Alberta Health Services
Alberta Health Services’ INSPIRED COPD Initiative (ICI) is a quality improvement initiative designed to strengthen Home Living options for clients with a diagnosis of COPD (Medical Research Council [MRC] 4 – 5), thereby enhancing community-based care options, diminishing reliance on hospital use, and facilitating appropriate and timely transitions back to the community. Services provided by the ICI advanced practice team include: standardized referral processes, client and caregiver education, individualized COPD action plans, opportunities for clients to engage in advance care planning (ACP; including tracked Goals of Care conversations), optimized home based pulmonary rehabilitation, the provision of smoking cessation counseling, expanded primary health care options for clients with advanced COPD in the community, and a focus on building upon the strengths and resiliency of the clients and caregivers.

Bruyère Continuing Care
Bruyère Continuing Care’s initiative aims to develop a comprehensive, interdisciplinary respiratory program that provides consultation and education to patients and their families. The initiative focuses on implementing a model for smoking cessation, with the goal of systematically identifying smokers, patients with a diagnosis of COPD, and those with risk factors for developing COPD, to ensure that they receive appropriate diagnosis, treatment and follow-up.

Central Health
Central Health’s initiative capitalizes on new and existing resources to provide holistic patient-centred care to patients and families with moderate to severe COPD. Continuing the work underway towards implementation of an outreach initiative, the team created a model of care that includes community-based care, community social work, and palliative care. Ultimately, leaving patients and families equipped with better self-management skills and other tools to optimize their health and reduce strain on the healthcare system. The initiative focuses on the defined geographical area of communities served by the James Paton Memorial Regional Health Centre.

Centre de Santé et de Services Sociaux Pierre-de-Saurel
CSSS Pierre-de-Saurel’s initiative aims to provide a continuum of services for patients with COPD by establishing an interdisciplinary early diagnosis program. Individualized action plans to prevent acute exacerbations of COPD (AECOPD) are being used to assess the impact on whether this contributes to decreased hospital utilization. Other critical components of the initiative include the management of dyspnea attacks in patients in advanced phases of COPD; the integration of a respiratory therapy navigator in the emergency department (ED) to coordinate a collaborative, interdisciplinary approach towards users arriving in the ED; post-hospitalization follow-up with a respiratory therapist; and the development of a patient care pathway.
Centre de Santé et de Services Sociaux de Rimouski-Neigette
CSSS de Rimouski Neigette’s initiative was prompted by an increase in ED visits by certain COPD clients in recent years. The initiative aims to improve the continuum of multidisciplinary services offered to patients with COPD and provide the tools needed for patients to self-manage their illness. By improving referral and guidance mechanisms and using individualized action plans, the initiative aims to optimize the monitoring of patients before, during and after their hospitalization. The initiative seeks to strengthen the links between care providers and promote the self-management of illness by the patients.

Grey Bruce Health Services
Grey Bruce Health Services’ initiative aims to improve patient and family caregiver education and self-management; continuity of care across the hospital-to-home transition; home-based care; effective ACP; and reduce reliance on hospital-based care including ED visits, hospital admissions and lengths of stay.

Hamilton Health Services
Hamilton Health Sciences’ (HHS) initiative aims to implement a holistic, proactive, evidenced-based model of care for patients living with moderate to severe COPD while supporting caregivers, reducing reliance on hospital-based care and containing costs. This innovative public-private partnership between HHS, the Hamilton Niagara Haldimand Brant (HNHB) Community Care Access Centre (CCAC) and VitalAire Homecare builds upon previous foundational work related to HHS’ Quality Improvement Plan, COPD Quality Based Procedures and the HNHB Local Health Integration Network COPD Discharge Transitions Bundle. It is also aligned with work currently underway in the Hamilton West Health Link. The initiative specifically aims to reduce the number of ED visits, decrease the absolute unplanned readmission rate, and achieve a positive experience with the INSPIRED program for patients admitted to the Hamilton General Hospital with a diagnosis of COPD. These aims are being achieved through implementation of six focused interventions: 1) Use of the MRC Breathlessness Scale; 2) Use of COPD action plan; 3) Patient education and self-management training; 4) Collaboration with Family Practice; 5) Psychosocial and spiritual support to complete ACP and advanced directives; and 6) VitalAire respiratory therapist assessment of respiratory status and reinforcement of COPD action plan.

Health PEI
Health PEI’s initiative builds on the work underway since 2010 to support the estimated 2,000 people living in PEI with moderate to severe COPD. The objective of the initiative is to build a coordinated, integrated team around advanced COPD patients and their caregivers, ensuring they are empowered with a self-management action plan to prevent and minimize the impact of exacerbations post-hospital discharge. A key component of the initiative is to discuss and determine the best approach to integrate the hospital-based COPD team(s) with the primary care network COPD team(s).

Horizon Health Network
Horizon Health Network’s initiative aims to provide more consistent, continuous patient care for patients and families with moderate to severe COPD. The initiative focuses on formalizing and strengthening communication with the existing Extra Mural Program and Community Health Centers in addition to increasing patient and family education and the use of individualized action plans.
**Joseph Brant Hospital**

Joseph Brant Hospital’s initiative aims to improve the quality and coordination of care for patients with moderate to severe COPD by providing a more holistic, proactive transition from hospital-to-home, and linking patients with community resources. The interdisciplinary team is improving individualized care for patients by implementing self-management education, action plans, psychosocial and spiritual care, and ACP support. Care is taking place in conjunction with already established community partners, such as: CCAC Rapid Response Transitional & Palliative Teams, specialist outpatient visits, primary care, Palliative Care Outreach Team and Health Links as appropriate.

**London Health Sciences Centre**

London Health Sciences Centre's (LHSC) initiative is being undertaken in partnership with St. Joseph's Health Care London and the South West CCAC and focuses on high-user COPD patients of the Family Medical Centres at LHSC and St. Joseph's, as well as the COPD patients who were admitted to LHSC's two hospital centres from March 2013 – March 2014. The aim of the initiative is to reduce hospital readmission rates and improve outcomes for advanced COPD patients in their transition back to home through enhanced coordination of care across the community. This includes leveraging partnerships to provide care and support in the home to help to better meet patient needs, identifying/organizing community resources needed to fill gaps in care and developing individualized action plans for each patient.

**L'Hôpital du Sacré-Coeur de Montréal**

L'Hôpital du Sacré-Coeur de Montréal’s (HSCM) initiative focuses on the use of health services by COPD patients who are identified as large consumers of care. Using an integrated approach in collaboration with patients and care-provider partners from neighboring Centres de Santé et de Services Sociaux (CSSSs), the initiative aims to develop an inter-institutional plan to reduce ED visits and hospital stays. The initiative includes systematizing referrals to the various programs available for COPD patients. The initiative is be carried out at HSCM, in collaboration with community partners: the Montreal and Laval CSSS network, the regional home-care service (SRSAD) and the Laval regional service for patients with respiratory insufficiency.

**L’Institut Universitaire de Cardiologie et de Pneumologie de Québec**

The Institut Universitaire de Cardiologie et de Pneumologie de Québec’s (IUCPQ) initiative aims to improve patient self-management, provide psychosocial and spiritual support, provide ACP, and increase collaboration with front-line care providers. This initiative seeks to optimize the processes for patient referral prior to discharge, and in-home patient follow-up has been standardized to include: needs assessments, patient and family self-management education and tools, and referrals to additional provider resources, as needed. The initiative is being carried out with patients who frequently visit the IUCPQ’s ED, and those who have been readmitted to hospital within 30 days of discharge. The goal of the project is to reduce the target cohort’s 30-day readmission rate by 7%, thanks to improved, collaborative case management by front-line care providers.

**Providence Health Care**

Providence Health Care's initiative aims to build bridges between hospital and community care to help patients with COPD stay as healthy as possible. The team is continuing to reduce both ED visits and hospital admissions, and provide individualized care for COPD patients with complex needs. The
initiative catalyzed an assessment of their team’s ability to further improve overall care for patients with chronic diseases; one such improvement includes integrating a Spiritual Care Provider on their team.

**Saskatoon Health Region**

Saskatoon Health Region’s initiative evaluates key outcomes associated with social work for patients with complex psychosocial needs enrolled in the LiveWell with COPD program. By comparing outcomes for patients with complex needs who receive or do not receive the social work intervention, the team is comparing improvements to usual care across three key areas: psychosocial adjustment, patient activation, and patient and family satisfaction.

**Nova Scotia Health Authority (South Shore)**

Nova Scotia Health Authority’s (South Shore) initiative focuses on implementing care pathways for patients who are hospitalized with exacerbations of moderate to severe COPD. It includes implementing clinical care guidelines; applying a coordinated, interdisciplinary approach; and providing health provider and patient education. The initiative is building and strengthening the linkages between primary health care, acute care, home care, and other community-based supports to support patients post-hospitalization. The initiative is currently being piloted at South Shore Regional Hospital before being implemented across the entire health authority.

**The Ottawa Hospital**

The Ottawa Hospital’s initiative aims to improve care quality, effectiveness and efficiency for patients, families and health care providers. With a focus on COPD patients with repeated hospital admissions, the initiative is optimizing: self-management education, including a written action plan; transition planning from hospital-to-home; the referral process to community resources, such as pulmonary rehabilitation, lung maintenance and smoking cessation programs, and/or ACP. Additionally, the team is providing post-discharge phone calls, home visits and follow-up support.

**University Health Network**

University Health Network’s initiative aims to reduce ED visits and hospital admissions for patients with COPD, through the establishment of inpatient/outpatient COPD services including: rapid assessment and follow-up after discharge; diagnostic and evaluative testing; comprehensive, interdisciplinary needs assessment including end-of-life planning and symptom management; COPD education; and self-management training and support. The ability to operate this care is through coordination and collaboration with CCAC, VitalAire homecare therapists, and the Family Health Team to support care transitions and care at home.

**Winnipeg Regional Health Authority**

Winnipeg Regional Health Authority’s initiative aims to improve the patient experience and mobilize community services for patients with COPD through integrated partnerships with Concordia Hospital, the Regional Home Care Program, the Regional Palliative Care Program, Community Therapy Services, the regional pulmonary rehabilitation program, and family physicians. Tools are being implemented to augment and standardize patient self-management support, bridge patient care during the transition to home, and to provide follow-up at home during the transition process. The team is also working with family physicians to implement standardized in-patient COPD order sets and protocols, and individualized action plans inclusive of the use of opioids for dyspnea management.