Our future health built with care

Integrated Care

Corporate Strategy 2012–2018

Ontario
Cancer Care Ontario

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1

Forewords

Our future health built with care

Ontario's healthcare system is large and complex. While our healthcare professionals and the care they provide are among the best in the world, patients often face challenges in navigating the system and transitioning through different stages of care, and navigating among different providers and across different settings.

When we developed CCO's first corporate strategy in 2012, we recognized that in order to truly improve patients' experience of their care and their health outcomes, we needed to develop a more integrated approach, not only within the cancer and chronic kidney disease systems but across Ontario's vast healthcare landscape. From the patient's perspective, this requires a person-centred system and collaborative care teams who work together to ensure the right care is provided, in the right setting, at the right time. A more integrated approach to care provides an opportunity to improve the quality of care – particularly for those patients with complex conditions such as cancer or chronic kidney disease or multiple comorbidities – while also creating a more efficient and sustainable health system.

Over the past five years, CCO has undertaken foundational work with our partners to develop the relationships, capabilities and accountabilities necessary to deliver care that is better integrated. We developed a framework that standardizes how integrated care is defined across CCO, enabling different programs throughout the organization to work collectively towards a common goal. With clinical leadership and system partners, we developed and promoted a standardized approach to integrated care planning, which can be implemented across sites, providers and settings and addresses all stages of the care journey. We also established a preliminary method for measuring progress towards the adoption of integrated care principles at the system level and identifying areas for improvement.

The examples in this report illustrate how CCO programs, with our regional and local partners, have contributed to building a more person-centred, collaborative and continuous health system for people with cancer and chronic kidney disease.

There is still work to be done, however. Integrated care across the health system requires transformation, collaboration and system partnership. Opportunities exist to improve transitions for all patients along their care journey and between primary, community and specialty care services.

Working with the Ministry of Health and Long-Term Care and our other partners, CCO will leverage its experience in improving the integration of care for people with cancer and chronic kidney disease and continue to drive broader system improvements to create a more integrated care delivery system for all Ontarians.

Rebecca Harvey
Vice President, Ontario Renal Network

Cancer Care Ontario

When patients have an integrated care plan, everyone benefits. Patients are more satisfied with the care they receive, as are healthcare professionals with the care they provide.

Outcomes are better, too: Studies show that a person-centred approach and strong inter-communication with a multidisciplinary team can lead to reduced complications, decreased length of stay, fewer hospital readmissions and lower healthcare costs.

An integrated approach is especially important for patients with cancer, as their cases are complex. For these patients, an integrated care plan is optimized and best facilitated by a dedicated nurse navigator.

CCO's work to standardize integrated care planning offers an opportunity to improve the quality of care, empower patients, help with system efficiencies and help clinicians manage their practices better.

Dr. Vishal Kukreti
Clinical Lead, eTools and Technology,
Integrated Care Plans,
Cancer Care Ontario

Ontario Renal Network

Improving the integration of care for patients with chronic kidney disease is one of the central goals of the Ontario Renal Plan II.

There are three areas where improved integration of care can have the most benefit: primary care, palliative care and transplantation. We need to improve connections between primary care physicians and our Regional Renal Programs in order to ensure timely referral for patients requiring dialysis, and to help patients with comorbidities receive care from the appropriate healthcare provider. For patients who are older, frailer and sicker, we need to ensure access to palliative care services. We also need to enhance access to, and improve patient's experience of, kidney transplantation.

I am pleased to say that much work has been done to integrate care for people with chronic kidney disease across all stages, settings and providers. Particularly important have been initiatives that strengthened communications between primary care, nephrology, palliative care and transplantation. There are significant opportunities for CCO to leverage the learnings of the Ontario Renal Network as we work together to expand integrated care principles with all our health system partners.

Dr. Peter Blake
Provincial Medical Director,
Ontario Renal Network

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Voice of the Patient

As chronic disease rates rise in Ontario and around the world,[1] the demand for integrated care continues to grow. This is because people with chronic disease (e.g. cancer and chronic kidney disease) are often complex and require support from various health professionals who deliver care across a range of clinical settings.[2]

The following account from a patient going through the diagnostic phase of the cancer care continuum illustrates the need for care coordination from the patient's perspective:

"Communication between nurse navigator and surgeon's office wasn't ideal. I would have missed my follow-up appointment, which was already causing me increased anxiety. I felt I had to be my own advocate to ensure that I didn't fall through the cracks."

At the point of direct care, key barriers to integrated care include referrals that are often incomplete; patient assessment and medication reconciliation that are ad hoc or absent; patients who are often not engaged in a discussion regarding their goals of care; care planning that is fragmented across professionals and organizations; respective roles and responsibilities among professionals that are not clarified and made explicit; and care plans that are not shared with the patient or across all professionals.

As patients and their families enter, traverse and exit the cancer and chronic kidney disease (CKD) systems, the services they need and the types of health professionals they see, evolve and change. Integrated care from the patient's perspective involves person-centred, collaborative care teams that work together across settings to ensure the right care is provided, at the right time. The following reflection from a patient exiting the treatment phase of the cancer continuum demonstrates the need for continuous care across transition points:

"The cancer centre should be advising patients how to care for themselves post-surgery…The patient [should not be] left hanging in no man's land between the cancer centre and family doctor with no one taking responsibility for their care in the aftermath."

Driving integrated care across the health system presents a significant opportunity for CCO and its system partners to improve the patient experience across providers and care settings.

3

Purpose of the Report

One of the key focus areas of CCO's Corporate Strategy is driving integrated care across the health system and within CCO to accelerate and build capacity for integrated care. CCO's efforts have focused on building a foundation for system improvements. This report summarizes important and innovative work that is being done for people with cancer or CKD, and includes three key results: development of an integrated care framework, measurement of adoption of integrated care concepts and practices across CCO and health system measurement of CCO's contributions to integrated care.

Looking to the future, CCO and its system partners will continue to collaborate on and strive towards the broader system transformation required to create a more integrated care delivery system. As CCO's Corporate Strategy comes to an end in 2018, this is an opportune time to reflect on achievements in the field of integrated care, celebrate areas of success, and identify opportunities for continued improvement as we move towards a more integrated care delivery model.

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Integrated Care in Ontario and Around the World

In the past, health systems have focused primarily on improving access to traditional health and care services for complex patients. Today, however, there is a growing body of knowledge indicating that "lifestyle, the influence of the local environment, and the wider determinants of health"[3] play a major role in a patient's health outcomes.

This is shifting the focus from improving care for people within traditional care settings to improving health systems across communities. Increasingly, policy-makers and health leaders are looking to integrated care strategies that bridge health and social care services. The objective is to "change behaviours and living conditions across communities rather than focusing on single organizations or within the boundaries of traditional health and care services"[4]. As a result, integrated care strategies are aimed at addressing fundamental health and social care challenges such as demographic shifts (e.g., an aging population), a change in the disease burden, avoidable differences in health outcomes, and continued financial pressures.

Around the world, every country has and will continue to experience growth in the proportion of older persons in their population.[6] By 2036, the proportion of seniors within the Canadian population is projected to grow to 25% (from 8% in 1960)[5].

Health spending has trended upward since 1975, representing 11.5% of Canada's gross domestic product in 2017.[9] Citizens are looking for greater value, including better experiences in the health system, as opposed to greater costs.[10]

The social determinants of a person's health (e.g., income, literacy, housing status, food stability, ethnicity) **influence the type of care they receive** in terms of access, quality and health promotion.[7]

Chronic disease is rising; people are living longer with more complex diseases that require larger care teams to carry patients over longer periods of time.[8]

A more integrated approach to care provides an opportunity to improve service quality and lower system costs, particularly for complex patient populations, such as the frail elderly, people with cancer, and those with multiple comorbidities.

Health System Successes in Integrated Care

Over the past five years, there has been emphasis on and priority given to creating a more integrated health system in Ontario. Examples include:

- Implementation of Health Links
- Ministry of Health and Long-Term Care's (MOHLTC) Patients First Focus Areas:
  - expanded role for Local Health Integration Networks (LHINs);
  - integration of primary care;
  - consistent accessible home and community care;
  - links to population and public health; and,
  - inclusion of Indigenous voices in planning.

These provincial priorities demonstrate that patient-centred, integrated care delivery across the care continuum is a high priority.

Around the globe, there is also an increased emphasis on integrated care and a shift from health systems designed around organizations to health systems designed for people and focused on person-centred care. Some organizations in particular have looked to move beyond the integration of care for patients to explore how they can use their resources to improve the overall health of the populations they serve. One such organization is Kaiser Permanente in the United States, which uses prevention and primary care strategies to improve the health of the broader community it serves[11]. For example, to address issues of food insecurity, which impact the social determinants of health of a population, Kaiser Permanente began stocking fresh fruits and vegetables in grocery stores in low-income areas, setting up farmers' markets in its facilities, and funding food banks. It also monitors the health data of the population it serves and tailors interventions to groups of people to support preventative healthcare services. These and other strategies have led to reduced use of hospitals and better health outcomes for Kaiser Permanente clients compared to similar jurisdictions.

MOHLTC Funds Bundled Care Teams

As part of moving the provincial Patients First strategy forward, MOHLTC expanded its bundled care model to six additional regions in 2015. Under a bundled care model, discrete organizations and providers are no longer reimbursed for individual services, but rather a fixed payment covers all services administered during a single episode of care. This approach promotes collaboration and aligns financial incentives across organizations, creating smoother transitions into and out of hospital. It also coordinates services around the patient's needs, so as the patient moves through the system and back to their home, most of their healthcare team remains the same and any transitions are closely managed. Results of these efforts have been positive: patients exiting acute care settings experience fewer visits to the emergency department after discharge and have a reduced risk of hospital readmission[(11-A)].

NHS Funds Integrated Health and Social Care Teams

Since early 2000, the National Health Service (NHS) in the UK has funded the development of more integrated community and social care by establishing integrated health and social care teams. This approach involves pooling budgets and introducing social care coordinators to hospital wards to help organize care around the patient. Integrated community and social care teams prioritize older people in need, helping them live independently in the community by offering a wider range of intermediate care services and working more closely with primary care. The results of these efforts, similar to those described above, include reduced use of hospital beds, lower rates of emergency hospital admission for those 65 years of age and over, and minimally delayed transfers of care[(11-B)].

One way Ontario and the UK are trying to advance integrated care is through bundled care strategies that better align financial incentives across care settings (see examples on page 8). While bundled payment approaches are innovative and have shown positive results in creating smoother transition points for patients, there are other ways of driving the adoption of integrated care.

Organizations must also look to system transformation strategies that do not require ownership of the financial levers. Released this year, the advanced health links model points to standardization, shared performance management and oversight, and wider system integration through collaboration and partnership as additional policy and operational activities that will support greater integrated care delivery in the short term[12]. In addition, as demonstrated in the NHS example provided above, it is from partnerships and initiatives at the local level that pockets of integrated care and clinical integration will emerge.

"Pre-op and post-op care and information were excellent. However, upon my discharge, information on what to expect or what to do when medical issues arose was almost non-existent. I felt like I was abandoned."

Patient representative,
Breast Diagnosis Assessment Project,
Cancer Care Ontario

Current Barriers to Integrated Care Delivery

Despite progress made to date in moving the needle towards a more integrated health system, there are still a number of barriers that need to be addressed for people in Ontario and around the world.

In the long term, there is a need for higher-level structural changes, such as investment in information systems that transcend organizations, and realignment of incentives through funding model redesign. However, this need can be bolstered in the short term by incremental change focused on shifting culture, processes and leadership to adopt and promote mechanisms to drive integrated care.

There are also few examples to date of jurisdictions that have set out to develop integrated care at a system level. Successful integration of care has been demonstrated at the local level with specific disease groups and populations[13]. This is where CCO can leverage its experience in improving the integration of care for specific renal and cancer sub-populations across settings, as well as in standardizing approaches to care for patients who are complex and have multiple comorbidities. There is a need for a culture shift among organizations and providers that will change how they communicate and collaborate. A culture of collaboration will require greater trust and partnership at the local level as well as among different levels of government (federal, provincial and municipal).

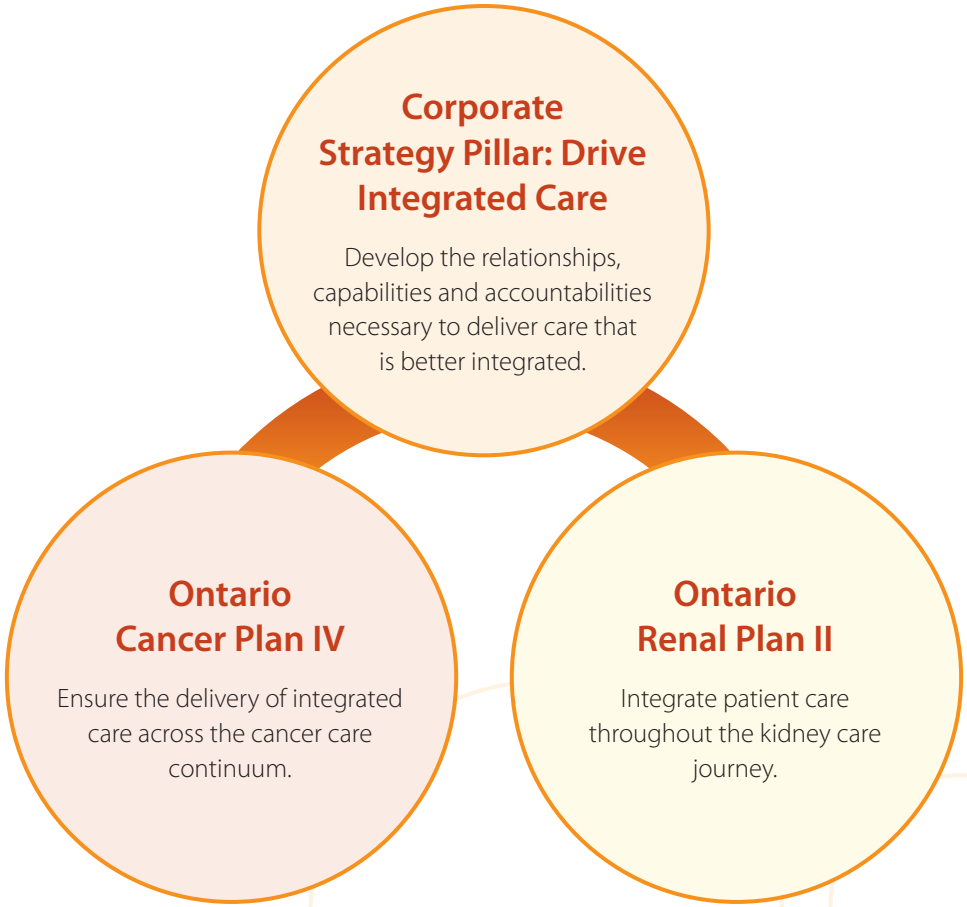
5

Strategic Accomplishments

CCO's 2012–2018 Corporate Strategy specified **five key focus areas** for the organization: patient-centred care, prevention of chronic disease, integrated care, value for money, and knowledge sharing and support.

As a result, integrated care has been an increasing priority at CCO and is also a core part of the organisation's System Plans (Ontario Cancer Plan IV and Ontario Renal Plan II). The corresponding diagram provides an overview of the high-level goals that CCO set for itself in both its 2012–2018 Corporate Strategy and its most recent System Plan (2015–2019).

These higher-level goals focus CCO collectively on creating a seamless journey for people with cancer and people with CKD through the development of the relationships, capabilities and accountabilities necessary to drive integrated care. To operationalize these higher-level goals, CCO has worked collaboratively with clinical leadership and system partners to develop an integrated care framework, a standardized approach to integrated care planning and a preliminary method for measuring integrated care at a system level. The following sections provide an overview of these three key strategic accomplishments.



Integrated Care Framework

CCO began its efforts to drive the adoption of integrated care by developing an integrated care framework. The aim of these efforts are as follows:

1. To standardize how integrated care is defined through the development of a clearly structured framework;
2. To disseminate the framework to promote awareness and adoption of integrated care concepts; and
3. To use the integrated care framework to evaluate the ways in which CCO programs are helping to drive integrated care across the cancer and chronic kidney disease systems.

Through the framework, CCO defines *integrated care* as care that is coordinated across professionals and organizations; maintained over time and between visits; tailored to patients' needs and preferences; and based on the shared responsibility of patients and professionals to optimize health. The framework identifies three key principles that are essential to a coordinated care approach: **person-centred care, collaboration** between providers and inter-professional teams and **continuity** across hospital/speciality care, and primary and community care providers (see section 12 Appendix 1: CCO Integrated Care Framework). It also emphasizes the need to prioritize patients with complex needs (e.g., frail elderly or those with multiple co-morbidities) who receive services from several healthcare professionals and organizations that frequently operate in silos, resulting in poor health outcomes.

Cancer requires healthcare management across disease stages and types of care providers (including acute, community and primary care). A significant proportion of people with cancer are high users of the health system and thus require an integrated approach, particularly among patients who are more complex. Early identification of complexity and development of individual care plans with the patient and their family can lead to better coordination and integration. This includes improving communication among providers at the time of referral and across disease stages, and is particularly important for complex cancer patients who are in need of ongoing support to manage comorbidities and the long-term side effects of treatment.

Integrated Care Planning

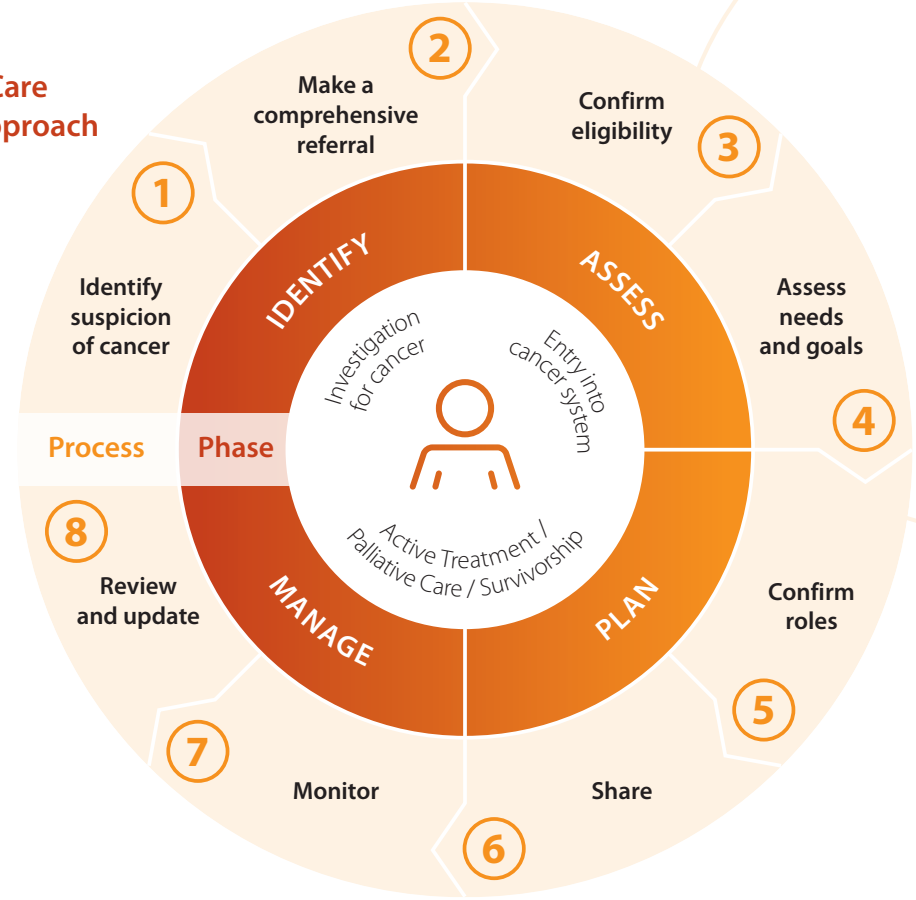
In the Ontario Cancer Plan IV (OCP IV), developing a standardized care plan for integrated care was identified as a key strategic objective. By 2019, CCO intends to create a standardized approach to integrated care planning that can be *"used to improve communication of goals of care and expected outcomes among patients, families and providers"*. The purpose of such an approach is as follows:

1. To support the management of medically and socially complex patients;
2. To enhance coordination of care across the patient journey;
3. To improve communication and information exchange across providers, disciplines and care settings; and
4. To positively impact patients and their families, providers and the health system.

In support of these efforts, CCO conducted a literature review with stakeholder input on integrated care planning for people with cancer[14]. Findings indicated that, unlike disease pathways and clinical guidelines, which outline a standard of care for a group of patients, integrated care plans focus on the needs of an individual patient at the point of clinical care. Integrated care plans transcend specific treatments and encompass the overall needs and goals of the patient across multiple stages of the care journey, including transitions into, within, and out of the cancer care system.

Results of this work[15] were used to develop a standardized integrated care planning approach that can be implemented across sites, providers and settings to guide program-level efforts at improving patient navigation and care planning.

Integrated Care Planning Approach



At its core, this process is aligned to the cancer patient journey and focuses on key methods to ensure continuity of care, improve communication and information exchange across patients and providers, phases of care and settings, and to enable a positive impact on the experience and outcomes of the patient.

System Measurement

Over the past five years, CCO has worked to develop an approach for measuring integrated care at the system level, with these objectives:

1. To monitor progress towards adoption of integrated care practices and concepts;
2. To identify gaps and reallocate efforts, resources and funding accordingly; and
3. To leverage key learnings from what is working in one area, in other areas of the system.

CCO first partnered with the Institute for Clinical Evaluative Sciences (ICES) to determine whether health administration data housed and managed by ICES could be used to measure integrated care. These efforts focused on reviewing the Continuity of Care Index (COCI) to determine if the number of physicians providing services to a patient and the percentage of care provided by each physician was a predictor of high complexity following a cancer episode. However, further analysis indicated that COCI showed a bias towards the number of providers in the circle of care and hence was not suitable to serve as an indicator.

Alternatively, CCO conducted a jurisdictional scan to examine whether other approaches have been identified for measuring integrated care at a system level. Results indicated that other jurisdictions often use patient and provider survey data to assess integrated care[16]. Based on these findings, CCO conducted a scan of the literature to identify validated survey instruments, and looked at existing province-wide CCO surveys that could be used to measure integrated care. The following survey instruments were identified:

- **Patient Perceptions of Integrated Care Survey:** designed and validated by Harvard scholars and used in several jurisdictions;
- **Ambulatory Oncology Patient Satisfaction Survey:** CCO-administered survey for cancer patients with questions on integrated care;
- **Patient Assessment of Chronic Illness Care Survey (PACIC-26):** CCO-administered survey for renal patients that includes questions on integrated care; and
- **Palliative Care Survey:** CCO-administered survey for renal providers revised to include questions on integrated care.

CCO has since adopted a phased measurement approach in which it will evaluate findings from the patient and provider renal surveys as a first step towards developing a system-level indicator for both the CKD and cancer care systems. Piloting the measures of integrated care in the CKD system using existing surveys is a cost-effective approach that allows for iterative learning and expansion into the broader health system.

> "Standardized integrated care planning offers an opportunity to improve the quality of care, empower patients, help with system efficiencies and help clinicians manage their practices better."
>
> **Dr. Vishal Kukreti,** Clinical Lead, eTools and Technology, Integrated Care Plans, Cancer Care Ontario

6

Current State of Integrated Care at CCO

At a local level, CCO has made good progress in partnership with its regional centres and system partners in building more person-centred, collaborative and continuous transitions into and out of the health system. Although there is still work to be done, these accomplishments have created a foundation upon which CCO can continue to build and drive adoption of integrated care across the system.

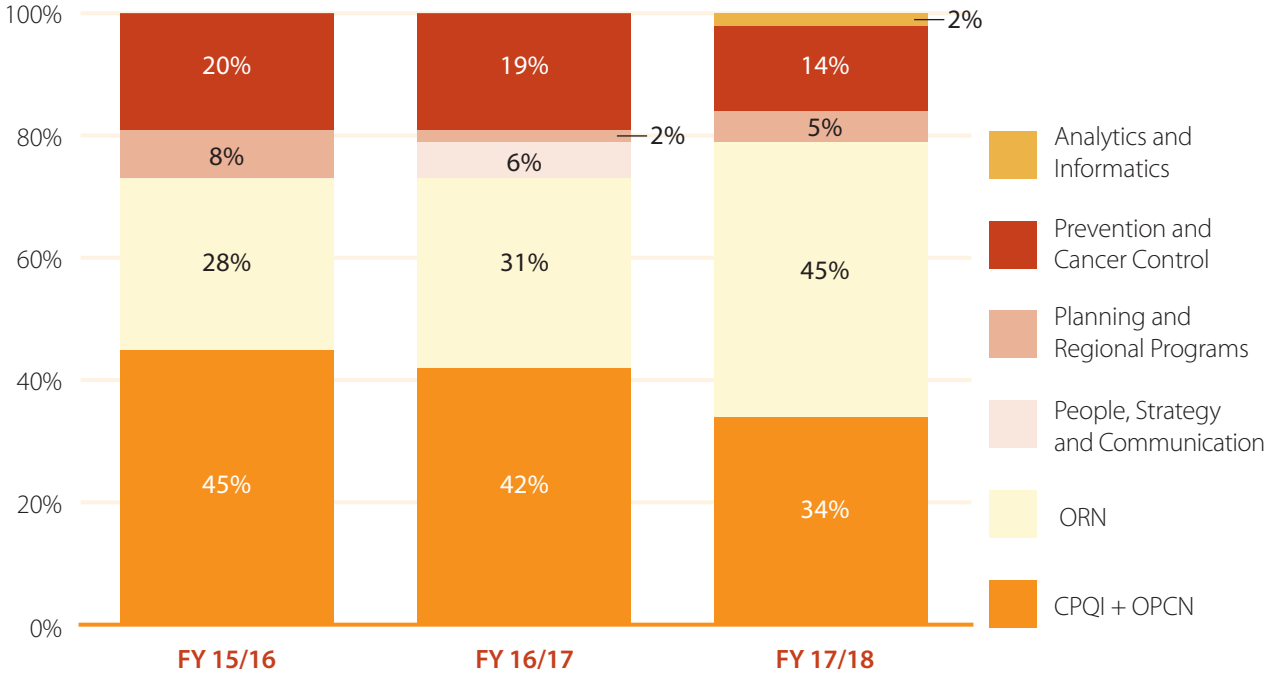
Integrated Care Initiative Alignment

One of the objectives of prioritizing integrated care as a strategic focus area has been to drive adoption of integrated care planning practices in CCO's everyday work. To understand CCO's contribution towards integrated care delivery at an operational level, CCO has measured alignment of program initiatives to the integrated care concepts and practices outlined in the framework described in Appendix 1. The areas of alignment that CCO looks to in particular are as follows:

- Whether initiatives demonstrate the integrated care principles (person-centred care, collaborationand continuity);
- Whether they are focused on supporting patients across transition points (acute, community and primary care settings); and
- Whether they prioritize complex patients (e.g., the frail elderly and/or those with multiple comorbidities).

To be considered 'highly aligned,' initiatives in the operating plan had to achieve full alignment with these integrated care concepts. Measuring integrated care across CCO in support of the Corporate Scorecard began in 2015–16.

Percent of CCO Program Areas with Initiatives that have a Score of 4–5



Over the past three years, the range of 'highly aligned' initiatives has been between 43 and 61 percent. In the past year (2017–18), medium to highly aligned initiatives accounted for 80 percent of the pool of initiatives reviewed[17]. Results also indicate that highly aligned initiatives have been implemented across CCO, with the majority in Clinical Programs and Quality Initiatives (CPQI) and the Ontario Renal Network (ORN).

Of the initiatives that show alignment, a high proportion commonly exhibit practices that are person-centred, collaborative and continuous and support the needs of complex patients, but which are not always connected to services in the community. While this makes sense in some cases, in others it creates an opportunity for CCO to focus effort on building the connections among specialty, community and primary care to further drive integrated care.

The following section provides a qualitative review of examples that describe both medium and highly aligned initiatives that are moving the integrated care agenda forward at CCO. These examples highlight current successes that various program areas have had in progressing towards a more integrated health system.

7

Examples Showing Progress in Integrated Care

The **ten examples** outlined in this section highlight CCO program initiatives that have contributed to improving integrated care across the Ontario health system for people with cancer and people with CKD over the past five years.

Examples from Cancer Care Ontario

1 Diagnostic Assessment Programs (DAPs)

A program focused on improving the diagnostic phase of the cancer continuum through implementation of a single point of entry to the cancer care system, supported by a multidisciplinary team and nurse patient navigator.

2 Breast Diagnosis Assessment Project

A project focused on ensuring that all individuals with signs and symptoms of breast cancer benefit from a coordinated assessment process; and that all newly diagnosed breast cancer patients get the right pre-treatment evaluation and do not undergo tests which will not provide benefit.

3 Shared Decision-Making with First Nations, Inuit and Métis (FNIM) Communities

A program focused on enabling peers to support shared decision-making and to enhance participation of First Nations, Inuit and Métis people in decisions about their care.

4 INTEGRATE

A program focused on enabling identification and management of patients who may benefit from palliative care early and across settings.

5 Survivorship Care Improvement Project (SCIP)

A program focused on supporting patients in receiving follow-up care based on their needs and ensuring they get the right surveillance testing and monitoring for late effects regardless of where care is provided.

Examples from the Ontario Renal Network

1 Integrated Dialysis Care

A pilot program funding hospitals to identify community providers with the capabilities and capacity to provide community dialysis services supporting patients as they transition from acute care to their home community.

2 Your Symptoms Matter (YSM)

A program focused on improving symptom awareness for people living with chronic kidney disease by providing an organized approach to symptom screening, assessment and management.

3 Dementia Capacity Planning

A program focused on establishing a provincial capacity planning framework for persons living with dementia to enable health system planners to observe provincial system changes and regional variations in service delivery.

4 Ontario Renal Network Palliative Care

A program focused on establishing an integrated process for the early identification and management of people with chronic kidney disease who would benefit from palliative care.

5 Chronic Kidney Disease (CKD) Screening in Wikwemikong Unceded First Nation

A program focused on providing community members in Wikewemikong with CKD point of care, referral and screening services.

These examples demonstrate the significant work and planning completed to date, contributing to the advancement of integrated care. The following examples from Cancer Care Ontario and the Ontario Renal Network elaborate further on these initiatives.

Examples from Cancer Care Ontario

"I was very impressed by the thoroughness with which all my physical concerns were addressed. One has the comfort of knowing that nothing is being overlooked."

Patient representative,
Breast Diagnosis Assessment Project,
Cancer Care Ontario

Diagnostic Assessment Programs (DAPs)

Evidence-based DAPs are across Ontario designed to improve the diagnostic phase of the cancer continuum. The impetus for this work came out of an investigation conducted by the Cancer Quality Council of Ontario, which found that patients could benefit from a single point of entry to the cancer care system, supported by a multidisciplinary team and nurse patient navigator who could help to improve the patient experience. Cancer Care Ontario demonstrated program success and was awarded long-term funding for both provincial expansion and regional sustainability of existing DAPs. As part of implementing this work, Cancer Care Ontario established program guidelines, promoted the program with primary care providers and created 43 patient navigator positions across 13 Regional Cancer Programs. Cancer Care Ontario supports regional DAPs for people with lung, colorectal and prostate cancers. Outcomes of this work include reduced anxiety and improved patient experience scores. Cancer Care Ontario also found that DAPs have reduced wait times for diagnosis and contributed to integrated care delivery among services and providers.

Breast Diagnosis Assessment Project

The Ontario Breast Screening Program (OBSP) is a province-wide screening program that provides high-quality breast cancer screening for Ontarians. The OBSP coordinates care for patients who are referred to an OBSP assessment site during the diagnostic phase. However, the treatment pathways for patients with signs and symptoms of breast cancer who are not referred to an OBSP assessment site are less clear. Further to this, a review of ten jurisdictions found that Ontario has the longest time interval from the first medical consultation to the decision to treat for breast cancer. To address these issues, Cancer Care Ontario is looking at ways to build on the success of the OBSP to ensure that all people with signs and symptoms of breast cancer benefit from a coordinated assessment process and that all newly diagnosed breast cancer patients get the right pre-treatment evaluation and do not receive tests which will not provide benefit to them. This new initiative is in the early stages of implementation and involves three key work streams: first, to focus on ensuring that appropriate clinical guidance and standards have been set for the diagnosis and assessment of breast cancer; second, to design and support the implementation of a coordinated provincial model for diagnosis and assessment; and third, to develop and execute a measurement strategy for the diagnostic phase of the breast cancer journey.

Shared Decision-Making with First Nations, Inuit and Métis (FNIM) Communities

FNIM communities experience disproportionate rates for certain cancers and lower likelihood of survival. These disparities are associated with several factors including barriers and access to healthcare, screening and appropriate treatment. Cancer Care Ontario has partnered with Ottawa Hospital Research Institute on an initiative to remove barriers to care faced by FNIM peoples in order to improve health outcomes and to better align care practices with FNIM values and expectations of care. Shared decision-making (SDM) has been found to improve people's participation and outcomes in healthcare; peer support with SDM further increases these benefits. The purpose of this initiative is to enable peers to support SDM and to enhance participation of FNIM people in decisions about their care. This initiative is also a key product of Aboriginal Cancer Strategy II and III, which support an integrated approach to care at a systems level. The ultimate goal is to expand key learnings from this work and advance care delivery approaches across other care settings. An early outcome of this work has been the development of a recruitment process to gather data from three FNIM communities on how to tailor and field-test a peer SDM strategy for use in cancer care.

INTEGRATE Project

Canadian Partnership Against Cancer partnered with Cancer Care Ontario to fund a cross-provincial quality improvement project that involved four main high level steps: education, development, implementation and evaluation of the palliative care early identification model. The INTEGRATE Project aimed to identify and manage patients who would benefit from a palliative approach to care early in the illness trajectory and across healthcare settings. Palliative care-integrated models were pilot-tested in three regions in Ontario (four cancer centres (CCs) and four primary care (PC) practices). All participating sites completed Pallium Canada's LEAP module, which provides primary-level palliative care education. Whether a patient might benefit from a palliative care approach was determined using the Surprise Question: "Would you be surprised if this person died in the next 6 to12 months?", initiating symptom assessment, Advance Care Planning and Goals of Care discussions, and referrals as needed (e.g., psychosocial services, home and community care and financial planning supports). The outcomes of this work led to standardized referral criteria across three home and community care regions, creation of a standardized report that distilled information from oncology to primary care, and regular communication touch points between patient care coordinators and primary care or oncology to support improved care delivery and patient outcomes.

"The INTEGRATE initiative demonstrated the benefits of primary care, oncologists and home care working together to identify people with cancer who could be helped by a palliative care approach for their symptom needs to support better quality of life."

Esther Green, Director,
Canadian Partnership Against Cancer

Survivorship Care Improvement Project (SCIP)

Cancer Care Ontario is developing a model to promote optimal follow-up care for patients as they transition from active treatment to post-treatment care. The goals are to improve communication and coordination across specialist and primary care settings and to ensure family physicians are ready and able to provide relevant components of follow-up care with the right supports in place. Through stakeholder engagement and environmental scanning, Cancer Care Ontario has better defined the communication needs of healthcare providers and patients, and identified tools that can be used to support seamless transitions. Survivorship care is a provincial priority that, through a standardized approach, can improve timely and coordinated care, proactive health maintenance and disease prevention, and ensure holistic, high-quality care for cancer survivors.

Examples from Ontario Renal Network

"As a patient advisor on the YSM project, it was my hope that this initiative would promote more patient involvement in their own care and future treatment. To date, I am satisfied that the framework has been laid [out] to accomplish these goals and enhance person-centred care in a more structured format."

Patient representative,
Your Symptoms Matter, Ontario Renal Network

Integrated Dialysis Care

Since 2014–15, the Ontario Renal Network has been funding community care providers for the provision of assisted peritoneal dialysis services. This is in addition to 26 chronic kidney disease programs it had already been funding in acute care regional delivery centres. However, when funding was expanded to include community care, different hospitals having different relationships with community providers and community nurses often needing to be retrained created issues of access to care. As a result, the Integrated Dialysis Care program was developed, through which Ontario Renal Network began working directly with eight regional centres to pilot one point of accountability for the funding and provision of care. The goal of this new program is to create more continuous service for patients where funding is allocated to one organization that is then responsible for care in both the acute and community setting. Under this new approach, hospitals work directly with their community providers to determine which organizations have the capabilities and capacity to provide homecare dialysis support. The Ontario Renal Network is also working with regional renal programs to evaluate success of the program by monitoring access, safety, value for money and care configuration.

Your Symptoms Matter (YSM)

The Ontario Renal Network Your Symptoms Matter (YSM) Project was implemented in June 2016 to improve symptom awareness for both people living with chronic kidney disease and their care team by providing an organized approach to symptom screening, assessment and management. Nine sites from participating Regional Renal Programs routinely assess patients undergoing in-facility hemodialysis with the Edmonton Symptom Assessment System Revised – Renal (ESAS-r:Renal), a self-reported symptom questionnaire. The new workflow encourages collaboration among the multidisciplinary care team and aims to improve patient-provider communication and the patient experience of dialysis care. Clinical Symptom Management Resources for six symptoms included on the ESAS-r:Renal questionnaire were created to support providers. Project evaluation includes examination of the impact of ESAS-r:Renal on patient service utilization, including primary care, community care, specialist visits, and hospitalization. The one-year pilot project will help determine the feasibility of a province-wide approach to renal symptom screening, assessment, and management in Ontario. Furthermore, the project will increase awareness of chronic kidney disease patient symptom burden.

Dementia Capacity Planning

Persons living with dementia (PLwD) represent a growing population in Ontario with complex health and social needs. To address the healthcare system needs of PLwD, a collaboration between MOHLTC, the Ontario Renal Network, Ontario Brain Institute, and Institute for Clinical Evaluative Sciences was formed to establish a provincial capacity planning framework. Strong networks of regional partners with expertise in dementia were leveraged throughout the project to develop a foundation for the work that was well-informed, and validated by the lived experiences of those accessing care and the providers of dementia-related services. The outcome of the first phase of this work was the development of a population-based scenario analysis model for community-dwelling PLwD. This interactive regional profile tool allows decision-makers at the provincial and LHIN levels to estimate system-level impacts through simulating changes in a person's care pathway based on evidence-based health system interventions. Health system planners and policy-makers will now be able to observe provincial system changes and regional variation in service delivery using a consistent approach and methodology.

Ontario Renal Network Palliative Care

In the Ontario Renal Plan II (2015–2019), palliative and end-of-life care were identified as priorities. Palliative care in advanced chronic kidney disease (CKD) is much more than end-of-life care and is provided in addition to the care to treat the disease. The goal of palliative care is to help people live well by keeping them as comfortable and free of pain or other symptoms as possible. As a result, Ontario Renal Network developed the Person-Centred Decision-Making (PCDM) initiative for people living with advanced CKD. PCDM conversations help to ensure that decisions are aligned with patient wishes, values, and beliefs with respect to their healthcare and health condition, and that patients are supported throughout their care journey. These conversations also offer an opportunity for providers to introduce the concepts of palliative care and share some of the benefits of early integration with treatment and referrals as needed (e.g., psychosocial services, home and community care). To increase the comfort and knowledge of healthcare providers in the delivery of primary-level palliative care to people with CKD, Ontario Renal Network partnered with Pallium Canada to provide training. Local clinical champions were identified in the 26 regional renal programs to spearhead the initiative at the local level. Ontario Renal Network is collecting data across the province to determine the prevalence and timing of PCDM conversations. Early outcomes of this work include the training of over 400 renal healthcare providers and a provincial standard for collecting data on PCDM conversations with people with CKD.

"Working together and communicating effectively across acute care, home and community care, primary care and specialty care are essential for responding to the increasing needs of patients with complex conditions and their caregivers. Improved communication helps deliver a seamless care experience and meet the ongoing needs that patients have."

Health Shared Services Ontario

Chronic Kidney Disease (CKD) Screening in Wikwemikong Unceded First Nation

In 2012, the Wikwemikong community reached out to Health Sciences North (HSN) and the Ontario Renal Network as community members were experiencing challenges with accessing diabetes services. Access challenges included: community members having to travel far distances to receive care, no public transportation to distant renal service delivery locations, and a lack of clarity regarding whether there were additional individuals living in the community with undiagnosed diabetes. In 2014, stakeholders met and agreed to develop a CKD and risk factor screening program, based on an anticipated high volume of undiagnosed disease. The Ontario Renal Network worked in collaboration with HSN and the Wikwemikong community to develop a CKD point of care, referral and screening program. The program was rolled out at a local Community Health Centre and delivered by a community member who provided clients of the Centre with access to CKD screening services. The program was publicized through a promotional video, social media and radio, and the community member also attended local community events to provide access to CKD screening services. Community members found to have undiagnosed diabetes, CKD and/or hypertension were then referred on to primary/speciality care for further services. Outcomes of this work include identifying individuals with undiagnosed CKD, diabetes and hypertension for treatment, and the ability to make/develop a business case for expanded diabetes services in the Wikwemikong community.

The ten examples above provide snapshots of some of the foundational work CCO has been conducting over the past five years in the field of integrated care. All of these initiatives are aligned with the principles of integrated care (person-centred, collaborative and continuous) and support the needs of complex patients. In some cases, there is the potential opportunity to identify ways to engage acute, community and primary care (if appropriate), and/or to work with programs internally at CCO that support the next phase of the disease pathway, ensuring continuous connections across transition points for patients.

8

Why Should CCO Continue to Care?

Since the launch of CCO's 2012–2018 Corporate Strategy, there has been significant movement in the health system.

This includes ongoing pressures in CCO's external environment to move towards a more integrated system as a result of the implementation of Patients First legislation and the transformation of the LHINs to focus on home and community care, Health Links and MOHLTC Patients First focus areas (e.g., an expanded role for LHINs, integration of primary care, consistent accessible home and community care).

More broadly, most organizations in health systems around the world are facing pressure to better coordinate care to improve patient outcomes and reduce healthcare costs. CCO is not alone in the journey towards a system that better integrates care around the patients' needs, and in many ways is ahead of its time in terms of identifying integrated care as a strategic direction.

As the 2012–18 Corporate Strategy comes to an end, CCO has an opportunity to continue to build on the foundational work it has undertaken in this field.

At the same time, CCO has grown and developed experience, capabilities and assets in areas such as capacity planning, adoption and improvement methodologies as well as performance management that could be shared with system partners to address barriers and system challenges.

The cancer patient population is also complex and often transcends care settings beyond CCO's mandate (e.g., 55 percent of people with cancer have two or more comorbid conditions and they often interact with primary and/or community care providers and other specialties while receiving treatment). This is a call to provide more integrated care for shared patient populations through partnerships and collaborations that enable organizations across the health system to have a greater collective impact on patient outcomes and experience, provider satisfaction and health system sustainability, than would otherwise be possible in isolation.

9

Future Directions

CCO has an opportunity to work with partners in the health system and lead the change to a more integrated delivery model for its patients. To build on the work completed to date, CCO has identified three key future directions that the organization will take in these efforts.

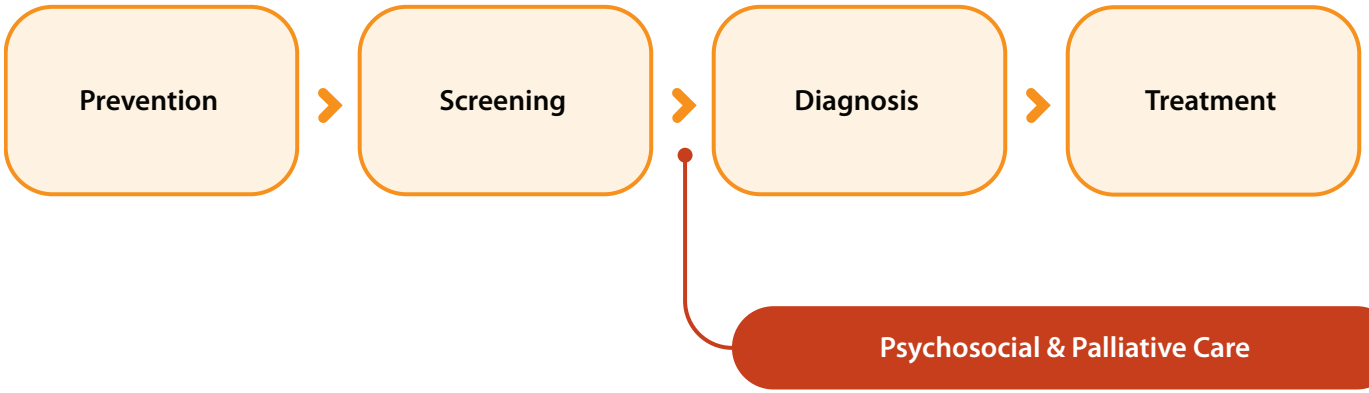
1 Continue to adopt integrated care principles and practices in program planning and design.

CCO has been deliberate about linking internal program practices and driving a 'One CCO' organizational culture. However, patients continue to describe their experience in the health system as fragmented, so that it is both challenging and confusing to navigate their health and social care across multiple providers and care settings. CCO thus intends to work towards linking its programs along the full disease pathway for people with cancer and people with CKD.

2 Alignment with broader government direction on integrated care.

System pressure to move towards strategies that enable integrated care have grown and will continue to be a focus area for MOHLTC. There is a need to work collaboratively with MOHLTC and LHIN leadership to identify the ways in which CCO can support the broader health system in creating a more integrated experience for its renal and cancer populations.

Integrating Care Along the Disease Continuum



3 Build actionable partnerships with broader system partners.

CCO operates within a complex web of system players. A key area of improvement internally is increased connections among CCO programs and home and community care. To drive organizational success, CCO will need to continue to work with and through the LHINs and home and community care, as well as acute and primary care, to identify opportunities for collaboration and understand how CCO can best contribute to system improvements for shared patients.

Recovery/ Survivorship

End-of-Life Care

As chronic disease rates rise, the demand for integrated care continues to grow.

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Contributors

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CCO:

- Diagnostic Assessment Programs
- Disease Pathway Management
- Ontario Palliative Care Network
- Patient and Family Advisory Council
- Person-Centred Care
- Primary Care
- Survivorship

Ontario Renal Network:

- Dementia Capacity Planning
- First Nations, Inuit and Métis
- Funding, Policy and Operations
- Palliative Care
- Your Symptoms Matter

Canadian Partnership Against Cancer Care

Health Shared Services Ontario

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References

1. Alderwick, Hugh, Chris Ham and David Buck. "Population health systems: Going beyond integrated care". The King's Fund: February 2015. Report website: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/population-health-systems-kingsfund-feb15.pdf
2. Government of Canada. "How Healthy Are Canadians?: A trend analysis of the health of Canadians from a healthy living and chronic disease perspective". 11 April 2017. Report website: https://www.canada.ca/en/public-health/services/publications/healthy-living/how-healthy-canadians.html#s1
3. Government of Ontario, Newsroom. "Ontario Funds Bundled Care Teams to Improve Patient Experience". 02 September 2015. Report website: https://news.ontario.ca/mohltc/en/2015/09/ontario-funds-bundled-care-teams-to-improve-patient-experience.html
4. Government of Ontario. "Guide to the Advanced Health Links Model". Accessed on 14 December 2017. Report website: http://www.health.gov.on.ca/en/pro/programs/transformation/docs/Guide-to-the-Advanced-Health-Links-Model.pdf
5. Heiman, Harry J. and Samantha Artiga. "Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity. Kaiser Family Foundation: 04 November 2015. Report website: https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/
6. Mastellos, Nikolaos, Laura Gunn, et al. "Assessing patients' experience of integrated care: a survey of patient views in the North West London Integrated Care Pilot". International Journal on Integrated Care: 9 June 2014. Publication website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4059210/
7. National Health Expenditure Database, Canadian Institute for Health Information. "How much does Canada spend on health care?". 2017. Accessed on 14 December 2017. Report website: https://www.cihi.ca/en/how-much-does-canada-spend-on-health-care-2017
8. Statistics Canada. "An Ageing Population". 07 October 2017. Report website: http://www.statcan.gc.ca/pub/11-402-x/2010000/chap/pop/pop02-eng.htm
9. Robertson, Ruth, Lara Sonola, et al. "Specialists in out-of-hospital settings: Findings from six case studies". The King's Fund: October 2014. Report website: https://www.kingsfund.org.uk/publications/specialists-out-hospital-settings
10. The Economist Intelligence Unit. "Value-based Healthcare: A Global Assessment". Commissioned by Medtronic. 2016. Report website: http://vbhcglobalassessment.eiu.com/value-based-healthcare-a-global-assessment/
11. United Nations, Dept. of Economic and Social Affairs, Population Division. "World population ageing, 2015 (ST/ESA/SER.A/390)". Report website: http://www.un.org/en/development/desa/population/publications/pdf/ageing/WPA2015_Report.pdf

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Appendix 1: CCO Integrated Care Framework

Definition

Integrated care is grounded in improving patient care, focusing on transitions into and out of the healthcare system and coordination of treatment.

This coordinated approach should be **person-centred, continuous and collaborative**. At the provider level, care should be delivered by interdisciplinary teams, enabling primary care involvement over time, where each member understands his or her role and the roles of the team members.

Person-Centred Care is designed with the patient and family to achieve best outcomes.

Collaborative Inter-professional teams work together to provide personalized care for each patient.

Continuous Providers plan and navigate with the patient and family over time to address their changing needs.

Goal

Continually improve patient outcomes and experiences through **partnerships** and the implementation of integrated patient care for patients with **complex needs**.

Aims

- Co-design point-of-care integration and communication mechanisms with patients, families and providers using evidence and best practice
- Implement models of integrated care to deliver high-quality care across hospital and community settings
- Drive a shared performance management and quality improvement approach at the local, regional and provincial levels

Impact

- Providers will be empowered to ensure care takes place in the setting which provides the **best care for patients and the greatest value for the system**
- Patients will have **better outcomes and care experiences** as a result of more integrated care

Patient Perspective

"My care is planned with people who work together to understand me and my caregivers, coordinate and deliver services to achieve my best outcomes and experience."

Provider Perspective

"My role and my colleagues' roles are clearly defined and we effectively and efficiently communicate with one another about our shared patients."

System Perspective

"There is a common service delivery model, with standards, processes and indicators shared among organizations to improve patient transitions, manage complex conditions and reduce adverse events."

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