CQCO Cancer Quality Council of Ontario

Signature Event Report: Recommendations and Proceedings

Align • Bridge • Collaborate

Strengthening primary and specialist care links for seamless patient care

Cancer Quality Council of Ontario

2012 Signature Event

November 29, 2012

Marriott Bloor-Yorkville Hotel, Toronto

Cancer Quality Council of Ontario – membership as of November 29, 2012

The Cancer Quality Council of Ontario (CQCO) Council is a multidisciplinary group of healthcare providers, cancer survivors, and experts in the areas of oncology, health system policy and administration, performance measurement and health services research.

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1.0 Executive Summary

The Cancer Quality Council of Ontario (CQCO) is an arm's length advisory group that was established in 2002 to guide Cancer Care Ontario and the Ministry of Health and Long Term Care in their efforts to improve the quality of cancer care in Ontario. Our mandate is to monitor and publicly report on the quality of cancer services in Ontario and to improve cancer system quality by identifying quality gaps and, through the use of international expertise and advice, commission special studies to address them.

The CQCO Signature Event series is one of our key tools to achieve our mission. The annual Signature Event brings together stakeholders and decision makers to address a quality gap to help us to better understand quality issues. The events are action-oriented and bring together international leaders and experts, clinical leaders, managers, providers, patient representatives and decision-makers to work together to solve pressing quality challenges for Ontario's cancer system.

CQCO's ninth Signature Event, *Align, Bridge, Collaborate: Strengthening primary and specialist care links for seamless patient care,* was held in Toronto on Thursday, November 29, 2012. With a view to addressing important quality gaps in Ontario's cancer system, the 2012 CQCO event focused on primary care integration with specialist care. The event's objectives were to:

- Learn from international jurisdictions that encourage greater coordination of care within primary care, as well as between primary care and other sectors;
- Discuss tangible solutions to strengthen transition points in the patient journey; and
- Discuss how to best encourage continual involvement from primary care throughout the patient journey for those patients with cancer, renal and chronic diseases.

The November 29, 2012 CQCO event featured an analysis of the current state of primary care in Ontario and discussion about what are the priorities for change, an international comparison based on data from The Commonwealth Fund, three case studies from the UK, Netherlands and New Zealand, describing what lessons Ontario can learn from these countries in terms of integration and care coordination. The day also included a number of interactive components including a rapid rounds session with local and provincial presentations on tangible solutions for improving primary care integration; a dynamic cross-discipline panel discussion on strengthening linkages between primary care and specialists; a breakout session where event participants discussed improving integration throughout the patient journey; and a commitments panel that included seven key leaders of organizations who articulated their plans for strengthening integration in the health system in Ontario.

Based on the presentations and discussions of November 29, 2012, the audience helped create the CQCO recommendations outlined below in the areas of communication, engagement, accountability, system navigation, guidelines and risk stratification and networks.

1. Engagement

- Partner with patients and families when conducting system design, pilots and implementation.
- Encourage empowerment through self-management programs.

2. Communication through Transitions

- Enhance information management systems to enable information sharing and links with patients and providers that facilitate transitions as well as rapid re-entry (when needed) into the system.
- Develop information sharing tools that are clearly understood by all audiences (for eventual inclusion into Electronic Medical Records with clear standards and enforcement)
- Incent funding for alternative methods of communication, such as telemedicine and email between providers regardless of location or affiliation and with patients.

3. Accountability

- Create clear delineations of responsibilities during overlap periods for primary care and specialists for all phases of care and especially during times of diagnosis and follow-up care.
- Measure accountability with indicators addressing adherence to guidelines, wait times from suspicion to diagnosis to first treatment from the patient perspective and patient-reported outcomes.

4. System Navigation

- Expand navigator resources and coordinate all existing navigator programs.
- Use navigators to help identify where there are opportunities to simplify or coordinate parts of the patient journey.

5. Guidelines and Risk Stratification

- Create guidelines for rapid re-entry and survivorship, advanced directives for end of life care and care plans for self-management.
- Apply risk stratification approaches to identify which patients have high needs and target addressing their needs before issues arise.

6. Networks

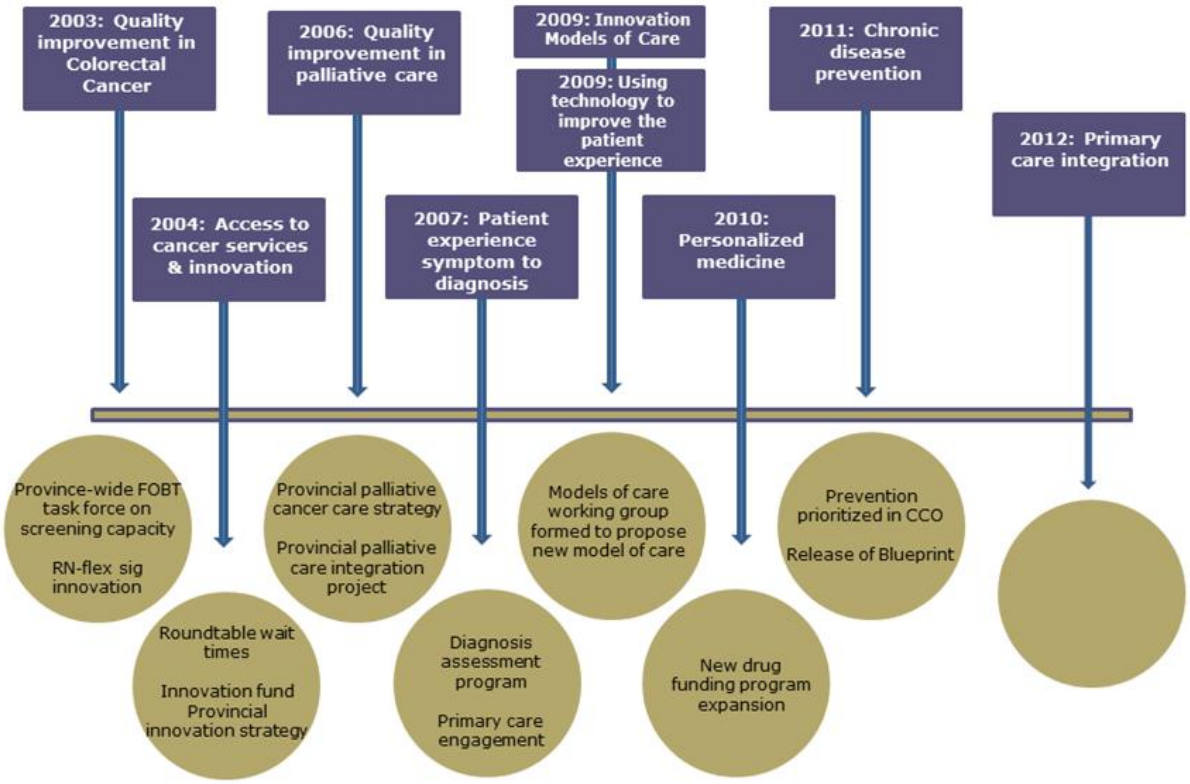
- Establish primary care as the 'medical home' (defined as having a regular doctor, timely access, has the patient's medical history and arranges care with other providers).
- Build regional networks (natural clusters) to enable networking and access to support resources.

2.0 Introduction

2.1 CQCO Signature Event Series

The Cancer Quality Council of Ontario (CQCO) plays host to an annual Signature Event that addresses quality gaps in cancer and fosters better understanding of quality issues. The events are action-oriented and bring together stakeholders, decision-makers, international experts, local leaders, clinicians, managers, providers, and patient representatives to work together on solving Ontario's pressing cancer system quality challenges.

The diagram below shows the themes and outcomes from CQCO Signature events from 2003 to 2011.



Source: *Cancer Quality Council of Ontario*

2.2 CQCO's 9th Annual Signature Event: Focus on Primary Care Integration

On November 29th, 2012, the Cancer Quality Council of Ontario held its ninth annual Signature Event in Toronto entitled *Align, Bridge, Collaborate, Strengthening primary and specialist care links for seamless patient care*. This report summarizes the event's proceedings and recommendations drafted by the Council based on input from presentations by international and local experts, panel discussions and participants discussions in breakout groups.

The Council identified the need to strengthen primary care and specialist care coordination from its work on system performance measurement via the Cancer System Quality Index at www.csqi.on.ca. The topic aligns with the Drummond Commission Report's mandate to review and identify improvements to the health care system and how the components work together as well as the Ministry of Health and Long-Term Care's Excellent Care for All Act to improve care for Ontarians.

The event's objectives were to:

- Learn from international jurisdictions that encourage greater coordination of care within primary care, as well as between primary care and other sectors;
- Discuss tangible solutions to strengthen transition points in the patient journey; and
- Discuss how to best encourage continual involvement from primary care throughout the patient journey for those patients with cancer, renal and chronic diseases.

The Agenda and day's events, seen in Appendix 1, featured an analysis of the current state of primary care in Ontario and what needs to change, an international comparison based on data from The Commonwealth Fund, three case studies from the UK, Netherlands and New Zealand, on what lessons we can learn from these countries in terms of integration and care coordination with the inclusion of electronic medical records and financial models embedded in their work.

The day also included a number of interactive components including a rapid rounds session comprised of ten presentations on tangible solutions for improving primary care integration in the areas of models, tools and networks; a panel discussion on strengthening linkages between primary care and specialists, with panelists including a patient, nurse navigator, surgical oncologist, medical oncologist and family physician; a breakout session where event participants contributed to discussions on improving the integration throughout the patient journey; and a panel on Commitments by organization leaders to demonstrate solidarity to strengthen integration in Ontario and provide a collective expression of commitment on their vision and plans for strengthening integration in the health system. The biographies of all the speakers can be found in Appendix 2. Presentation slidedecks can be found at www.cqco.ca/pc_integration.

3.0 CQCO Recommendations for Strengthening Primary and Specialist Care Links for Seamless Patient Care

The 2012 Cancer Quality Council of Ontario Signature Event on primary care integration began the day on the pretext that integrating care improves the quality of care and patient experience and reduces overall costs to the health system. Within the global context of austerity and the drive to make care more patient-centred, event participants heard from international and local expertise on the landscape of primary care integration across a number of jurisdictions and in Ontario, the drivers for integrating care, case studies from leading jurisdictions on how they are working to integrate care by changing financial remuneration models, enhancing communication opportunities, risk stratifying patients and employing electronic tools as collaborative spaces.

Event participants provided valuable contributions throughout the day. Presentations by attendees provided examples of pilots already underway to employ new models of care to enhance integration and improve the patient experience, applying electronics tools for data management and referrals and creating learning opportunities for primary care providers. Group discussions provided tangible ideas and priorities to improve care integration, many of which are captured in the below recommendations. Based on the presentations and discussions of November 29, 2012, the CQCO recommends:

1. Engagement
    - Partner with patients and families when conducting system design, pilots and implementation.
        - E.g. Expand use of Patient Family Advisory Councils such as CCO's Patient and Family Advisory Committee
    - Encourage empowerment through self-management programs.

2. Communication through Transitions
    - Enhance information management systems to enable information sharing and links with patients and providers that facilitate transitions as well as rapid re-entry (when needed) into the system.
        - E.g. Electronic referral system with capabilities similar to New Zealand and the Netherlands
        - E.g. Champlain LHIN e-consult and e-referral system for primary care and specialists
    - Develop information sharing tools that are clearly understood by all audiences (for eventual inclusion into Electronic Medical Records with clear standards and enforcement)
        - E.g. 'Discharge kit' outlining patient information for diagnosis, treatment and discharge
    - Incent funding for alternative methods of communication such as telemedicine and email between providers regardless of location or affiliation and with patients.

3. Accountability
    - Create clear delineations of responsibilities during overlap periods for primary care and specialists for all phases of care and especially during times of diagnosis and follow-up care.
    - Measure accountability with indicators addressing adherence to guidelines, wait times from suspicion to diagnosis to first treatment from the patient perspective and patient-reported outcomes.

4. System Navigation
    - Expand navigator resources and coordinate all existing navigator programs.
        - E.g. Look at expanding the Diagnostic Assessment Program-Electronic Pathway Solution (DAP-EPS) to include treatment and survivorship
        - E.g. Look at the Health Coach concept to connect individuals with resources

- Use navigators to help identify where there are opportunities to simplify or coordinate parts of the patient journey.

5. Guidelines and Risk Stratification
    - Create guidelines for rapid re-entry and for survivorship care, advanced directives for end of life care and care plans for self-management.
    - Apply risk stratification approaches to identify which patients have high needs and target addressing their needs before issues arise.
        - E.g. Create standard screening tools for all providers addressing isolation, fatigue, distress, fear by building on CCO's ESAS tool and applying to other diseases.

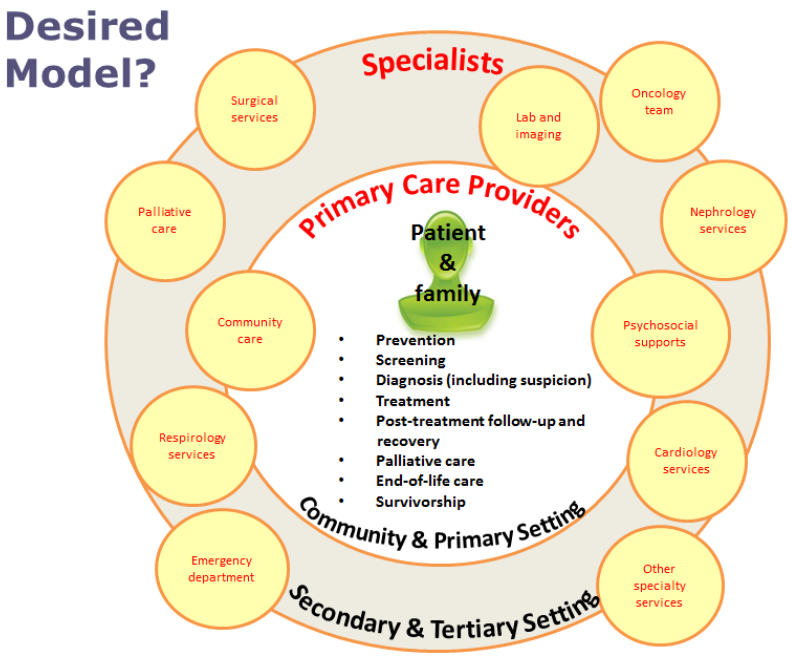
6. Networks
    - Establish primary care as the 'medical home' (defined as having a regular doctor, timely access, custodian of the patient's medical history and coordinator of care with other providers).
    - Build regional networks (natural clusters) to enable networking and access to support resources.
        - E.g. Networking and educational sessions between primary care and specialists such as the Ontario College of Family Physicians mental health mentorship program and the Ontario Renal Network Mentorship Pilot Program.
        - E.g. Access to support resources through Community Health Centres, Community Care Access Centres and Non-Government Organizations

4.0 Landscape and Current State of Primary Care Integration

4.1 Understanding the Bigger Picture: The landscape of primary care integration

Dr. Robert Bell, Chair of the Cancer Quality Council of Ontario, introduced the timely topic of integration of care delivery; the primary issue facing the publicly funded Canadian health system and the potential solution to the sustainability of the system. Research shows that systems with strong primary care have higher system performance and lower costs (Starfield, 2001). This is demonstrated in one example with the early detection of cancer with patients enrolled in a Patient Enrolment Model having greater participation rates in colorectal cancer screening than those who are not enrolled. Both provider and patient surveys identify a number of areas requiring improvements. For example, primary care physicians experience long waiting times to have their patients see a specialist and patients with multiple chronic diseases feel their care needs to be improved.

There is an opportunity to improve system effectiveness with the Minister of Health and Long-Term Care focusing on primary care integration for patients who have multiple needs. The recent government settlement with the Ontario Medical Association may encourage creativity in integrating various elements of care in our system. Dr. Bell stated the current model of patient journey has too many transitions which are not supported by electronic data or have an appropriate description of care that is required from the next provider. The desired model, seen in the diagram on the next page, revolves around the patient and links services at the provincial level to the local hubs or integrated networks of collaborative care to ensure that the system should move seamlessly around the patient.



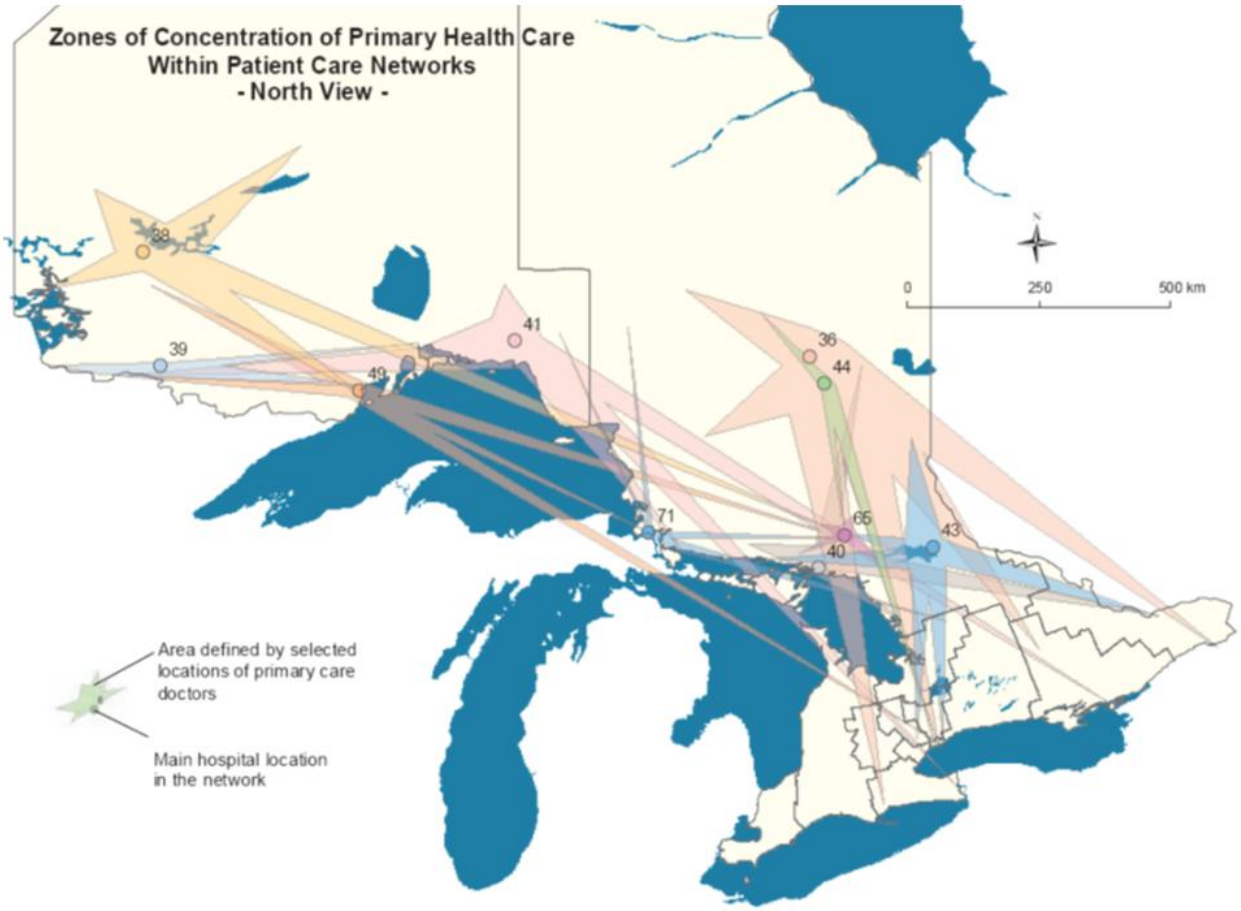
Source: *Cancer Quality Council of Ontario*

4.2 Current State of Integration of Primary and Specialty Care in Ontario: An overall picture on what we know, what needs to change and how we can change

Dr. Rick Glazier, Senior Scientist and Program Lead of Primary Care and Population Health at the Institute for Clinical Evaluative Sciences (ICES), started by summarizing Canada's health care resources and use of services in comparison to other jurisdictions. Canada ranks below many developed countries in timely access to care, after hours care, emergency department use, use of non-physician professionals, chronic disease management, electronic medical records and quality improvement initiatives. With individuals citing family physicians as the provider visited by the most people within a year, it demonstrates the need for primary care as a strategy rather than a sector of the health system.

Since reforms from 2004, Dr. Glazier stated that Ontario physicians have been moving into blended capitation models of financial remuneration and into interprofessional teams. There are financial incentives for patient rostering, patient retention within the group, cancer screening, immunizations, and care for diabetes and other chronic diseases. However, he explained there is no formal publicly available robust evaluation with clear conclusions on the success of the investments. For example, access bonus fees have increased, but there is no evidence to suggest a change in timely or after-hours access to care. Participation rates in colorectal cancer screening have increased, but it is difficult to attribute the increase to the incentives due to a major media campaign. He also highlighted that inequities have been built into the system where people with low income and immigrants are poorly represented in capitation blended models and interprofessional teams.

Dr. Glazier discussed solutions, highlighting four recommendations including aligning activities and incentives, measurement for monitoring and accountability, support for quality improvement initiatives and for implementing best practices including open access scheduling and care coordination. He spoke to work happening at ICES on patient care networks by assigning patients to doctors according to rostering and virtual rostering. Family physicians are assigned to hospitals where their patients are admitted and specialists to where they work, which are then aggregated into small networks to achieve a population of 50,000. The diagram below shows the 'spider webs' of existing patterns of how care is provided, which begins to establish the basis for virtual accountable care organizations aimed to assist in local quality improvements, health system integration and decision-making. Implementation is proposed for use through the bestPath initiative, led by Health Quality Ontario (HQO) for readmissions, safety and avoidable admissions and Health Links for high users. Dr. Glazier concluded that with appropriate support, cross-sectoral networks, which can be measured, reported publicly and have accountability, may address health system needs.



Source: *Glazier (2012) 'Current State of Integration of Primary and Specialty Care in Ontario: An overall picture on what we know, what needs to change and how we can change' (Presentation at CQCO 2012 Signature Event) Slide 54. Toronto, November 29, 2012*

5.0 International Comparison and Drivers of Primary Care Integration

5.1 Improving Care Coordination for Patients with Chronic Illness: Learning from international experience

Dr. Robert Bell presented on behalf of Robin Osborn, Vice President and Director, International Program in Health Policy and Innovation, The Commonwealth Fund, due to personal circumstances. The Commonwealth Fund has a number of partners and co-funders in Ontario including Health Quality Ontario and the Health Council of Canada. Dr. Bell presented results from the latest Commonwealth Survey (2012), of which there are two components, a provider survey and a patient survey. From the patient perspective, the Survey of Sicker Adults identified that in Canada seventy percent of chronically ill adults feel the system requires changes. Out of eleven countries, patients in Canada had the most difficulty in accessing a doctor or nurse for a same-day or next-day appointment and accessing after-hours care without going to the emergency room. Areas also requiring improvements were communication gaps and coordination issues between doctors and specialists and for the coordination of test results for appointments.

The Survey of Primary Care Physicians contained a number of questions related to the use of health information technology. Canada consistently did poorly with just over fifty percent of doctors using electronic medical records (EMRs) in their practice in 2012 compared to other jurisdictions including the Netherlands, United Kingdom, New Zealand nearing one hundred percent. Doctors in Canada have limited ability to generate computerized lists of patients by diagnosis or by drugs a patient is taking and has the least number of physicians who can electronically exchange patient summaries and test results with doctors outside their practice. In areas of care coordination and transitions, the majority of doctors in Canada do not receive information about changes to medications or care plans after a specialist visit or required information to manage a patient within forty-eight hours of a hospital discharge.

Dr. Bell highlighted a number of questions based on chronically ill patient responses regarding a medical home with about half of the patient population indicating they have a medical home (defined as having a regular doctor, timely access, has the patient's medical history and arranges care with other providers). The patient's without a medical home have greater rates of medical, medication or lab test errors, coordination gaps, and rated their quality of care as lower than those chronically ill patients with a medical home.

The presentation highlighted a few innovative examples from the Commonwealth Fund's perspective of changing practice including "virtual wards" in the NHS as well as Toronto and the United States. The "wards" comprised of predictive risk modeling to target care to patients at risk of emergency hospitalization. Other examples included disease management programs, re-designing patient flow with "open access" scheduling, and in Ontario, Family Health Teams were noted as an innovative model of care. Two opportunities for learning were the need for "meaningful use" of EMRs and leveraging the use of feedback on performance and incentives.

5.2 The Imperative for Integrating Care: The drivers for integrated care, the evidence and how to create the environment for change

Sir John Oldham, National Clinical Lead for Quality and Productivity at the Department of Health, participated via video, which can be found at www.cqco.ca/pc_integration. Dr. Oldham stressed the challenges healthcare systems face in industrialized countries with the increase in the number of individuals with comorbidities multiplying by 252% by 2015 who currently consume the majority of healthcare costs and specifically unscheduled admissions. The current response is separating the person into siloed parts, creating the potential for safety issues due to poor hand-offs and communication. Sir John Oldham suggests three key drivers, largely based on Wagner's chronic disease model, for integrating care. The first is to risk stratify your population with long-term conditions to have a reliable list or virtual ward that is systematically reviewed by an integrated care team in that locality. The second driver is to determine who is best situated to coordinate the patient's care and the third driver is to systematize and maximize the number of people or carers who can co-manage their conditions because evidence suggests it improves outcomes and increases the capacity and efficiency of the system. Most importantly, all the drivers need to be put in place.

However, he explained it is not sufficient to simply change the care model, the financial models need to reinforce the care models to ensure sustainability. In England, they are in the process of creating a year of care risk-adjusted capitation model for the tariff for monitoring people with chronic conditions by grouping population by risk stratifications of high, medium and low. They are asking providers, who transcend different sectors, to care for those people for a year with incentives for looking after people at home. The second change is to the Quality and Outcomes Framework where the three drivers have been included in the framework, accounting for thirty percent of GPs income. He emphasized that integrated care teams don't cost more money, but they must have providers work differently. Sir John Oldham described the progress that has already taken place with 35 million people in England served by integrated care teams and early outcomes such as a twenty-four percent reduction in unscheduled admissions and length of stay in parts of the country.

6.0 Case Studies

6.1 United Kingdom: Integrated primary and specialty care, the right care, at the right place, by the right person

Dr. Charles Alessi is a primary care physician, Chair of the National Association of Primary Care, Interim Chair of the NHS Clinical Commissioners and Senior Advisor at Public Health England. He described the financial and structural changes to primary care that have taken place in the United Kingdom since 2010. Legislation was enacted to push decisions for localities to localities by empowering clinicians to make decisions for their populations. These changes tie clinical behaviours to fiscal consequences and begin to move to a population health model of care. Dr. Alessi explained that clinicians are required to participate in clinical commissioning groups formed around communities and these groups manage seventy percent of the National Health Service (NHS) resources at the local level in a capitated based system. Because social care was selected as a determinant in the model, there are health and welfare boards and social care assisting each commissioning group. They are also thinking about what it means to corporatize the organizations of primary care

to make it more predictable, homogeneous and use metrics to increase transparency while balancing these changes with community and personal contact.

He explained that they are moving to year of care funding models, which fund patients with a whole host of conditions in primary care. This is challenging because hospitals are paid on levels of activities and the primary care tariffs do not equate to the costs of care. He emphasized the incentives for primary care involvement needs to be a zero sum gain. Issues considered are funding secondary care through primary care to begin managing the health budget as a whole and how to measure the outcomes of these grouped conditions based on patient-reported outcomes and patient experience. They view an opportunity to commission for outcomes, for example pharmaceutical companies receiving gain share for using a drug, directly resulting in a reduction of acute admissions. Other areas of focus include looking at non-health determinants, non-treatment options, empowering patients by educating them sooner, reaching out to populations prior to them contacting primary care, and training and resource requirements when navigators may not need to be clinical.

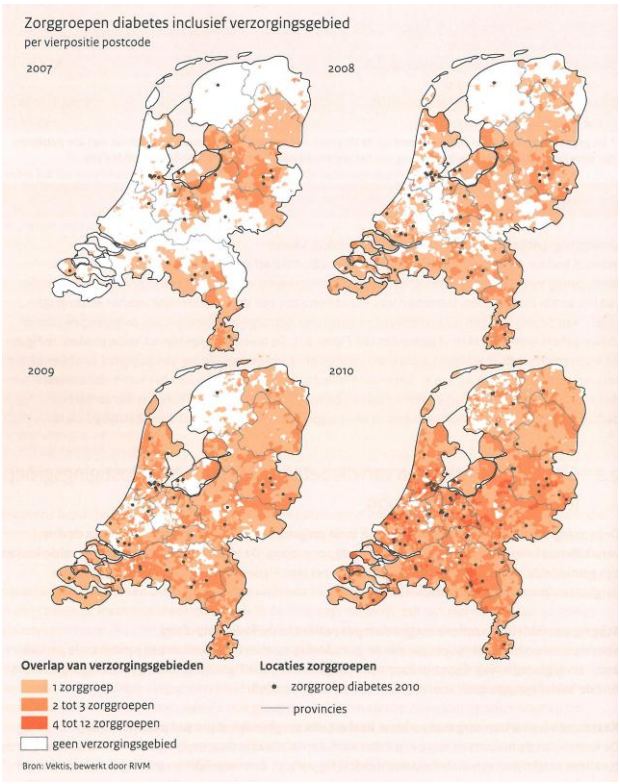
6.2 Netherlands: Integrated care, achieving better coordination of care for the chronically ill

Dr. Dinny deBakker, Head of the Research Department at the Institute for Health Services Research (NIVEL), recently Chaired a committee evaluating the bundled payment system of care, introduced in 2010 with an aim to achieve better care coordination for the chronically ill. He provided an overview of the Netherlands' healthcare systems beginning with the implementation of universal mandatory health insurance and the introduction of market elements including competition between insurers to contract high quality care at a low cost. General Practitioners (GPs) receive payments through a capitation and fee for service and they are increasingly working in small group practices. They use electronic medical records and have electronic interchanges for services such as hospitals and pharmacies and are increasingly using systems where providers can be seen and participate in the system. He described one particular referral system that is a private initiative free to GPs and paid for by hospitals who advertise to gain access to patients through the system.

Dr. deBakker explained that despite high scores on equity, access and quality in the system, collaboration within primary care and between primary and specialist care is an area that needs improving and the latter is hindered by differences in financing resulting in a lack of coordination for the chronically ill. A bundled payment system was introduced for type 2 diabetes, COPD and vascular risk management to resolve these issues. The fee was negotiated between insurers and the care group whereby the care group, comprised of GPs, was responsible for the organization and delivery of care including subcontracting to other providers such as physiotherapists and specialists participating on a consultative basis. The care takes place according to disease specific standards with performance indicators set by a multidisciplinary team covering the care continuum outlining the treatment, but exclude the type of provider to allow for care groups to use different forms of care. The bundled payment did not include all costs for the patient such as costs resulting from other complaints or hospital costs. Prices were kept at a reasonable level by competition among care groups and subcontractors.

Rapid growth of diabetes care groups

- Owned by gp's
- 50 – 100 gp's
- Av 6500 patients
- GP, nurse, dietician, internist, ophtalmologist



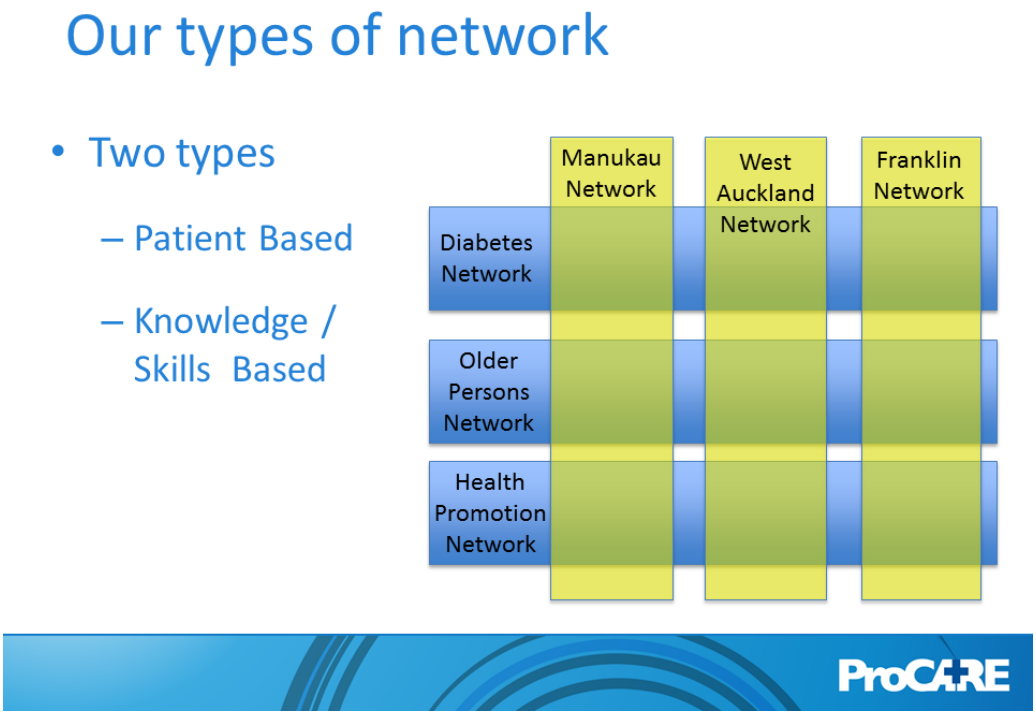
Source: *deBakker (2012) Integrated care: achieving better coordination of care for the chronically ill Lessons from the Netherlands Bundled-Payment Initiative'. (Presentation at CQCO 2012 Signature Event) Slide 17. Toronto, November 29, 2012*

Dr. deBakker outlined the key results from the report submitted in 2012 reviewing the bundled payments. The main conclusions were networks of care groups across the country were organized in a short time shown in the diagram above, some positive effects on quality of care including guideline adherence, routine check-up carried out by practice nurses and small effects on outcomes such as blood sugar levels for diabetes patients. Cost analysis showed that there were higher costs initially but measures were too early to provide definitive answers on effects to cost and quality of care. Areas for improvement highlighted were the need for quality assurance and transparency in the care groups, further inclusion of the patient in policy changes and self-management, resolving issues of competition and regional monopolies and finally the exclusion of costs related to comorbidities in the bundled payments.

6.3 New Zealand: Strengthening integration between primary and specialist care for patients with multiple chronic conditions

Mr. Paul Roseman, Senior manager of Healthcare Integration at ProCare Health, provided a brief overview of the health system in New Zealand and described their model of networks and integration. He described their system as set up by hospitals known as District Health Boards, which serve a duel function of providing secondary care and distributing funding for the population in the region. New Zealand has focused reforms on the 'micro-decisions' made by patients and clinicians to support them in better decision-making. Work is completed through the use of patient-based networks for which there's a common

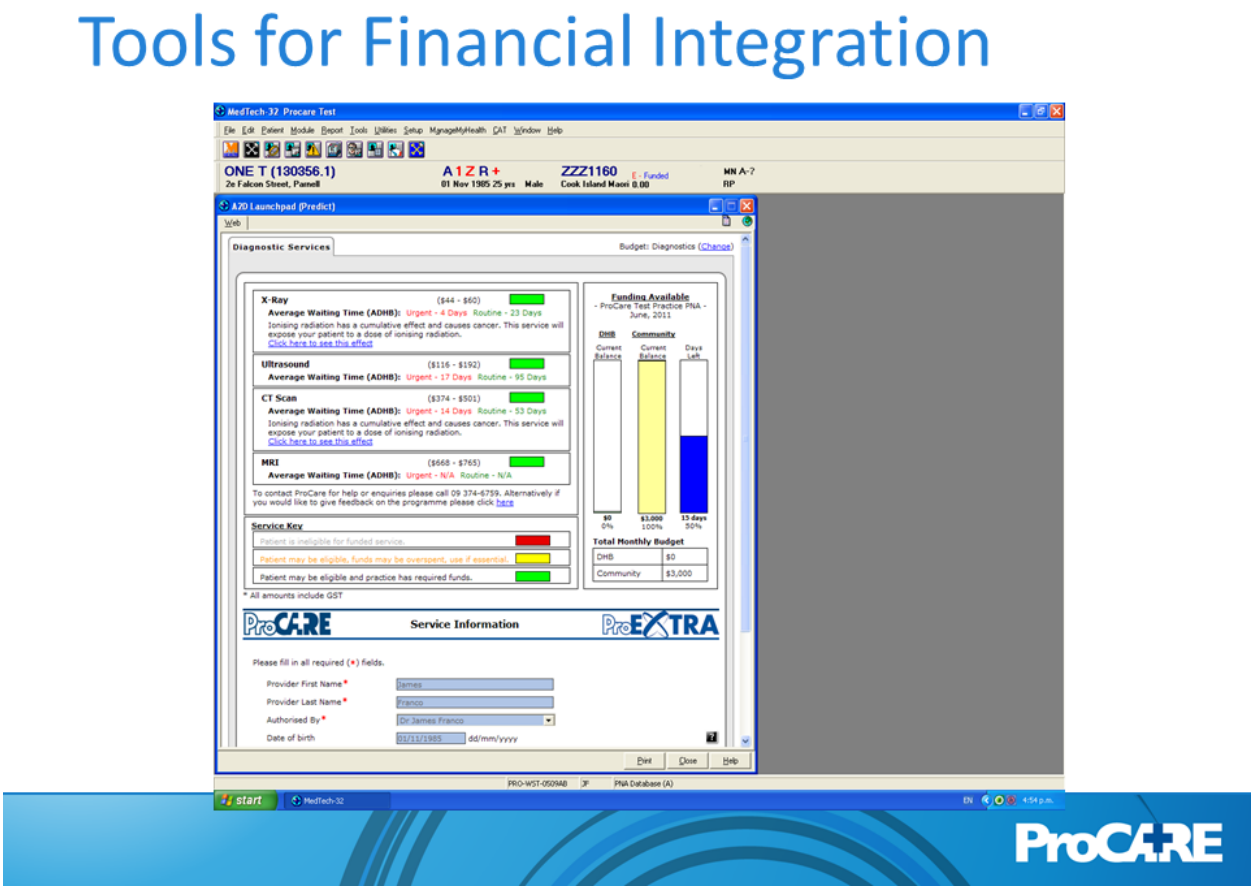
population and knowledge/skills based networks consisting of care plans that would be consistent across patient networks, but implemented by the locality seen in diagram below.



Source: *Roseman (2012) 'Strengthening Integration to Improve Care in New Zealand' (Presentation at CQCO 2012 Signature Event) Slide 5. Toronto, November 29, 2012*

Mr. Roseman described the model of network development or integration that they use from the Nuffield Trust with six different integrative processes including normative, information, clinical, financial, administrative and organizational of which he reviewed the first five as they consider organizational to be less critical. He shared the importance of normative integration to ensure there are shared common beliefs and measurable goals. In order to measure the goals, they need an understanding of the population and have ninety-eight percent enrolled in a primary care medical home. He described the importance of building trusted relationships and in one example he described how in a tertiary hospital they are building multidisciplinary teams oriented to one patient-based network or locality. Information integration is the second area where instead of focusing on 'warm hand-offs', (shared time between providers to ensure no patient is referred without all their providers understanding of the next steps), they have shared health records where providers are invited into the patient's record with a task. Currently, New Zealand has one hundred percent computerization in general practice and are able to extract information from one GP system and import it into another, allowing them to analyze data. They have performance indicators with nested suites of indicators that translate to specific tasks, which when improved, achieve an outcome for the higher level indicators. Mr. Roseman suggested that because Canada is in the earlier stages of computerization, there is an opportunity to create a good set of standards and be strict about their enforcement.

Clinical integration is the third area in which they are looking at taking a more systematic approach to care delivery by risk stratifying the population to identify those at risk of readmission to hospital and frequent users of GPs. They have created multidisciplinary interventions for high intensive users to reduce the number of hospital bed days they would use. The fourth type of integration is financial and they are using technology to demonstrate resource availability through virtual budgets. For example, they have a visual in practice management systems, which shows the expected resources of a practice for a month beside the percentage of the month left seen in the diagram below. Another example he shared was from secondary care experiencing a twenty-five percent reduction in inappropriate referrals by creating a list of criteria for referrals as a quality improvement initiative. Mr. Roseman stated they are demonstrating accountability through risk-sharing agreements and designing aligned incentives. Part of risk-sharing includes pooling risk by looking at innovations, for example, to reduce the need for hospital growth. The fifth type of integration is administrative by resolving the networks to a size where the locality has all the specialists they require but are a manageable size for providers to know one another. He also described work in community pharmacy, in which the new contract took away eighty percent of dispensing fees and increased payments for long-term conditions to encourage collaboration with primary care.



Source: *Roseman (2012) 'Strengthening Integration to Improve Care in New Zealand' (Presentation at CQCO 2012 Signature Event) Slide 31. Toronto, November 29, 2012*

7.0 Rapid Rounds

Event participants volunteered to participate in a Rapid Rounds session to share their best ideas and tangible solutions for primary care integration. The list of presenters can be found in Appendix 3. There were three groups of presentations on the topics of models, tools and networks.

7.1 Presentations on Models

BRIDGES Model

Dr. Onil Bhattacharyya, a Clinician Scientist with the Keenan Research Centre of the Li Ka Shing Knowledge Institute of St. Michael's Hospital, presented Building Bridges to Integrate Care funded by the Ministry of Health and Long-Term Care Health Quality Branch and based at University of Toronto Department of Family and Community Medicine. The purpose of the project is to reduce the cycle time from new idea to new model, increase success rates of new models and build a community of partnerships for primary and specialty care and community services for the highest users of the system. The BRIDGES approach includes soliciting ideas from the front line and selecting innovative ideas based on scientific merit and review by system stakeholders. Successful applicants receive up to two years of support in terms of finance, intervention and evaluation design, and data management. The most promising projects are then scaled up in partnership for example with Health Quality Ontario.

SCOPE Model

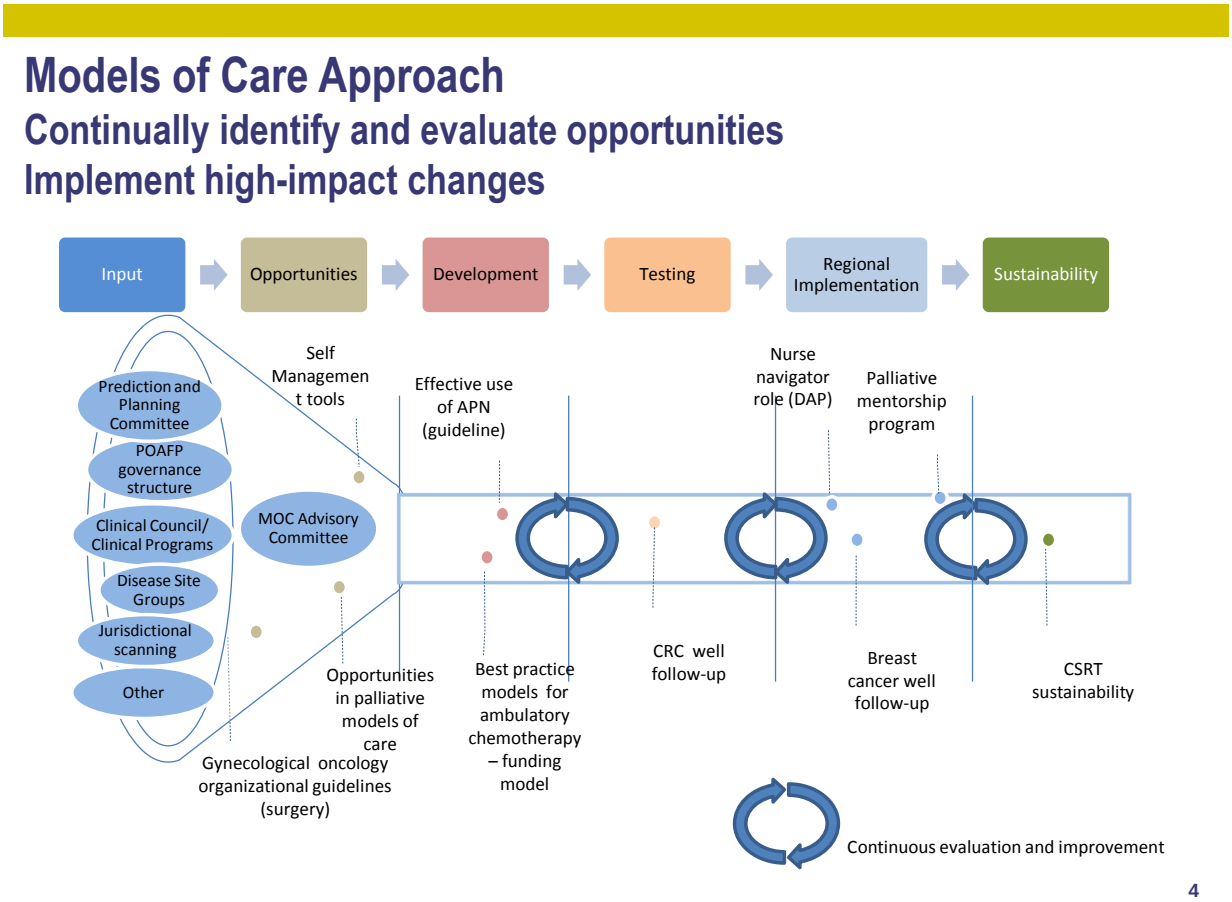
Dr. Pauline Pariser, Associate medical Director and Primary Care Lead for University Health Network, highlighted three interventions comprising the Seamless Care Optimizing the Patient Experience (SCOPE) model. These include a navigation hub with availability of a nurse or community care access centre (CCAC) navigator, an internist on call to respond to queries quickly, and patient results on-line to improve connectivity. The model's strategy identifies needs to inform interventions, engages at the grassroots to improve relationships and work with patients to manage their conditions, quality improvement initiatives through the BRIDGES project and measures how SCOPE is making an impact.

Models of Care Program

Ms. Jillian Ross, Director of Clinical Programs, Strategy and integration at Cancer Care Ontario, described the work being undertaken as part of the strategic priority in the latest Ontario Cancer Plan on developing and implementing innovative models of care delivery. The Models of Care approach comprises an ongoing repetitive cycle of developing opportunities for new models of care, carrying out testing followed by regional implementation and finally building them into sustainable models, seen in the diagram on the next page. A multidisciplinary body helps identify models utilizing both forecasting and evaluation models to understand their impact. Examples of work include a mentoring program in palliative care with primary care providers, the Diagnostic Assessment Program and the use of nurse navigators, implementing evidence-based best practices for well follow-up care and working with teams developing new funding models to ensure they promote the appropriate models of care and scopes of practice.

Considerations for models:

- Communication between primary and specialty care is enhanced when there are more formal mechanisms such as the use of on-line tools and collaborative opportunities.
- Commitments were made to take a more user-centric approach when selecting interventions and to use patient and family advisory groups similar to physician advisory groups.



Source: *Ross (2012) 'Cancer Care Ontario's Models of Care Program' (Presentation at CQCO 2012 Signature Event) Slide 4. Toronto, November 29, 2012*

7.2 Presentations on Tools

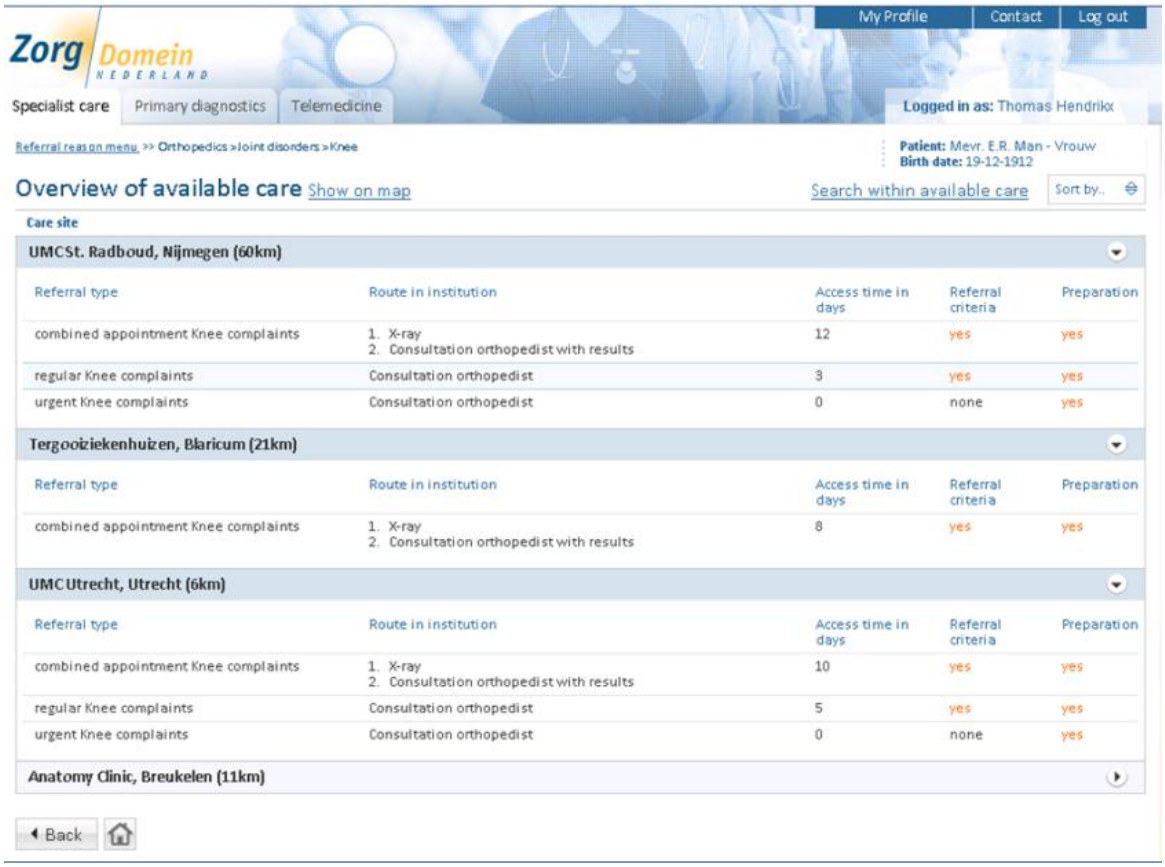
Primary Health Care Data Integration Program

Mr. Gregory Webster, Director of Primary Health Care and Clinical Registries at the Canadian Institute for Health Information (CIHI), highlighted the importance of properly implementing electronic medical record data standards to support primary care delivery, measurement and improvement. Data is needed at the practice and system level with better coordination from sources including EMR, administrative and surveys from patients and providers. CIHI has a program of work focused on some of these gaps for indicators

and measures and co-led a summit with Health Quality Ontario to begin to get agreement on the core set of priority measures for primary care for Ontario. CIHI, Infoway and other jurisdictions across Canada have agreed on a minimum data set that should be embedded in primary care EMRs. On the development side, he explained about the voluntary reporting system where they receive EMR data from over 200 physicians across Ontario and provide them with feedback reports.

Dutch Referral System

Dr. Doug Woodhouse, Executive Director of Apix Performance, presented a referral solution widespread across the Netherlands with an uptake of eighty percent of family physicians, sixty percent of hospitals and processes more than one million referrals a year, seen in the diagram below. The key aspects of its success are it helps find the appropriate service to meet patients needs by managing the supply and demand of the referral services, it provides a structured way of communicating between healthcare providers increasing the efficiency of the process and raises the quality of the referral and treatment through a directory of appropriate services, expected pathway, information to judge the appropriateness to view with the patient. The system also empowers the family physicians to assess the urgency of the referral to override access times and empowers the patients to involve them in the decision-making process.



Source: *Woodhouse (2012) 'Dutch Referral System' (Presentation at CQCO 2012 Signature Event). Toronto, November 29, 2012*

eReferral Project

Dr. Darren Larsen is the Senior Physician Peer Lead of the Quality, Partnerships and Integration at OntarioMD and a member of the CQCO. Dr. Larsen introduced the concept of a Provincial eReferral Project being created by OntarioMD on behalf of eHealth Ontario. This was delivered as a proof of concept and business framework on December 31, 2012. The goal of the project is to connect primary care providers and patients from systems in the community via EMRs through the health information access layer, to systems in the specialist world including individual providers and regional programs. He explained the development process of bringing together a group of providers including family physicians, nurse practitioners, specialists and programs to perform an international jurisdictional scan, work through referral scenarios and patient case examples, and provide a provincial model for consideration for approval.

Considerations for tools:

- Important to create linkages between EMRs so data can be translated rather than stored.
- Balanced approach to privacy where interests of patients are protected while information can be exchanged; 'privacy by design'.

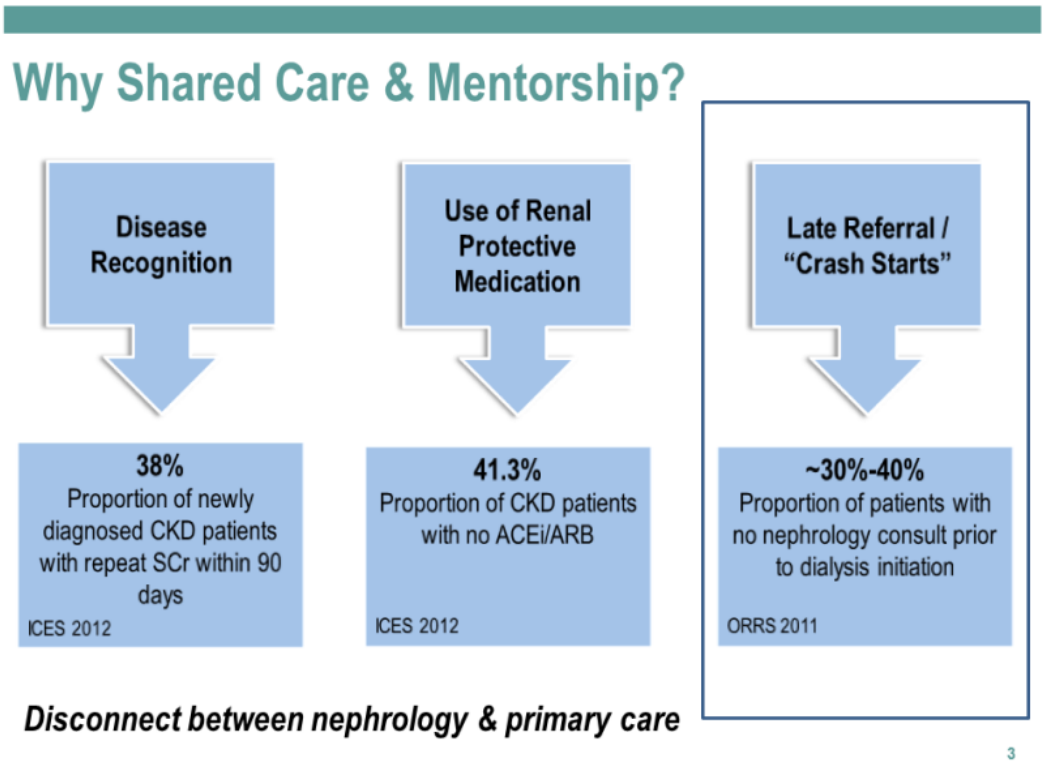
7.3 Presentations on Networks

Physician Directory

Dr. Lee Donohue, Primary Care Lead for the Champlain Regional Cancer Program in Ottawa, spoke about the creation of a regional collaborative space where providers can go with ideas, meet with others and speak electronically. In addition to the Directory, the region has initiated e-consultation and a Clinical Document Repository translating information for use at point of care. They currently have over 4000 users from across 500 organizations.

Mentee Program

Ms. Nurin Thawer, Program Manager for Renal Clinical Programs at the Ontario Renal Network (ORN), shared the recent launch of the ORN's Mentorship pilot program between primary care providers and nephrologists initiated from the recognition that thirty to forty percent of patients have no nephrology consult prior to beginning dialysis, seen in the diagram on the next page. Through consultation with the Ontario College of Family Physicians (OCFP), the ORN established a mentoring network. The pilot has begun with seven nephrology mentors, two hundred primary care mentees including physicians who are eligible to receive credits from the OCFP, and nurse practitioners. They engage in a variety of interactions such as small group sessions, email and telephone to build relationships. ORN will evaluate the pilot to assess the demand and feasibility of a provincial mentoring network.



Source: *Thawer (2012) 'Ontario Renal Network Mentorship Pilot Program' (Presentation at CQCO 2012 Signature Event) Slide 3. Toronto, November 29, 2012*

Collaborative Cancer Care Network

Jan Kasperski, Chief Executive Officer of the Ontario College of Family Physicians (OCFP), spoke about the on-going work of the OCFP on developing collaborative networks over the last twelve years starting with the mental health care network, which currently has six hundred family physicians and sixty specialists. Cost sparing coaching and mentoring models bring the expertise of specialist colleagues to family physicians for patients that are generally more complex and have higher use of urgent care and prevents patients from being the navigator and having to carry information from secondary to primary care. The College connects GPs who have a focused practice or interest in an area and pairs them with a specialist to provide them with evidence-informed medicine organized in small groups with almost immediate responses and is also used in journal club experiences. She highlighted the opportunity to have a collaborative cancer network across the whole patient journey and build on work already happening for example in palliative care.

Proposal on Cancer Care/Primary Care Integration

Dr. Sandy Buchman, Primary Care Lead for the Toronto Central Regional Cancer Program is Co-Chairing a Steering Committee consisting of a partnership with the Canadian Partnership Against Cancer, the College of Family Physicians Canada and the Canadian Association of Provincial Cancer Agencies to guide an initiative focused on improving transitions between primary and oncology care and back again to focus on the patient experience. The scope includes particular disease site groups, breast, prostate, colorectal and hematological, which are commonly seen in primary care where primary therapy has concluded. Initiatives

should address areas of accountability, roles, communication issues, education and patient and family empowerment with a measurement component from beginning to end. The diagram seen below, identifies a number of potential outcomes and measures of the projects.

Outcomes •(Tactics)	Potential Measures
Improve transitions of care between cancer and primary care •survivorship/transitional care plans, practice guidelines, nurse navigation • define roles & responsibilities of HCPs	% increase in number of patients transferred to primary care for follow-up when active treatment ends
Enhance quality of care • Education initiatives for oncologists to improve understanding & confidence about primary care • Improve Knowledge in Primary Care Cancer care •Fully Integrated EHR between RCC/Hosp & Community	Accessibility, effectiveness and safety of treatment measures Adherence with follow-up guidelines % increase in primary care accessible 24/7 or longer after-hours availability
Increase system efficiencies •Improved communication •Innovative funding models	% decrease in number of ER visits % decrease in oncology appointments % decrease in patient utilization statistics
Improve the patient experience •Patient empowerment • Clarify roles & expectations of patients & families •Address cultural issues	% increase in patient satisfaction rates with continuity of care, emotional distress through patient surveys, interviews, focus groups % increase in health care provider satisfaction

Source: *Buchman (2012) 'CPAC Proposal on Cancer Care/Primary Care Integration' (Presentation at CQCO 2012 Signature Event) Slide 3. Toronto, November 29, 2012*

Considerations for networks:

- Networks are striving to assist family practices in real time and there are other jurisdictions who Ontario can look to for examples such as British Colombia's Rapid Access to Consultative Expertise (RACE) line. The "RACE" line provides family physicians and other primary care providers with just-in-time access to specialist expertise with the intention that the primary care provider manages the patient care without having to refer to a specialist or to the emergency department.

8.0 Panel Discussion

Dr. Adelsteinn Brown, member of the CQCO and Director of the Institute of Health Policy, Management and Evaluation at the University of Toronto, moderated a panel discussion about how primary and specialists care links can be strengthened. Panelists comprised a

number of perspectives from point of care including a patient, nurse navigator, medical oncologist, surgical oncologist and family physician.

8.1 Katharina Sammut, patient

Ms. Katharina Sammut described her experience as a patient beginning at age 18 when she presented symptoms that proved challenging to diagnose. She sought both medical and natural treatments from other jurisdictions before she found a 'medical home' at a hospital in Ontario. During this time, Ms. Sammut had minimal contact with a primary care provider. When she was diagnosed with chronic kidney disease, she began in-centre dialysis and expressed disappointment in the lack of information provided to her regarding the risks of previous treatments for CKD and with the poor quality of life due to the timely in-centre treatments. She learned about the Nocturnal Home Dialysis informally from a nurse at the program and she researched the program herself. Her experience in the program has empowered her to manage her own health, but she also has strong communication with providers including the option to email her nephrologist with urgent issues.

8.2 Sue Stein, nurse navigator

Ms. Sue Stein described the Diagnostic Assessment Programs (DAPs) patient-centred approach to coordinating care for patients and families by creating a single point of access for regional diagnostic services specifically for the suspicion to confirming diagnosis phase of the patient journey. Her navigator role liaises between patients and their families, providers and services to assist primary care in accessing timely services and providing the patients with a guide and advocate who monitors their symptoms and communicates with the appropriate teams. The navigator improves the patient experience through enhanced communication, education, support and empowerment. DAPs are organized differently between regions depending on the region's needs. For example, Ms. Stein works in a lung DAP, working out of three sites with four thoracic surgeons, thirteen respirologists and primary care leads as well as peripheral hospitals requiring her work to be mostly virtual.

8.3 Peter Anglin, medical oncologist

Dr. Peter Anglin provided his perspective from working in a community cancer centre. He highlighted issues of family physicians knowing the 'least line of resistance' to have their patients seen in a facility, detachment from primary care once patient is in the cancer system with updates that are not timely and the lack of clarity surrounding roles and responsibilities of primary care physicians at the time of treatment as well as after. Dr. Anglin is currently involved in an initiative with Cancer Care Ontario engaging primary care to manage follow-up care of cancer patients during their survivorship phase. He expressed the need to make the system sustainable and suggested a more autocratic approach to define who should be doing what at a system level.

8.4 Peter Stotland, surgical oncologist

Dr. Peter Stotland is a surgical oncologist working between a large teaching hospital and a community hospital. He describes to his patients the journey from diagnosis to survivorship and one of the most important parts of work has been the realization of the DAP program. The nurse navigator is a direct line for helping navigate the system and his patients have had positive experiences with the program. Dr. Stotland highlighted the need for leadership to bring about the changes required for seamless transitions.

8.5 Scott Wooder, family physician

Dr. Scott Wooder, a family physician, described his recent work with negotiating the Physician Services Agreement with the Ministry of Health and Long-Term Care to make evidence-informed changes to the way care is funded. The new models of care will have to either demonstrate a reduced cost or offset another cost and lead to improved patient outcomes and patient experience. Dr. Wooder highlighted an existing primary care integration project in Hamilton for medically complex patients that requires measurable improvements or funding would be withdrawn. Project leaders have six months to develop a model of care, which would include home visits, education reviews, virtual visits, communication with Community Care Access Centres or other community providers, secondary and tertiary specialists in hospital with demonstrated results in for example, decreased morbidity or mortality, improved patient experience, fewer admissions to hospitals and emergency rooms, and savings in hospital budgets.

7.6 Discussion Highlights

- Pilot projects need to have targets, be evaluated and financial investments should be available to scale up the successful projects.
- Facilitate personal communication to ensure 'warm hand-offs' through the system while ensuring system design includes interprofessional teams to ensure to coordinate care.
- Specialist and primary care roles during the transitions need to be clarified to ensure the optimum use of resources for high quality care.
- Models of care need to include and empower the patient.
    - Provide opportunities for patient to meet one another and interface with physician to put a face to the experience.
    - For example in Thunder Bay, the Oncology Interactive Navigator is a resource for the patient to have for their care plan.

9.0 Breakout Discussion Highlights

Virginia McLaughlin, Vice-Chair of the Cancer Quality Council of Ontario introduced, the Breakout Session to discuss the next steps and who needs to be involved. Participants were grouped by geography via their Local Health Integration Network and discussed one of three topics along the patient journey; transitions from suspicion to treatment; coordination of follow-up care, surveillance, rapid re-entry, palliative and/or end-of-life care; and the provision of on-going (non-treatment related) supports. The purpose of the discussions was to identify the highest priority for action, which solutions could be implemented immediately, and identifying the necessary groups and their responsibilities. Near the end of the breakout session, three groups provided highlights from their discussion, which are summarized in this section. (See Appendix for the list of participants and for the full detailed notes from each breakout discussion topic.)

9.1 Smooth transitions from suspicion to diagnosis to treatment

- Examine the use of Diagnostic Assessment Programs (DAPs), currently funded by CCO, as a best practice for other disease sites.
- Navigators can be a resource to create connections and bridge gaps for patients but, are not a 'Band-Aid' for problems that can be simplified by improving system design.
- Information technology should be maximized as a valuable tool to navigate the system and assist patients with self-management and providers with clinical guidance. For example, Champlain LHIN's primary care and specialist e-referral e-consult system.
- Use diagnosticians to trigger best practice. For example, in North East LHIN, they have a standardized recommendation for chest x-rays for referral to lung diagnostician or surgeon.
- Clear roles of practice for primary care and specialists that can be tailored to local context by determining natural networks.
- Provide multiple mechanisms and opportunities for communication between primary care and specialists.
- Involve patients and families as partners in solutions.

9.2 Follow-up, surveillance and rapid re-entry for treatment of a recurrence and/or end-of-life care

- Use current resources to expand the navigator role with existing nurses and others.
- Produce passports to guide patients through follow-up care and work into electronic medical record.
- Utilize existing funding structures with the addition of fee codes for telephone and email consultations as well as promoting virtual networks.
- Involve patients and families as partners in solutions.

9.3 On-going (non-treatment related) supports

- Involve patients and families as partners while making changes to the system.
- Ensure equitable access to psychosocial support services including standard assessment building on CCO's existing tool for cancer that could be applied outside care.
- Risk stratify patient populations to anticipate future health needs.
- Look at other options to nurse navigators such as health coaches.
- Ensure patients have a medical home to guide patients to resources.
- Encourage the use of email between patients and providers with an emphasis on higher risk patients.

10.0 Commitments Panel

For the final session of the day, Dr. Robert Bell moderated a panel discussion on commitments from a number of leaders in organizations with a role in primary care integration. Commitments focused on building structures to enable the inclusion of patients and families in system decision, defining clear accountability structures for primary care while encouraging more flexibility in the process of how the outcome is achieved, fostering leadership through educational opportunities for providers within primary care and focusing on initiatives which improve transitions within the health system.

10.1 Cancer Care Ontario

Michael Sherar, CEO and President of Cancer Care Ontario (CCO), stated that his organization is working to better integrate primary cancer into the health system for cancer and chronic kidney disease. Current activities includes supporting primary care providers to help increase screening rates, integrating primary care with palliative care to have more decision supports earlier in the patient journey, examining the best use of skills through the new Models of Care Program, establishing a mentorship program for family physicians and nephrologists through the Ontario Renal Network, supporting work by nurse navigators through the Diagnostic Assessment Program to assist in organizing the patient's journey and investing in leadership of primary care regional leads.

10.2 Health Quality Ontario

Ben Chan, former CEO and President of Health Quality Ontario, focused on two initiatives, BestPath, which offers tools and supports to better integrate care and Health Links, which is focused on developing regional structures for care. Dr. Chan discussed the anticipated supports of the package with of specific initiatives across the province such as the need to address readmissions by identifying patients based on their risk and triaging high risk patients to more robust levels of care. Then, establishing timelines for these high risk patients to receive home care and primary care appointments, and ensure all patients have medication reconciliation, experience 'warm hand-offs' from one provider to another, understand their care instructions through 'teach-back' methods will be important. Finally, Dr. Chan spoke about having a repository of best practices to disseminate practices and organize assistance with coaching for example.

10.3 Local Health Integration Network

Paul Huras, CEO of the South East Local Health Integration Network (LHIN), stated that LHINs have been committed to integration since their inception in 2006. There now needs to be accountabilities and alignment for primary care similar to how the LHINs are held accountable for the rest of the system. In order to meet the 2% environment outlined in the Drummond Report, it is necessary to align primary care and create accountability structures. At present, there are diverse resources in primary care and patients have unequal access to the resources. Primary care is situated to coordinate care for patients with high needs requiring multiple components that are not being met by the system. Organization needs to occur within primary care and with partners to share resources and set common targets. The LHINs are working with the Ministry of Health and Long-Term Care to overcome these challenges by having regions submit concepts and ideas with how clusters can move forward on improving transitions within the health system.

10.4 Ministry of Health and Long-Term Care

Susan Fitzpatrick, Assistant Deputy Minister of Negotiations and Accountability Management for the Ministry of Health and Long Term Care, stressed the need to create partnerships for change because no single entity can be successful on their own. An important component is learning best practices from other jurisdictions and implementing them with rapid cycle improvements. Patient experience will measure performance to ensure the system is focused on what's best for the patient and not what's convenient for providers. Ms. Fitzpatrick highlighted the need to 'do the right thing' will be driven by evidence and funding will then follow the patient. The Ministry of Health and Long-Term Care will create a low rules environment for innovation and a concentrated effort to remove barriers and align incentives.

10.5 Ontario College of Family Physicians

Jan Kasperski, President of the Ontario College of Family Physicians (OCFP), stated that her organization is best placed to understand family practices. OCFP has established Leadership Connect, which comprises all the physicians who have a leadership role in practice by LHINs and by referral patterns. The OCFP also provides small group facilitated learning opportunities and can assist in bringing leadership within the profession they represent to collaborative agendas such as working with Cancer Care Ontario on screening and palliative care. Encouraging family-centredness focuses on improving communication with the patient and family as well as communicating between providers to not rely on patients to carry information across the system.

10.6 Ontario Medical Association

Ron Sapsford, CEO of the Ontario Medical Association, highlighted his organization's generative discussion around key issues facing the system, including quality, improving the primary care experience and integration of health services. The OMA is committed to advocating to the profession about the importance and need for alignment of primary care and to rest of system on the best ways to achieve alignments by engaging clinicians with decision-making in local community, identifying barriers and opportunities to reforms to lever agenda forward, providing education to the profession as needed, identifying the infrastructure needs for these changes, identifying engagement opportunities at the local level, continuing their leadership training program, continuing support for subsidiary organization, OntarioMD, and additional e-solutions for health records, extending the peer physician program, continuing advocacy with eHealth Ontario for funding more initiatives to improve functionality of electronic systems in primary care offices and helping providers and practices who might be left out.

10.7 Registered Nurses' Association of Ontario

Doris Grinspun, CEO of the Registered Nurses' Association of Ontario, stated that registered nurses have always been anchored in a primary care framework. The need to strengthen primary care was an impetus for the RNAO to publish a report recommending the restructuring of community services starting with primary care networks to move to a patient-centred system with patient and family councils at each LHIN. Ms. Grinspun stressed that the resources are available, provided the system utilizes the full scope of practice for nurses and other providers. Registered nurses are prepared to become the system navigators, care coordinators and case managers for patient including case workers in Community Care Access Centres, who can be transferred to primary care. It is the RNAO's belief that LHINs should have the responsibility of system planning and accountability for all health sectors.

11.0 Final Words

Dr. Bob Bell thanked the international, national and local speakers and everyone who participated in the day. He also recognized the efforts of the members of the CQCO, the Steering Committee and working group members who helped shape the content for the event. Dr. Bell explained that the views heard throughout the day will be included in a proceedings document with recommendations. Most importantly, he expressed that CQCO looks forward to continued collaboration to create a more integrated system.

Appendices

Appendix 1:	Agenda of the CQCO 2012 Signature Event held on November 29, 2012
Appendix 2:	Speaker Biographies of the CQCO 2012 Signature Event
Appendix 3:	Rapid Rounds Session, 10:45am-11:45am
Appendix 4:	Attendee List for CQCO 2012 Signature Event
Appendix 5:	Summary of Breakout Discussions, 3:05pm-4:00pm

CQCO Cancer Quality Council of Ontario

The Cancer Quality Council of Ontario is pleased to present our Ninth Annual Signature Event.

Align • Bridge • Collaborate

Strengthening primary and specialist care links for seamless patient care

Marriott Bloor Yorkville
90 Bloor Street East
Toronto, Ontario
7:30am – 5:00pm

The Cancer Quality Council of Ontario (CQCO) advises Cancer Care Ontario and the Ministry of Health and Long-Term Care in their efforts to improve the quality of cancer care in the province. For more information, go to **cqco.ca**

Ontario
Cancer Care Ontario
Action Cancer Ontario

Morning:

7:30 am	**Registration and continental breakfast – Forest Hill Ballroom**	
8:00 am	**Welcome and Overview of the day**	**Robert (Bob) Bell** – Chair of Cancer Quality Council of Ontario [CQCO Event Co-Host] **Understanding the bigger picture: The landscape of primary care integration**
8:15 a.m.	**Current State of Integration of Primary and Specialty Care in Ontario: An overall picture on what we know, what needs to change and how we can change**	**Keynote speaker: Rick Glazier** – Senior Scientist and Program Lead of Primary Care and Population Health, Institute for Clinical Evaluative Sciences, Ontario, Canada
8:45 a.m.	**Q & A**	
8:55 a.m.	**Improving Care Coordination for Patients with Chronic Illness: Learning from international experience**	**Keynote speaker: Robin Osborn** – Vice President and Director, International Program in Health Policy and Innovation, The Commonwealth Fund, New York City, United States
9:25 a.m.	**Q & A**	
9:35 a.m.	**The imperative for integrating care: The drivers for integrated care, the evidence and how to create the environment for change**	**Via pre-recorded video: Sir John Oldham** – National Clinical Lead, Quality and Productivity, Department of Health, London, United Kingdom
9:45 a.m.	**Case Study: United Kingdom** **Integrated primary and specialty care: The right care, at the right place, by the right person**	**Charles Alessi** – Chair of the National Association of Primary Care, Senior General Practitioner and partner of a large group practice in Kingston upon Thames, United Kingdom
10:15 a.m.	**Q & A**	
10:25 a.m.	**Refreshment & Networking Break**	
10:45 a.m.	**Rapid Rounds**	Select attendees share their best ideas and tangible solutions for integration between primary and specialist care.
11:45 a.m.	**Lunch**	

Afternoon:

12:30 p.m.	**Open Panel Discussion** Open discussion about how we strengthen primary and specialist care links. **Panel moderator: Adalsteinn (Steini) Brown** – Director, Institute of Health Policy, Management and Evaluation, University of Toronto	**Panel speakers:** **Katharina Sammut** – Patient representative, Cobourg, Central East LHIN **Peter Anglin** – Medical Oncologist, Stronach Regional Cancer Centre, Central LHIN **Peter Stotland** – Surgical Oncologist, North York General Hospital, Central LHIN **Scott Wooder** – Family Physician in Stoney Creek, Hamilton Niagara Haldimand Brant LHIN and President-Elect, Ontario Medical Association **Sue Stein** – Diagnostic Assessment Program Nurse Navigator, South West Regional Cancer Program, South West LHIN
1:30 p.m.	**Case Study: Netherlands** **Integrated care: Achieving better coordination of care for the chronically ill**	**Dinny de Bakker** – Head of Research Department, Netherlands Institute for Health Services Research (NIVEL) Utrecht, The Netherlands
2:00 p.m.	**Q & A**	
2:10 p.m.	**Refreshment & Networking Break**	
2:25 p.m.	**Case Study: New Zealand** **Strengthening integration between primary and specialty care for patients with multiple chronic conditions**	**Paul Roseman** – Senior Manager, Healthcare Integration, ProCare Health Limited, Auckland, New Zealand
2:55 p.m.	**Q & A**	
3:05 p.m.	**Breakout Group Discussions** **Key question:** What are the critical next steps and which organizations need to be involved to support the bidirectional relationships throughout the patient's journey?	**Virginia McLaughlin** – Vice-Chair, Cancer Quality Council of Ontario, Toronto [CQCO Event Co-Host]
4:00 p.m.	**Commitments Panel** A collective declaration of commitment to work purposefully to improve integration. **Moderator: Robert (Bob) Bell** – Chair of Cancer Quality Council of Ontario, Toronto, Canada	**Panel members:** **Cancer Care Ontario: Michael Sherar** – President and CEO **Health Quality Ontario: Ben Chan** – President and CEO **Local Health Integration Networks: Paul Huras** – CEO, South East Local Health Integration Network **Ministry of Health and Long Term Care: Susan Fitzpatrick** – Assistant Deputy Minister, Negotiations and Accountability Management **Ontario College of Family Physicians: Jan Kasperski** – CEO **Ontario Medical Association: Ron Sapsford** – CEO **Registered Nurses' Association of Ontario: Doris Grinspun** – CEO
4:50 p.m.	**Final words and adjournment**	**Bob Bell** – Chair of Cancer Quality Council of Ontario, Toronto, Canada

CQCO Cancer Quality Council of Ontario

Cancer Quality Council of Ontario – Members

CQCO Council Members are a multidisciplinary group of healthcare providers, cancer survivors, and experts in the areas of oncology, health system policy and administration, and performance measurement and health services research.

Dr. Robert Bell (Chair)
President and CEO, University Health Network,
Toronto General Hospital

Julia Abelson
Director, CHEPA, McMaster University

Arlene Bierman
Chair, Women's Health, Ontario Women's Health Council, Li Ka Shing Knowledge Institute, St. Michael's Hospital

Adalsteinn Brown
Director, Institute of Health Policy, Management and Evaluation
Division Head of Public Health Policy, Faculty of Medicine, University of Toronto
Scientist, Keenan Research Centre Li Ka Shing Knowledge Institute, St. Michael's Hospital

Jenny Cockram
Clinical Product Manager, OntarioMD

Ruthe Anne Conyngham
Chair of the Board of Directors, London Health Sciences Centre

Winnie Doyle
VP, Clinical Services
Chief Nursing Executive,
St. Joseph's Healthcare Hamilton

Bill Evans (Vice-Chair)
President, Juravinski Hospital and Cancer Centre

Darren Larsen
Lead Physician, Thornhill Village Family Health Organization
Senior Physician Peer Lead, OntarioMD

John MacNaughton
Chairman, Business Development Bank of Canada
Director, TransCanada Corporation

Michael Marcaccio
Head of Surgical Oncology, Hamilton Health Sciences & JCC
Professor, Department of Surgery, McMaster University

Virginia McLaughlin (Vice-Chair)
Co-Chair, Cancer Campaign Cabinet Sunnybrook Health Sciences

Kevin Mercer
Health care consultant and national accreditor with Accreditation Canada

Dawn Powell
President, Dawn M Powell Appraisals Inc
Chair, Patient and Family Oncology Partnership Council, Thunder Bay Regional Health Sciences Centre

Carol Sawka
Provincial VP, Clinical Programs and Quality Initiatives, Cancer Care Ontario

Michael Sherar
President, CEO
Cancer Care Ontario

Cancer Quality Council of Ontario Secretariat

Rebecca Anas – Director,
Cancer Quality Council of Ontario
Staff: **Charlotte Bailey, Nicoda Foster, and Jennifer Stiff**

Acknowledgements:

With acknowledgement and gratitude to the members of our CQCO Signature Event Steering Committee for their guidance and support in planning this event:

Robert (Bob) Bell (Chair), Tupper Bean, Ben Chan, Christine Chan, Susan Fitzpatrick, Alana Halfpenny, Amanda Hey, David Kaplan, Jan Kasperski, Darren Larsen, Virginia McLaughlin, Linda Rabeneck, Carol Sawka, and Jennifer Zelmer

Additional acknowledgements:

Richha Arora, Judy Burns, Dafna Carr, Cheryl Chapman, Gail Dobell, Melissa Farrell, Doina Lupea, Judith Miller, Jillian Paul, Jillian Ross, Stephanie Ryan-Coe, Zahra Sheraly and Suzanne Strasberg

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Ontario
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CQCO 2012 Signature Event
Biographies of Speakers
[In order of presentation]

Dr. Robert S. Bell, MD

Dr. Robert Bell was appointed as President and CEO of University Health Network (UHN) in June 2005. An internationally recognized Orthopaedic surgeon, health care executive, clinician-scientist, and educator, Dr. Bell brings more than 20 years of experience in academic health care to leadership of Canada's largest research hospital. From 2000 to 2005, he served as Chief Operating Officer of UHN's Princess Margaret Hospital where he was responsible for leading Canada's largest comprehensive cancer centre. From 2003 to 2005, he served as Regional Vice President and Chair of the Clinical Council of Cancer Care Ontario.

Dr. Bell earned a Doctor of Medicine from McGill University in 1975 and a Masters of Science from the University of Toronto in 1981. He completed a Fellowship in Orthopaedic Oncology at Massachusetts General Hospital and Harvard University in 1985. During his career as a clinician-scientist at the University of Toronto, he received more than five million dollars in peer reviewed funding and published more than 170 peer-reviewed papers. He participated in the Advanced Management Program at Harvard Business School in 2005. Dr. Bell is a Fellow of the Royal College of Physicians and Surgeons of Canada, the American College of Surgeons and the Royal College of Surgeons of Edinburgh.

Dr. Rick Glazier, MD

Dr. Richard H. Glazier is a Senior Scientist and Program Lead of Primary Care and Population Health at the Institute for Clinical Evaluative Sciences (ICES); a Family Physician, Department of Family and Community Medicine, St. Michael's Hospital; and Scientist, Centre for Research on Inner City Health (CRICH) at St. Michael's Hospital. Dr. Glazier is a Professor in the Department of Family and Community Medicine (DFCM), and cross-appointed at the Dalla Lana School of Public Health.

He is an author on 160 peer-reviewed publications, a Co-Editor of *Neighbourhood Environments and Resources for Healthy Living – A Focus on Diabetes in Toronto: An ICES Atlas* (2007), and of *Arthritis and Related Conditions in Ontario: ICES Research Atlas* (2004); and a major contributor to *Primary Care in Ontario: ICES Atlas* (2006). He has presented his research globally to a variety of stakeholders and decision-makers, as well as advocacy group and lay audiences.

Dr. Glazier received his MD (Honours) at the University of Western Ontario, in London (Canada). He then earned a Master of Public Health (Honours) at the Johns Hopkins University School of Public Health and Hygiene in Baltimore, Maryland. He completed his residency in Family Medicine at Queen's University in Kingston, Ontario.

His many honours include: *Family Medicine Researcher of the Year* (2005, College of Family Physicians of Canada), the inaugural *Research Mentorship Award* (2009, Department of Family and Community Medicine, University of Toronto), the *President's Award for Contributions to Primary Care Research* (2011, North American Primary Care Research Group), and the *Award for Outstanding Contribution to Family Medicine Research* (2011-12, Department of Family and Community Medicine, University of Toronto).

Dr. Glazier's current research focuses on primary care health services delivery models, the health of disadvantaged populations, chronic disease management (especially diabetes mellitus and obesity), and population-based and geographic methods for improving equity in health.

Mrs. Robin Osborn, M.B.A.

Mrs. Robin Osborn is vice president and director of The Commonwealth Fund's International Program in Health Policy and Practice since 1997, has responsibility for the Fund's annual international symposium on health policy, annual international health policy surveys and comparisons of health systems data, the Commonwealth Fund-Nuffield Trust international conferences on quality, the Fund's International Working Group on Quality Indicators, the Harkness Fellowships in Health Care Policy and Practice, the Australian-American Health Policy Fellowships, and 22 international partnerships with Ministries of Health, research organizations, and health foundations.

The core countries participating in the Fund's international program are: Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Switzerland, the United Kingdom and the United States. In addition, she serves on the editorial board of the *Health Systems in Transition* series of the European Observatory.

Prior to joining the Fund in 1997, Mrs. Osborn was director of fellowship programs at the Association for Health Services Research where she directed the Picker/Commonwealth Scholars Program and served as deputy director of the Robert Wood Johnson Foundation Investigator Awards in Health Policy Research Program.

While living in the United Kingdom from 1986-1992, she held management positions at BUPA, the largest private health insurer in the United Kingdom, with responsibility for developing managed care programs. Her previous positions include managing director of the Miller Institute for Performing Artists at St. Luke's-Roosevelt Hospital Center; executive director of Blue Cross and Blue Shield of Greater New York's corporate foundation, The Health Services Improvement Fund; special assistant to the vice president of Blue Cross and Blue Shield for the division charged with cost containment, quality, pilot benefits and health services research; and assistant director of Bronx Municipal Hospital Center, a 1,400-bed, public safety net hospital. She earned a B.S. with honors at Tufts University and an M.B.A. from Columbia University.

Sir John Oldham, MD

Sir John Oldham is the National Clinical Lead Quality & Productivity at the Department of Health, England. He qualified at Manchester Medical School in 1978 and worked in various teaching hospitals, culminating as a GP trainee in inner city Manchester. He joined Manor House Surgery, Glossop in 1983, and became a senior partner in 1988.

In 1992, he gained an MBA with Distinction from Manchester Business School; his dissertation was on Continuous Quality Improvement in Primary Health Care. The work in the practice led to him being asked to present a paper to the 1st European Forum on quality improvement in health care, and subsequent invitations to the US and Sweden..

Don Berwick, CEO Institute of Health Care Improvement invited him in 1997, to be on a national project group with the IHI in Boston, U.S.A., looking at redesigning surgery systems in the U.S. This was being done using the Collaborative method, which he then brought back to the UK. He first proposed a primary care collaborative in 1997 and ultimately this led to him being asked to create and head the National Primary Care Development Team, which launched in February 2000.

The Primary Care Collaborative was the largest improvement programme in the world covering 32 million patients in 40 months and delivering 72% improvement in access to GPs and substantial reductions in mortality to patients with CHD.

In 2000, he received the OBE for services to patients and in 2003 was awarded a knighthood for services to the NHS. He conducts workshops and presentations internationally. He does, however, still undertake regular clinical sessions.

Sir John was a Board member of ISQUA (International Society for Quality and Accreditation) from 2007-2012 and Hon Treasurer from 2009-2012.

Dr. Charles Alessi, MD

Dr. Charles Alessi is a practicing GP in South West London.

Charles has extensive experience of the NHS in a variety of senior positions in both primary and secondary care as well as PCTs and Health Authorities. He is chairman of the National Association of Primary Care, a national membership organisation representing primary and community care in England and interim Chairman of NHS clinical commissioners. He is also senior advisor to Public Health England.

He was intimately involved in the formation of and is still actively involved in the work of the Kingston Clinical Commissioning Group providing services to over 195,000 patients, 29 practices and over a 130 GPs.

He has extensive experience of working at senior levels both nationally and internationally, in Europe and the Americas. As Chair of the NAPC, and interim chair of NHS Clinical Commissioners, he is at the heart of the recent health reforms.

Internationally he has been prominent advising both Governments and international organisations. He also has experience of military medicine until recently acting as Director of Medicine and Clinical Governance for the British Armed Forces in Germany.

On the 1st July 2012 Charles was appointed Adjunct at the Ivey School of Business, University of Western Ontario, Canada for the MBA in Health Innovation.

Dr. Adalsteinn D. Brown, PhD

Dr. Adalsteinn (Steini) Brown is the Director of the Institute for Health Policy, Management and Evaluation at the University of Toronto. He also leads the Division of Public Health Policy at the Dalla Lana School of Public Health and is a Scientist at the Keenan Research Centre in the Li Ka Shing Knowledge Institute at St. Michael's Hospital.

Past roles include the Dalla Lana Chair of Public Health Policy at the University of Toronto, Assistant Deputy Minister for Strategy and Policy at the Ontario Ministry of Health and Long-term Care and for Science and Research at the Ontario Ministry of Research and Innovation, and Principal Investigator for the *Hospital Report Project* that created scorecards covering more than 95% of hospital care in Ontario.

He received his undergraduate degree in government from Harvard University and his doctorate from the University of Oxford, where he was a Rhodes Scholar. He has received several leadership awards including being named one of Canada's "Top 40 Under 40" in recognition for his work on performance measurement in health care. He has held founding roles in consulting, software, and Internet companies and has advised the World Health Organization, banks, software and insurance companies, and health care providers in North America, Europe, and Asia.

Mrs. Katharina Sammut

At the age of 18 Mrs. Katharina Sammut was diagnosed with a liver disease called Primary Sclerosing Cholangitis. This began a medical journey that included a liver transplant at the age of 20, a diagnosis of Burkitt's Lymphoma at the age of 25, and a second liver transplant in 1998 at the age of 26. Several years later, in 2003, Katharina was diagnosed with chronic kidney failure due to a combination of factors, including the effects of chemotherapy and medication relating to the liver transplantation. She began dialysis treatments in a hospital setting but for the past 8 years she has been on nocturnal home hemodialysis.

Katharina is married to Paul Sammut and they have two children, Magdalena, aged two and Samuel, aged one. Katharina holds a Masters degree in counselling psychology and works as a psychotherapist and clinical case consultant for the Highland Shores Children's Aid Society.

Dr. Peter Anglin, MD, FRCPC, MBA

Dr. Anglin is a Physician Lead, Medical Oncology at Stronach Regional Cancer Centre He obtained his medical degree from Queens University at Kingston and followed this with clinical fellowships in internal medicine, haematology, and oncology. He has been in clinical practice for the last 15 years in the Greater Toronto Area, and is a clinical investigator with the National Cancer Institute of Canada.

Dr. Anglin completed his MBA through the executive programs of the Rotman School of Management, University of Toronto, and he has served as a consultant for a number of health-related organizations. Dr. Anglin has a particular interest in the process design and human resource issues around the out-patient delivery of oncology services. His clinical areas of expertise include gastrointestinal and haematolgic malignancies, particularly myeloma and the lymphoproliferative disorders.

Dr. Peter Stotland , MD

Dr. Peter Stotland graduated from medical school at the University of Toronto in 2002. While a resident in general surgery at the University of Toronto, Dr. Stotland was the recipient of many local and national teaching awards, including the Canadian Association of General Surgeons Best Resident Teacher Award. He became a Fellow of the Royal College of Physicians and Surgeons of Canada in 2007.

After a combined fellowship in general surgical oncology and minimally invasive surgery at the University of Toronto, he began a clinical staff appointment at Sunnybrook Hospital. Dr. Stotland is currently an attending surgeon at North York General Hospital and clinical associate at Sunnybrook Hospital. His clinical practice is focused on the treatment of gastrointestinal malignancies and the implementation of minimally invasive techniques. His academic interest is medical student, resident, and fellow teaching.

Dr. Scott Wooder, MD

Dr. Scott Wooder is a family physician who practices in Stoney Creek. He is Associate Lead Physician for the Hamilton Family Health Team and is an Assistant Clinical Professor at McMaster University.

Dr. Wooder is President –Elect of the Ontario Medical Association and is a member of the Board of Directors of the CMA. He has been involved with physician-government negotiations for more than 10 years and was Chair of the OMA Negotiations Committee in 2008. Dr. Wooder played an important part in developing the current Primary Care payment and practice models.

He has a special interest in patient centered care and in improving the value for health care investments.

Ms. Susan (Sue) Stein

Ms. Sue Stein is the Nurse Navigator for the Thoracic Diagnostic Assessment Program (DAP) —South West Regional Cancer Program in London, Ontario. She possesses extensive nursing experience in providing and directing the delivery of acute patient care in a diverse range of clinical services. Sue has fulfilled many roles including staff nurse, educator, mentor, clinical leader and navigator.

As a Nurse Navigator, she delivers patient-centered care that actively guides those enrolled in the DAP through a coordinated, streamlined pathway of diagnostic services and follow up. Cancer patients are provided with an efficient, single point of access to testing that simplifies their journey through the diagnostic assessment process. Sue's primary responsibility is to expedite the diagnostic process but a large part of her role is to provide support and reduce the amount of stress experienced by patients and their families. Talking to patients, answering questions, understanding their concerns and being a contact they feel comfortable calling at any time is often among the most valuable and rewarding services she provides.

Dr. Dinny de Bakker, PhD

Dr. Dinny de Bakker is a senior researcher at the Netherlands institute for Health Services Research (NIVEL), where he leads one of the research departments.

He is also the Professor of Structure and Organization of Primary Care at the Scientific Centre for Care and Welfare (TRANZO), Tilburg University in the Netherlands.

Dr. Dinny de Bakker chaired the evaluation committee that was assigned by the Dutch Minister of Health to advise on further implementation of bundled payments for chronic care in the Netherlands. His research includes structure and financing of primary, integrated primary care and electronic patient records.

Dr. Dinny de Bakker's publications are in the fields of general practice care, integrated care, pharmaceutical care, medical informatics and paramedical care. He has co-authored 75 international scientific publications and 190 national publications.
He holds a doctorate in geography at the Utrecht University.

Dr. Paul Roseman

Dr. Paul Roseman is a registered Pharmacist and the Senior Manager of Healthcare Integration for ProCare Health Limited. Paul has 17 years experience working in Primary Health Organisations.

Paul has designed and implemented a wide variety of primary care clinical programmes including chronic disease management, hospital avoidance, electronic clinical decision support and performance indicator programmes.

ProCare Health Limited has 198 contracted General Practices in Auckland, NZ and serves an enrolled patient population of over 800,000 Aucklanders.

Virginia McLaughlin

Virginia McLaughlin currently serves as a volunteer trustee on the Boards of the University of Guelph, Wellspring and the Canadian Museum of Science and Technology Corporation.

In addition she is Honorary Lieutenant-Colonel of the 25 (Toronto) Field Ambulance. She is a past Chair of the Board of Directors, Sunnybrook Health Sciences Centre and a past chair of the Governance Leadership Council of the Ontario Hospital Association. She continues to co-chair the Cancer Campaign Cabinet.

Prior to becoming a member of the Sunnybrook & Women's Board of Directors, Ms. McLaughlin was a member of the Board of Trustees, York Central Hospital (1985-1997) and Chair of the Board from 1995-97. She chaired the GTA/905 Healthcare Alliance from 1995-1998 and the York Region Tri-Hospital group from 1995-97.

Ms. McLaughlin has also participated in governance for the Ontario Hospital Association as a member of the Regional Council Executive Committee for Region 3 (Toronto, York, Peel and Durham) 1998-2008, as chair of the RCEC 2000-2002, member of the OHA board of Directors 2000-2002 and chair of the OHA Advocacy Committee (2001-2002) and from 2004 until November 2007 was the Chair of the Ontario Hospital Association Governance Leadership Council.

In private life, Ms. McLaughlin is President of Helmhorst Investments Limited, a family owned company comprising agricultural operations, real estate and a portfolio of market investments. She is married and has two adult children and two grandchildren.

Dr. Michael Sherar, PhD

Dr. Michael Sherar is President and CEO of Cancer Care Ontario. From 2006 to 2011, he was the provincial agency's Vice-President, Planning and Regional Programs, leading the development of Regional Cancer Programs, including capital planning for cancer services across the province. In this role, he led the development of the *Ontario Cancer Plan 2011-2015*.

Dr. Sherar is Professor of Medical Biophysics at the University of Toronto and Senior Scientist at the Ontario Cancer Institute/Princess Margaret Hospital where he carries out research and development of minimally invasive thermal therapy technologies for cancer including radiofrequency ablation.

In 2001, he was selected as one of *Canada's Top 40 under 40* for achievements in leadership. He was previously Regional Vice President, Cancer Services, London for Cancer

Care Ontario and Vice President, London Regional Cancer Program (LRCP), London Health Sciences Centre (LHSC).

Dr. Sherar received a BA in Physics from Oxford University in 1985 and his PhD in Medical Biophysics from University of Toronto in 1989.

Dr. Ben Chan, MD

Dr. Ben Chan is President and CEO of Health Quality Ontario (HQO), and a leading figure in healthcare quality in Canada. At HQO, Dr. Chan oversees an ambitious agenda to evaluate the effectiveness of healthcare technologies and services, report to the public on the quality of healthcare, support quality improvement activities and make evidence-based recommendations on healthcare funding.

In his past role as CEO of Saskatchewan's Health Quality Council, Dr. Chan was named Canada's Outstanding Young Health Executive in 2006, in recognition of his organization's leadership in improving chronic disease management, wait times and patient safety.

Dr. Chan is a former Senior Scientist with the Institute for Clinical Evaluative Sciences (ICES), where he authored over 60 academic publications. He has worked as a locum general practitioner in 75 rural communities and 8 provinces and territories across Canada. He received his BSc and MD from the University of Toronto, Master of Public Health from Harvard and Master of Public Affairs from Princeton.

Dr. Paul Huras, PhD

Dr. Paul Huras is the founding CEO of the South East Local Health Integration Network in Belleville where he provides the leadership for the LHIN's responsibilities of local health system planning, community engagement, and allocating the funds and monitoring the performance of the one billion dollar SE Health System. Since the beginning of the LHINs, in 2005, Paul has taken on expanding roles locally and provincially, including Co-Chairing the provincial Physician LHIN Tri-Partite Committee (PLTC).

He has over 25 years of health system leadership experience, including 14 years as CEO of the Thames Valley District Health Council and previously 5 years as Vice President of Planning and Information Services at Peel Memorial Hospital, where he also served as Acting Executive Vice President.

Paul is a Fellow with the School of Policy Studies, Queen's University and holds an adjunct appointment with Queen's in the Department of Community Health & Epidemiology, Faculty of Health Sciences. He formerly held the position of Assistant Professor in the Department of Epidemiology at the University of Western Ontario where he also taught courses in health management and strategic management.

Paul is a past Board Member of the Institute of Clinical Evaluative Sciences (ICES) and a past Vice Chair of the provincial Association of Colleges of Applied Arts and Technology

(ACAATO). He is also past Chair of both The Michener Institute in Toronto and Fanshawe College in London.

Paul holds a MBA and a MSc (Epidemiology), as well as the CHE designation with the Canadian College of Health Service Executives and a FACHE designation with the American College of Healthcare Executives.

Ms. Susan Fitzpatrick

Ms. Susan Fitzpatrick is the Assistant Deputy Minister, Negotiations and Accountability Management Division, Ministry of Health and Long-Term Care. Susan has worked for the Ontario Public Service since 1982. She has progressed through a number of jobs including Manager, Director of Provider Services Branch and Executive Director, Negotiations and Accountability Management.

Susan is responsible for a large health care programs portfolio including health services, primary care, health quality and provincial programs with transfer payments of more than $13.1 billion and 350 staff. She has developed strategies and mandates to address key government priorities and negotiate innovative performance-based funding arrangements, restructuring relationships, and transforming the way business is conducted.
Susan has a Bachelor of Arts, Honours Business Administration from the University of Western Ontario and a Master of Public Administration from Queen's University.

Ms. Jan Kasperski

Ms. Jan Kasperski is the Chief Executive Officer of the Ontario College of Family Physicians, an Associate Professor of Clinical Education at the Northern Ontario School of Medicine and a Board Member of the Toronto East General Hospital. Ms. Kasperski is a Registered Nurse and a Board Certified Health Executive. She has more than forty years' experience in a variety of healthcare settings, as a clinician, an educator, a researcher and a hospital administrator. Ms. Kasperski broad-based background allows her to view healthcare from various perspectives. She has a thorough understanding and deep respect for the role that family physicians play within the healthcare system.

Ms. Kasperski's extensive knowledge of healthcare and her ability to facilitate dialogue and collaboration amongst physicians and other healthcare providers has helped to position the OCFP to provide leadership in identifying changes needed in our system that will result in better healthcare for the people of Ontario. She has written extensively about primary care and family medicine and is a frequent guest speaking at provincial and national conferences. With a background in behavioural medicine, Ms. Kasperski led the development of the OCFP's Collaborative Mental Healthcare Network and its Medical Mentoring for Addictions and Pain Network.

Mr. Ron Sapsford

Ron Sapsford is Chief Executive Officer of the Ontario Medical Association. He has had a long career in health services management, most recently as Deputy Minister of Health and Long-Term Care, for Ontario.

Previously, Mr. Sapsford was the Executive Vice-president and Chief Operating Officer of Hamilton Health Sciences Corporation.

He has held several positions at the Ministry of Health including, Assistant Deputy Minister of Institutional and Community Services, as well as Vice-president, Teaching Hospitals, and Chief Operating Officer with the Ontario Hospital Association.

Mr. Sapsford holds a bachelor of science from the University of Toronto and a master of health administration from the University of Ottawa.

Dr. Doris Grinspun, PhD

Dr. Doris Grinspun is the Chief Executive Officer of the Registered Nurses' Association of Ontario (RNAO) since 1996.

Prior to this, she worked in clinical and administrative positions in Israel and the United States and from 1990 to 1996 served as Director of Nursing at Mount Sinai Hospital in Toronto.

Dr. Grinspun has for over two decades led numerous international projects in Latin and Central America, Europe, China and Australia. Publishing and speaking extensively in Canada and abroad, Dr. Grinspun is a forceful advocate of the Canadian health-care system and the contribution of registered nurses to its success.

She has received numerous professional and scholarly awards and in 2003 was invested with the Order of Ontario which recognizes the highest level of individual excellence and achievement in any field.

In 2010 Grinspun was named one of the top ten Hispano-Canadians. In 2011, she was conferred an honourary Doctor of Laws by the University of Ontario Institute of Technology (UOIT) for her eminent career as a visionary, advocate and tireless champion of excellence in patient care, and for transforming nursing and health-care practice at the bedside with the introduction of best practice guidelines. Dr. Grinspun has been featured in numerous publications as a positive change agent.

Rapid Rounds Session Presenters

Name	Organization	Title	Presentation Topic
Topic : Models			
Onil Bhattacharyya	Keenan Research Centre of the Li Ka Shing Knowledge Institute of St. Michael's Hospital	Clinician Scientist	Bridges model
Pauline Pariser	University Health Network	Associate Medical Director and Primary Care Lead	SCOPE model
Jill Ross	Cancer Care Ontario	Director, Clinical Programs, Strategy and Integration	Models of Care program
Topic: Tools			
Gregory Webster	Canadian Institute for Health Information	Director, Primary Health Care & Clinical Registries	Primary Health Care data integration program
Doug Woodhouse	Apix Performance	Executive Director	Dutch referral system
Darren Larsen	OntarioMD	Senior Physician Peer Lead	eReferrals project
Topic: Networks			
Lee Donohue	Champlain Regional Cancer Program	Regional Primary Care Lead	Physician Directory
Nurin Thawer	Ontario Renal Network	Program Manager, Renal Clinical Programs	ORN Mentee Program
Janet Kasperski	Ontario College of Family Physicians	Chief Executive Officer	Establishing a Collaborative Cancer Care Network
Sandy Buchman	Toronto Central	Regional Primary Care Lead	CPAC proposal on Cancer Care/Primary Care Integration

Cancer Quality Council of Ontario Signature Event 2012
Attendee List

Organisation	Name	Title
CQCO Member	Adalsteinn Brown	Director, Institute of Health Policy, Management and Evaluation, University of Toronto
Upper Canada Family Health Team, Brockville and Area Hospice Palliative Care Program	Adam Steacie	Family Physician
eHealth Ontario	Ali Mir	Vice President, Chronic Disease Management Systems and Consumer eHealth
Health Sciences North	Amanda Hey	Regional Primary Care Lead, North East LHIN
Li Ka Shing Knowledge Institute	Andreas Laupacis	Executive Director
Odette Cancer Centre	Andy Smith	Regional Vice President
Association of Family Health Teams in Ontario	Angie Heydon	Executive Director
	Anya Humphrey	Caregiver
Princess Margaret Cancer Centre	Audrey Friedman	Director, Patient Education & Survivorship
Health Quality Ontario	Ben Chan	Chief Executive Officer
Athens District FHT	Ben Stobo	Lead Physician
Drenth Consultants Inc.	Bernita Drenth	President
CQCO Co-Chair	Bill Evans	President, Juravinski Hospital and Cancer Centre
	Brad Gualtieri	Patient
Cancer Services, Kingston General Hospital	Brenda Carter	Regional Vice President
Cancer Care Ontario	Carol Sawka	Vice President, Clinical Programs and Quality Initiatives
Royal Victoria Regional Health Centre	Carole Beals	Manager of the systemic treatment unit, North Simcoe Muskoka Regional Cancer Centre
Canadian Institute for Health Information	Caroline Heick	Executive Director, Ontario and Quebec
	Catherine Yanchula	Family Physician, Windsor, ON
Cancer Care Ontario	Cathy Cattaruzza	Senior Manager, Access to Care
Juravinski Cancer Centre	Cathy Bennett	Patient Education Coordinator
London Family Health Team	Cathy Faulds	Lead MD London Family Health Team
Department of Health	Charles Alessi	Chair of the National Association of Primary Care, Senior General Practitioner
Cancer Quality Council of Ontario	Charlotte Bailey	Senior Administration Assistant
Health Quality Ontario	Cheryl Chapman	Director, Access and Chronic Disease
Central East LHIN	Christopher Jyu	Primary Care Lead, Central East
Cancer Program, Windsor Regional Hospital	Claudia Den Boer Grima	Regional Vice President, Windsor Regional Cancer Program
Nurse Practitioners Association	Claudia Mariano	President
Ontario Renal Network	Connie Twolan	Clinical Director, Nephrology Programs
Liberation Marketing	Corey Bainerman	Director
Credit Valley Hospital,Trillium Health Centre	Craig McFadyen	Regional Vice President, Carlo Fidani Peel Regional Cancer Centre
Cancer Care Ontario	Dafna Carr	Director, Policy, Planning and KTE
Champlain Regional Cancer Program	Daniel Smith	Regional Primary Care Lead, Champlain LHIN
Thornhill Village FHO	Darren Larsen	Lead Physician, Thornhill Village FHO and Senior Physician Peer Lead, OntarioMD
Central Local Health Integration Network	David Kaplan	Primary Care Physician Lead, Central LHIN
CQCO Member	Dawn Powell	President of Dawn M Powell Appraisals Inc. Chair, Patient and Family Oncology Partnership Council, Thunder Bay
Cancer Care Ontario	Deanna Blair	Director, Communications
Ontario Pharmacists' Association	Dennis Darby	Chief Executive Officer
Netherlands institute for Health Services Research (NIVEL)	Dinny De Bakker	Head Research Department
Cancer Care Ontario	Doina Lupea	Senior Manager, Primary Care
	Don Park	Patient
Registered Nurses' Association of Ontario	Doris Grinspun	Chief Executive Officer
Apix Performance	Doug Woodhouse	Executive Director and Owner
Cancer Care Ontario	Edward Kucharski	Regional Primary Care Leads, Toronto Central – South LHIN
Cancer Care Ontario	Elaine Martinovic	Cancer Imaging Lead
Cancer Care Ontario	Esther Green	Provincial Head, Nursing and Psychosocial Oncology
Health Quality Ontario	Gail Dobell	Director, Evaluation
Cancer Care Ontario	Garth Matheson	Vice President Planning & Regional Programs
Windsor Regional Hospital	Gordon Giddings	Regional Palliative Care Lead, Erie St. Clair
Canadian Institute for Health Information	Greg Webster	Director, Primary Health Care Information and Clinical Registries, CIHI
Cancer Care Ontario	Hakim Lakhani	Director, Reporting & Analytics - CIO
Canadian Association of Provincial Cancer Agencies	Heather Logan	Executive Director
South East Regional Cancer Program	Hugh Langley	Regional Primary Care Lead, South East LHIN
Cancer Care Ontario	Jackson Wood	Planning Officer, Office of Strategy Management
Association of Ontario Health Centres	Jacquie Maund	Policy and Government Relations Lead
Ontario College of Family Physicians	Jan Kasperski	Chief Executive Officer □
Ontario Renal Network	Janice McCallum	Regional Director
Ontario Renal Network	Jay Wilson	Regional Director
Cancer Quality Council of Ontario	Jennifer Stiff	Senior Policy Advisor
Canada Health Infoway	Jennifer Zelmer	Senior Vice President, Clinical Adoption and Innovation
CQCO Member	Jenny Cockram	Clinical Product Manager, OntarioMD
Ministry of Health and Long Term Care	Jillian Paul	Manager, Policy Development and Implementation, Health Quality Branch Negotiations and Accountability Management Division
Cancer Care Ontario	Jillian Ross	Director, Clinical Programs
Lakeridge Health	Jimmy Mui	Radiation Oncologist
Cancer Care Ontario	Joël Simard	Director, Communications
Credit Valley Hospital	John Srigley	Chief of Laboratory Medicine
Cancer Care Ontario	Jonathan Irish	Provincial Head, Surgical Oncology
Cancer Care Ontario	José Pereira	Provincial Head Palliative Care, Clinical Programs
Cancer Care Ontario	Judy Burns	Director, Corporate Projects
Ontario Renal Network	Julia Salomon	Manager, Renal Services
Ontario Renal Network	Julie A. Gordon	Regional Director, Ontario Renal Network
Canadian Partnership Against Cancer	Julie Klein- Geltink	Program Manager, System Performance
	Katharina Sammut	Patient
University Health Network	Kathy Sabo	Senior Clinical Vice President
	Ken Arnold	Family Physician
STAR Family Health Team	Ken Hook	Physician
Cancer Care Ontario	Ken Sutcliffe	Director of Technology Services & Chief Technology Officer
Association of Family Health Teams in Ontario	Keri Selkirk	Vice President and Executive Director, Thames Valley Family Health Team, London
CQCO Member	Kevin Mercer	Health Care Consultant and National Accreditor with Accreditation Canada
Central LHIN	Kim Baker	Chief Executive Officer
Cancer Care Ontario	Laura Macdougall	Director, Clinical Programs - Patient Experience
Champlain Regional Cancer Program	Lee Donohue	Regional Primary Care Lead, Champlain LHIN
Simcoe Muskoka Regional Cancer Program	Lesley MacInnis-Miller	Manager Prevention, Screening & Education
Central East Regional Cancer Programme	Leta Forbes	Chief Oncology

Cancer Quality Council of Ontario Signature Event 2012
Attendee List

Organisation	Name	Title
Cancer Care Ontario	Linda Rabeneck	Vice President, Prevention and Cancer Control, Cancer Care Ontario
Sunnybrook Hospital	Lisa DelGiudice	Regional Primary Care Lead, Toronto Central- North LHIN
Cancer Care Ontario	Lisa Sarsfield	Director, Cancer Information Program, CIO, Cancer Care Ontario
Ontario Renal Network	Brenda Lynn	Regional Director, Ontario Renal Network
Cancer Care Ontario	Loraine Marrett	Director, Surveillance
Southlake Regional Health Centre	Louis Balogh	Regional Vice President, Stronach Regional Cancer Centre
Cancer Care Ontario	Lynn Guerriero	Managing Director, Cancer Screening
Ontario Medical Association	Maggie Keresteci	Director, Regional Engagement and Constituency Services, OMA
Cancer Care Ontario	Maggie Wang Maric	Senior Communications Strategist
Cancer Care Ontario	Maria Grant	Program Manager, Survivorship, Cancer Care Ontario
Credit Valley Hospital	Maria Rugg	Manager, Supportive Care and Psychosocial Oncology, Credit Valley Hospital
Grand River Hospital	Mark Berry	Regional Vice President, Grand River Regional Cancer Centre
Health Sciences North	Mark Hartman	Regional Vice President, Northeast Cancer Centre/Health Sciences North
Thunder Bay Regional Health Sciences Centre	Mark Henderson	Regional Vice President
Ontario Renal Network	Marni Van Kessel	Regional Director, NSM LHIN
University Health Network (UHN)	Marnie Escaf	Senior Clinical Vice President
Cancer Care Ontario	Marnie MacKinnon	Director, Prevention and Cancer Control
Canadian Cancer Society	Martin Kabat	Chief Executive Officer
Princess Margaret Cancer Centre	Mary Gospodarowicz	Regional Vice President, Princess Margaret Hospital
Ontario College of Family Physicians	Mary Manno	Family Physician
Southlake Regional Health Centre	Massey Nematollahi	Regional Lead, Patient Education
Ontario Renal Network	Melanie Tremblay	Program Director, Renal Dialysis, Ontario Renal Network
Ontario Renal Network	Melinda Fowler	Family Physician, Hamilton
South West LHIN	Michael Barrett	Chief Executive Officer, South West LHIN
CQCO Member	Michael Marcaccio	Head of Surgical Oncology, Hamilton Health Sciences & JCC
Juravinski Cancer Centre	Michael Mills	Regional Primary Care Lead, Hamilton Niagara Haldimand Brant LHIN
Cancer Care Ontario	Michael Sherar	President & CEO
Health Quality Ontario	Michelle Rey	Director, Research
South West Regional Cancer Program	Millie Litt	Manager Regional Prevention and Screening Services, South West LHIN
Ontario Renal Network	Nancy Webster	Renal Administrative Director
London Regional Cancer Program	Neil Johnson	Regional Vice President, London Regional Cancer Program
Cancer Care Ontario, Board of Directors	Neil Stuart (Chairman of the Board)	Board Member
Cancer Quality Council of Ontario	Nicoda Foster	Policy Research Analyst
Health Quality Ontario	Nizar Ladak	Executive Vice President & Chief Operating Officer
Ontario Renal Network	Nurin Thawer	Program Manager, Renal Clinical Programs
St. Michael's Hospital	Onil Bhattacharyya	Primary Care Provider
Cancer Care Ontario	Padraig Warde	Provincial Head, Radiation Treatment Program
South East Local Health Integration Network	Paul Huras	Chief Executive Officer, South East LHIN
Peel Region CancerCentre	Paul Philbrook	Regional Primary Care Lead, Central West LHIN
ProCare Health Limited	Paul Roseman	Senior Manager, Healthcare Integration
	Paul Sammut	Carevgiver to Katharina Sammut
Ottawa Hospital, Regional Cancer Centre	Paula Doering	Regional Vice President
Cancer Care Ontario	Paula Knight	Vice President, Communications
University Health Network	Pauline Pariser	Primary Care Lead
Stronach Regional Cancer Centre	Peter Anglin	Medical Oncologist
North York General Hospital	Peter Stotland	Attending Surgeon
Ontario Renal Network	Peter Varga	Program Director Renal Dialysis
Grand River Regional Cancer Centre	Rachael Halligan	Regional Primary Care Lead, Waterloo Wellington LHIN
Cancer Quality Council of Ontario	Rebecca Anas	Director
Ontario Renal Network	Rebecca Harvey	Vice President
Cancer Care Ontario	Richha Arrora	Corporate Events Specialist
Ontario Renal Network	Rick Badzioch	Director, Clinical Services
Institute for Clinical Evaluative Services	Rick Glazier	Senior Scientist & Program Lead of Primary Care
University Health Network	Robert Bell	President & CEO
The Commonwealth Fund	Robin Osborn	Vice President & Director, International Program in Health and Policy, The Commonwealth Fund
Ontario Medical Association	Ron Sapsford	Chief Executive Officer
Canadian Cancer Society	Rowena Pinto	Vice President, Public Affairs and Strategic Initiatives
CQCO Member	Ruthe Anne Conyngham	Chair, Board of Directors of the London Health Sciences Centre
Ontario Renal Network	Salim Bandali	Project Lead
Cancer Care Ontario	Sandy Buchman	Regional Primary Care Lead, Toronto Central – South LHIN
Cancer Care Ontario	Sarah Benn	ARCC Network Manager, Pharmacology
Cancer Care Ontario	Saul Melamed	Director, Clinical Programs-Diagnosis & Treatment
Cancer Care Ontario, Board of Directors	Scott Campbell	Board Member
Ontario Medical Association	Scott Wooder	President-Elect
Cancer Care Ontario	Sean Molloy	Program Manager, OCSMC
11. Regional Primary Care Leads	Sheila-Mae Young	Regional Primary Care Lead, Central East LHIN
Cancer Care Ontario	Stephanie Ryan-Coe	Senior Communications Strategist
	Steve Cord	Family Physician
Ontario Hospital Association	Sudha Kutty	Director, Patient Safety, Physician and Professional Issues
South West Regional Cancer Program	Sue Stein	Nurse Navigator
Ministry of Health and Long Term Care	Susan Fitzpatrick	Assistant Deputy Minister, Negotiations and Accountability Management Division
Cancer Care Ontario	Suzanne Strasberg	Provincial Lead, Primary Care, Cancer Care Ontario
Health Quality Ontario/Timmins FHT	Tanya Spencer Cameron	NP-PHC
Nurse Practitioners Association	Theresa Agnew Cell	Executive Director
Institute for Clinical Evaluative Sciences	Thérèse Stukel	Senior Scientist
Lakeridge Health	Tom McHugh	Regional Vice President, RS McLaughlin Durham Regional Cancer Centre
DFCM, University of Toronto	Trish O'Brien	Manager, QI Program
Centre for Effective Practice	Tupper Bean	Executive Director
Cancer Care Ontario	Vickie Welch	Director, CIO - Informatics
Cancer Care Ontario	Victoria Hagens	Manager, Regional Programs and Wait Times
CQCO Co-Chair	Virginia McLaughlin	Co-Chair, Cancer Campaign Cabinet Sunnybrook Health Sciences
CQCO Member	Winnie Doyle	Chief Nursing Executive, St Joseph's Healthcare, Hamilton

CQCO 2012 Signature Event
Summary of Group Discussions

TOPIC 1: Smooth transitions from suspicion to treatment

Overarching question for the breakout session:
What are the critical next steps and which organizations need to be involved to support the bidirectional relationships throughout the patient's journey?

Action-oriented questions:

a) What is the highest priority action and what solution could be implemented tomorrow?
b) Who should be involved and what should be their responsibilities? *Give us your advice on the immediate next steps and who owns as well as who drives them.*

Specific areas that outlined by event attendees on November 29, 2012 included:

1. **Increase use of navigators:** One of the highest priorities was the addition of navigators/ nurse navigators to enhance the patient experience.
    1.1. Nurse navigators are essential for Diagnostic Assessment Programs (DAP) and for patients without primary care support.
    1.2. Navigators also help take the variation out of wait times for patients in some cases.
    1.3. Patients who have limited or no computer literacy and/or patients who do not speak English as their first language would benefit from the use of a nurse navigator.
    1.4. Patients have expressed their appreciation of the nurse navigators.
    1.5. In parallel with the addition of navigators, there needs to be reappraisal of why the system is so complex. Instead of relying solely on navigators as a 'patch or bridge' need to ensure the underlying reasons for complexity are analyzed and are amendable to the system re-design.

2. **Implement an electronic referral system:** Immediate action needs to be taken to enhance information management systems to enable information sharing.
    2.1. The transfer of information should be easily accessible by the hospital staff regardless of location or affiliation to avoid patients repeating their information on multiple occasions.
    2.2. Electronic Medical Records (EMR) could assist with redundancies within the system (e.g., acute chemotherapy). Especially, integration of existing systems to provide timely access to reports. For example, Hamilton Family Health Team uses one referral tool and includes the timeline for the specialists.

2.3. There has been an expansion of electronic systems, such as DAP, pathways (My Cancer Guide), and patient portal. EMRs are especially important to tie into patient portals.

3. **Improve transparency and accountability:** Measuring wait times and publicly reporting will ensure transparency in the system and is a key piece to patient experience.

    3.1. Need to increase transparency by publicly reporting on suspicion to diagnosis wait times. Public reporting will also bring accountability to performance.

    3.2. Need to build in accountability. Accountability for patient should be within primary care.

4. **Use consistent pathways:** To avoid any delays in diagnosis the pathway and journey of a patient should be clearly outlined to know what needs to be done.

    4.1. To maintain consistent pathways, providers should be ensuring all the necessary tests are complete before making a referral.

    4.2. Patients are expecting the right information is provided at the outset with clear direction through the pathway.

    4.3. Standardized recommendations from diagnostics to best practice referral.

    4.4. Ensure the pathway is effective and based on the best evidence or guidelines.

    4.5. It was found to be beneficial to disseminate Cancer Care Ontario's (CCO) guidelines.

5. **Important to coordinate care:** Coordination with patient's EMRs and primary care providers needs to occur with cancer care in all hospitals and health centres, including far north and remote communities.

    5.1. Different cancer centres seem to be at different stages in EMR, DAP, pathways, patient involvement, patient education, etc.

    5.2. Patients with a suspicion of cancer should be able to access supportive care services at cancer centres.

    5.3. Although each region has different challenges, there should be some degree of centralization in the delivery of services, particularly to ensure that all patients are being treated equal.

6. **Empower patients:** Important to empower the patient in decision making and to inform the patient to make those educated decisions regarding their care.

    6.1. Patients should receive a hard copy of their journey from diagnostic testing, diagnosis, treatment, drugs, side effects, late effects, list of physicians, etc. Many patients travel between hospitals & clinics and this information should follow the patient.

    6.2. Patient education equates to patient empowerment. Patient education can be completed through interactive navigation, pathways, etc.

    6.3. Patients should also be accountable for their care, which requires greater patient education.

6.4. The way to empower patients is to ensure that they are part of the process and that they understand the process. There needs to be clear delineation between responsibilities of primary care providers, specialists, cancer care (oncologists, nurses, etc.) and patients.

6.5. The time from suspicion to diagnosis can be lengthy and stressful and a referral or self-referral system should be in place to empower patients.

7. **Increase education for providers:** Education on cancer care, community services and programs available for primary care providers and healthcare providers needs to increase and providers need to commit to the education.

   7.1. Consider education as part of the medical school curriculum to inform primary care providers.

8. **Implement system-level infrastructure**: There needs to be effective solutions in the long-term, such as building regional networks. The infrastructure is in place but there needs to be adherence to the appropriate utilization to ensure the proper use and outcomes.

   8.1. Systems with feedback mechanism that identify incomplete or inappropriate referrals. Additionally, system incentives that promote effective and appropriate referrals but need to ensure system incentives are not solely 'financial'.

   8.2. Optimizing capacity of primary care leads at CCO and within each LHIN. Providing Regional Primary Care Leads (RPCL) at CCO with knowledge, transfer and exchange (KTE) tools on DAP objectives, framework and early outcomes with regional data.

   8.3. Since variation exists between services available in different regions, need to catalogue services offered by each region.

   8.4. Needs to be awareness, adoption, and accessibility to the system. Systems have been developed but they need to be evaluated and appraised to determine if they are beneficial to the patient and if they work as intended.

9. **Improve transitions:** Need to actively thing about the human side of transitions and interactions with primary care providers from a patient and family's perspective to avoid the patient's feeling 'dropped' in the process.

   9.1. Support can come from in-person and/or electronic alumni peer support groups and connections. This may not be wanted by everyone but the transitions should be marked, e.g., through the telemedicine consult involving primary care, specialists, and patients to ensure warm handoffs.

   9.2. Normalizing advance directives, e.g., include in the discussions at well patient visits when the patient turns 50 years of age. Advance directive discussions regarding decisions for end-of-life could be done along with changes in screening protocols at that age or supported by public education approaches.

Challenges*, which reflect the heterogeneity of the issue, were acknowledged that can inhibit or interrupt the smooth transition from suspicion to treatment, which included:*

1. **Referrals based on relationships:** In an urban setting it is more difficult to establish relationships with hospitals and specialists in primary care. The strength of relationships

influences the referral rate for patients, especially among younger physicians who have not yet developed relationships with specialists.

1.1. Patients express that the communication from the cancer system following referral was poor and there was no further discussions from the primary care physicians.

2. **Lack of patient-centred care:** Patients feel abandoned and they are not provided enough information regarding who to call throughout their care journey. There needs to be more clarity by the physician.

3. **Funding:** The challenge with supporting DAP is acquiring adequate funding to enable the program to be sustained. Suggestions were made to measure from time to diagnosis with the assertion that it would focus the data and build a case for how DAP navigators create efficiencies in the system.

4. **Information barriers affecting primary physicians:** All the information required for a patient's appointment is rarely accessible and usually comes late after the primary care providers has reiterated with the patient what was discussed in their last appointment.

   4.1. Primary care providers are not informed following a patient's referral to a cancer centre, which provokes the feeling that the patients care is someone else's responsibility. While the cancer centres historically do not think they have a responsibility for the patient.

   4.2. Primary care providers can provide exceptional monitoring of cancer patients, yet due to lack of information and communication it can be difficult to distinguish their role in relation to the cancer system.

5. **Long wait times and shortage of providers:** There are currently long wait times to meet with primary care providers, especially in the North. Therefore, time between tests and receiving results, getting more tests and waiting for more results can be lengthy with too many delays.

   5.1. Due to shortages in primary care providers, patients depend on walk-in clients and emergency care. There is no system to ensure proper follow-up of patients. There are many examples of coordination of services in rural and remote communities.

TOPIC 2: Patient journey: Follow-up, surveillance and rapid re-entry for treatment of a recurrence and/or end-of-life care

Overarching question for the breakout session:
What are the critical next steps and which organizations need to be involved to support the bidirectional relationships throughout the patient's journey?

Action-oriented questions:
a) What is the highest priority action and what solution could be implemented tomorrow?
b) Who should be involved and what should be their responsibilities? Give us your advice on the immediate next steps and who owns as well as who drives them.

Specific areas that were outlined by November 29, 2012 attendees included:

1. **Engage and empower patients:** Patients need to be engaged in the definition and design of transition processes and identify patient goals of care.

    1.1. Expand the Patient and Family Advisory Council (PFAC) to Local Health Integrated Networks (LHIN) level and make use of Canadian Health Foundation's 'toolkit' on building patient committees.

    1.2. Ensure all of the options are shared with the patient and the treatment is known. Choices need to be laid out to the patient at all stages of the journey.

    1.3. A greater role in self-management needs to be undertaken so everyone is speaking the same language, e.g., Central East LHIN choices and changes program. There are also self-care guidelines where primary care practitioners can inform the patient to go to a certain site and get the information needed.

    1.4. After-death support is still needed, where currently the support ends very quickly. Need a better culture of patient-centeredness.

2. **Identify and leverage other resources:** Need to utilize other resources to assist in transition and re-entry.

    2.1. The Canadian Cancer Society (CCS) has thousands of volunteers who could be very helpful and supportive.

    2.2. Support could be enabled by reorganizing the system to have better geographic alignment, family practice affiliated with acute care, and Community Care Access Centres (CCACs) as an example.

    2.3. Ideal system would be to have a support system established at a community level as opposed to in the cancer centre, so patients could connect to community resources for varying levels of needs.

3. **Develop tools and share knowledge that enables all players**: Tools and knowledge need to be readily available to primary care, secondary care, other practitioners and patients to better enable seamless patient care.

    3.1. Tools used need to support primary care regarding the impact of oncology treatment, e.g., primary care involvement in survivorship programs for breast cancer patients. When women are transitioning out of cancer system – cluster them in groups of 10 and create that mentorship relationship.

    3.2. 'Discharge Kits' that outline clear patient pathways and help set expectations for care.

    3.3. In Central East LHIN, outreach coordinators make official calls to each primary care providers in the area, making inroads to show diabetic resources. They send resources that are laminated so the physicians know who to call and where to refer.

    3.4. For example, in the Netherlands doctors are educated to have the "right" conversations with patients regarding end-of-life. Videos of consultations were created for providers to understand how the conversation may occur. Could put together a campaign introducing the idea of advanced care planning, general awareness to normalize the idea, e.g., when you go to the emergency room.

    3.5. Advanced directives for end-of-life would be appropriate to assist with the communication. Yet, it can be difficult when the family's views on the directive are different from the patients' view. There is a need to involve the family early and to

provide support for the family. Could have advanced directives upon admission, therefore the providers know all the patients choices.

4. **Enhance communication between all providers across the whole journey:** Enhanced communication between specialists and primary care providers when taking on a patient (e.g., during survivorship) to discuss supports that would be required.

    4.1. For example, telemedicine visit with the family doctors, patient, family and palliative care specialist and the feedback was incredibly positive. This made the family doctors feel comfortable managing the patient, which prevented hospitalization and caused system savings and enhanced patient quality of care.

    4.2. Telemedicine has not been used to its full potential of supporting patients, specialists and family doctors. Need to involve a telemedicine champion. Telephone and email consults are now covered by Ontario Health Insurance Program (OHIP) so there are ways to improve care through this avenue.

    4.3. Funding models can impede primary care engagement in the case of palliative care. Need to engage the LHIN and Ministry of Health and Long Term Care (MOHLTC) to resolve this issue.

5. **Enhance information management systems**: EMRs will enable information sharing between primary care providers and specialists.

    5.1. It would be ideal to have EMRs that spanned across the system so information could go back and forth; link info to the patient and the family provider for connections so rapid re-entry can be provided if needed. This includes all aspects of care, e.g., palliative care when providers are not sure what to do.

    5.2. Cancer portal where you could go and get all the information you need – for clinicians, patients and families.

6. **Improve continuity of care across patient's journey:** Transfer back to primary care starts when the patient enters the cancer system and continues, not just at one point in time. Care and support is also still needed for the family after a patient's death.

    6.1. Transition is not really about hand-off, from day 1 all correspondence back to primary care should be educational and focused on planning. From the beginning the oncology team should tell the patient to stay in contact with primary care and explain that the primary care physician will need to take lead at times.

    6.2. Need information pertaining to transition from cancer system to primary care in writing with clear guidelines in terms of what is to be expected with regards to surveillance. Should be clear to primary care how to get the patient back in the cancer system (rapid re-entry) if needed.

    6.3. Primary care perspective: Stratification is important for people and geographically. Specialists need to try to understand and profile their practice (patients) as primary care does. For example, an average oncologists practice probably cannot profile their patients and determine when they will finish their treatment.

    6.4. Patient passport are suggested as a tool to manage after discharged care in a way that connects appropriately with primary care and patient empowerment. The passports need to be guideline based. Ultimate goal is to have passport integrated into the personal health record of each patient.

7. **Survivorship care plans**: The transition from specialist to primary care is shown to be effective in survivorship. Sharing of information and guidance in terms of follow up care with latest guidelines and evidence.

    7.1. For example, pilot a survivorship program and measure patient satisfaction, physician satisfaction and outcomes.

8. **Educate patients and providers on the role of primary care as the "medical home" to ensure continuity of the patients care:** Providing the patients with information about where they are at with their condition, when to seek follow-up, and to ensure guidelines get to primary care ensuring that everyone is on the same page.

    8.1. Engage the LHIN activities occurring for the palliative and end of life piece and ask specialists to advise patients upon entering to keep in touch with their family doctors throughout the journey.

    8.2. When promoting the role of family doctors amongst patients it is important not to demean their role. The overall messaging to patients needs to go out in a systematic way.

9. **Networking and educational sessions between primary care providers and specialists:** Ongoing mentorship from specialist to primary care providers. The physicians who are interested in system level change are the people to reach out to as they are the ones that will be the bridge between the system and their peers.

    9.1. Engagement and education between the cancer system and family doctors would be of value and the Ministry will help. In a LHIN such as Southeast, might have 6-7 clusters of family doctors. There is also a cluster of primary care physicians that specialist should reach out to, and discuss how they can work together for their patients. For example, each family doctor in the cluster will bring their charts of relevant patients and the expert will consult on the group of patients within the cluster-education on a patient the family doctor is dealing with right then and there will register.

    9.2. Ontario Renal Network (ORN) Mentorship Pilot: one committed nephrologist with 22+ primary care providers who expressed interest in understanding how to better manage chronic kidney disease (CKD) patients. The primary care providers came with their cases and there was 4 hours of consultation, teaching and dialogue, this process will continue for 18 months.

    9.3. Consider having these educational opportunities accredited for continuing medical education.

10. **Patient reported outcomes (PRO):** Add PROs within primary care settings for patients to identify their concerns and link them to appropriate services afterwards; not just for cancer follow-up but for other needs.

11. **Involvement of key players:** Key players should be involved to take action and leadership.

    1.1. All players need to be involved, including family doctors, other primary care physicians, specialists, MOHLTC, LHINs, patients, and the cancer system.

    1.2. Regional Cancer Programs (RCP) will be critical to address community needs, help develop patient-specific plans, and manage providers across domains.

1.3. System navigators and the scope of practice must be inter-professional.

1.4. Good use can be made of both registered nurses and community health staff.

1.5. Cancer Care Ontario has a role to play in managing performance. Successful transitions should be a performance measure for regional cancer programs.

1.6. All the players need to ensure priorities are set and adhered to.

TOPIC 3: On-going (non-treatment related) supports

Overarching question for the breakout session:
What are the critical next steps and which organizations need to be involved to support the bidirectional relationships throughout the patient's journey?

Action-oriented questions:
a) What is the highest priority action and what solution could be implemented tomorrow?
b) Who should be involved and what should be their responsibilities? *Give us your advice on the immediate next steps and who owns as well as who drives them.*

Specific areas that were outlined by November 29, 2012 attendees included:

1. **Need for cultural shift and change in mindset for providers and patients:** A culture shift is required through colleges, associations, and training from school. Providers need a change in mindset regarding the role of patients in their healthcare.

   1.1. A change in education will take a long time and may not be seen until the next generation. A culture shift is required on the part of patients as well, to be more active in their health. Some patients want to be told what to do by their physicians. Not easy to accomplish a culture change for patients when there is a vastly different level of education and need or want to be empowered.

   1.2. Current mindset of providers is a paternalistic view towards patients and a neglect to view patients as partners in their healthcare— happens to them rather than with them.

   1.3. Engage patients and families to be part of teams redesigning services and change view from 'to the patient' to 'with the patient.'

2. **Empower patients**: There needs to be empowerment of the patient so they feel they are allowed to ask for support. Dialogue is required to understand how involved patients want to be in their care/treatment. The question encompasses the need for more information to physicians, which will allow them to make informed decisions and subsequently the patients will be able to make better decisions.

3. **Create a long term plan**: A long term plan would help patients avoid having to scavenger hunt, absorbed in living than thinking about long-term effects.

   3.1. Create a portal to help navigate information and make it simpler for patients and their families.

   3.2. Additional support in psychosocial. There needs to be constant navigation between the system which can cause stress – is there added role and broaden scope. It is beyond the treatment aspect and it is varied across the province but it needs to become equitable.

3.3. Risk stratification to identify what the patients may need and/or standard screening tools for everyone who comes into contact with the patient.

4. **Availability and access to services:** Need to figure out a way to make services available to patients not attached to a family health physician, e.g., Black Creek Community Health Centre is a centre that offers great services and support. The services need to be affordable for the patients or they will not be utilized to their fullest capacity.

   4.1. Patients are often unaware of the services available to them. Care providers are also unaware and lack knowledge of what other providers are doing and providing to patients. Family doctors cannot be the only providers with the responsibility to educate patients.

   4.2. Need to build the resources, but the problem is the capacity in the system.

   4.3. There is an abundance of information available, yet it is difficult for health care personnel to provide filters and the right information at the right time.

   4.4. There are many services available for patients to access resources for their care, the ones discussed included:

   - North Simcoe Muskoka: Creates a central common resource, starting with the providers. They are starting to pool information to one place for easy accessibility by physicians, patients and families.
   - Google: There is access to information, but guidance is needed to ensure the qualities of the resources are adequate.
   - Health Coach Concept: Connects individual to resources. Resources could be a person or the patients could be linked by other methods, e.g., social media or video conferencing.
   - Kaiser Permanente Model: Everybody needs somebody. Resources are available from simple needs to complex needs, e.g., may need a nurse practitioner or translation.
   - Medical Home: Primary care should be able to provide a connection.
   - Wellspring: Back to work. Patient found out about this from speech language pathologist who saw a flyer posted at the hospital, it was serendipity and not planned.
   - Personal connection with provider, however, this is not the conventional approach: Determining when the patient's last treatment is and giving them a package including what the provider thinks the patient needs following treatment.
   - Email: Currently patients are unable to email physicians. With emails physicians need to be able to respond to them and be able to act on what they promise. Having a phone or email is a consult in funding models.