Ambulatory Care

Strategic Plan

2013-2016

Exemplary Patient-Centred Ambulatory Care Experiences

UHN Princess Margaret Cancer Centre

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1.0 Executive Summary

Princess Margaret Cancer Centre (PM) is Canada's largest cancer centre with more than 18,000 new cancer patients seen each year. With ongoing research, education and innovation, PM continues to be at the frontier of medical, surgical and radiation oncology; embracing the latest technology, international best-practices, and setting standards for patient care.

The Ambulatory Care program at PM receives 400,000 visits annually and provides specialized diagnostic, treatment and follow-up care to patients locally, provincially and nationally. This care is delivered by approximately 3,000 highly specialized inter-professional oncology professionals from across 12 disease site groups.

With an increase in cancer awareness, early detection and diagnoses, treatment care complexities, and an aging population; PM must transform patient care to meet the growing needs of patients. PM strives to advance innovative ambulatory care models, research, and clinical practices to deliver the highest quality cancer care for our patients and families. To create a sustainable oncology system, the Ambulatory Care program will empower patients as partners in care decisions, ensure care outcomes are achieved in an integrated and seamless method and utilize resources efficiently and effectively.

To transform, the PM Ambulatory Team must support an environment that advances collaborative and integrated care, fosters inter-professional teams, maximizes talent and expertise, and cultivates a culture of inquiry and quality performance.

With a focus on research and personalized cancer medicine, the Ambulatory Care Program is committed to innovate and enhance care delivery pathways and patient experiences. The 2013-2016 Ambulatory Care Strategic Plan will create the roadmap to deliver "*Exemplary Patient-Centred Ambulatory Care Experiences*".

In 5 years, the Princess Margaret Cancer Centre will:

- Foster site specialized inter-professional collaborative teams
- Improve the patient experience and outcomes by delivering high-quality care
- Create innovative models of care that ensure seamless coordinated patient care
- Create a sustainable ambulatory cancer program that optimizes effective and efficient use of resources
- Integrate patient care with research and education across the patient journey

2.0 Background and Context

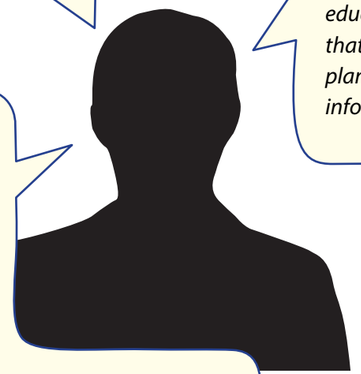
It is estimated that the number of Canadian women and men affected by cancer is 40% and 45%, respectively[1]. Changes in the prevalence and treatment of cancers are occurring rapidly and have been driven by research-based evidence[2]. These improvements mean that more patients are cured and require monitoring, and patients with incurable cancers are living longer and receiving increasingly complex treatment for longer periods of time. Many innovative oncology treatment options can be delivered on an outpatient basis and this demand is increasing at a rate of 5% per year.

There is significant evidence that coordinated service delivery models improve clinical and patient outcomes. As such, processes that improve service integration are fundamental to an enhanced cancer system. The Princess Margaret Ambulatory Strategic Plan recognizes that the current cancer journey must be transformed and guided by the vision of providing an "*Exemplary Patient-Centred Ambulatory Care Experience*".

We commit to exemplary patient experiences…

My physician referred me to the Princess Margaret Cancer Centre and received prompt acknowledgement with an appointment time, including instructions where I was to go, what to do and what to expect.

Upon arrival at PM, I was immediately greeted by my care team who explained the process in a comforting setting. The inter-professional team assessed my needs and provided exceptional education and support. Before leaving that first appointment, I had a written plan of next steps and valuable contact information.



As my Princess Margaret journey continues, my family and I feel well supported and know we are receiving timely, exemplary care from the right provider at the right time. During treatment, my physician is kept informed of my progress and is given clear guidelines on how to support me when I am transitioned from PM back to the community. I am confident, that if the need should arise, I can easily return to the Princess Margaret for further assessment and treatment.

A few days later, I received a phone call from the nurse, to follow up and answer any outstanding questions that I had.

1 Canadian Cancer Society's Steering Committee on Cancer Statistics. Canadian Cancer Statistics 2011. Toronto: Canadian Cancer Society, 2011. p. 5.

2 Romanow, Roy J. "Building on Values: The Future of Health Care in Canada." Commission on the Future of Health Care in Canada. Nov. 2002. 9 Aug. 2004 <http://www.hc- sc.gc.ca/english/pdf/romanow /pdfs/HCC_Final_Report.pdf>.

3.0 The Ambulatory Care Model at Princess Margaret

The Princess Margaret Cancer Centre at the University Health Network (UHN) in Toronto, Ontario, is the largest cancer program in Canada. This world-class comprehensive cancer program consists of almost 3,000 staff, managing over 400,000 patient visits annually. Princess Margaret sees over 1,000 patients each day, delivering diagnostic, treatment and follow-up care.

The Ambulatory Care service is organized as a matrix of modality-based departments, structured across 12 disease site-specific inter-professional groups. Over 350 clinics are arranged by oncology sub-specialty in radiation oncology, medical oncology, surgical oncology, and psychosocial palliative care. Each disease site group is governed by a medical Site Group Lead and a Patient Care Coordinator.

Ambulatory Care Teams promote specialized care practices and collaborative care delivery to support wellness and healing, at all stages of a patient's cancer journey. Integrated in this team approach is the clinical and academic teaching of Medical, Nursing, and Health Professional students.

Ambulatory Clinics	Healthcare Team
1. Breast	***Oncologists***
2. Central Nervous System	***Physicians (e.g. Psychosocial, Palliative, etc.)***
3. Endocrine (e.g. thyroid, pituitary)	***Nursing***
4. Gastrointestinal (GI) (e.g. colon, liver, pancreas)	***Health Professionals (e.g. SW, Dietician, SLP, etc.)***
5. Genitourinary (GU)	***Administrative/Clerical Staff***
6. Gynecology	***Support Staff***
7. Head & Neck	***Research***
8. Hematology (e.g. BMT, Lymphoma, Myeloma & Leukemia)	***Residents/Fellows/Students***
9. Lung/Thoracic	***Volunteers***
10. Ocular/Eye	
11. Sarcoma	
12. Skin/Melanoma	

4.0 Strategic Planning Process

4.1 Ambulatory Care Strategic Plan Journey 2009-2012

Recognizing rapid growth of outpatient cancer services in 2009, PM focused strategic objectives to design, implement and evaluate a new Model of Ambulatory Care that improves the patient experience, creates effective inter-professional teams, and optimizes clinic efficiency. To achieve this, several initiatives and work flows were developed. The transformation to a disease site based model, embraced the functions of inter-professional teams centred on patients.

4.2 Ambulatory Care Strategic Plan Refresh 2012-2013

In May 2012, the Ambulatory Care Steering Committee decided to refresh the strategic direction and develop a plan for the next three years (2013 to 2016). Key stakeholder consultations provided advice in identifying the priorities for change.

In October 2012, a one-day Retreat was held to set the direction and vision for the Ambulatory Program. The Retreat identified areas of importance and strategic themes of focus for the future.

4.3 Strategic Plan Alignment

The Princess Margaret Cancer Centre's Strategic Plan (2013-2018) has set the direction for the Ambulatory Care Service to *Transform the Delivery of Patient Care*.

The Ambulatory Care journey includes laboratory and pathology services, medical imaging, chemotherapy and transfusion medicine, and radiation therapy and planning. In addition, to support the needs of cancer patients, patient care experiences may include acute care, inpatient and other outpatient resources.

For the context of this Strategic Plan, Ambulatory Care includes the disease site groups' clinical structure and inter-professional staff. Implementation of strategic projects will occur in conjunction with these partnering programs to complement their strategic priorities and align with the Cancer Centre's overall Strategic Plan.

The goals and objectives of the Ambulatory Care Strategic Plan (2013-2016) reflect the need for integrated patient-centred care, evidence-based cancer care, treatment complexity, and the increased demand for efficient and effective use of health care system resources. The Ambulatory Care Strategic Plan will focus on our patients' experiences, outcomes, staffing and service delivery. This plan will provide an approach to system changes that focus on clarity and informed decision-making.

5.0 Ambulatory Care Strategic Plan Framework

VISION

Exemplary Patient-Centred Ambulatory Care Experience

MISSION

To transform, implement and evaluate the ambulatory care experience that achieves excellent patient care, improves the patient experience, creates effective inter-professional teams, integrates clinical care, research and education and optimizes clinical efficiencies at the Princess Margaret Cancer Centre

GOALS

WE

Foster site specialized inter-professional collaborative teams

CARING

Improve the patient experience and outcomes by delivering high-quality care

CREATIVE

Create innovative models of care that ensure seamless coordinated patient care

ACCOUNTABLE

Create a sustainable ambulatory cancer program that optimizes effective and efficient use of resources

ACADEMIC

Integrate patient care with research and education across the patient journey

5.1 Ambulatory Care Guiding Principles

Guiding Principle	Patient Perspective	Clinician and Staff Perspective
Excellent Patient Care Experience	• Addressing physical, emotional and psychosocial needs • Knowing team members • Timely access to the healthcare team • Having all relevant information • Involving family in care planning • Including patient feedback to foster changes	• Meeting the needs of the patient through integrated best practice procedures, processes and flow • Optimizing clinic efficiencies to improve point-of-care • Coordinating care for a seamless patient experience
Inter-Professional Collaborative Teams	• Partnering in care planning • Experiencing coordinated, seamless care • Knowing the healthcare team is working together to deliver the best possible care	• Collaborating to make effective decisions • Creating work-life balance • Establishing team empowerment and equity • Defining, understanding, and appreciating the team's role
Culture of Innovation & Discovery	• Participating in leading edge, personalized cancer medicine • Supporting and integrating the latest research for the best possible outcomes	• Establishing environments where creativity is encouraged and supported • Inspiring and challenging each other to advance discovery • Recognizing efforts in a culture of innovation
Continuous Quality Improvement	• The safest care provided by a cohesive care team • Seamless transitions throughout the cancer journey • Striving for improved quality	• Creating a culture of inquiry, evaluation and continuous improvement • Delivering safety in practice • Standardizing tools and resources
Research Integration in Clinical Care	• Receiving personalized cancer medicine • Engaging as a partner in research	• Practicing evidence-based care • Creating links between quality and clinical outcomes • Applying research to practice • Establishing shared accountability • Accessing and delivering new research
Culture that Enhances Patient Safety	• Trusting the system and its healthcare providers • Providing feedback when safety concerns arise	• Working in a safe environment • Prioritizing organizational initiatives to improve patient safety • Creating systems to alert, review & evaluate changes

6.0 Strategic Goals

The strategic goals will enable the Ambulatory Care Team to holistically support patients and their families with the right information and tools; empower patients as partners in their care; and develop new models of care to address the unique needs of cancer patients. Each goal aligns with the guiding principles.

WE *Foster site specialized inter-professional collaborative teams*

Exceptional ambulatory care is the direct result of the devoted team members who contribute to each patient's journey. By focusing on our people and fostering a collaborative work environment, the foundation required for an effective team will be formed. The Site Operations Committee structure will capitalize on teamwork for effective decision making and communication. Education, training, and working at full scope of practice will ensure ambulatory staff are equipped with the right tools to deliver the highest quality care to meet the patient's needs. To advance staff engagement and promote team building, new recognition programs and team goal setting will encourage a positive work environment.

Goal #1 Each team will have a clear governance structure to support clinical care and management

i. Each site will create an inter-professional Site Operations Committee structure to govern and drive operational performance. Membership will also include representatives from partnering programs and services. This foundational structure will enable effective decision making to enhance the Ambulatory Care team.

ii. Each site team will develop and implement annual team priorities that align with the Ambulatory Care Strategic Plan.

Goal #2 Enhance highly engaged and effective working inter-professional teams

i. Develop and define team member's role and scope to enhance clarity and performance expectations. This will ensure effective and collaborative teams with accountability and appreciation. The right team member will be completing the right function.

ii. Create an engaging work environment that fosters collaboration, idea generation, and knowledge sharing from all team members.

iii. Create, implement, and evaluate team specific educational materials such as orientation manuals, clinical and operational standards of practice.

Goal #3 Develop tools and processes that enable clear transitions between providers, site teams, departments and modalities

i. Establish care team communication pathways for high risk and complex patient populations (e.g. concurrent therapy, palliative, identified coordinating physician and clinical trials).

ii. Expand care collaboration via inter-professional debriefs and MCC rounds.

iii. Establish an Ambulatory Care communication strategy to share expertise and learning across disease sites.

Goal #4 Promote a work environment that supports balance and wellness of all staff and is based on mutual respect, transparency, engagement, and leadership at all levels

i. Create an Ambulatory Recognition Program for individuals, peers, teams, and site groups.

ii. Develop team charters that promote positive engagement and team building.

iii. Create a welcoming and comfortable clinic environment for patients and staff members using service excellence standards of practice.

iv. Promote and exemplify UHN staff wellness and work-life balance strategies to improve staff satisfaction, health and absenteeism.

CARING *Improve the patient experience and outcomes by delivering high-quality care*

To ensure patients receive personalized, evidence-based care, Ambulatory Care Services will transform to a culture of excellence by implementing seamless and coordinated care pathways. Educational materials will be designed to explain the care journey steps, treatments, and identify team members to improve navigation for patients and their families. Emphasis on patient-reported distress screening and symptom management approaches will improve quality of care, outcomes, identification and access to supportive services. With patients as partners, personalized care planning will capture what matters most to our patients.

Goal #1 Create the best experiences for patients across their personal care journey

i. Develop standard navigation pathways for patients, outlining care treatment expectations, their care team members, and overall clinic information.

ii. Maximize the Patient Portal and enable patients' home access to their PM information including appointment scheduling.

iii. Design and implement patient experience surveys to assess care experiences at all points of interaction.

iv. Explore and implement efficient, coordinated booking strategies to optimize the patient's time spent at PM (external blood work, imaging, pathology, external partners, etc.).

Goal #2 Develop disease specific clinical pathways across the care continuum that include standard patient and provider education, order sets and clinical documentation

i. Each team will create clinical pathways within their site group that improve care coordination and care planning.

ii. Embed clinical trials and research accrual practices as a standard of care for all patients.

iii. Create a standardized annual review process to modify and evaluate the effectiveness of clinical pathways.

Goal #3 Develop standard ambulatory processes that ensure consistent, quality and seamless care

i. Develop and implement standardized processes and tools that ensure seamless care transitions amongst care providers internal and external to Princess Margaret (IT, e-referrals, discharge summaries, etc.).

ii. Enhance communication pathways with primary care providers throughout treatments to enable partners in care across the continuum.

iii. Develop and implement a patient-centred ambulatory palliative care model and algorithm to support patient and provider needs.

iv. Create an Open House Program to educate ambulatory staff on the services and resources available to their patients.

Goal #4 Support patients holistically to improve care goals, symptom management and quality of life

i. Lead and evaluate practice changes that support distress screening and symptom management across site groups.

ii. Improve symptom management documentation practices to improve quality of care and patient outcomes.

iii. Create strategies and materials to assist and support patients with treatment options and decision-making.

CREATIVE *Create innovative models of care that ensure seamless coordinated patient care*

Ambulatory Care Teams will promote and encourage a culture of discovery and innovation that challenges current care models to meet the ongoing needs of patients. Through creative approaches and collaborative partnerships, Ambulatory Care Teams will strive to advance the delivery of cancer care and emphasize the integration of research into clinic operations across the continuum of care. Team collaboration will enable knowledge sharing, problem solving, and bring forth new enhancement opportunities. As subject matter experts, Ambulatory Care staff will participate in new program and pathway development. Creating an environment and process conducive to fostering new ideas will accelerate innovation and heighten team engagement.

Goal #1 Each site will actively challenge and evaluate current practices to determine new models of care

i. Establish a Think Tank Innovation Forum to identify top ambulatory issues and collaborate around solution design with both providers and patients.

ii. Create regular forums and sessions for team members to reflect on current processes.

Goal #2 Create and implement an inventory of existing and future partnership opportunities for collaboration

i. Expand site capacity to support vulnerable cancer populations including adolescent and young adults (AYA), geriatrics, and palliative patients.

ii. Identify future partnership opportunities for strategic development in addressing population needs for cancer care.

Goal #3 Explore opportunities for a virtual follow-up visit and outreach structure

i. Review and evaluate the opportunity to design virtual visits to enhance the patient experience.

ii. Explore the development of mobile applications to improve provider efficiency and satisfaction.

Goal #4 Active participation in UHN's Advance Clinical Documentation for Cancer Program

i. Ensure new systems meet our Ambulatory Care Team needs by participating as clinical and technical experts.

ACCOUNTABLE

Create a sustainable ambulatory cancer program that optimizes effective and efficient use of resources to meet the ongoing needs of our patients

The Ambulatory Care Service is committed to building a sustainable system that meets the growing cancer demands. Creating capacity and evaluating appropriate utilization of existing resources and staffing models will be essential. Each disease site group will be responsible for creating and managing criteria for referrals and discharges to ensure appropriate system utilization. Focusing on integration beyond the Ambulatory Care Service will support acute care management and build effective system capacity. Proactive health human resource planning will be an essential strategy for talent management recruitment and retention. In addition, reporting structures and performance reporting standards will form an accountability framework to manage quality and safety across Ambulatory Care Services. Delivering the safest quality care will be a top priority monitored by ongoing data review, quality reports, and satisfaction surveys.

Goal #1 Develop and support an acute care management strategy

i. Identify acute patient volumes and needs to develop supportive and sustainable strategies for an acute care model.

ii. Evaluate resources required for each site group to meet current care delivery needs.

Goal #2 Create sustainable capacity growth for proactive resource planning

i. Develop criteria and algorithms at all care transition points (to and from Ambulatory Care Clinics), to enhance care coordination and the patient experience (e.g. acute, primary and palliative).

ii. Perform and evaluate succession planning for each inter-professional discipline across disease site groups.

iii. Develop criteria to ensure appropriateness of new and follow-up patients. Strategies will be developed for ongoing evaluation to ensure PM is meeting the needs of the current cancer demand.

Goal #3 Establish regular performance reporting processes and metrics for decision making and evaluation

i. Implement and manage utilization of site scorecards and data infrastructure to measure and monitor performance. Evaluate metrics to ensure sites are tracking the most appropriate indicators to improve patient care and experience.

Goal #4 Enhance a culture of safety across Ambulatory Care Services

i. Evaluate and implement best practices and standards of care for patient safety including Positive Patient Identification (PPID), infection, prevention and control (IPAC), falls prevention, and occupational health requirements.

ii. Review quality reports and incident trending to identify opportunities for continuous improvement strategies across Ambulatory Care Services.

ACADEMIC

Integrate patient care with research and education across the patient journey

Creating the *Research Hospital of the Future* will require academic leadership and a culture of discovery. Ambulatory Care Teams will expand the focus on clinical trials enrolment and embedding data collection practices into care. The standard of care will reflect a research component resulting in a greater emphasis on participant accrual within Ambulatory Care Clinics. As well, optimization of care delivery will require maximum utilization in scope of practice for all Ambulatory Care roles. Education and research integration will further advance cancer care delivery models, treatments and outcomes, and develop healthcare leaders.

Goal #1 Promote and support continuing education and training for all team members

i. Develop new staff, student and volunteer orientation manuals for each site group.

ii. Create education strategies across sites that foster knowledge translation and a greater understanding of team roles and the patient's journey.

iii. Promote and support continuing education opportunities for ongoing professional development.

Goal #2 Increase opportunities for patients to participate in research and clinical trials

i. Enhance alignment of research and clinical trials teams with disease site groups through communication and education initiatives.

ii. Create processes that foster research integration.

iii. Expand recruitment and enrolment strategies as standard of care within Ambulatory Care Sites.

Goal #3 Integrate translational research and correlative research into clinical practices

i. Assess and evaluate current data management and outcome reporting in Ambulatory Care Sites.

ii. Promote knowledge and awareness of current research opportunities through creation and dissemination of research inventory.

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