

# Executive Summary

---

## Purpose of the Document

There is a growing demand for updated models of systemic treatment for cancer patients in Ontario. Increased demand for systemic treatment is driven by an aging population and advances in treatment, resulting in more complex care. The shortage of health human resources has had a profound impact on the delivery of ambulatory systemic treatment, affecting both providers and patients. Provider burnout, extended wait times, delays, and diminished accessibility to services have significantly impacted patients, especially those belonging to equity-deserving groups. Given the prevalence of provider burnout, it has become necessary to re-evaluate our existing models of care within the Ontario cancer system. While virtual care has been adopted, it may not be suitable for certain patient populations or appointments and can impact the delivery of team-based care. In response, Ontario Health (Cancer Care Ontario) has developed recommendations to optimize service delivery models for oncology providers and patients, using a range of methodologies including current state surveys, interviews, a multidisciplinary working group and focus groups with clinicians, patients, families, and care partners. The recommendations aim to optimize health care resources, settings, and processes in the oncology clinic, oncology pharmacy, and systemic therapy suite, improving provider well-being, sustainability of the cancer system, patient experience, and outcomes in cancer care.

A leading healthcare system is committed to weaving the principles of equity, inclusion, and diversity into its organizational fabric. This commitment forms the foundation for all our recommendations, which utilize an equity-focused lens to enhance outcomes for patients, families, care partners, and providers within the cancer care framework.

We acknowledge that Indigenous, Francophones, and equity-deserving communities face disparities in healthcare access and treatment outcomes. To address these disparities, we have crafted recommendations that specifically address the obstacles and challenges associated with ambulatory systemic treatment.

Our recommendations directly address the unique circumstances and needs of First Nations, Inuit, Métis, and Urban Indigenous (FNIMUI) communities, Francophones, and other underserved groups in Ontario. We recognize the distinct sociopolitical, historical, and geographical challenges these groups encounter, which influence their health disparities and outcomes. In accordance with our commitment to partner with FNIMUI communities, our efforts support the First Nations, Inuit, Métis, and Urban Indigenous Cancer Strategy 2019-2023, aiming to promote equitable access and smooth transitions for Indigenous people through the cancer care system.

In Ontario, the French Language Services Act (FLSA) guarantees that Francophones have access to services in their language within 27 designated areas across the province. The FLSA requires health service providers to actively offer and deliver services in French, ensuring the needs of Francophone communities are considered during the development and implementation of health programs, policies, and procedures.

While our recommendations highlight certain groups, the overarching aim is to improve healthcare accessibility, experiences, and outcomes for all communities deserving of equity. This commitment aligns with the Ontario Health [Equity, Inclusion, Diversity, and Anti-Racism Framework](#), propelling us towards a more inclusive healthcare environment.

The responsibility for achieving these recommendations extends beyond the systemic treatment facilities alone. We commit to working collaboratively between Ontario Health and Regional Cancer Programs to establish and implement the necessary next steps for these recommendations. This collective approach ensures shared accountability and facilitates more comprehensive, equitable and sustainable improvements in systemic treatment delivery.

## How to Read the Document

The recommendations are organized into the following sections:

- [Referral to Diagnostic Services for Suspected Cancer](#)
- [Referral to Medical Oncology, Hematology, and Gynecologic Oncology Services](#)
- [Scheduling Appointments for the Oncology Clinic and Systemic Therapy Suite](#)
- [Service Delivery in the Oncology Clinic](#)
- [Patient Education](#)
- [Order Verification and Drug Preparation](#)
- [Dispensing and Administering Community-Based Treatments](#)
- [Service Delivery in the Systemic Therapy Suite](#)
- [Proactive Monitoring, Symptom and Toxicity Management, and Unplanned Care](#)
- [Service Delivery Through Virtual Care](#)
- [Transitions in Care: Survivorship and End-of-Life](#)
- [Provider Health and Well-Being](#)
- [First Nations, Inuit, Métis, and Urban Indigenous Peoples](#)
- [Francophone Populations and Equity Deserving Groups](#)

Each section provides a set of recommendations along with an examination of the existing challenges, the importance of addressing them, key enablers for success, and implementation considerations and options. [Appendix A](#) provides further information on provider roles, which are discussed in more detail within the document.

The distinction between the [Regional Models of Care for Systemic Treatment: Standards for the Organization and Delivery of Systemic Treatment \(RSTP Standards\)](#) and this document lies in their purposes and functions. The Regional Models of Care standards serve as established standards for organizing safe and effective care and act as a benchmark for consistency and quality in systemic treatment delivery.

On the other hand, this document takes an aspirational approach by presenting a vision for the future of systemic treatment. It acknowledges the need for updated models of care and proposes recommendations to optimize service delivery. Its aim is to inspire positive change and guide the transformation of systemic treatment practices, improving patient experience, provider well-being, and healthcare outcomes.

## RECOMMENDATIONS

### [Referral to Diagnostic Services for Suspected Cancer](#)

1. Expedited and standardized referral and diagnostic processes should be established to streamline entry into the cancer system.
  - 1.1. A diagnostic service for suspected cancer should be established to enable timely and coordinated investigations for patients (e.g., bloodwork, diagnostic imaging, and biopsy).
  - 1.2. Standardized referral criteria should be established to assist referring physicians in determining which patients require referral, to reduce unnecessary or duplicate testing.
  - 1.3. Standardized lab and diagnostic imaging order sets aligned with guidelines and best practices should be developed to support high-quality clinical decision-making and referral to the first appropriate service.

### [Referral to Medical Oncology, Hematology, and Gynecologic Oncology Services](#)

2. A centralized referral intake system should be established to ensure that patients who require referral to medical oncology, hematology, or gynecologic oncology services are seen by the first available specialist within the hospital or region.
  - 2.1. A standardized workflow for new patient triage and prioritization should be developed to identify who reviews the referral and how quickly a consultation is scheduled based on clinical information, improving efficiency and workload balance among team members.
  - 2.2. The specialist should deliver the diagnosis to the patient, while also informing the physician who initially referred the patient to the diagnostic service.

### **Scheduling Appointments for the Oncology Clinic and Systemic Therapy Suite**

- 3.** Appointment scheduling for the oncology clinic and systemic therapy suite should be completed by individuals with knowledge and expertise to ensure that multiple interrelated factors related to scheduling are considered and adjusted based on changing resource availability.
- 4.** Evidence-based tools and technologies should be used to optimize resources and scheduling processes in the outpatient oncology clinic and systemic therapy suite.

### **Service Delivery in the Oncology Clinic**

- 5.** Local Cancer Programs should expand the type of providers included in oncology care teams to manage increasing patient volumes and care complexity in the oncology clinic.
  - 5.1.** The care team should be designed around the patient with a focus on developing consistent patient-provider relationships to ensure safe and effective coordination and continuity of care.
  - 5.** Providers should receive support to build their proficiency in providing person-centred care, encompassing palliative and psychosocial oncology concepts, as well as addressing the unique needs and preferences of diverse individuals.
  - 5.3.** Additional roles should be integrated into the oncology clinic:
    - Medical Oncologist/Hematologist/Gynecologic Oncologist
    - Alternate Prescribers (General Practitioner in Oncology, Nurse Practitioner)
    - Extenders (Physician Assistant)
    - Pharmacists
    - Clinical Nurse Specialists/Registered Nurses.
  - 5.4.** There should be established identification and referral processes in place to Psychosocial Oncology providers and Palliative Care teams along with other patient support roles (e.g., Drug Access Navigators, Patient Navigators).
  - 5.5** Medical directives should be effectively utilized, enabling team members to work autonomously, promote shared care or supervision of systemic treatment patients, and improve workload management.
  - 5.6.** The roles and responsibilities of each team member should be clearly defined with expectations clarified about how each discipline will communicate with each other and collaboratively provide patient care.
  - 5.7.** Local Cancer Programs should consider exploring opportunities to collaborate with hospitals in their regions to help manage clinic visits and provide care close to home, where appropriate (e.g., new consult at Level 1 or 2 hospitals with follow-up and urgent care at Level 3 or 4 hospitals).

- 6.** A non-same-day systemic treatment model should be implemented, where appropriate, to reduce patient wait times, increase provider and patient safety, and improve clinic flow and efficiency.
  - 6.1.** Local Cancer Programs should partner with community laboratories to enable patients to complete their bloodwork closer to home and utilize virtual care platforms to complete pre-treatment assessments, where clinically appropriate.
  - 6.2** Consider an 'exception' process for a one-day model for patients who may face barriers to accessing care.
- 7.** A standardized process, utilizing medical directives where appropriate, should be developed and implemented to obtain a timely treatment decision for commonly observed abnormalities or out-of-range findings from blood work and/or pre-treatment assessment.

### **Patient Education**

- 8.** Patients, families, and care partners should have access to health literate, inclusive education materials in the language that they feel most comfortable using to support them in managing their care, making informed decisions, and actively participating in their care.
  - 8.1** Resources should be evidence-based and incorporate health literacy best practices, including:
    - Writing resources in plain language (e.g., less than grade 6 reading level, appropriate level of understandability and actionability, created with patient and family advisor input)
    - Include diverse representation (e.g., adverse effects that may differ across skin tones, gender inclusive terms, cultural considerations)
  - 8.2** Resources should be available in accessible formats, including:
    - Compliance with the Accessibility for Ontarians with Disabilities Act (e.g., captions for images).
    - Translation into multiple languages
    - Availability in multiple formats (e.g., web, print, video, audio)
  - 8.3** A resource library of multilingual, inclusive education materials in plain language should be created at the provincial level.

### *Order Verification and Drug Preparation*

9. A tech-check-tech model should be utilized for systemic treatment preparation to ensure safe and efficient preparation practices, increasing pharmacy technician role satisfaction, while allowing pharmacists to focus on activities specific to their scope of practice.
10. Remote order verification and/or regional preparation and delivery of systemic treatment should be considered at facilities experiencing challenges with medication preparation efficiency, physical space needs, staffing challenges, and drug wastage issues.

### *Dispensing and Administering Community-Based Treatments*

11. A two-step clinical verification process should be used for treatments dispensed (e.g., take-home cancer drugs) and administered (e.g., infusions, injections) in community settings to prevent serious harm or adverse reactions that can result from medication errors.
  - 11.1. Community sites dispensing (e.g., take-home cancer drugs) and/or administering (e.g., injections, infusions) systemic treatment should have access to additional patient information with every prescription (e.g., lab test results, clinical parameters, care plan) to enable the completion of the clinical verification process.
12. Dispensing (e.g., take-home cancer drugs) and/or administration (e.g., injections, infusions) of systemic treatment should be conducted at designated community sites that have received additional education and training to ensure that patients receive consistent care and medication management throughout their treatment journey.

### *Service Delivery in the Systemic Therapy Suite*

13. Local Cancer Programs should explore opportunities to optimize workflows, allocate resources efficiently, and monitor nurse-patient assignments and the number of systemic treatments prepared per day to effectively manage the increasing patient and treatment volumes in the systemic therapy suite.
  - 13.1. Nurse-patient assignments should be distributed equitably throughout the day.
  - 13.2. The number of drug preparations that pharmacy staff can complete per day should take into account the availability of pharmacy technicians, number, and capacity of biological safety cabinets (BSCs) as well as the presence of any available technology (i.e., IV workflow solutions or robotics).
  - 13.3. Mid-cycle treatment assessments (e.g., Day 8 and 15) should be completed either virtually or in person before the patient meets with the administration nurse for infusion setup.
  - 13.4. Pre-approved orders with clinical parameters should be created to prevent unnecessary delays or interruptions on treatment day (e.g., through medical directives, built into Computerized Prescriber Order Entry regimen order sets).

- 13.5.** Chair time for patients on clinical trials should be reviewed and approved by the hospital-based pharmacy and therapeutics committee to ensure that it is used efficiently and effectively.
- 13.6.** Local Cancer Programs should work with other areas of the hospital (e.g., day medicine unit) to accommodate supportive care treatment (e.g., hydration, blood product infusions).
- 13.7.** Local Cancer Programs should consider exploring opportunities to collaborate with hospitals in their regions to improve patient access to treatment, where appropriate (e.g., administering the initial treatment at Level 1 or 2 hospitals, followed by subsequent treatment at Level 3 or 4 hospitals).
- 13.8.** Patients who require supportive care or injections (e.g., hydration or hormone injections) should be referred to Home and Community Care Support Services (HCCSS), participating community pharmacies, as well as community-based injection services. Alternatively, patients who meet criteria can be taught to self-inject or have a care partner assist with injecting with proper education and training.
- 13.9.** If private infusion clinics are utilized, Local Cancer Programs should establish oversight through a memorandum of understanding (MOU), in accordance with the [Regional Models of Care for Systemic Treatment: Standards for the Organization and Delivery of Systemic Treatment](#).

#### **Proactive Monitoring, Symptom and Toxicity Management, and Unplanned Care**

- 14.** Proactive monitoring, symptom, and toxicity management plans should be developed and implemented by Local Cancer Programs for patients receiving systemic treatment, particularly for high-risk patients (e.g., double immunotherapy, concurrent chemotherapy/radiation treatments, acute leukemia, head and neck cancers) to optimize self-management and decrease the need for acute care services.
- 15.** Acute oncology structures should be established for unplanned care to reduce emergency department visits and hospital admissions.

#### **Service Delivery Through Virtual Care**

- 16.** Local Cancer Programs should establish a dedicated Virtual Care Coordinator role to enhance the utilization, comfort, and overall experience of virtual care for patients and providers.
  - 16.1.** If patient volumes are low, smaller centres may assign the Virtual Care Coordinator's responsibilities to other administrative staff to ensure continuity of virtual care services.

- 17.** Local Cancer Programs should explore opportunities to integrate virtual care services and implement standardized processes to optimize care delivery.
- 17.1.** Local Cancer Programs should identify areas where virtual care can be used to optimize care delivery (e.g., follow-up visits, patient education).
  - 17.2.** Virtual care should be flexible and adaptable to address patient, family and/or care partner preferences including scheduling, language, and cultural considerations.
  - 17.3.** Virtual care should be designed to foster patient, family and/or care partner engagement and participation in their care (e.g., symptom screening tools, patient education).
  - 17.4.** Patients, families, and/or care partners should be provided with education and resources including proactive support to help them prepare for the virtual visit to avoid interruptions or delays during the appointment.
  - 17.5.** Virtual visits should be scheduled with a similar structure, including designated appointment times, as in-person appointments, with every effort made to reduce patient, family, and/or care partner waiting times.
- 18.** Patients should have access to multidisciplinary care in the virtual setting to ensure that they receive all the supports and services they need for their care.

#### **Transitions in Care: Survivorship and End-of-Life**

- 19.** Local Cancer Programs should have a transition model that provides standardized survivorship and follow-up care to support the ongoing needs of patients who have completed systemic treatment or are currently on adjuvant hormonal therapy.
- 19.1.** Survivors should transition to a level of care that is more tailored to their current needs with access to specialized resources and support systems such as psychosocial oncology, structured self-management, and group-based programs.
  - 19.2** A streamlined process should be established for re-entry into Local Cancer Programs, if required.
- 20.** The oncology and palliative care teams, in collaboration with patients, families, and care partners, should regularly engage in discussions and utilize validated tools to guide palliative care provision and to determine the appropriate timing for transitions to end-of-life care.
- 20.1.** The oncology care team should have access to palliative care supports and services in the community to help address the needs of systemic treatment patients when they become more extensive or complex than the oncology care team can manage.



### *Provider Health and Well-Being*

**21.** Local Cancer Programs in conjunction with organization leadership should develop a comprehensive plan to address provider wellbeing.

**21.1.** Organizations should:

- Identify the root causes of provider burnout.
- Implement changes that are proposed to address the root causes.
- Measure and assess the change in provider well-being.
- Create dedicated leadership roles to address provider well-being.

**21.2.** Organizations should consider provider well-being in any process or policy change including technology and health information services.

### *First Nations, Inuit, Métis, and Urban Indigenous Peoples*

**22.** Local Cancer Programs should develop and implement a voluntary, confidential self-identification process for patients who identify as First Nations, Inuit, Métis, or urban Indigenous to enrich the patient experience, improve health services, identify areas of need in the health care system, and provide data to measure the effectiveness of health care for Indigenous patients.

**23.** All members of the oncology team should be aware of the Non-Insured Health Benefits (NIHB) program and how to access it for eligible First Nations and Inuit patients.

**23.1.** Ontario Health should advocate to the NIHB program to change processes to allow:

- Indigenous Navigators to sign-off on patient applications.
- Flexibility in providing supports through the NIHB program to enable additional care partners and family members to easily accompany First Nations and Inuit patients to medical appointments and pre-assessment tests.

**24.** In partnership with Indigenous leadership and health care providers, co-design patient resources, care delivery policies and processes that utilize grassroots, participatory and collaborative approach and incorporate cultural knowledge into all aspects of care.

**24.1.** Facilitate the hiring of First Nations, Inuit, Métis and urban Indigenous peoples for navigation, coordination, peer support, and resource development roles within Regional Cancer Programs.

- 24.2.** Ontario Health, in partnership with Regional Cancer Programs, should advocate to formalize and appropriately resource the Indigenous Navigator role expansion across all regions to coordinate and connect patients with community care and social services programs, arrange language interpretation services, and facilitate connections with Indigenous Elders, Traditional Healers, or Knowledge Keepers and the oncology care team.
- 24.3.** Oncology care teams should work in partnership with Elders, Traditional Healers, Knowledge Keepers, and Indigenous providers, to support holistic care that addresses cultural, social, and medical needs.
- 24.4.** All members of the oncology care team should be required to complete mandatory Indigenous cultural safety and awareness training to ensure culturally appropriate, person-centred care delivery.

### **Francophone Populations and Equity Deserving Groups**

- 25.** Local Cancer Programs should enable patients to self-identify with a community or group and indicate specific preferences or needs at the onset of their cancer care, ensuring they are matched with appropriate information and supports, including translation and interpretation services, which remain accessible throughout their entire journey.
  - 25.1.** Aligned with the *French Language Services Act* in Ontario, oncology care teams should identify Francophone and French-speaking individuals and be trained in active offer of French-language services to patients, families, and care partners.
- 26.** The oncology care team should assess the financial, transportation, and other social supports or needs of all patients upon entry to the cancer system and identify and provide appropriate interventions, while facilitating access to supports and services based on the unique needs of each equity-deserving group.
  - 26.1** In collaboration with community members, advocacy groups, and support organizations, Local Cancer Programs should strive to develop patient navigation services and peer support programs that are specifically tailored to the unique needs of Francophone populations and equity-deserving groups.
  - 26.2.** Local Cancer Programs should increase awareness, promote, and enable access to existing patient and provider resources available, including French language materials, on the Ontario Health (Cancer Care Ontario) website.
  - 26.3.** Local Cancer Programs should develop local content that can be translated into French and other non-English languages based on the demographic needs of their population.
  - 26.4.** Local Cancer Programs should implement referral systems that facilitate a smooth transition and provide access to tailored community-based supports and programs for equity-deserving groups.