Our future health built with care

Integrated Care

Corporate Strategy 2012–2018 | Executive Summary

Ontario
Cancer Care Ontario

Integrated Care Framework

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

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

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

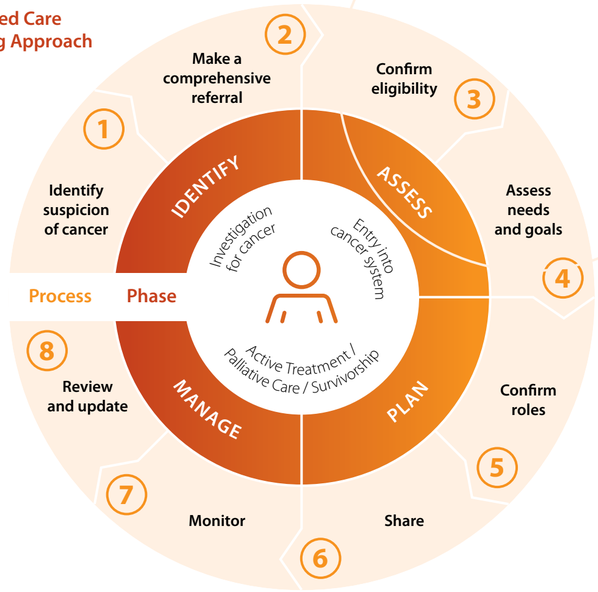
Cancer requires healthcare management across disease stages and types of care providers (including acute, community and primary care). A significant proportion of people with cancer are high users of the health system and thus require an integrated approach, particularly among patients who are more complex.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

Integrated Care Planning

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

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

Integrated Care Planning Approach



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

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

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

System Measurement

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

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

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

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

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

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

"Standardized integrated care planning offers an opportunity to improve the quality of care, empower patients, help with system efficiencies and help clinicians manage their practices better."

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

Examples of Integrated Care from Cancer Care Ontario

1 Diagnostic Assessment Programs

A program focused on improving diagnosis through implementation of a single point of entry to the cancer care system, supported by a multidisciplinary team.

2 Breast Diagnosis Assessment Project

A project focused on ensuring that individuals with signs and symptoms of breast cancer benefit from a coordinated assessment process and that newly diagnosed patients get the right pre-treatment.

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

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

4 INTEGRATE

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

5 Survivorship Care Improvement Project

A program focused on supporting patients in receiving the right follow-up care, surveillance testing and monitoring for late effects regardless of where care is provided.

Examples of Integrated Care from the Ontario Renal Network

1 Integrated Dialysis Care

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

2 Your Symptoms Matter

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

3 Dementia Capacity Planning

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

4 Ontario Renal Network Palliative Care

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

5 Chronic Kidney Disease Screening in Wikwemikong Unceded First Nation

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

To learn more about CCO's progress in Integrated Care, please see the full Integrated Care Report.
www.ccohealth.ca/en/integratedcarereport

620 University Avenue
Toronto, ON M5G 2L7
416.971.9800
accu@cancercare.on.ca
ccohealth.ca
ocp.cancercare.on.ca

Need this information in an accessible format?
1.855.460.2647, TTY 416.217.1815,
publicaffairs@cancercare.on.ca

Ontario
Cancer Care Ontario