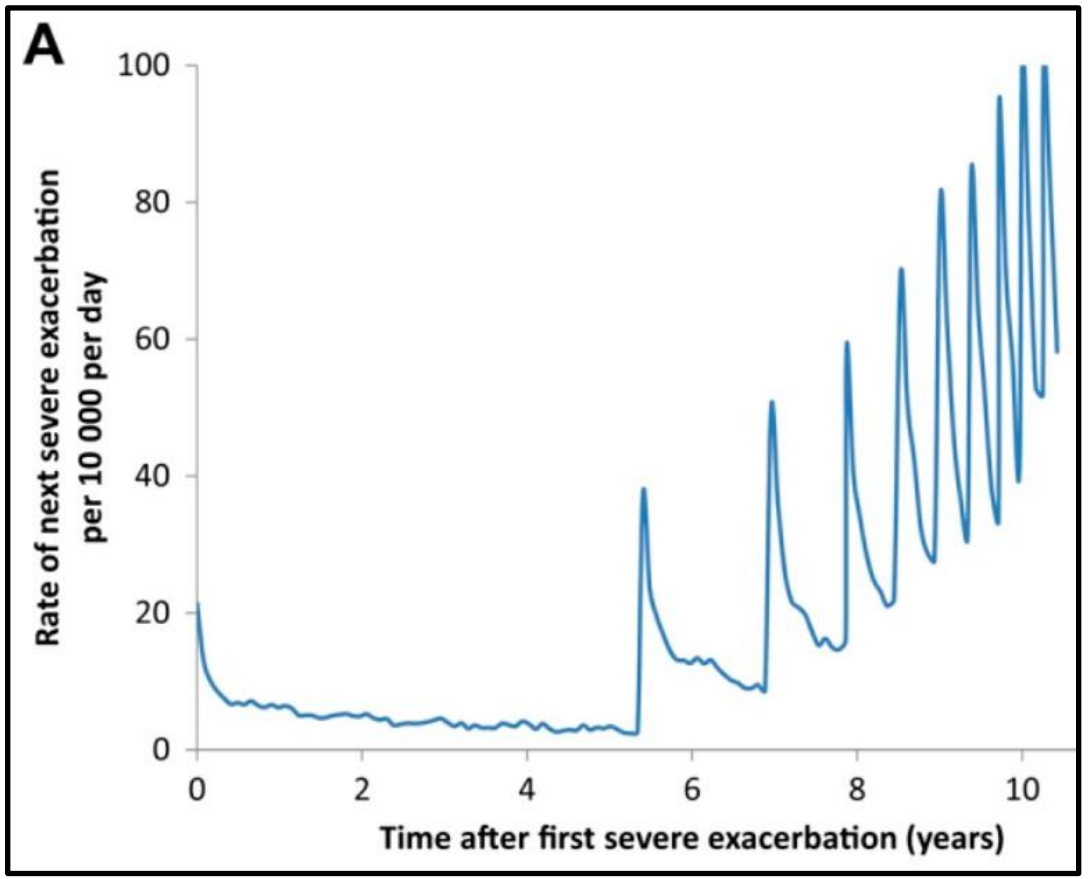
HIGH COPD HOSPITALIZATION RATES HAVE PERSISTED OVER TIME IN MULTIPLE HEALTH JURISDICTIONS

- Rising Hospitalization Trend in Canada



Joseph E. Amegadzie et al. CMAJ 2023;195:E1172-E1179

- Rising Patient Risk of Hospitalization Over Time



S. Suissa et al. Thorax. 2012 Nov; 67(11): 957–963.
doi: 10.1136/thoraxjnl-2011-201518

ACUTE CARE COSTS FOR HF AND COPD IN ONTARIO

COPD AND HF ARE THE #1 AND #2 CAUSE OF HOSPITALIZATION IN ONTARIO

COPD (900,000 people)

- 195,000 hospital days = $250 million dollars
- $250 million in potentially avoidable acute care costs / year, every year

HEART FAILURE (327,000)

- 261,563 hospital days = $327 million dollars
- $327 million in potentially avoidable acute care costs / year, every year

Ontario is on target to spend more than 6-billion dollars on HF and COPD hospitalizations over the next decade
Best Care reduces hospitalizations by up to 70%

Incremental change is insufficient. Transformative change is required!

Let’s begin by describing how we supported primary care to transform the care of patients with Heart Failure and COPD

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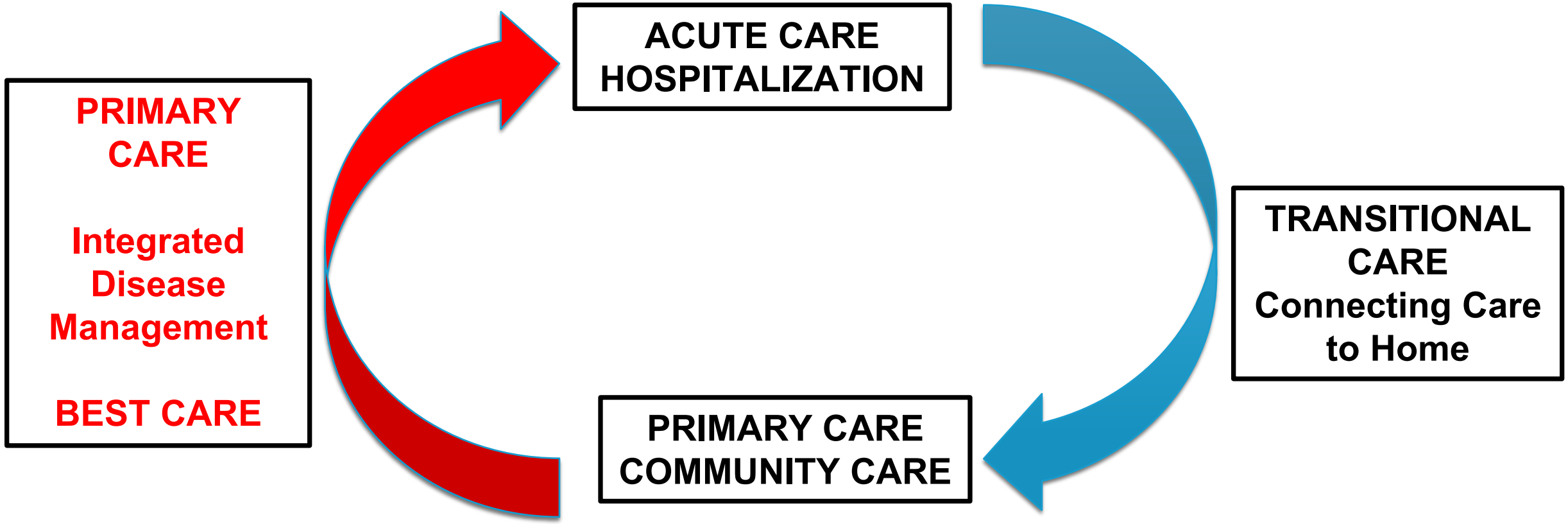
Best Care is an innovative proactive upstream solution to improve quality of life and disrupt the annual cycle of hospitalizations



THE CHALLENGE

Limited primary care capacity in Canada makes integrated disease management (IDM) essential; there is growing evidence of impact in the primary care setting[1,2]

THE SOLUTION

Best Care delivers guideline-concordant care improving the lives of people with chronic disease and health system performance

1. Poot CC, et al. Cochrane Database Syst Rev 2021;9:CD009437; 2. Vachon B, et al. Int J Chron Obstruct Pulmon Dis 2022;17:259–272

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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	Proactive, 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

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EMBEDDING GUIDELINE EXPERTS INTO PRIMARY CARE PRACTICES
BUILDING A COMMUNITY OF CARE TO SUPPORT MEDICAL MANAGEMENT

- 1 Director of Operations
- 1 CEO & Medical Director
- 1 Project Manager
- 1 Evaluation Officer
- 6 Program Coordinators
- 28+ Case Managers

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

- Designed to work in a primary care practice
- Educator / case manager in your practice seeing your patients
- Educator /case manager seeing 6 patients per day (1 or 2 are yours)
- Need 5 - 7 minutes of physician / NP time per patient
- Patient leaves with **all** elements of evidence-based care (Diagnosis, Rx, education, action plan, case management)
- Continuing Care Relationship
- Brief report into your EMR

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

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COPD Quality Standards

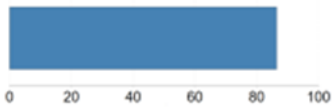
WEST REGION

Unique Patients	Total Visits	Initial Visits
6,418	10,722	3,254

Quality Standards met by the Best Care Program

Quality Statement 1: Diagnosis confirmed with spirometry

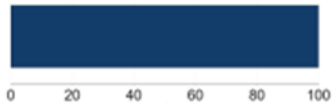
Spirometry (%)



Denominator: total having COPD. Nu denominator who confirm a diagnosi Best Care program

Quality Statement 2: Comprehensive Assessment

***Disability assessed (%)**

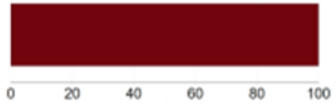


Denominator: total number of people disability has been score and MRC)

***Exacerbation risk assessed (%)**

Denominator: tota number of people exacerbation of C months (antibiotic

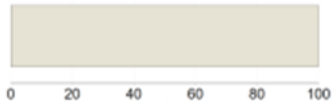
***Comorbidities assessed (%)**



Denominator: total number of people evaluation of comc

Quality Statement 3: Goals of Care and Individualized Care Planning

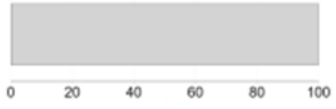
***Goals of care discussed (%)**



Denominator: total number of people goals of care with respiratory educat

Quality Statement 4: Education and Self-Management

***Received self-management interventions (%)**



Denominator: total number of people more interventions health care profes

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Heart Failure Quality Standards Report

WEST REGION 01/04/2023 - 31/03/2024

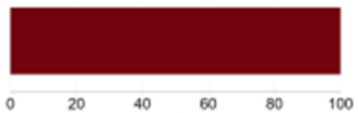
Unique Patients	Total Visits	Initial Visits	Follow-up Visits
643	1,333	339	994

Quality Standards met by the Best Care Program

Ontario Health Quality Ontario

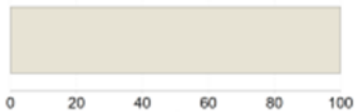
Quality Statement 1: Diagnosing Heart Failure

***Medical History (%)**



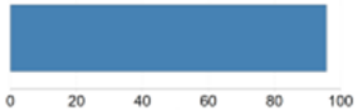
Denominator: total number of people clinically suspected of having heart failure and are referred to the Best Care program. Numerator: number of people in the denominator whose initial evaluation included a medical history to inform their heart failure diagnosis

***Physical Examination (%)**



Denominator: total number of people clinically suspected of having heart failure and are referred to the Best Care program. Numerator: number of people in the denominator whose initial evaluation includes a physical examination to inform their heart failure diagnosis

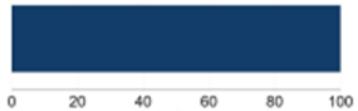
Echocardiogram (%)



Denominator: total number of people clinically suspected of having heart failure and are referred to the Best Care program. Numerator: number of people in the denominator who have received an echocardiogram to inform their heart failure diagnosis

Quality Statement 2: Individualized, Person-Centered, Comprehensive Care Plan

***Care Plan (%)**



Denominator: total number of people with heart failure. Numerator: number of people in the denominator who have a care plan that guides their care

Care Plan reviewed in the last 6 months (%)

Denominator: total number of people with heart failure who have a care plan. Numerator: number of people in the denominator whose care plan has been reviewed in the past 6 months

Quality Statement 3: Empowering and Supporting People with Heart Failure to Develop Self-Management Skills

MEASURING THE IMPACT OF BEST CARE

HEART FAILURE

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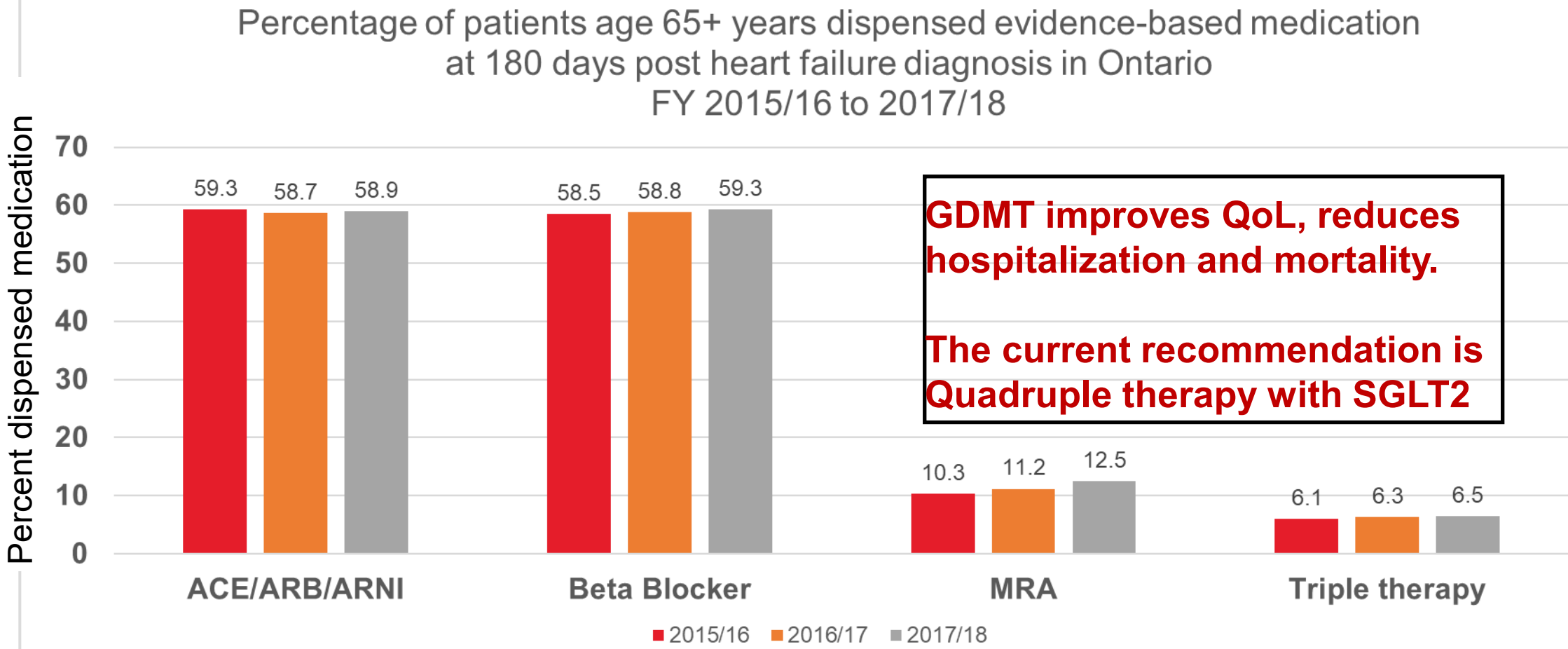
A minority of patients with HFrEF are receiving guideline directed triple therapy



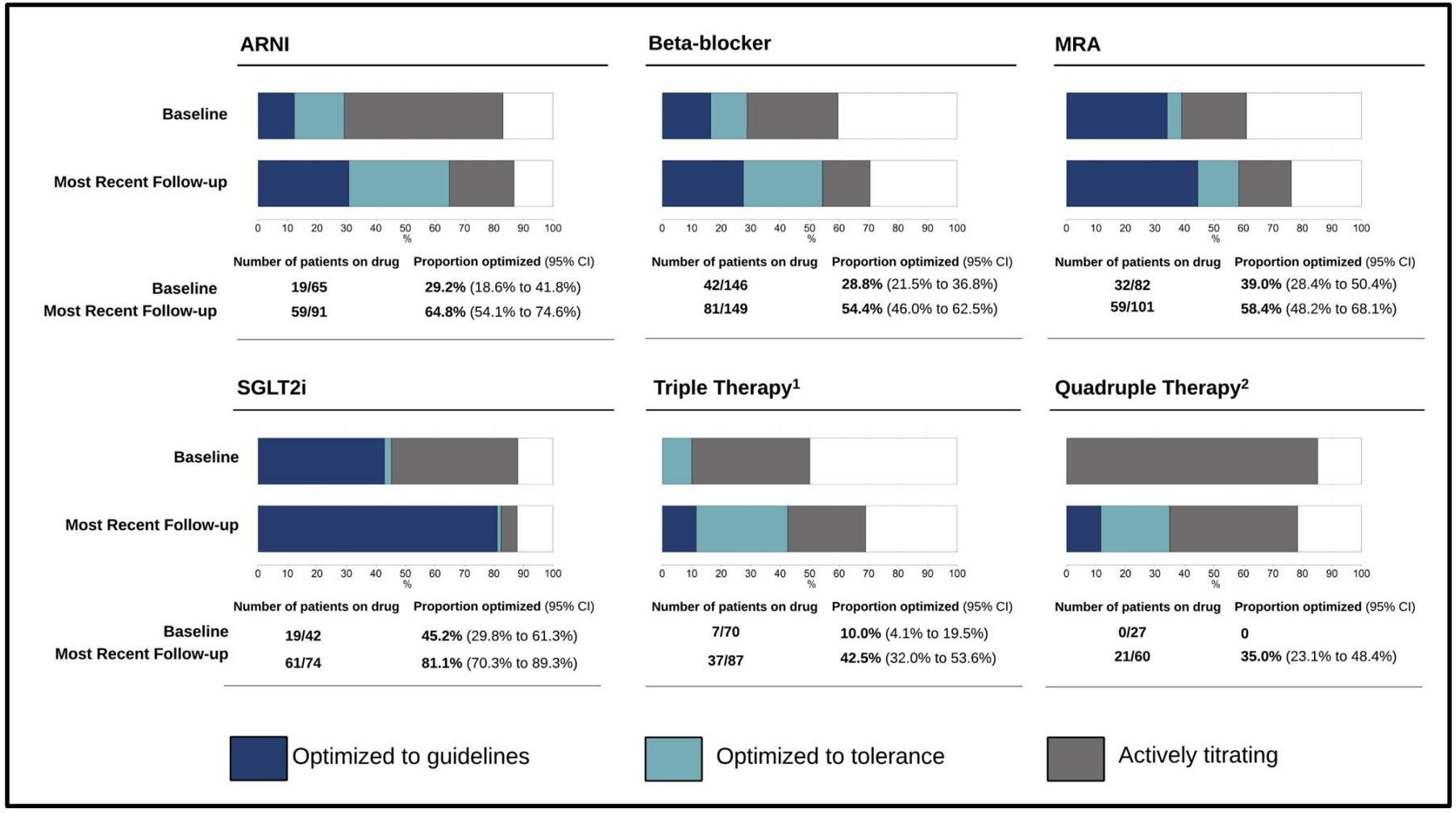
GDMT improves QoL, reduces hospitalization and mortality.

The current recommendation is Quadruple therapy with SGLT2

Data source: Discharge Abstract Database (DAD), Heart Failure Cohort (Schultz et al. 2013); National Ambulatory Care Reporting System (NACRS), Ontario Drug Benefit Claims (ODB), Ontario Health Insurance Plan (OHIP) Claims Database, Registered Persons Database (RPDB)

Impact #1: 60% of HFrEF patients are now receiving guideline-concordant care**

Of these patients, 50% are at target or tolerance dosing, improved since our publication in 2024

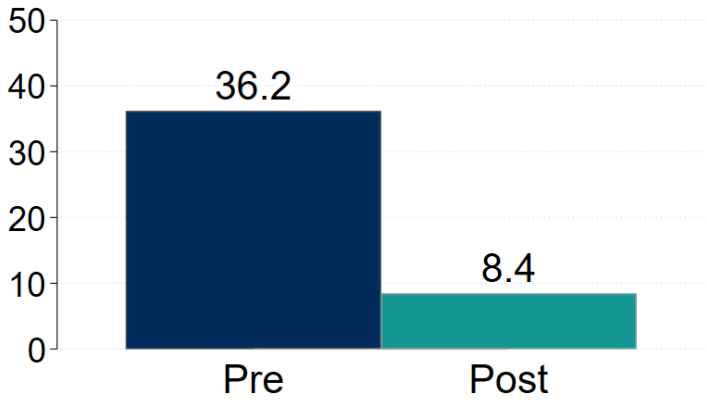


Licskai, C; Hussey, A. An innovative patient-centred approach to heart failure management: the Best Care heart failure integrated disease management program. DOI: https://doi.org/10.1016/j.cjco.2024.03.015 **most recent performance report

Best Care Heart Failure improved or stabilized quality of life and reduced hospitalizations and ED visits

Impact #3: 70% reduction in hospitalizations and ED visits

Hospital Admissions



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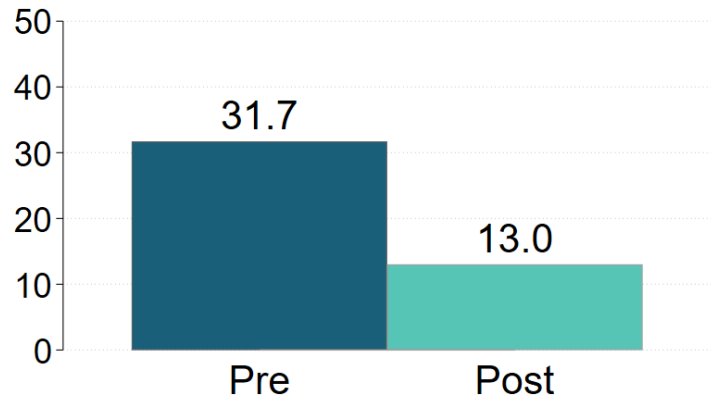
ED Visits
(not leading to a hospital admission)



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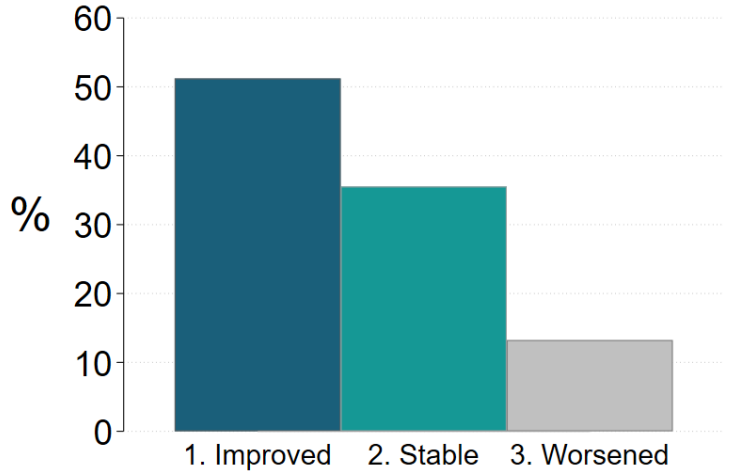
Impact #2: 85% with improved or stabilized Quality of Life

Quality of Life



Number of events / 100 patients with heart failure / year

Licskai, C; Hussey, A. An innovative patient-centred approach to heart failure management: the Best Care heart failure integrated disease management program. DOI: https://doi.org/10.1016/j.cjco.2024.03.015

MEASURING THE IMPACT OF BEST CARE COPD

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IMPACT: 80% OF GOLD E PATIENTS ARE NOW RECEIVING GUIDELINE-CONCORDANT CARE

GOLD E patients with confirmed or suspected COPD diagnosis at most recent visit

Pharmacological therapy Controller medication	Initial visit Number of patients (%) N = 917	Most recent follow-up Number of patients (%) N = 917
Closed triple (ICS/LABA/LAMA)	139 (15%)	465 (51%)
Open triple (ICS/LABA/LAMA)	384 (42%)	271 (30%)
Total triple (open and closed)	**523 (57%)**	**736 (80%)**
Dual (LABA/LAMA)	91 (10%)	64 (7%)
Dual (ICS/LABA)	103 (11%)	61 (7%)
Single (ICS)	23 (3%)	6 (1%)
Single (LAMA)	78 (9%)	30 (3%)
Single (SABA/SAMA)	18 (2%)	6 (1%)
No therapy	69 (8%)	14 (2%)

GOLD, Global Initiative for Chronic Obstructive Lung Disease; ICS, inhaled corticosteroid(s); LABA, long-acting β_2 agonist; LAMA, long-acting muscarinic antagonist; SABA, short-acting β agonist; SAMA, short-acting muscarinic antagonists

Unpublished data. Best Care – GOLD E Pharmacological Treatment

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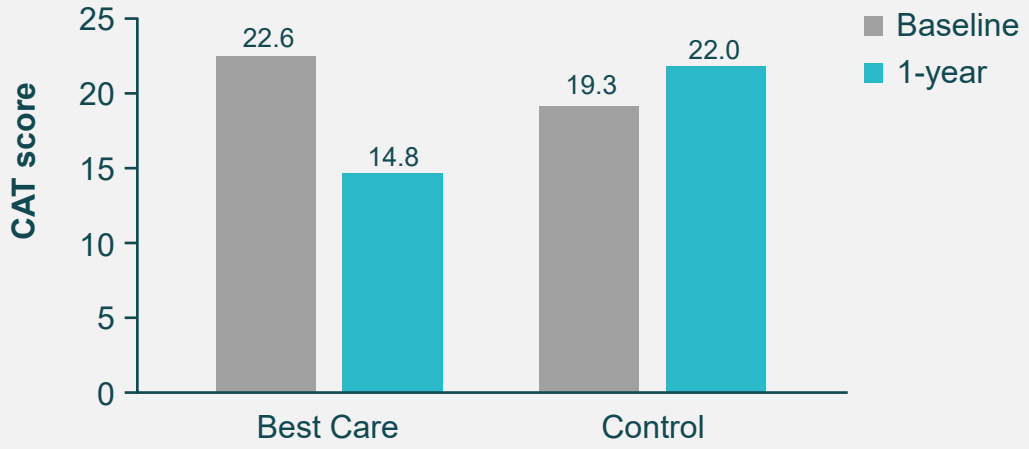
BEST CARE COPD IMPROVED QUALITY OF LIFE AND REDUCED HOSPITALISATIONS AND ED VISITS

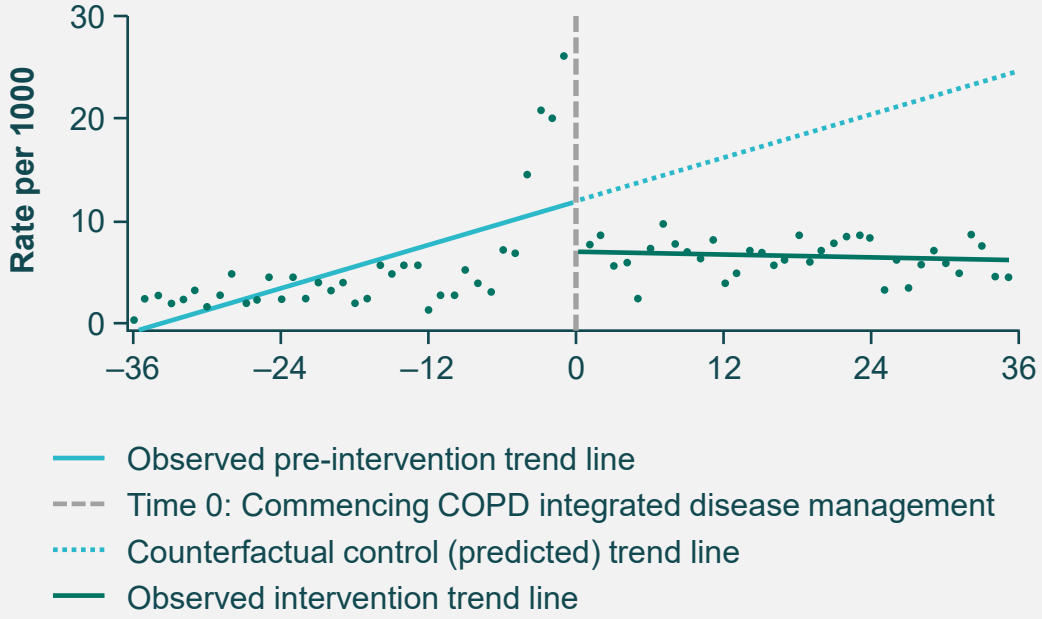
87% had an improved quality of life mean difference of > 9 on the CAT score

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

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A MODEL OF CARE FOR MULTIPLE CHRONIC DISEASES

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THE BEST CARE MODEL IS EXPANDING TO ADDITIONAL DISEASE STATES

A MODEL OF CARE

By building on a model of care that provides easier access to specialists, enhanced team-based care coordination, and reduced hospital use, Ontario could enhance its position as a leader in all aspects of chronic disease care

Heart failure

COPD

Asthma

Atrial fibrillation

Lung cancer screening / early diagnosis COPD

Dementia – holistic brain health

Chronic kidney disease (CKD kit)

Hypertension

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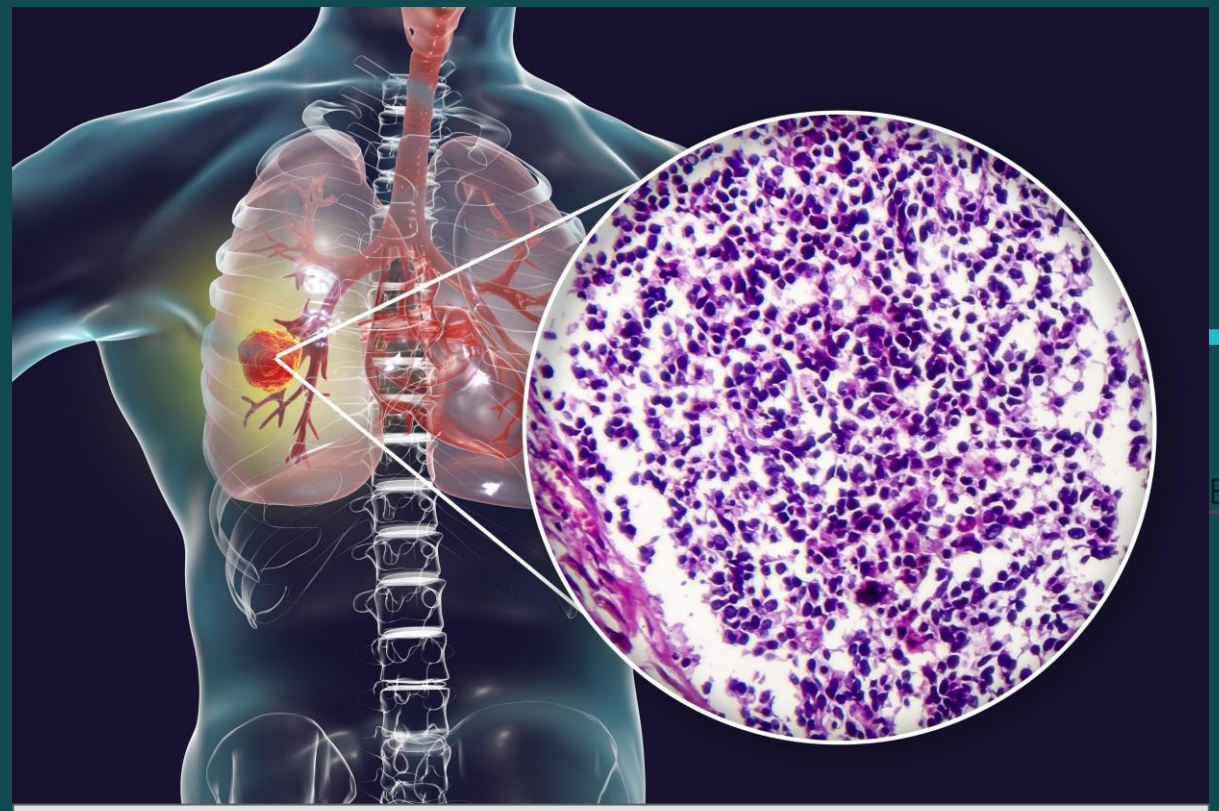

An innovation partnership with AstraZeneca

BEST CARE ONE-LUNG

Early Diagnosis of COPD and Lung Cancer

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GOLD RECOMMENDS COMBINING THE SCREENING FOR LUNG CANCER AND COPD

> Lung cancer and COPD share common risk factors, and COPD is also an independent risk factor for lung cancer and represents the majority comorbidity affecting survival in patients with cancer … assessing symptoms and performing spirometry in individuals undergoing LDCT … represents a unique opportunity to simultaneously screen

LDCT, low-dose computed tomography

Global Initiative for Chronic Obstructive Lung Disease. 2024 GOLD Report. Available at: https://goldcopd.org/2024-gold-report/. (Accessed 4 November 2024)

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MODELLING THE IMPACT OF ONE LUNG ON FIRST DIAGNOSIS OF LUNG CANCER AND COPD

PILOT PROJECT

New diagnosis of lung cancer = 130 (200)

With an inversion of 70% Stage 3 and 4 to 70% Stage 1 and 2

New diagnosis of COPD = 4330

Assumptions

- 250 physicians (250,000 patients)
- 9500 patients initial risk assessment
- 800 patients / CRE / year for 2 years
- Mean risk 2.5%

FULL IMPLEMENTATION ACROSS BEST CARE NETWORK

New diagnosis of lung cancer = 770

With an inversion of 70% Stage 3 and 4 to 70% Stage 1 and 2

New diagnosis of COPD = 25875

Assumptions

- 1500 physicians (1,500,000 patients)
- 57000 patients initial risk assessment
- 800 patients / CRE / year for 2 years
- Mean risk 2.5%

CRE, certified respiratory educator
Data provided by Best Care and speaker's experience

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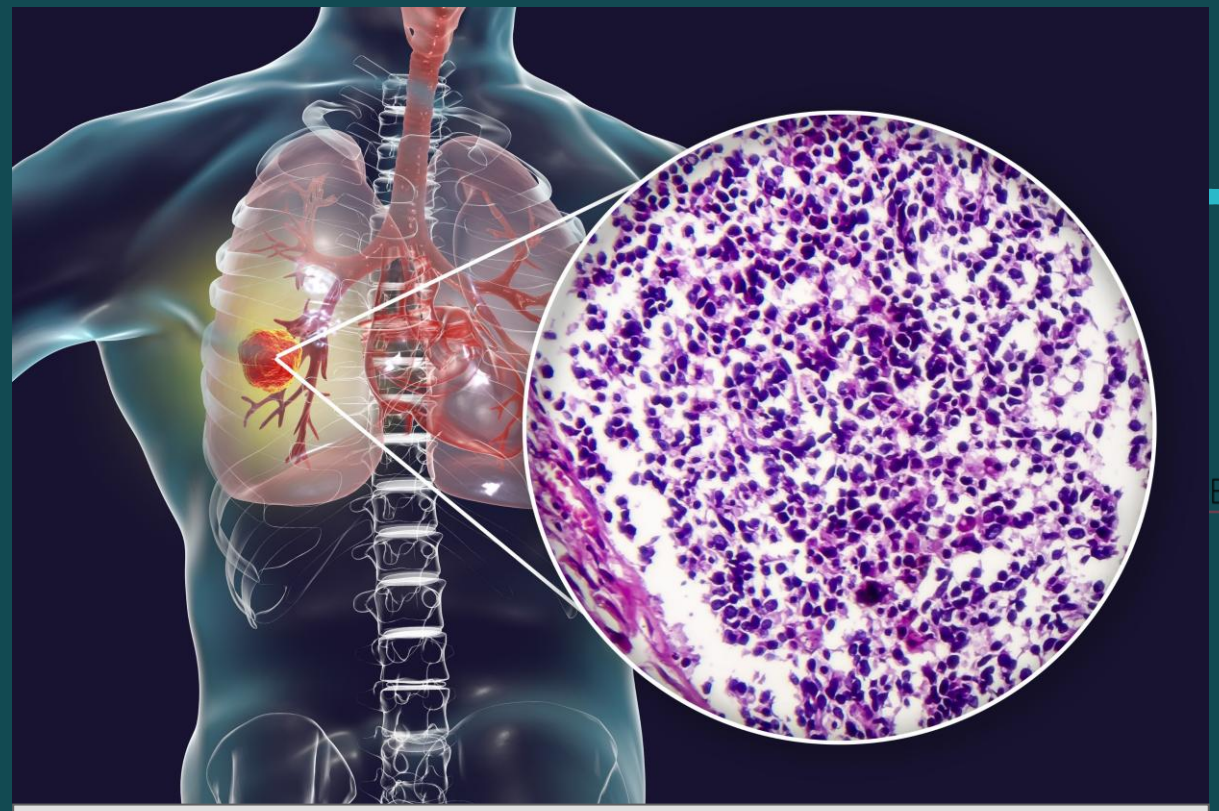

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MEASURING THE IMPACT OF BEST CARE ONE-LUNG

Early Diagnosis of COPD and Lung Cancer

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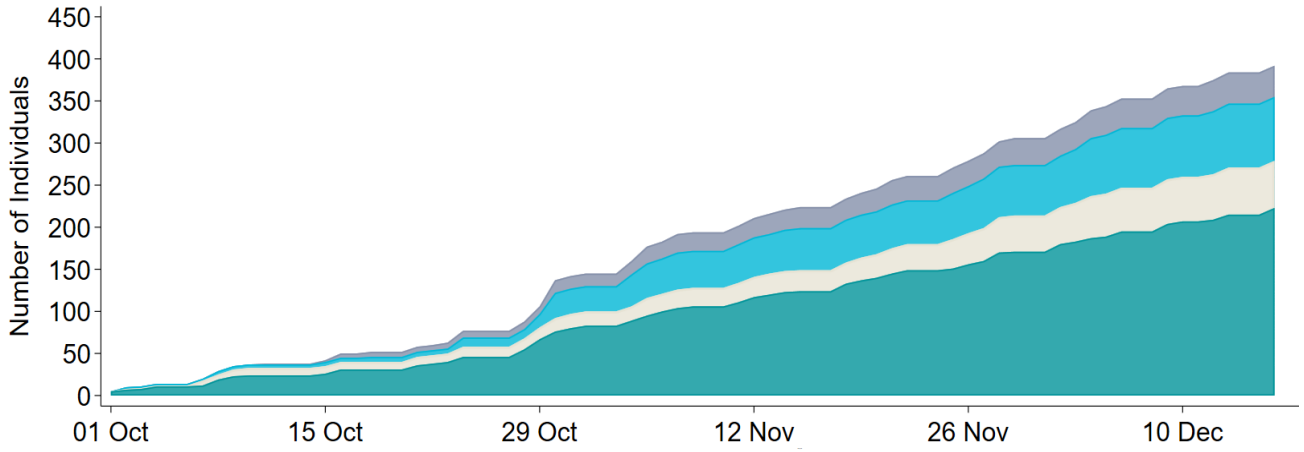
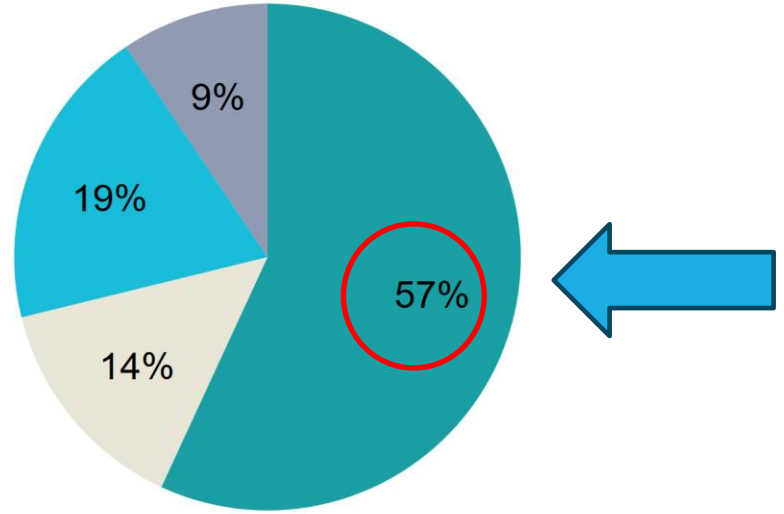
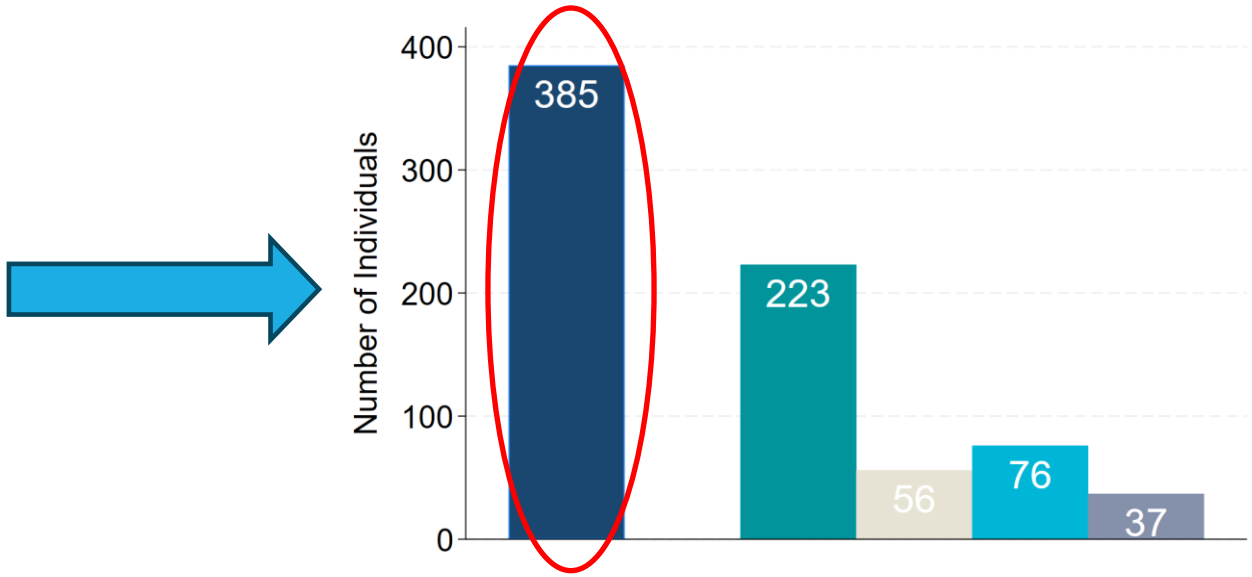
Identification and assessment of lung cancer screen eligible patients







Individuals Approached

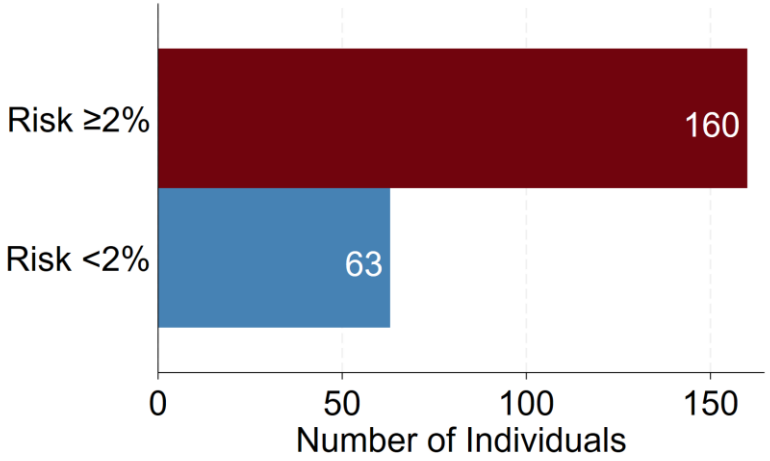
Risk Assessed using the calculator

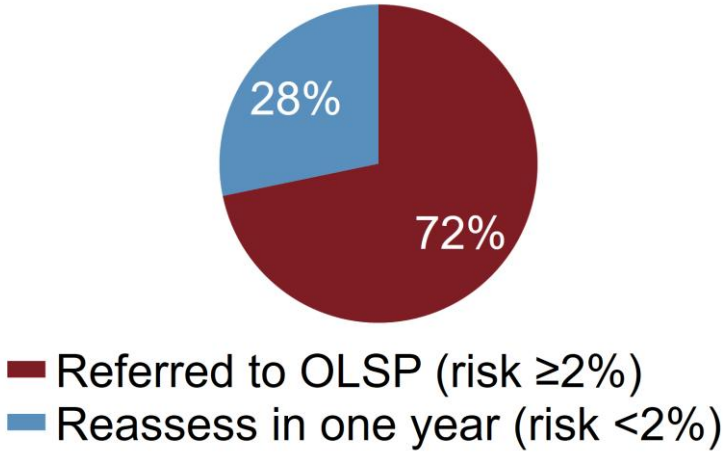
Declined

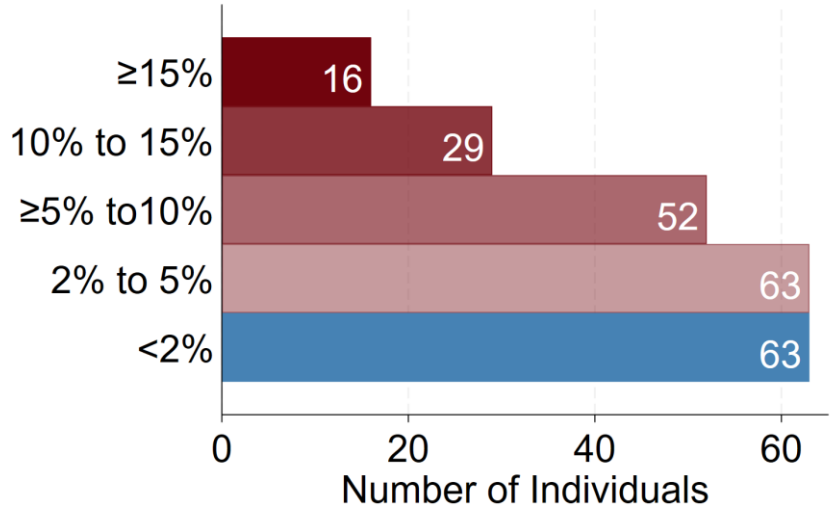
Do not meet criteria

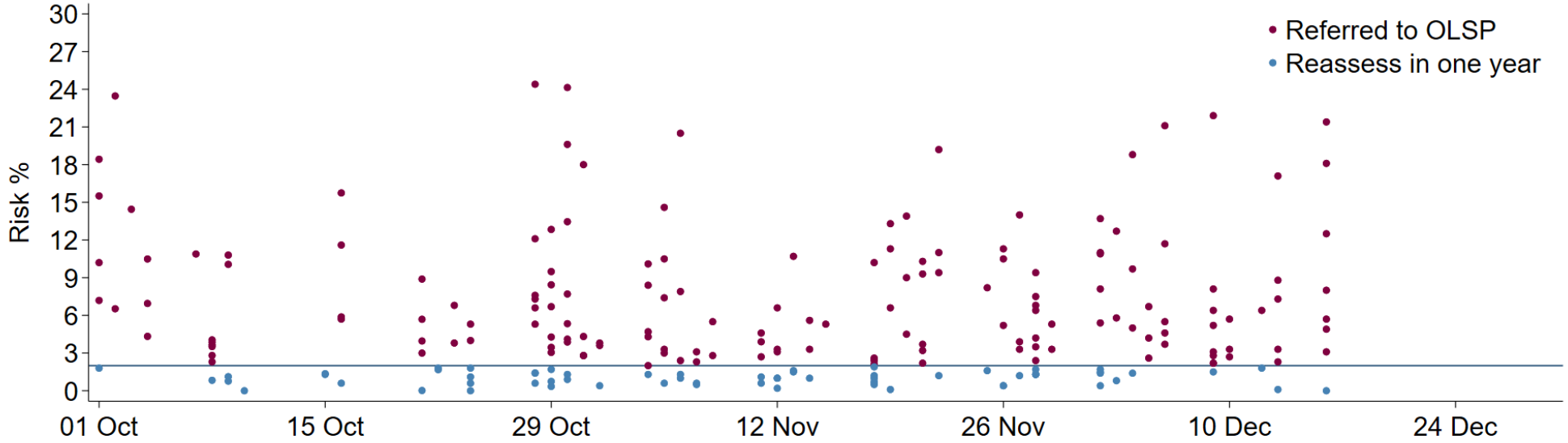
Already in the OLSP

Predicted 6-year risk of lung cancer for individuals assessed using the PLCOm2012noRace calculator









Key learnings and predicted impact after 10-weeks at one RCP

Of the 385 people approached, 223 were assessed and **referred for low dose CT** screening.

For the 223 people referred the **median risk** of developing lung cancer over the next six years is **5.8%.**

Therefore, from the 385 people approached we can expect to detect up to 13** individuals with lung cancer over the next 6 years. (2* on first CT)

Notes: *using 1.72% reported in the Ontario Pilot study (Tammemägi et al (2021). Selection of individuals for lung cancer screening based on risk prediction model performance and economic factors – The Ontario experience. Lung Cancer, 156, 31–40. https://doi.org/10.1016/j.lungcan.2021.04.005)
**using the median risk score from the PLCOm2012 Calculator

HOLISTIC PATIENT CARE

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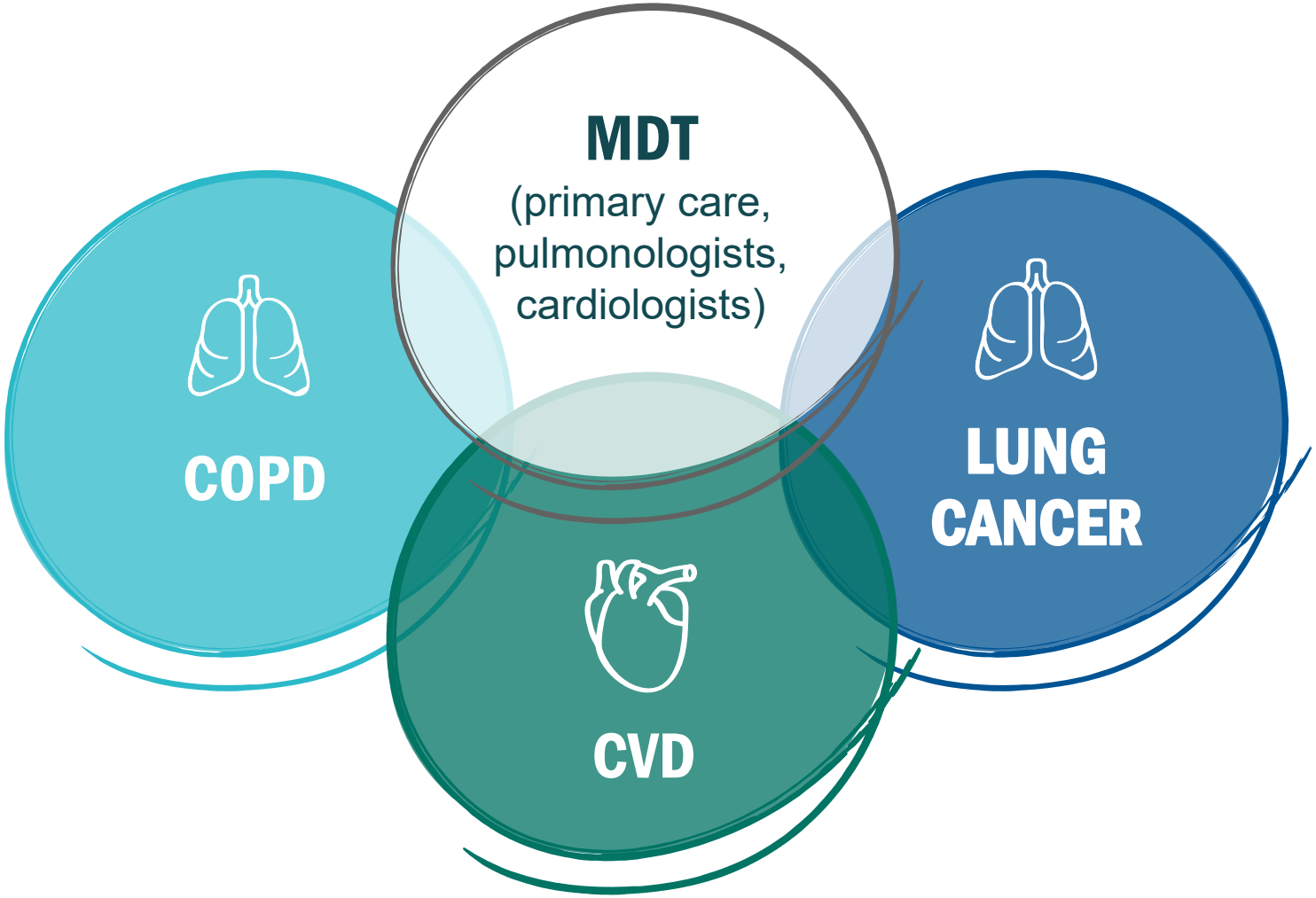
HOLISTIC PATIENT CARE: MANAGING DISEASE(S) AND REDUCING RISK



WHEN CONNECTED TO INTEGRATED DISEASE MANAGEMENT, PEOPLE EXPERIENCE REDUCED HSU AND IMPROVED SYMPTOMS, QOL AND LUNG FUNCTION VERSUS USUAL CARE[1,2]

CVD, cardiovascular disease; HSU, healthcare service utilisation; IDM, integrated disease management; QOL, quality of life

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

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HEALTH SYSTEM TRANSFORMATION IN ACTION

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Northern exemplar: building an integrated healthcare system with primary care at the foundation

North Bay healthcare system transformation

2022

Initiated Best Care Heart Failure
In 18 months, completed 800 visits in 300 patients in primary care

Created a **primary care network** including **every** primary care clinic in the region

Established shared care with the cardiologist

Supported an unattached / orphan HF clinic at the regional hospital

2024

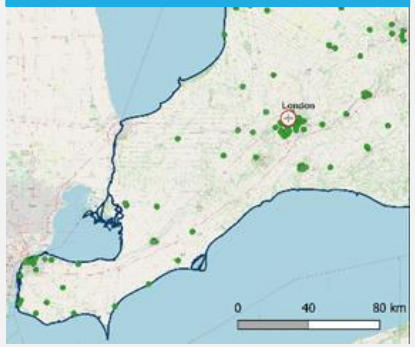
Initiated Best Care COPD, now building shared care with two respirologists

Q4 2024: will initiate **Best Care One-Lung for Early Diagnosis COPD and Lung Cancer** with active primary care screening and case finding

Northern Ontario

Eastern Ontario

Southwestern Ontario

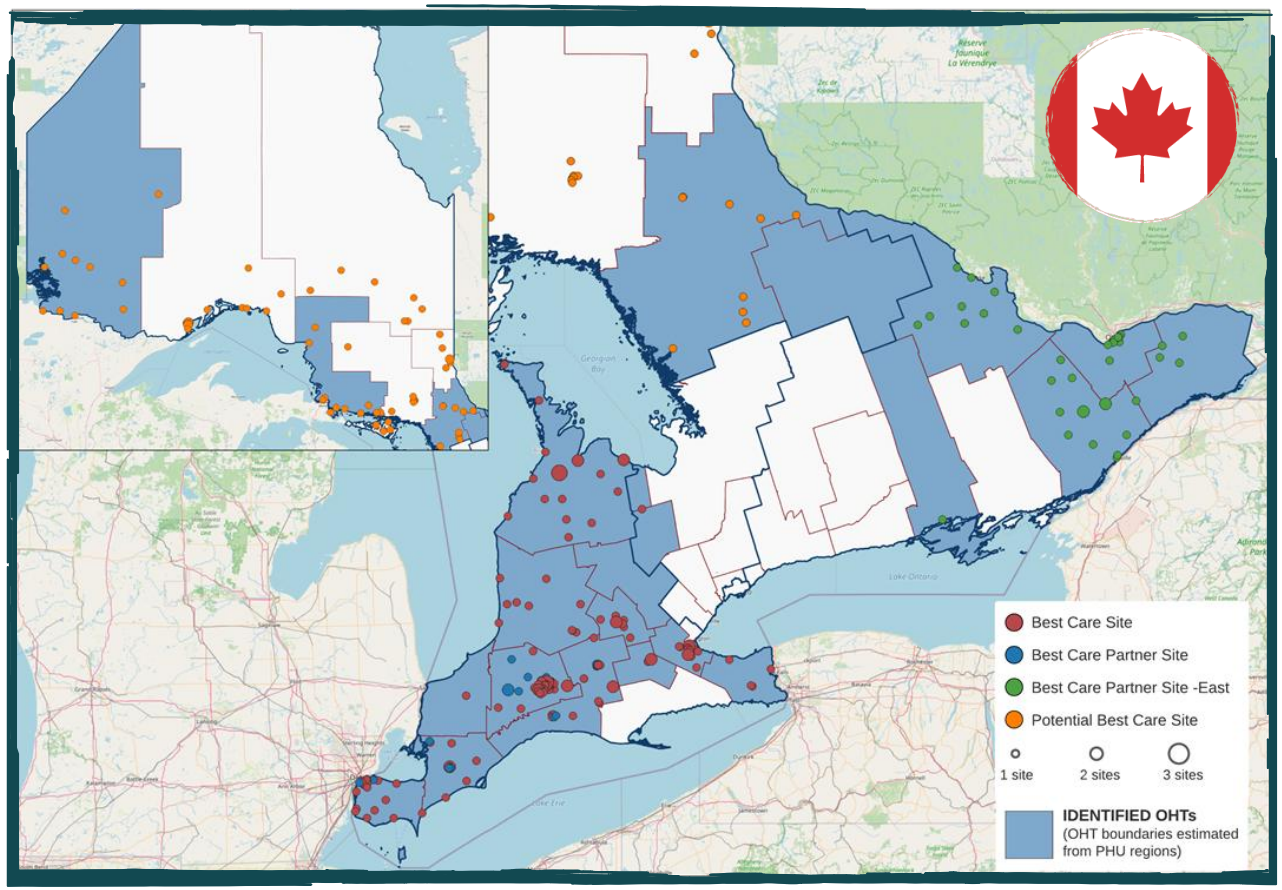


Southwestern Ontario

- Active Best Care sites to commence Lung Cancer Screening
- Potential Best Care sites
- Active Best Care sites available for Lung Cancer Screening
- Lung Cancer Screening Site Location
- Lung Cancer Screening Site Location 2025

OLSP, Ontario Lung Screening Program
Information reflects the personal clinical expertise of the speaker

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



- Is scalable at a health system level
- Exponential growth over 3 years
- 100% of providers say yes
- 270 primary care clinics
- 1300 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

BEST CARE HAS NATIONAL AND INTERNATIONAL APPLICABILITY

BEST CARE MEETS THE CHALLENGES AND BREAKS DOWN BARRIERS THAT ARE SHARED BY HEALTH SYSTEMS GLOBALLY

PRIMARY CARE IS THE FOUNDATION OF RESILIENT AND SUSTAINABLE HEALTH SYSTEMS, AND THE CARE GAPS, TREATMENT STANDARDS AND BARRIERS TO CARE ARE THE SAME ACROSS THE GLOBE

Care standards are international – they apply globally

Team-based care has proven effective in 52 different studies around the world

Care gaps and barriers to care are common

Best Care is cost effective in Canada, England, Germany and Japan

Speaker's own opinion based on experience with the Best Care programme?

BEST CARE IN PRIMARY CARE CANADA

BEST CARE

- Is proactive, preventive, upstream care for early intervention, diagnosis and treatment
- Provides excellence in clinical care delivering guideline-directed medical therapy in the majority or patients
- Is supported by strong science and health economic data
- Breaks down long-standing barriers to care
- Is scalable at the health system level in all models of primary care
- Is trusted by primary care practitioners
- Is a repeatable platform for multiple diseases that supports holistic care
- Supports primary care as the foundation of a future resilient health system

BEST CARE IS RAPIDLY EXPANDING ITS SERVICES TO SUPPORT LUNG CANCER SCREENING, CARE TO EQUITY DESERVING POPULATIONS, ACCESS TO DIAGNOSTIC SPIROMETRY AND COMPREHENSIVE TEAM-BASED CARE

BestCare

Working side-by-side with primary care
Best Care Canada is opening a door toward a future health system that is
holistic, resilient and sustainable

BEST CARE PROGRAMME IN PRIMARY CARE

QUESTIONS DISCUSSION

BestCare

A PARTNER IN ADVANCING YOUR GOALS

Working with OHTs, Best Care can deliver a meaningful value proposition for primary care providers to participate in **laying the foundation for clinically active Primary Care Networks** as we work towards our shared goal of improving patient care and transforming the health system.

Working with OHTs, Best Care can:

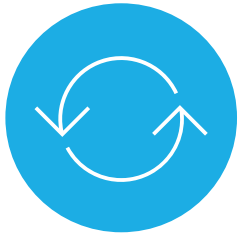
Quickly support the move from ICP planning to implementation

Increase capacity in primary care, specialty care, EDs and hospitals

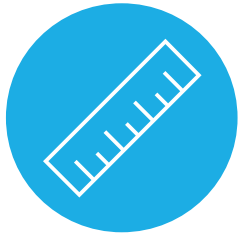
Deliver on-site spirometry aligning with OH goals

Co-develop solutions for unattached populations

Provide better care at a lower cost with an ROI of 4:1



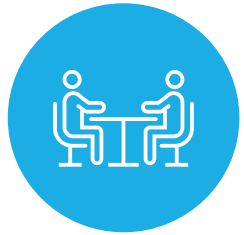
Serve as a scalable and repeatable platform



Support measurement and reporting aligned with OH

Support a community-focused system design

Support program fidelity with robust quality assurance



Co-develop solutions for equity deserving groups

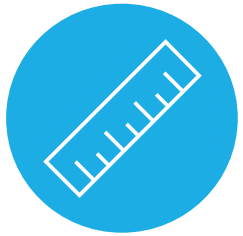
BestCare

A PARTNER IN ADVANCING YOUR GOALS

Working with participating clinicians, Best Care can **reduce the administrative burden in primary care** by delivering clinically relevant summary notes to the provider EMR and collaborating on disease-related quality improvement and quality assurance programs.

Working participating clinicians, Best Care can:

Support providers to deliver all internationally proven evidence-based best practices.



Advance vertical integration between primary and specialty care

Reduce urgent visits to primary care practice, reducing practice related time stressors

Create an opportunity to transform care locally and share success internationally

Improve provider experience

BestCare