Working Together to Build a More Integrated Cancer Care System in the South West

South West Regional Cancer Blueprint
2020 - 2023

South West
Regional Cancer Program
in partnership with Cancer Care Ontario

Overview of the South West Cancer Blueprint

The South West Cancer Blueprint includes four sections. It starts with a clear understanding of the scope, breadth, successes and opportunities for change in the management of patient care within the current South West Cancer System (Appreciating the Current Landscape); it establishes a picture of the future care delivery system and promise that was informed by stakeholders to help guide how we will work together as a system of care (Establishing a Future Model & Promise); it provides three building blocks for action that will help the system achieve the promises for care (Setting Building Blocks for the Cancer System); and it provides a clear roadmap for how the SW-RCP and its partners will work together to realize the plan (Building a Roadmap for the Future).

Section 1	Section 2	Section 3	Section 4
Appreciating the Current Landscape	**Establishing a Future Model & Promise**	**Identifying Building Blocks for the Future Cancer System**	**Building a Roadmap for the Future**

Building a Cancer System Blueprint for South West Ontario

The South West Regional Cancer Program (SW-RCP), as an agent of Cancer Care Ontario, is dedicated to work with patients, health care providers, and community partners to continually improve and advance cancer care and services for the people across South West Ontario.

As the SW-RCP looked to developing its next Regional Cancer Plan, it acknowledged that this Blueprint must be different. While the SW-RCP and its partners will continue to support the Ontario Cancer Plan, this Blueprint must also align with the health transformation underway through the creation of Ontario Health and Ontario Health Teams to improve cancer care and supports for patients, families and providers across the continuum.

As a result, development of the Blueprint adopted a "bottom-up" approach that was grounded in engaging over 150 stakeholders inclusive of patients, caregivers, providers, and physicians from across the continuum. Interviews, focus groups, and Think Tank sessions ensured the voice of those whose care will be impacted and for those who will support this care directly informed this Blueprint.

This Blueprint provides a plan that was co-designed and inform by a broad group of stakeholders to *Work Together to Build a More Integrated Cancer Care System in South West Ontario*.

Development of the Blueprint started with a recognition that there a number of foundational supports to build on.

- The many strengths and successes of the current service model and the people who deliver care;
- Key partnerships and relationships that have advanced more integrated, sustainable care; and
- A commitment to patients, families and caregivers that they are important contributors to helping to continually improve the care delivery system.

It was also recognized that to be transformative, "new ways of thinking and acting" would be necessary. To support this, the design of the Blueprint was guided by the following tenets:

- A very different partnership between the cancer care system and primary care system is needed;
- A focus on at-risk indigenous and high need marginalized populations must be a priority;
- A true attempt to improve transitions across the full cancer care continuum and providers;
- A strategic and tactical focus to align with the current health care transformations (OHTs); and
- An ongoing commitment to support the education and knowledge of patients, families and caregivers.

See Appendix A for a Summary of the SW-RCP 2016 - 2019

1 Appreciating the Current Landscape

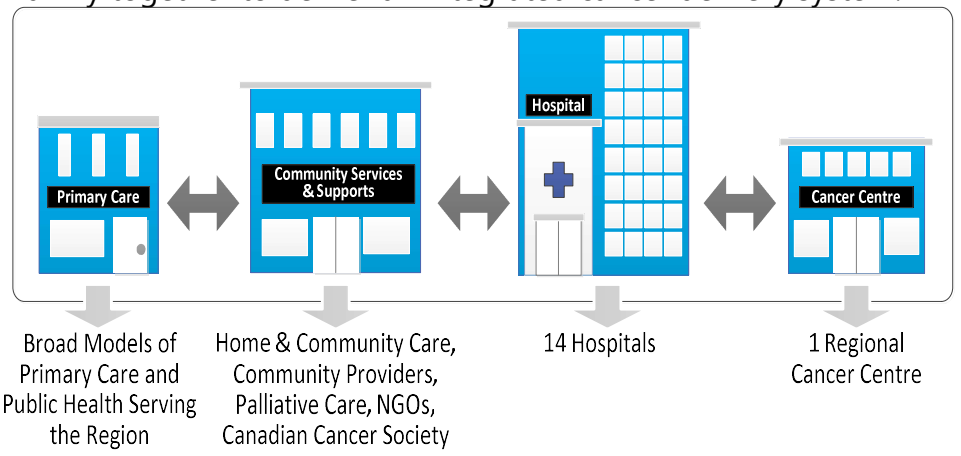
Our Focus:

Need to Meet Growing Demand for Services ~ Nearly 1 out of every 2 Ontarians will develop cancer in their lifetime

Appreciating the Breadth of the South West Cancer System

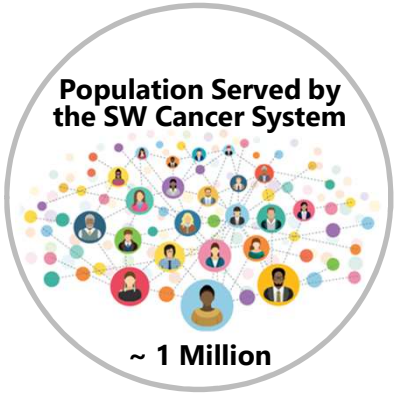
The South West Regional Cancer Program is grounded in a partnership philosophy to provide the highest quality of care, at the right time, by the right providers in the most appropriate setting.

To support this goal, the South West Regional Cancer Program includes a broad array of health care providers from across the South West Local Health Integration Network (South West LHIN) and the adjoining LHIN's of Erie St Clair and Waterloo Wellington to serve the needs of 1 million residents. Our partners include the full continuum of care partners bringing providers, patients and family together to deliver an integrated cancer delivery system:



See Appendix B for an Overview of South West Cancer Services

Understanding Current Cancer Services & Projected Future Needs



7,072 Projected New Cancer Cases

Summary of Cancer Services (2018)

22,563 patients seen

203,885 treatment & consultation visits

5,514 cancer related surgeries

More than 200,000 screening procedures

Ontario Statistics

- 1 in 2 Ontarians will be diagnosed with cancer in their lifetime
- 1 in 4 Ontarians will die from cancer
- A significantly higher proportion of Ontarians will die from cancer (29.6%) than any other leading causes of death including heart disease (19.9%)
- Ontarians diagnosed with cancer are 64.7% as likely to survive for five years after diagnosis compared to similar people in the general population
- More people live with a cancer diagnosis in Ontario today than 20 years ago
- The risk of getting cancer, accessing services and health outcomes are different among Ontarians. First Nations people, in particular, have more new cases of certain cancers than other people in Ontario; and cancer deaths rates are significantly higher in First Nations people than in other people in Ontario.

South West Region

- In 2018, over 200,000 visits were made to cancer clinics or cancer treatment centres in the South West region by over 22,000 patients
- In 2018, over 7,000 new cases of cancer diagnosed in the South West region
- Compared to Ontario as a whole, in the South West region:
  - Higher incidence rates of colorectal cancer (83.1 vs. 72.3 per 100,000) and melanoma (40.8 vs. 34.5 per 100,000)
  - Males have higher incidence rate of cancer (all types combined) (609.3 vs. 584.3 per 100,000)
  - There is a higher rate of cancer-related mortality (all types combined) (201.4 vs. 190.0 per 100,000)

Listening to Our Stakeholders – Their View of the Current Cancer System

Through a broad engagement process, stakeholders provided their views and thoughts on the current state of the cancer system. The following identifies key themes learned and examples of experiences (quotes) that helped inform the development of the plan.

Build Partnerships Across Continuum
"Primary care must be viewed as part of the team"

Engage Stakeholders in the Design & Evaluation of the System
"We need to tell our story so many times; must leverage people with lived experience"

Focus on Education. Set Clear Expectations & Awareness
"Need to invest more in health promotion and prevention; improve health literacy"

Optimize Engagement with Patients, Families and Providers
"Take time to educate patients & families; ensure right conversations at the right time"

Our Stakeholders

Rationalize Services to Support Care Closer to Home
"Bring care closer to home through new ways of working together and use of technology"

Ensure Knowledge of What Services are Available and How to Access
"We must enhance knowledge about what is out there and how to better transition information between providers"

Standardized Approaches to Care Delivery; Clear Responsibilities
"More consistent interprofessional teams across sites; reduce practice variability"

Ensure Needs of At-Risk are Met
"Problems with accessing services and supports for at risk or marginalized populations"

Improve Sharing of Information
"Need information resource centre to build literacy; need to connect our systems to improve better sharing of information"

Improve Flow & Transitions
"Access to primary care is critical – without a GP, there will be gaps in care; patients struggle to navigate the system"

2 Confirming a Future Model & Our Service Promise

Our Desired Outcomes:

Aligning the Care Delivery System ~ Improving Patient, Family and Provider Experience, Health of the Population, and Sustainability of the System

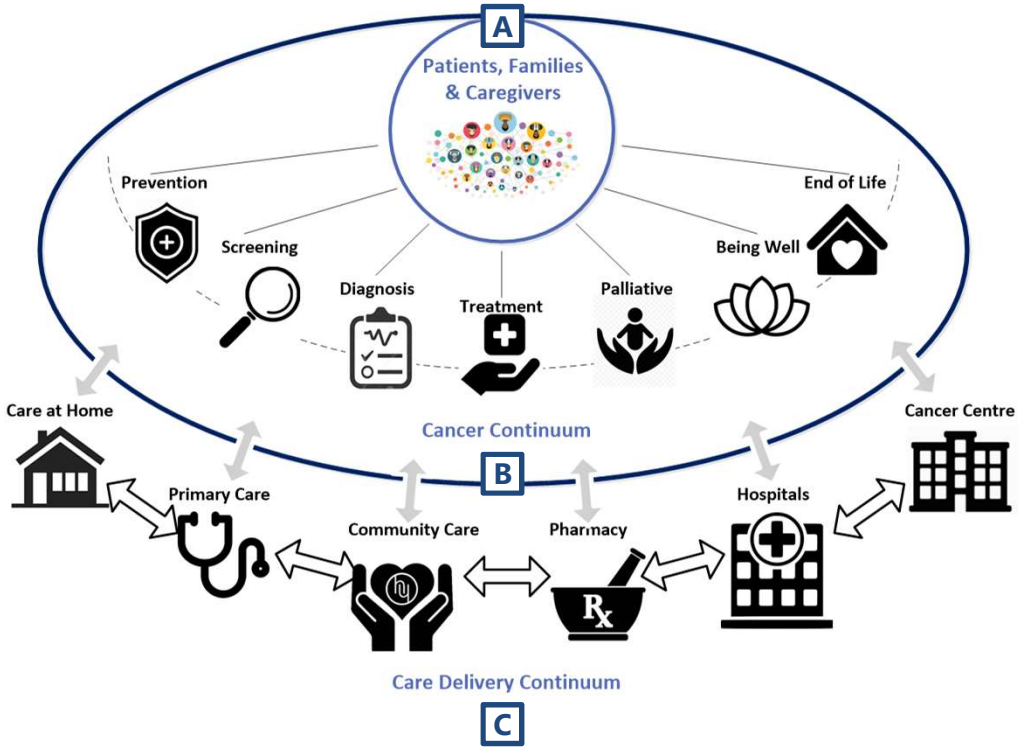
Designing a Cancer Service Model Aligned With Ontario's Transformation

The Cancer Blueprint was grounded in a Cancer Service Model that was informed by consultations with patients and families, providers, and system leaders from across the South West Cancer System. The model guided our thinking by ensuring all planning built on the many successes within the system; utilized an inclusive approach that took a broad view of the care delivery system and its many partners, and sought to align with the current provincial transformations. The conceptual model identifies three core priorities to build into the future cancer system.

A. **Patient, Families and Caregivers are at the Centre of all care planning and delivery.** Every solution must identify a priority population to clearly identify who we will impact and positively affect

B. **Patients get the care they need, at the right time, no matter where they live within the region.** By treating the cancer system as a full continuum of services, solutions must also be deployed across the care continuum partners

C. **Providers work together with patients, families and caregivers.** To meet the needs of patients, partners in care will be brought together under a new model that improves connectivity and relationships that enable delivery of the right care, in the right location, by the right provider - seamlessly.



Declaring Our Promise for the South West Cancer System

To set clear expectations for what this Cancer Blueprint will achieve, the following promises have been made.

By 2023, the South West Regional Cancer Program and its partners will:

- **Improve the Patient & Family Experience** by making access to care simple, timely and equitable by educating and ensuring people have the right information they need to support their own care and care for their loved ones
- **Improve the Health of Patient Populations** by building a team of providers spanning the continuum, that are committed to ensuring seamless, coordinated care; and increasing the use of data and information to continually improve the system of care
- **Improve Wellness and Experience of Providers** by designing systems of care and supporting provider skills and capacity to make it easier for providers to deliver services
- **Ensure System Sustainability** by ensuring high quality of care to patients is delivered in the most sustainable manner; and building and sharing leading practices through research, innovation and education.

All work is aligned with the goals and objectives of the Ontario Cancer Plan 5.

3 Identifying Building Blocks for the Future Cancer System

Our Building Blocks:

Transforming How We Work Together ~ Connecting Patients to Care, Empowering Patients & Families, Partnering Across the Continuum

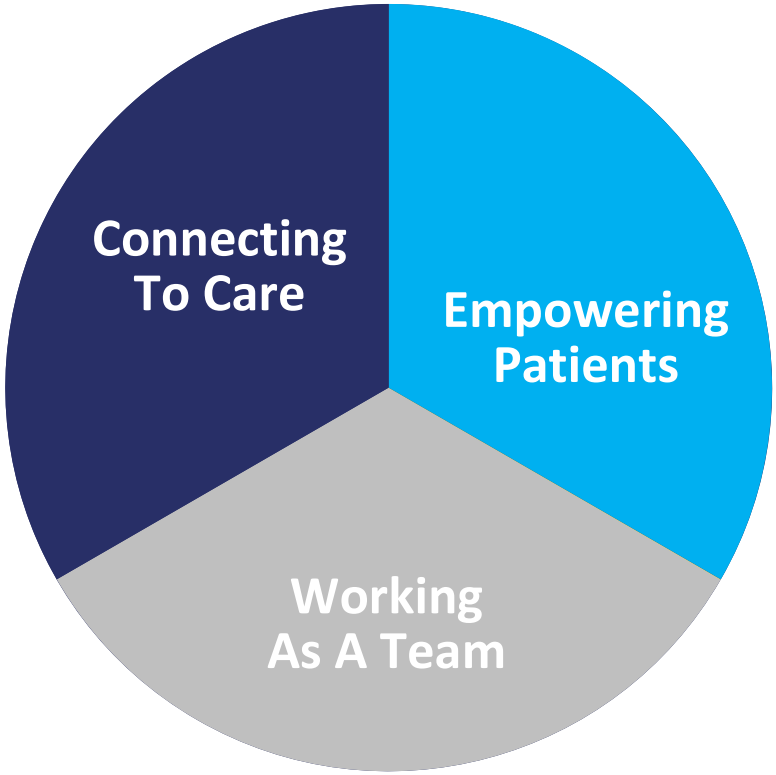
Building Blocks for the Cancer Plan

To deliver on our promise, three inter-connected building blocks were identified to advance care and supports for South West Residents.

- **Connecting to Care.** Improving Intake, Navigation, Transitions & Communication Along the Patients' Journey
- **Empowering Patients.** Enabling Patients Through Active Participation, Information Sharing & Education
- **Working as a Team.** Bringing Providers and Patients Together Under an Integrated Care Model to Improve Patient and Provider Experiences and Outcomes

This building block model recognizes the following:

- Each building block does not exist alone, but must be connected with one another – nurturing capacity for synergies and alignment
- The collective three building blocks must be capable of connecting to another pieces – allowing for growth and expansion
- While there are other pieces of the puzzle, these three building blocks represent the starting point – this is the foundation for this Cancer Blueprint



Building Block: Connecting to Care

"It is easy to get to the information and care I needed, and people were always ready to help"

Why is connecting to care so important?

Stakeholders said:

- *"Access to care has got to be simple and easy"*
- *"Problem with accessing screening for marginalized populations"*
- *"Patients struggle to navigate the system to get the care they need"*
- *"Still have opportunities to bring more cancer care closer to home"*

Connecting to Care will transform how patients enter and move through the cancer system, and will specifically place special attention on improve access for at-risk or high needs populations to enhance health equity.

SWRCP Initiatives

- **Screening Assessments to Early Identify Higher Needs or At Risk Patients** and provide navigation/wrap-around services. Immediate focus will focus on at-risk Indigenous populations and high-need marginalized populations.
- **Centralized Intake to Improve Continuity of Care** by improving navigation, coordination, and alignment of care across the system (e.g., One # for patients/providers 24/7, align with OHT advancements, and explore smoothing practices as part of a centralized access models)
- **Enhancing Services for Patients** by exploring opportunities to extend existing people and space resources, and leveraging technology to ensure effective and efficient access to care closer to home (e.g., extend service hours, expand transportation supports, partner with OHT community providers to deliver services, adopt new technologies (virtual care) to enable access to support at home)

Building Block: Empowering Patients, Families & Caregivers

"Me and my family were listened to and educated throughout our care journey"

Why is empowering people so important?

Stakeholders said:

- *"Need to build health literacy"*
- *"Need to invest and focus on health promotion and prevention"*
- *"Need to take time to educate patients and families"*
- *Need to make it easier to have conversations"*
- *"Need to tell our story to many times"*

Empowering Patients, Families and Caregivers will build knowledge, capacity and overall health literacy so people can advocate for themselves and their loved ones so they can be a true partner in care delivery.

SWRCP Initiatives

- **One-stop Cancer Information Repository for Patients & Families** to get information they need to build their confidence and knowledge (e.g., written, videos, virtual tours, apps using self-serve and passive information distribution, integrate with CCO Information Hubs) to improve health literacy
- **Expert Cancer Navigation Tools** to assist patients in coordinating care across multiple providers and ensure appropriate , timely and seamless communication. Immediate focus will be transforming the My Cancer Binder to incorporate individualized content, and enhance provider promotion of the binder
- **Patient and Caregiver Oriented Tools, Programming and Educational Supports** to help patients, families and caregivers gain the knowledge and supports they need to support themselves and their loved ones by enhancing capacity and understanding of the care delivery system (e.g., create virtual programming to be accessed across the region)

Building Block: Working as a Team

"I worked with other providers across the continuum to deliver the very best care"

Why is working as a team so important?

Stakeholders said:

- *"Access to primary care is critical - without a GP there will be gaps in cancer care"*
- *"Need more consistency in interprofessional teams/ resources across all sites"*
- *"Variability in practice is a problem"*
- *"Primary care providers must be viewed as part of the care team"*

Working as a Team will advance an interprofessional and inter-sectoral service delivery model and mindset that will enable effective, efficient and coordinated care that will benefit patients, families and providers.

SWRCP Initiatives

- **Enabling Effective Transitions Between Primary Care and the Cancer System** through an effective and efficient information exchange and highly efficient transfer of accountability flow (e.g., shared and communicated patient Goals of Care used by all providers, primary care provider orientation of available resources, shared records, data agreements, eReferrals, triage criteria, pathways, post treatment reports, services inventories, secure communication). Tools to be co-designed with patients and caregivers.
- **Advance Communities of Practice Across Providers** to enable greater social interactions for communication, knowledge sharing and creation, and ultimately improving provider wellness. Activities include sharing leading practices, technology rollout, referral processes, communication to ensure the right conversations and decision occur at the right time (e.g., palliative care referral, timely discharge)
- **Standardized Roles of Interprofessional Team Members** to enhance consistency in the delivery of care, improved safety, and improved transitions through more collaborative ways of working together across primary care, community care, and acute care. Activities include enhancing accountability, greater standardization of roles across interprofessional teams, improving communications with patients, and cultural training)

4 Building a Roadmap for the Future South West Cancer System

Our Roadmap:

A Three Year Plan that Our Patients, Families and Providers Can Deliver Together

South West Regional 2019 – 2022 Cancer Blueprint

Our Promise

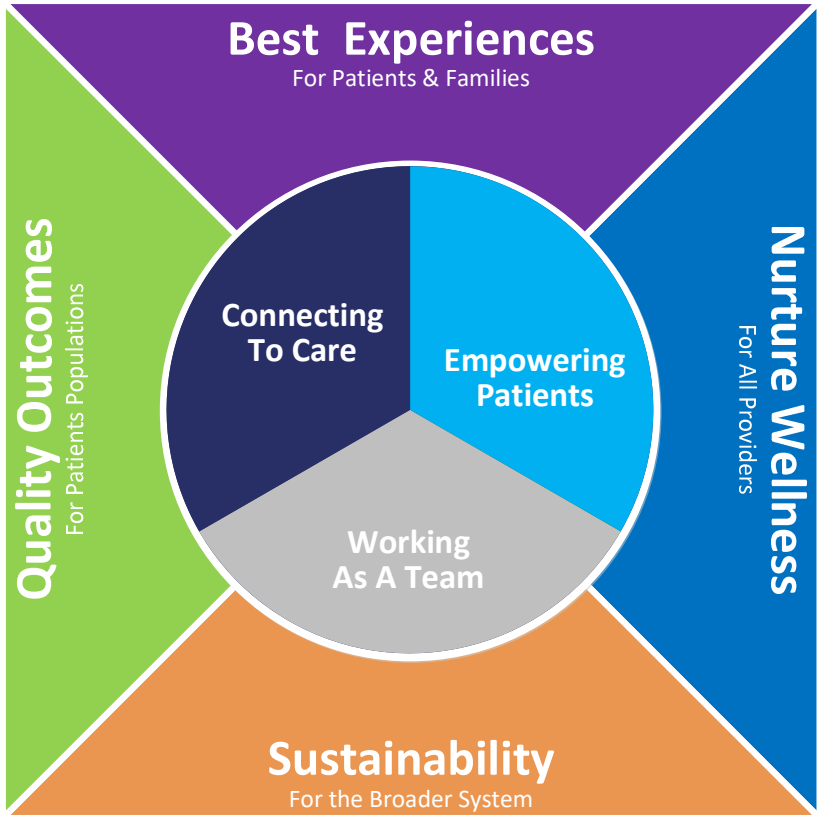
- **Best Experiences for Patients & Families**
- **Quality Outcomes for Patient Populations**
- **Nurture Wellness for All Providers**
- **Sustainability for the Broader System**

Our Building Blocks

- **Connecting to Care**
- **Empowering Patients**
- **Working as a Team**

Our Desired Outcomes

- **Access to care is simple, timely and equitable**
- **Providers are committed and enabled to ensure seamless care for patients**
- **Providers personal wellness and safety is supported and valued**
- **Highest quality of care for patients is delivered in a sustainable manner**



Benefit for Patients, Families & Caregivers

My Home

Patient, Family, Caregivers Helping to Stay Healthy at Home

- Patients and family can access information to support their learning goals, promote self-efficacy, and improve health literacy (aligned with CCO's patient education strategy).
- Patients and family have tools to help them self-navigate and improve their access to supports

Primary Care

Patient, Doctor, Care Team Delivering Primary Care Services

- Education is available early in the process, structured to enhance patient and family understanding of the disease, and designed for everyone
- Patients benefit from standardized scripts that ensure they get the information they need no matter who their provider is or where they receive their care and services

Community Services

Patient & Community Based Providers Ensuring Key Services and Care Available Close to Home

Hospital

Patient & Hospital Based Care Team Ensuring Acute Care & Diagnostics Available When Needed

- Patients have a passport that guide them along their journey that is shared and used by providers across the system
- All information is provided in an easy to read and understandable format
- Family and caregivers are supported with education and other tools to ensure participation and inclusion in the care

Cancer Centre

Patient & Cancer Centre Team Ensure Timely and Appropriate Diagnosis, Treatment, Recovery

- Patients are in-charge of their own care by having personalized information (My Care Binder, care plan that is shared across providers from the start of the care journey), and tools to manage their own appointments and care (self-scheduling, portals)

My Home

Patient, Family, Caregivers Have Knowledge to Care for Patient at Home

Hospice

Patient & Family Have Support of Hospice to Care for the Patient

- Patients are able to access services they need (transportation supports, extended hours of operations)
- Patients have more choices to access some care (e.g., screening, diagnosis, treatment, recovery) closer to home under the regionalized cancer model

Benefit for Providers Across the Continuum

My Home

Patient, Family, Caregivers Helping to Stay Healthy at Home

- Providers proactively screen patients to identify risk and align appropriate services
- Patient navigators are available for patients to support navigation and coordination of care
- Patients and providers benefit from a central Intake(s) to access services by patients and providers
- Providers benefit from standardized services ensuring greater consistency, efficiency and effectiveness of care

Primary Care

Patient, Doctor, Care Team Delivering Primary Care Services

- Providers benefit from patient information that is easily available and securely shared across providers to support the right care decision at the right time, and reduce duplication of efforts related to information collection, use and storage
- Providers benefit from streamlined communication processes and tools that standardize and simplify how providers communicate

Community Services

Patient & Community Based Providers Ensuring Key Services and Care Available Close to Home

Hospital

Patient & Hospital Based Care Team Ensuring Acute Care & Diagnostics Available When Needed

- Providers benefit from Pathways that are patient centred and guide patients through their journey
- Primary care providers are valued as part of the care team
- Providers across the cancer continuum are brought together to design and establish relationships and ways of working together to improve trust, coordination, communication, and communities of practice
- Cancer system is interconnected together

Cancer Centre

Patient & Cancer Centre Team Ensure Timely and Appropriate Diagnosis, Treatment, Recovery

- Providers consistently work together to understand the patient's goals in their care journey and help tailor a plan of care to meet goals
- All providers benefit from standardized education and training supports to help maintain competency
- New service models explore more innovative ways of delivering care and supports through better utilization and access
- Patients and providers benefit from enhanced capacity and resources that support in-home care

My Home

Patient, Family, Caregivers Have Knowledge to Care for Patient at Home

Hospice

Patient & Family Have Support of Hospice to Care for the Patient

- Patients have smooth transition from the cancer system back to their primary care
- Primary care providers feel they always have a clear and direct line into the cancer system if they have a question or need support
- Patients and providers benefit from virtual care technologies to support care at a distant to reduce potential travel time and enhance care team utilization

South West Regional Cancer Program 2019-2022 Strategy Map

Our Promise	Best Experiences For Patients & Families **Improving the Patient & Family Care Experience**	Quality Outcomes For Patient Populations **Improving the Health of Patient Populations**	Nurture Wellness For All Providers **Improving Wellness & Experience of the Provider**	Sustainability For the Broader System **Ensuring Value for Money**
Our Building Blocks				
Connecting to Care	▪ Screening Assessments to Early Identify Higher Needs or At Risk Populations	▪ Centralized Intake to Improve Continuity of Care	▪ Enhancing Services for Patients	
Empowering Patients	▪ One-Stop Cancer Information Repository for Patients & Families	▪ Expert Cancer Navigation Tools	▪ Patient & Caregiver Oriented Tools, Programming and Educational Supports	
Working as a Team	▪ Enabling Effective Transitions Between Primary Cancer and the Cancer System	▪ Advance Communities of Practice Across Providers to Enhance Wellness & Effectiveness	▪ Standardized Roles of Interprofessional Team Members	
Our Outcomes	**Access to care is simple, timely and equitable**	**Providers are committed to ensuring seamless care**	**Providers' personal wellness and safety is supported and valued**	**Highest quality of care delivered sustainably**