1. Why Do we Need a Models of Care Program?
2. How It All Started
3. Progress to Date
4. Understanding the Impact of Models of Care
5. What have been our Challenges...What do we need to do for the future?
1. Why Do We Need a Models of Care Program

- Increasing demand for cancer services
- Financial constraints
- Shortage of health human resources
- Emerging new technologies and new practices
Sustainability of Healthcare

Total health expenditure is expected to amount to $6,144 per Ontarian in 2016

Source
National Health Expenditure Database, Canadian Institute for Health Information
2. How It All Started

**Models of Care**

- Models of Care Workstream
  - Implementation of new models of care
- Alignment and Accountability Workstream
  - Provincial Oncology Alternate Funding Plan (POAFP)
- Prediction and Planning Workstream
  - Health human resources planning for medical, radiation and gynecologic oncology
Models of Care Program Vision and Goals

Vision: A sustainable, integrated, person-centred model of cancer care

GOAL 1
Develop and implement new models of care to promote value for money

GOAL 2
Identify and address regulatory, funding, and other policy changes to sustain new models of care

GOAL 3
Enhance the accuracy of human resources planning by incorporating the impact of model of care
Ontario Cancer Plan IV

Strategic Goal

Ensure a sustainable cancer system for future generations

Strategic Objective

Optimize the models of care delivery to achieve the greatest benefit for patients and the cancer system

What does the Models of Care Program do?

We identify and support implementation of “models of care”, which are the ways we organize and deliver care that allow the right provider to give the right care at the right place.
3. Progress to Date
Progress to Date

Survivorship Care Improvement Project (SCIP)
Ensure that survivorship care is provided by the most appropriate provider in the most appropriate setting. (Clinical Lead - Dr. Jonathan Sussman)
• ~10,000 patients transitioned (breast and colorectal cancer) between 2011 and 2015

Clinical Specialist Radiation Therapist Model (CSRT)
Redirect some tasks from radiation oncologists to advance practice radiation therapists; ensures high quality, person-centred care; optimizes use of health human resources. (Provincial Head - Dr. Padraig Warde)
• 24 CSRTs at 9 centres, 8 of them in palliative care
New Ambulatory Models of Care (NAMOC)
Implement ambulatory models of care that improve access to symptom management during treatment, focusing on optimizing use of nursing role within a multidisciplinary team. (Chair of NAMOC Steering Committee - Paula Doering)

• Started in September 2015, will conclude in September 2017
• Ambulatory models of care
  o Urgent care clinic for symptom management (Ottawa and Hamilton)
  o Navigator role in concurrent chemotherapy-radiation treatment (Barrie)
  o In-home nurse-led oral chemotherapy (Sudbury)
  o RN-led palliative triage model (Trillium)
• Between September 2015 and April 2017 about 1,400 patients received services in one of these models.
Complex Malignant Hematology Models of Care

Implement models of care that improve access to complex malignant hematology services by shifting care to the most appropriate provider and setting.

- Multi-disciplinary working group with patient representative (CMH Models of Care Working Group Chair - Dr. Chris Bredeson) developed recommendations for CMH Models of Care

- Baseline data was collected to understand the status of implementation of CMH models at 14 Regional Cancer Centres.

- Each of 18 CMH Models of Care Recommendations have been implemented in at least one Regional Cancer Centre.
New! In Planning Phase

Palliative Models of Care

• Needs-based models of palliative care for patients at end of life

Models of care for Diagnostic Assessment of Breast Cancer

• Streamlined and coordinated model of care for individuals with suspicion of breast cancer

Models of Care for Toxicity Management

• Models of care for management of symptoms and side effects (toxicities) of patient undergoing cancer treatment
4. Understanding the Impact of Models of Care
Transitioning breast cancer survivors from oncology-led care to primary care (PC): how does it affect health system costs?
Every year, more oncologists are needed to address growing demand of care. With changes in models of care, the growth in demand for new oncologist positions can be reduced.

<table>
<thead>
<tr>
<th>Models of Care by Specialist</th>
<th>2014 Change in requested positions</th>
<th>2015 Change in requested positions</th>
<th>2016 Change in requested positions</th>
<th>2017 Change in requested positions</th>
<th>2018 Change in requested positions</th>
<th>2019 Change in requested positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Radiation Oncology Impact of new models • Well follow up • CSRT</td>
<td>-1.5 FTE (-30%)</td>
<td>-2.3 FTE (-43%)</td>
<td>-2.6 FTE (-49%)</td>
<td>-3.4 FTE (-63%)</td>
<td>-3.8FTE (-55%)</td>
<td>-1.5FTE (-18%)</td>
</tr>
<tr>
<td>Medical Oncology Impact of new models • Well follow up</td>
<td>-2.0 FTE (-25%)</td>
<td>-1.1 FTE (-14%)</td>
<td>-1.2 FTE (-14%)</td>
<td>-1.3 FTE (-15%)</td>
<td>-1.5 FTE (-17%)</td>
<td>-0.5 FTE (-9%)</td>
</tr>
</tbody>
</table>

Example: in 2015 the projected demand for radiation oncologist was 5.3FTEs. The models of care adjustment reduced the request by 2.3 FTEs (-43%).
# Monitoring Progress of Implementing CMH Models of Care

## Proposed Priorities for Provincial Implementation, Baseline

Regional Cancer Centres are encouraged to work on all recommendations but the provincial focus will be on selected recommendations with enhanced support and analysis.

**Pending data validation**

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### Complex Malignant Hematology Models of Care Implementation Survey Summary - April 2017

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Transplant &amp; Acute Leukemia sites</th>
<th>Acute Leukemia sites</th>
<th>Acute Leukemia Shared-Care sites</th>
<th>Transplant Day 1 service</th>
</tr>
</thead>
<tbody>
<tr>
<td>10. Consolidation chemotherapy and supportive care for AL patients are offered on an outpatient basis</td>
<td>Partially implemented</td>
<td>Not yet implemented</td>
<td>Partially implemented</td>
<td>Fully implemented</td>
</tr>
<tr>
<td>11a. Outpatient and toxicity management is available, as follows:</td>
<td>Not yet implemented</td>
<td>Not yet implemented</td>
<td>Partially implemented</td>
<td>Not relevant</td>
</tr>
<tr>
<td>11a.1. CMH (non-transplant) patients</td>
<td>Not yet implemented</td>
<td>Partially implemented</td>
<td>Not yet implemented</td>
<td>Partially implemented</td>
</tr>
<tr>
<td>11a.2. Auto HCT patients</td>
<td>Not yet implemented</td>
<td>Fully implemented</td>
<td>Partially implemented</td>
<td>Not yet implemented</td>
</tr>
<tr>
<td>12a.1. All HCT patients</td>
<td>Partially implemented</td>
<td>Not yet implemented</td>
<td>Partially implemented</td>
<td>Not relevant</td>
</tr>
<tr>
<td>17. &quot;Fly beds&quot; or &quot;protected beds&quot; are available to facilitate admission of eligible outpatients receiving, or being followed after, therapy</td>
<td>Fully implemented</td>
<td>Not yet implemented</td>
<td>Partially implemented</td>
<td>Not relevant</td>
</tr>
</tbody>
</table>

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* Regional Cancer Centres are encouraged to work on all recommendations but the provincial focus will be on selected recommendations with enhanced support and analysis.

** Pending data validation
5. Challenges

• Willing partners
• The health care environment
• Creativity and culture of innovation
• Commitment to spread and scale of successful models
• Acknowledgement that change management takes time
• Big change often is done in times of desperation
Right Care, Right Provider, Right Place: CCO’s Models of Care Program