



INSPIRING INNOVATION IN SERVICE DELIVERY:  
Optimizing the Cancer Workforce Symposium

A Summary of Symposium Findings

January 25-26, 2010  
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Montréal Québec

CANADIAN PARTNERSHIP AGAINST CANCER  
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The Canadian Partnership Against Cancer

## ACKNOWLEDGEMENTS

The Canadian Partnership Against Cancer sincerely thanks the members of the Health Human Resources Action Group's Symposium Planning Committee & Service Delivery Models Project Steering committee for their time, dedication and assistance in developing the program and planning all aspects of the symposium. The full listing of the committee members is provided in **Appendix A**.

The participation of all individuals who prepared posters and made presentations at the symposium is gratefully acknowledged. The richness of the posters and presentations was instrumental to the success of the event.

Thank you as well to Evelyn Lazare for attentiveness and creation of this report.

The Partnership extends their appreciation to the the Health Human Resources Action Group team: Andrew Padmos, Christine Da Prat, Jody Layer and Muneerah Kassam for their commitment and hard work in organizing the symposium.

Lastly, we thank you the participants for sharing your successes and challenges. The overwhelming response we received to the symposium and subject matter demonstrates the need for this type of forum and learning.

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## THE CANADIAN PARTNERSHIP AGAINST CANCER

The Canadian Partnership Against Cancer is an independent organization funded by the federal government to accelerate action on cancer control for all Canadians. We bring together cancer survivors, patients and families, cancer experts and government representatives to implement the first pan-Canadian cancer control strategy. Our vision is to be a driving force to achieve a focused approach that will help prevent cancer, enhance the quality of life of those affected by cancer, lessen the likelihood of dying from cancer, and increase the efficiency of cancer control in Canada.

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## Executive Summary



The Canadian Partnership Against Cancer's symposium, *Inspiring Innovation in Service Delivery: Optimizing the Cancer Workforce* broke new ground in addressing the issue of health human resource (HHR) challenges facing the cancer control system. It did so by inviting a wide variety of healthcare professionals, from both within and external to the cancer control system, to learn from each other and to think collectively about overcoming these challenges.

Through the opening and closing keynote addresses and plenary sessions, participants were encouraged to think beyond their particular jurisdiction and/or profession. The breakout sessions offered the participants the opportunity to hear about real models that have been developed to address particular cancer control issues. Each model presented includes a health human resource component: some stretch current scopes of practice; others have created new roles; still others have changed roles completely. More information on the models was made available throughout the symposium on posters, in the program booklet and on computer terminals hosting the developmental version of the model repository. Finally, the World Café brought all participants together, engaging them in a dynamic process of identifying problems, listing barriers and developing strategies to overcome the HHR challenges faced by the cancer system.

The discussions that followed the breakout sessions and the various panels, as well as the World Café, came to largely the same conclusions: that patient-centred, shared care is the preferred goal for cancer control including care; that technology can be utilized to enhance both communication and the delivery of services, whether real or virtual; and that further research can be channelled to demonstrate sound business cases for best practices across the country.

## Inviting Collaboration



“Science and medicine make it possible to have a world without cancer, but only people can make that a reality.”<sup>1</sup>

Andrew Padmos, MD FRCPC  
*Opening Keynote Address*  
 Chair  
 Health and Human Resources Action Group

The Health Human Resources Action Group of the Canadian Partnership Against Cancer (the Partnership) launched a three-part project in 2008 to gather models of cancer care and control highlighting innovative deployment of the workforce. The first phase of the project resulted in a comprehensive framework to describe innovative models of cancer care delivery in a consistent manner. The second phase, involves identifying and reviewing some 150 models of leading, innovative and promising care delivery, to populate and be shared electronically through Cancer View Canada.

The third phase of the initiative calls for fostering collaboration among the community of cancer control professionals involved in the planning, development and implementation of service delivery models. This phase essentially started with the symposium, titled “*Inspiring Innovation in Service Delivery: Optimizing the Cancer Workforce*” that took place on January 25 and 26, 2010, in Montreal. The goals of the symposium were to:

- Showcase innovation in service delivery in general and in health human resources in particular;
- Explore how to incorporate and adopt various service delivery models into planning efforts and to exchange ideas on leading practices;
- Identify opportunities for organizations to adopt aspects of innovative and leading models; and
- Identify opportunities for the Health Human Resources Action Group to promote innovation and implement the key outcomes of the symposium.

During the symposium, some 150 participants presented, listened, questioned, viewed, debated, discussed and, through the innovative process of a World Café, collaborated on positively focusing the agenda of health human resources for cancer control and care. This report aims to capture the essence of the dialogue and to summarize the energy of the participants. The symposium session schedule is provided in **Appendix B**.

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<sup>1</sup> National Cancer Policy Forum. Ensuring Quality Cancer Care through the Oncology Workforce: Sustaining Care in the 21st Century, Workshop Summary. Washington, DC.

## Encouraging Participation



The severity of the human resource challenges facing the healthcare system in general and the cancer control and care system in particular is well-known. The symposium brought together healthcare professionals from a wide variety of disciplines and a range of jurisdictions to share their models of care and to learn how others have developed approaches to address health human resource challenges. Recognizing from the outset that the solutions cross many jurisdictions as well as professional groups, the Partnership reached out broadly to attract a multi-disciplinary and multi-jurisdictional group of registrants. Participants came from all ten provinces; some also had national, international or territorial responsibilities.

The attendees represented many disciplines: academia, advanced practice nursing, clinical nursing, dietetics, epidemiology, human resource management, health administration, management consulting, medical biology, medical laboratory technology, medical oncology, medical physics, occupational therapy, oncology nursing, patient advocacy, patient navigation, pediatric oncology, physiotherapy, planning, policy analysis, psychiatric nursing, psychosocial oncology, quality control, radiation oncology, radiation therapy, research, science, social work, specialty nursing, speech and language pathology, and volunteers. Further, many participants wore more than one hat.

The health professionals came from aboriginal, rural and remote service settings, ambulatory care settings, cancer advocacy groups, cancer registries, clinical trials groups, home care, hospitals, hospital-based cancer centres, ministries of health, national and international professional organizations, not-for-profit community agencies, oncology day care service centres, palliative care settings and hospices, the pharmaceutical industry, private industry, provincial cancer agencies, regional and community health organizations and networks, telehealth, and universities.

In short, the 150 healthcare symposium participants (refer to **Appendix C** for participant list) were a diverse group of healthcare professionals from all regions of the country, with a very broad range of skills and workplace experience. Despite their different perspectives, all shared a common goal: an interest in finding ways to address and overcome the existing and projected deficiencies of health human resources in order to better provide quality cancer care to current and future patients.

## The Opening Session

The symposium began with a welcome from Jessica Hill, CEO of the Canadian Partnership Against Cancer (the Partnership). Hill reiterated that Canada is at a pivotal point in the development of a strategy for cancer control across the country. Because of economic constraints at national and provincial levels, the cancer care system will face even greater challenges in the next few years. This financial reality challenges the cancer control sector to do things differently, working collaboratively within oncology and with the broader healthcare system. It also emphasizes that innovation is vital, not merely for its own sake, but as a key element of strong business cases for productive improvements.

The goals and objectives of the Partnership are well-known: to reduce the expected number of cancer cases, to improve quality of life for cancer patients, to lessen the likelihood of recurrence for survivors and to increase effectiveness and efficiency of the system overall. Health human resources can advance all these objectives. It is the people in the system who can provide safe, effective, patient-centered, timely, efficient and equitable care. The question put to the symposium participants was how to accomplish all this in the current environment?

Hill stressed several broad areas for the symposium participants to consider: optimizing the use of professional and para-professional resources and employing multi-disciplinary approaches, providing supportive care, integrating technology, and empowering the client. The symposium program reflected these topics; Hill encouraged the participants to learn from the models presented in order to foster broader adoption of innovation.

Hill was followed by Brent Schacter, MD FRCPC, Professor in the Department of Internal Medicine, University of Manitoba and member, Department of Medical Oncology and Hematology, CancerCare Manitoba. Schacter is the Chair of the Partnership's Service Delivery Models Project Steering Committee.

The ultimate goal of the overall project is to better understand and promote the application of leading, innovative and promising models of service delivery that are effective in overcoming existing and future human resource challenges faced by the cancer control system. Its output will be a searchable database of approximately 150 leading, innovative and promising models of care, both Canadian and international. At this point, some 100 models have been described using a standardized and validated framework and template, and are available in a beta format on the Cancer View Canada portal, [www.cancerview.ca](http://www.cancerview.ca). Schacter encouraged participants to test the beta version of the repository, available at computer stations throughout the symposium.

Schacter described some of the drivers of innovation: increasing cancer incidence and prevalence rates, evolving patient needs and expectations, health human resource pressures, technology, and fiscal pressures. These are both enablers and barriers; that is, they have both positive and negative features. These drivers have contributed to the innovation that is occurring across the cancer continuum and across the country in both urban and remote settings. The challenge is to disseminate all the information about the models. Schacter emphasized that networking was key and the symposium was ideal for that purpose.

## Inspiring Dialogue – The Opening Keynote

Working Outside the Box: *Exploring Innovation*



The opening keynote address was delivered by Andrew Padmos, MD FRCP, CEO of the Royal College of Physicians and Surgeons and Chair of the Partnership’s Health Human Resources Action Group. Padmos acknowledged that health human resources have always been a major challenge and that it is “a smouldering issue underlying an impending crisis.” The workforce issues are not just in cancer, but in many other disease areas as well. Further, health human resources are affected by the looming demographic shift, at least in advanced nations, towards a more elderly population. Health human resource problems are not just in Canada or in a particular region of Canada; and a solution at the expense of other jurisdictions is not really a solution at all.

Padmos concluded by encouraging the participants not to be daunted by such concerns. He asked them to “be courageous, committed, search out, share, refresh, re-energize.” In particular, he reminded the participants to develop solutions through models of care that challenge existing roles, that integrate new technologies and that enable patients and families to be much more involved in their care planning and delivery.

*93% of evaluation respondents found the symposium program to be relevant to their work. Over 98% found the information shared through the program to be timely.*

## Learning from Others – The Breakout Sessions



The eight breakout sessions gave participants the opportunity to learn about 26 different models reflecting service innovations under three broad themes related to who performs the roles, where the work is performed and how it fits into the overall cancer control and healthcare system. Each of the break-out sessions involved three or four panelists discussing their particular model or addressing the theme generally. The models presented were also showcased in posters displayed throughout the symposium, along with 20 other posters that portrayed innovation in other jurisdictions. Brief write-ups of the 46 models presented are provided in **Appendix D**. Where available, links to the presentations are available on [www.cancerview.ca](http://www.cancerview.ca).

Participants were free to attend whichever breakouts they preferred and to move between breakouts that were held concurrently. This open approach provided participants with over 100 options through self-designed scheduling.

The breakout sessions were well-attended and generated lively question and answer sessions. These, in turn, frequently led to further discussion from other participants, each adding a dimension from their home jurisdiction and expertise. Although most comments referred to specific models, some messages had broader implications for the overall discussion of health human resources. It should be noted, however, that the allocation of time for discussion differed tremendously from session to session. So, too, did the discussions following the presentations; that is, in some sessions, the questions were very specific to particular models, with little opportunity to generalize. For these reasons, the summaries of the panel session discussions contained in the sections following may not appear to be balanced.

### Breakout Sessions: 1. Enhancing Service Delivery Through New and Advanced Roles

The first group of breakout sessions focused on the strategies and approaches used in three different settings to address the challenges of delivering care to hard-to-reach communities and populations. Special attention was given to the introduction of new and/or advanced roles to enhance the delivery of care.

Session 1A focused on rural and remote services and service delivery models for First Nations, Métis and Inuit communities. The models described colorectal cancer strategies for the Aboriginal population in Northern Ontario, the Northern Cancer Control Strategy in BC, and the Nunavik Pivot Nurse in Oncology pilot project in Northern Quebec.

The subsequent discussions centred on the importance of peer education, particularly as it relates to hard-to-serve populations and the collaboration between cancer specialists and other health professionals. The consensus was that involving patients in the planning process led to improved communication that enabled staff to stretch their skills and to take on broader scopes of practice. The key was to change how people work in addition to replacing losses in rural and remote locations. Participants noted that evaluations of the models, whether in a single metropolitan area, an entire province or particularly in remote areas, should include consideration of the quality of the patient's life at every point along the care pathway. Participants recognized that this can sometimes mean adapting best practices to the realities of the fiscal and geographic environment.

Session 1B shifted the setting to healthcare centres. It explored innovative approaches, including the use of advanced and enhanced roles, to deliver oncology care while optimizing health human resources. The models dealt with clinical specialists in radiation therapy, oncology clerical navigators, a rapid response oncology clinic, and a registered nurse performed flexible sigmoidoscopy project. With the exception of the navigator model from PEI, all the models were from Ontario cancer centres.

In the discussion following, the panelists highlighted how important it is for the various healthcare professionals, whether in specialty oncology or in general healthcare, to learn more about each other's roles. Participants commented that without a more widespread understanding of each professional contribution, it can be difficult to develop new approaches to the delivery of services. This is particularly true for "behind-the-scenes" professionals, such as medical laboratory technologists, whose work is essential to oncology services, but is not necessarily considered an oncology specialty.

The discussion also centred on patient involvement, including an appreciation for the patient's entire time related to treatment and care, not just the direct treatment time. The consensus was that collecting information from patients was essential, both before making changes to the system and afterwards, looking for feedback.

The session concluded with considerations specific to the workforce. The concept of developing new roles and professions vs. using and expanding the scope of current practitioners was raised. The caution was to look at all sides of the health human resources challenge, including training, recruiting and retaining personnel. Participants agreed that this helps to build stronger business cases, supported by improved patient outcomes.

Session 1C looked at community-based health care delivery. The presenters shared their approaches to enhancing the delivery of cancer control and care closer to home through new and/or advanced roles. The models cited dealt with three programs in Alberta: breast health and cancer prevention for the Chinese and Asian communities, community cancer support networks generally, and the provincial family physician initiative. The remaining model was an Ontario project on the use of exercise in the cancer care pathway.

Once again, the discussion centred on financial implications and the need for the models to include a cost-benefit analysis, including information on deferred costs and/or the impact of preventive measures. The participants noted that while there are no national indicators or guidelines that would make data comparable, health economists, academic health centres and insurance companies could provide assistance with this subject.

The panelists summarized their models in light of the participants' input. The key points were collaboration, multi-disciplinary teams and approaches, sharing knowledge with professionals and patients and the need for common indicators for cost-benefit analyses, including patient-outcomes.



## Breakout Sessions: 2. Improving the Work Environment

The second group of sessions showcased models that highlight the technological solutions currently used across the country to enhance the delivery of care, and ultimately the work environment. It also offered a panel discussion addressing system-wide change.

Session 2A focused on the role of technology, highlighting models involving virtual clinics, e-mentorship and tele-care in Quebec, Ontario and Alberta. The consensus was that patients do not fear technology and that its use in the various programs achieved two beneficial results. First, it improved the services provided to patients, even those with complex clinical issues, and second, it helped establish a therapeutic relationship with other professionals at a distance from the main cancer treatment centre. Participants commented that the key to using technology for providing services, either virtually or at a distance, is integration with the electronic medical record. Innovative programs involving technology do not necessarily require massive resources; as discussed in other sessions, the important factor is having a determined program head or champion to make the program a reality.

Session 2B offered a different format from the presentation of models. In this session, panelists representing four different geographic jurisdictions (Quebec, Ontario, Manitoba and Alberta) each discussed their provincial approach to implementing system-wide change. They provided insights on the opportunities and challenges to embrace innovation and its impact on human resources and other system-wide resources.

The panelists noted that patients and caregivers have different expectations of the healthcare system than they had even a few years ago. Meeting these expectations requires a vastly improved approach to communication, including internet-based options, such that not every interaction need be face-to-face, involving a physician and a patient. This highlights the focus on an interdisciplinary team approach, involving primary care professionals, an integrated network, evidence-based practice, training/support/supervision, and evaluation.

The group urged that more work be done on evaluating patient outcomes to ensure that changes are evidence-based. This would encourage adoption of the better models, rather than continuing to develop more and more pilot studies.

## Breakout Sessions: 3. Integrated Approaches to Healthcare Delivery

Three different break-out groups in this session highlighted integrated approaches that bring care closer to home.

Session 3A focused on three different programs in a variety of locales in communities, in Ontario, Saskatchewan and Alberta. The discussion following presentations of the models went beyond cancer, introducing the concept of other health concerns and issues faced by cancer patients that might be better recognized and accommodated in a community setting than in a cancer treatment centre. The discussion acknowledged that, particularly in models involving home-based care, when oncology nurses see co-morbidities in cancer patients, they have the opportunity to involve other professionals and agencies to help the whole patient. Participants also agreed that the overall health outcome of cancer patients with chronic health concerns can have an effect on the provision of other health and social services, suggesting the need to have inter-professional collaboration in evaluating such models.

In Session 3B, the presenters shared the integrated and collaborative team-based approaches used in their models to deliver optimal patient care. Four different models were presented, focusing on rehabilitation and nutrition in Quebec, volunteer-led assistance and shared care in Ontario and palliative radiation therapy in Alberta. While the majority of the discussion that followed focused on the specifics of the models, there was consensus that going beyond specialists to include primary care physicians and nurses is an important process, albeit one that is incremental and slow in development. Most importantly, these models were examples of changes that were enabled with very limited resources, engaging interdisciplinary teams.

Session 3C featured a selection of models focused on creating efficiencies in the delivery of cancer control and care. Special focus was given to those models using innovative, collaborative approaches. One model introduced a two-day treatment plan in Ontario; the other three were more provincial in scope, including the regional systemic treatment program in Ontario, cancer care pathways in Alberta, and the provincial pediatric oncology/hematology program in BC.

The panelists summarized that patients see their illnesses as being connected; it is the healthcare professionals who see them as fragmented. From this perspective, it is imperative to communicate with and involve patients more in their care planning decisions and in the care itself. This, in turn, can spur the development of systems to support novel delivery models. When reviewing models, participants noted that it is important to employ a broad perspective so that measurement and evaluation encompass all the components needed to achieve better outcomes, whether or not they fall strictly under the cancer umbrella.

*We have learned that we are no longer operating in isolation.  
“The innovation and passion at the symposium was tremendous  
— an opportunity to partner and capitalize on strengths across  
the country to improve delivery of patient care and best use of  
manpower”*

*(Participant)*

## Capturing Synergy – The World Café



George Eisler, MASC MBA PhD  
*President, EDC Consulting*  
Former CEO, BC Academic  
Health Council



Andréanne Saucier, MSc Inf  
CSIO(C)  
*Associate Director of Nursing  
Cancer Care Mission &  
Respiratory Services*  
McGill University Health Centre

*“If this room were speaking with one voice, we could not predict what it would say. Magic will arise out of these discussions.”*

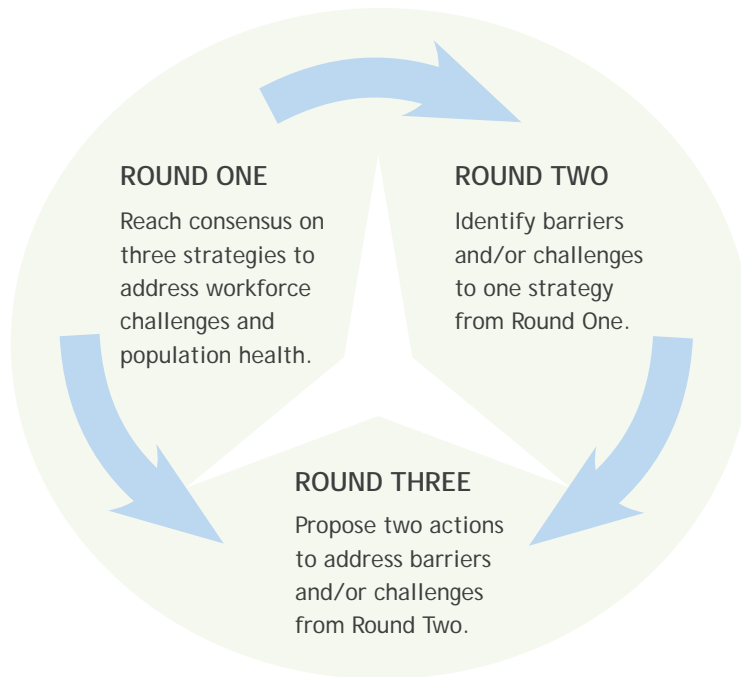
George Eisler  
*World Café Facilitator*

The symposium invited participants to engage in a free-flowing, yet directed, conversation through a concept known as The World Café. The website [www.theworldcafe.net](http://www.theworldcafe.net) defines this process:

*“As a conversational process, the World Café is an innovative yet simple methodology for hosting conversations about questions that matter. These conversations link and build on each other as people move between groups, cross-pollinate ideas, and discover new insights into the questions or issues that are most important in their life, work, or community. As a process, the World Café can evoke and make visible the collective intelligence of any group, thus increasing people’s capacity for effective action in pursuit of common aims.”*

The symposium’s World Café was held over two days and was facilitated by George Eisler, MSc MBA PhD and Andréanne Saucier, MSc Inf CSIO(C). Eisler acknowledged that health human resources planning and development for cancer care is complicated, unpredictable and ever-changing. For these reasons, real-time exchange of information across all relevant stakeholders is particularly important. The Symposium’s World Café offered such an opportunity, by actively engaging the participants to address the complexity of a non-linear health human resources world that is unpredictable and chaotic.

The World Café charged the participants with identifying optimal workforce and workforce development strategies for patient-centred cancer care by building on personal experiences and the lessons from the service delivery model presentations and breakout sessions. The overall objective was to identify high impact strategies for moving forward, possibly with a multi-stakeholder national collaboration, within a three-year timeframe.



## World Café Discussion Rounds

An innovative aspect of the World Café is that participants move to different tables between discussion rounds, with participants randomly assigned to tables of four or five people. The schematic shown above indicates the sequence of discussion topics for the three rounds of discussion. These three rounds were held during the afternoon of day one of the symposium.

In Round One of the World Café, the goal was to reach consensus at each table on three strategies expected to have a significant positive impact on improving workforce challenges as well as on population and patient health. The urgency was expressed by one of the participants: “We have a bazillion pan-Canadian strategies on everything. We are known for being one of the best places for gold standards and one of the worst for implementation.”

For Round Two, the goal for each newly populated table was to choose one strategy from Round One and to identify two or three barriers or challenges to system-wide implementation. The barriers are the cause of much frustration, not just among professionals, but among patients and families as well. The challenge for Round Two was to explain, for example, what barriers prevent care from being delivered consistently across the country. These could be financial, political, historical, demographic, social, environmental or other.

The goal of Round Three was to propose two actions to address the barriers and challenges identified in Round Two. Participants were asked to concentrate on actions that would benefit from a national and integrated approach, over a three-to-five year horizon.

The results of the first three rounds were summarized into a table that formed the basis for the next day’s session of the World Café. Table 1 presents these results.

1.	Shifting Care
1.1	Move work away from specialist to generalist
1.2	Transfer of survivorship care, establish partnerships with community and GPs
1.3	Develop effective models of transition across the continuum of care
2.	Role of Healthcare Providers
2.1	Optimize the roles of cancer care providers
2.2	Clarify roles of providers within the healthcare team
2.3	Work to full scope of practice
3.	Changing the way we work
3.1	Implement different models of care
3.2	Implement national policy on inter-professional care
3.3	Create a “one stop medical service” centre
3.4	Inter-professional collaboration for patient-centred care
4.	Patient Empowerment
4.1	Promote patient self-management
5.	Education
5.1	Standardize oncology education by using interdisciplinary curriculum
6.	Technology
6.1	Increase accessibility to technology for Inuit/North/remote regions/communities
6.2	Promote utilization of electronic medical and health records

During the day 2 discussions, each of the 16 tables were randomly assigned to focus on one of the six major themes that emerged. Each table group was asked to develop three recommendations for national and collaborative action for their theme. This resulted in a range of proposed actions, captured during the table report to the whole assembly.

A summary of the proposed actions generated during the World Café sessions is provided in **Appendix E**.

At the end of the World Café, participants were asked to reflect and comment on what they had heard during their World Café experience. The emerging concepts were:

- the importance of patient-centred care, patient self-management and patient engagement;
- the increased use of technology;
- the need for standardization in terms of care/pathways, roles involved, and education for the workforce, on a pan-Canadian basis;
- the need to work and interact effectively to meet the needs of the patient; and
- a call to action: it is time to move from planning, strategizing and piloting to action and implementation.

## Addressing the Needs of the Patient – Closing Keynote Panel



### *Future Perspectives on Innovative Service Delivery: Optimizing Health Human Resources and Improving Patient Outcomes*

The symposium concluded with a panel convened to discuss future directions in health human resources from a variety of viewpoints. The five panelists came from Quebec, Ontario and Alberta. They represented several different perspectives: education (Greta Cummings, RN PhD), system planning and administration (Antoine Loutfi, MD FRCSC FACS), research (Eva Grunfeld, MD DPhil FCFP), patient advocacy (Femma Norton), and the healthcare provider (Jennifer Wiernikowski, BScN MN NP-Adult CON (C)).

The panel began with the patient perspective, highlighting the frustration that occurs when patients are given nothing but a diagnosis. This set the stage for a discussion of the role of patients in planning and decision-making for their care. It was acknowledged that while there are locations across the country where the patient drives his/her care, there are many more pockets where patients are left out of the process, except to be recipients of services. The consensus was that while patient-centred shared care alternatives might not change patient outcomes, they can improve the patient's psychosocial health and this demonstrates that communication is often inadequate between healthcare professionals and between professionals and the family. Discussions during the symposium suggested that cancer care professionals acknowledge communication needs but do not implement solutions to address them.

There are many programs across the country with excellent models of patient-centred shared care that others can learn from. These examples highlight that partnerships with patients and families are possible. They also draw attention to the need for healthcare professionals to provide appropriate information and knowledge to assist patients in making the best decisions about their care throughout the course of their illness. They also emphasize that while technology can play a large part in disseminating information, healthcare professionals still must be part of the communication process.



The closing keynote panel discussion identified several themes:

- **Patient-involvement** – the cancer care community does not have to reinvent the wheel in terms of patient involvement. It can learn from healthcare advocacy groups how to involve patients and their families. There are also models for patient- and family-centred cancer care; some through private providers.
- **Patient information** – healthcare providers acknowledged that there is a lot of information available, both for patients and practitioners. However, the information can be inconsistent or conflicting and not always easy to understand. Moreover, the information that is available is not tailored to the individual patient and their particular situation.
- **Business cases** – creating better models of care is not just about identifying an outcome. It is important to add a financial or cost-offset component. This allows money saved to be redeployed for other purposes.
- **Improved communications** – some of the elements of improved communication are neither complicated nor costly. For example, healthcare workers should ask patients what are their information needs and direct the patient to where or how to access further information.
- **Research** – although much systems and organizational research has been done, there is a barrier to moving from knowledge to implementation. The barrier may be at the policy level; it might also be that improvement strategies are implemented from the perspective of the system, rather than the perspective of the patient. The consensus was that there is already enough information on what has to change. Research at this point should be on best practices to achieve those changes, coupled with evaluation and a feedback loop that includes changes in training programs to overcome identified communication and care delivery issues.

*“It is our fundamental responsibility as Canadians to create a legacy that is sustained. Flexible, evolving and “open” to change over time”.*

*(Participant)*

## Summarizing the Symposium

The breakout sessions, the World Café and the closing panel all generated discussion on the need to take what was learned from the various models and to apply and build on the relevant portions in the participants' home jurisdictions or begin to build the models necessary given the local needs. This recognized that thinking nationally and acting locally both offer opportunities to effect health human resources changes in an effort to improve the delivery of cancer care services.

The breadth of models discussed and displayed demonstrated an intuitive understanding that better cancer care can be delivered by changing the traditional concept of one patient: one physician. However, participants repeatedly commented that the business case for integrating health human resources is not clear and needs to be better developed.

The World Café introduced a process for building on the collective knowledge and wisdom of a diverse group of professionals who nevertheless share a common goal: conquering the challenge of health human resource deficiencies in the cancer control and care system. The outcomes of the Café, developed more organically, reflected the following themes: patient engagement, expanded use of technology, and standardization in terms of care/pathways, roles involved, education for workforce, all on a Canada-wide basis.

What was clear to participants throughout the symposium was that the cancer control system, from initial diagnosis through treatment and survivorship and/or palliation, must become more patient-centred. They acknowledged that this entails improving communications and bringing care to the patient, whenever possible, through real or virtual means. In turn, participants recognized that such improvements reflect the need for greater and more innovative uses of electronic communications and service delivery. They also suggest that roles for cancer specialty professionals and generalists must be used at their full scopes of practice, and that expanding the scope and/or developing new professional roles may also be required.

Participants agreed that research has shown that the current system can be improved. They stressed that further research must evaluate and determine the best practices to reorient care from the current system to a patient-centred system of shared care. This may require developing a common cancer care curriculum for the education of all healthcare professionals.

Participants strongly urged that the desired goal needs to be a continuing pan-Canadian colloquium on innovative solutions to the ongoing HHR crises. The symposium evaluations received underlined this collective call to action. (refer to **Appendix F** for a summary of the evaluations) The symposium provides the building blocks to establish virtual networks and communities of practice across the country and to mobilize the knowledge and learning and translate this into productive and effective action.

## Appendix A Steering Committee Members and Symposium Planning Staff



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**Diane Manii, MSW RSW**  
*Clinical Manager, Psychosocial Oncology Program, The Ottawa Hospital Cancer Centre*

CancerCare Manitoba  
**George Normandin, CHRP**  
*Chief Human Resource Officer*  
 McGill University Health Centre  
**Andr anne Saucier, MSc Inf CSIO(C)**  
*Associate Director of Nursing, Cancer Care Mission & Respiratory Services*

CancerCare Manitoba/University of Manitoba  
**Brent Schacter, MD FRCPC**  
*Professor, Department of Medical Oncology and Hematology*  
*Steering Committee Chair*

Lakehead University  
**Pat Sevean, RN MA MEd EdD(c)**  
*Faculty*

**Project Manager:**  
**Muneerah Kassam, MHA**

**Cancer Workforce Symposium Planning Committee Members & Organization**

EDC Consulting  
**George Eisler, MASC MBA PhD**  
*President*  
*Former CEO, BC Academic Health Council*

Canadian Association of Medical Radiation Technologists  
**Brenda Hubley, BSc RTT ACT**  
*Program Leader, Radiation Therapy Corridor Project, Alberta Health Services*

Inuit Tapiriit Kanatami  
**Soha Kneen, MA**  
*Senior Researcher, Health and Environment Department*

Canadian Association of Psychosocial Oncology  
**Diane Manii, MSW RSW**  
*Clinical Manager, Psychosocial Oncology Program, The Ottawa Hospital Cancer Centre*

CancerCare Manitoba  
**George Normandin, CHRP**  
*Chief Human Resource Officer*

CancerCare Manitoba/University of Manitoba  
**Brent Schacter, MD FRCPC**  
*Professor, Department of Medical Oncology and Hematology*  
*Planning Committee Chair*

Lakehead University  
**Pat Sevean, RN MA MEd, EdD(c)**  
*Faculty*

Canadian Nurses Association  
**Isabelle St-Pierre, PhD (c) RN**  
*Health Human Resources Consultant*

Conference Planners:  
 PR1ME





## Appendix C List of Symposium Delegates

#	Last Name	First Name	Registration Type	Title	Company	City	Prov
1	Allatt	Debora	Attendee	Leader Ambulatory Care	Tom Baker Cancer Centre	Calgary	AB
2	Anderson	Helen	Poster Presenter	Medical Oncologist	BC Cancer Agency	Victoria	BC
3	Anderson	Mélanie	Poster Presenter	Infirmière clinicienne	IUCPQ	Québec	QC
4	Arnaert	Antonia	Speaker/Presenter	Associate Professor	McGill/ St. Mary's	Montreal	QC
5	Atkin	Virginia	Poster Presenter	Volunteer	Princess Margaret Hospital	Toronto	ON
6	Atkinson	Susan	Attendee	CSMLS Past President	Canadian Society for Medical Laboratory Science	Moncton	NB
7	Batist	Gerald	Attendee	Director	Segal Cancer Centre	Montreal	QC
8	Beaudoin	Lynda	Poster Presenter	Coordonnatrice du centre de jour	Maison Michel-Sarrazin	Québec	QC
9	Bergevin	Denise	Speaker/Presenter	Infirmière clinicienne / Chargée de projets	CSSS Haut Richelieu Rouville Saint-Jean-sur-Richelieu		QC
10	Bertrand	Lise	Attendee	Technologiste médicale	OPTMQ	Repentigny	QC
11	Bhatti	Aslam	CPAC Staff	CFAO	Canadian Partnership Against Cancer	Toronto	ON
12	Boilard	France	Attendee	Adjointe à la direction des services professionnels et hospitaliers	CSSS de Portneuf	Saint-Raymond	QC
13	Boily	Charles	Attendee	Agent de recherche	Ministère de la Santé et des Services sociaux du Québec	Québec	QC
14	Bolesnikov	Grlica	Attendee	Coordinator - Quality Management and Accountability	New Brunswick Cancer Network	Fredericton	NB
15	Burnett	Carol	Attendee	Nurse Consultant	McGill University	Greenfield Park	QC
16	Buske	Lynda	HHR-AG Network	Director, Workforce Research	Canadian Medical Association	Ottawa	ON
17	Butts	Charles	Attendee	Associate VP Community	AHS-Cancer Care Oncology	Edmonton	AB
18	Carruthers	Pauline	Attendee		Horizon Health Network	Moncton	NB
19	Cass	Valerie	Attendee	Head Nurse	McGill University Health Center	Montreal	QC
20	Catton	Pamela	Poster Presenter	Medical Director of Patient Survivorship	Princess Margaret Hospital	Toronto	ON
21	Cheifetz	Oren	Poster Presenter	Physiotherapist	Hamilton Health Sciences	Hamilton	ON
22	Cherry	Louise	Attendee	Consultant/Québec Associate	Hollander Analytical Services	Verdun	QC
23	Chobanuk	Janice	Speaker/Presenter	Manager CBCP	AHS Cancer Care	Edmonton	AB
24	Chua-Alamag	Rina	Speaker/Presenter	Manager, Aboriginal Cancer and Prevention	Cancer Care Ontario	Toronto	ON
25	Cleary	Amanda	Attendee		Horizon Health Network	Moncton	NB
26	Collacutt	Vivian	Speaker/Presenter	Prov. Manager Community Cancer Support Networks	Alberta Health Services - Cancer Care	Edmonton	AB
27	Corsten	Maria	HHR-AG Network	Division Manager of Medical Physics	Eastern Health	St. John's	NL
28	Courjal	Frank	Attendee	Medical and Scientific Liaison - Oncology	Merck Canada	Kirkland	QC

#	Last Name	First Name	Registration Type	Title	Company	City	Prov
29	Craighead	Peter	Speaker/Presenter	Medical Director	Tom Baker Cancer Centre, Cancer Care, AHS	Calgary	AB
30	Cummings	Greta	Speaker/Presenter	President-Elect / Associate Professor	International Society of Nurses in Cancer Care/ Univ of Alta	Edmonton	AB
31	Da Prat	Christine	CPAC Staff	Project Director	Canadian Partnership Against Cancer	Ottawa	ON
32	de la Calzada	Angelito	Attendee	Implementation, Training & Support Specialist	Integrated Clinical Care	Montreal	QC
33	Deblois	Céline	Poster Presenter	Coordonnatrice du programme lutte contre le cancer et les soins palliatifs	CSSS Haut Richelieu Rouville	Saint-Jean -sur-Richelieu	QC
34	Dobbin	Liz	Speaker/Presenter	Manager	PEI Cancer Treatment Centre	Charlottetown	PE
35	Duguay	Louise	Attendee	Nurse	McGill University Health Centre	Pierrefonds	QC
36	Dunn	Harold	Attendee	Infirmier pivot en oncologie	CSSS de la Basse Cote-Nord	Blanc Sablon	QC
37	Duong	Cathy	Poster Presenter	Clinical Leader	Alberta Health Services- Cancer Care	Edmonton	AB
38	Dus	Tamara	Speaker/Presenter	Manager, Patient Care Systemic Therapy & Clinical Trials Centre	R. S. McLaughlin Durham Regional Cancer	Oshawa	ON
39	Duvalko	Katya	Attendee	Director, Cancer Quality Council of Ontario	Cancer Care Ontario	Toronto	ON
40	Eades	Margaret	Speaker/Presenter	Clinical Nurse Specialist	McGill University Health Centre	Montreal	QC
41	Eisler	George	Planning/Steering Committee	President	EDC Consulting Inc.	Vancouver	BC
42	Ernst	D. Scott	Attendee	Head, Div of Medical Oncology	London Regional Cancer Program	London	ON
43	Fairchild	Alysa	Speaker/Presenter	Radiation Oncologist	Rapid Access Palliative Radiotherapy Program	Edmonton	AB
44	Forbes	Leta	Speaker/Presenter	Head, Medical Oncology	R.S. McLaughlin Durham Regional Cancer Centre	Oshawa	ON
45	Forbes	Margaret	Poster Presenter	Advanced Practice Nurse Intern	Juravinski Cancer Centre at Hamilton Health Sciences	Hamilton	ON
46	Fotheringham	Sharon		HHR-AG Network	Director of Speech-Language Pathology CASLPA	Ottawa	ON
47	Fryer	Christopher	Speaker/Presenter	Pediatric Oncologist/ Radiation Oncologist	BC's Children's Hospital	Vancouver	BC
48	Gagné	Denise	Attendee	Agente de planification, de programmation et de recherche	ASSS Chaudière-Appalaches	Sainte-Marie	QC
49	Girard	Steve	Attendee	Vice-président exécutif	PG Documex	Montréal	QC

## Appendix C List of Symposium Delegates *Continued*

#	Last Name	First Name	Registration Type	Title	Company	City	Prov
50	Given	Mark	Attendee	Director of Professional Practice	CAMRT (Canadian Association of Medical Radiation Technologists)	Ottawa	ON
51	Green	Esther	Speaker/Presenter	Provincial Head, Nursing and Psychosocial Oncology	Cancer Care Ontario	Toronto	ON
52	Grunfeld	Eva	Speaker/Presenter	Director, Knowledge Translation Research Network / Director, Research Program	Ontario Institute for Cancer Research / University of Toronto	Toronto	ON
53	Hagen	Neil	Speaker/Presenter	Interim Director, Provincial Tumor Teams	Alberta Health Services, Cancer Care	Calgary	AB
54	Halton	Jacqueline	HHR-AG Network	Chief, Pediatric Hem/Onc Division	Children's Hospital of Eastern Ont	Ottawa	ON
55	Hamel	Marc	Poster Presenter	Directeur	MUHC Hôpital Général de Montréal	Montréal	QC
56	Hanvey	Louise	Attendee	Project Manager	Canadian Hospice Palliative Care Association	Ottawa	ON
57	Hartman	Mark	Poster Presenter	Interim VP NE Regional Cancer Program	Hôpital régional de Sudbury Regional Hospital	Sudbury	ON
58	Heick	Caroline	CPAC Staff	Acting Vice President, Knowledge Management	Canadian Partnership Against Cancer	Toronto	ON
59	Hill	Jessica	Speaker/Presenter	CEO	Canadian Partnership Against Cancer	Toronto	ON
60	Hladysh	Genevieve	Poster Presenter	General Manager Community Health Program Development	YMCA of Hamilton/Burlington/Brantford	Hamilton	ON
61	Holmes	Andrea	Poster Presenter	Tele-Dietitian, Oncology	HealthLink BC	Burnaby	BC
62	Hubley	Brenda	Planning/Steering Committee	Administrator	Alberta Health Services	Lethbridge	AB
63	Kassam	Muneerah	Planning/Steering Committee	Project Manager/Researcher	Kassam Management Group Inc.	Vancouver	BC
64	Kelly	Mary Lou	Speaker/Presenter	Infirmière Pivot en Oncologie	Centre de Santé Tulattavik de l'Ungava/ McGill University Health Centre	Montreal	QC
65	Kennedy	Margo	Speaker/Presenter	Social Worker	Princess Margaret Hospital	Toronto	ON
66	Kneen	Soha	Planning/Steering Committee	Senior Researcher/ Cancer File Lead	Inuit Tapiriit Kanatami (ITK)	Ottawa	ON
67	Koch	Shirley	Attendee	Coordinator - Radiation & Systemic Therapy	New Brunswick Cancer Network	Fredericton	NB
68	Krymalowski	Morris	Attendee	Senior Advisor	Integrated Clinical Care	Montreal	QC
69	L'Espérance	Bernard	Attendee		Hôpital Sacré-Coeur	Montréal	QC
70	L'Heureux	Michel	Attendee	Directeur général	Maison Michel-Sarrazin	Québec	QC
71	Laflamme	Brigitte	Attendee	Directrice adjointe	Ministère de la Santé et des Services sociaux	Québec	QC
72	Lafrenière	Renée	Poster Presenter	Coordonatrice des services de soutien à domicile	CSSS Haut Richelieu Rouville	Saint-Jean-sur-Richelieu	QC
73	Lascu	Daniela	Attendee	Agente de planification, programmation et recherche	Agence de la santé et des services sociaux Laval	Laval	QC
74	Layer	Jody	CPAC Staff	HHR-AG Project Team	Canadian Partnership Against Cancer	Ottawa	ON

#	Last Name	First Name	Registration Type	Title	Company	City	Prov
75	Lazare	Evelyn	Attendee	Consultant	EHL Consulting Inc.	Richmond	BC
76	Le	Dan	Speaker/Presenter	Project Manager, Special Projects	Northern Health	Prince George	BC
77	Legault	Christiane	Attendee	Adjointe administrative	Hôpital général du Lakeshore	Pointe-Claire	QC
78	Lehoux	Chantal	Poster Presenter	Conseillère	Agence de santé et des services sociaux de la Mauricie et Centre-du- Québec	Trois-Rivières	QC
79	Leonard	Melany	Attendee	Nurse Manager	McGill University Health Center	Montreal	QC
80	Leslie	Barb	Poster Presenter	Director, Dietitian Services	Emergency and Health Services Commission	Burnaby	BC
81	Léveillé	Gilles	Attendee	Directeur exécutif Conférence Nationale pour Vaincre le Cancer	Coalition Priorité Cancer au Québec	Montréal	QC
82	Levesque	Micheline	Attendee	Infirmière	Hôpital général du Lakeshore	Pointe-Claire	QC
83	Limburg	Heather	Poster Presenter	Epidemiologist	Public Health Agency of Canada	Ottawa	ON
84	Lischynski	Kris	HHR-AG Network	Registered Psychiatric Nurse	College of Registered Psychiatric Nurses of Canada	Winnipeg	MB
85	Loewen	Ruth	Attendee	Program Director, Community Oncology Program	CancerCare Manitoba	Winnipeg	MB
86	Logan	Heather	Attendee	Executive Director	CAPCA	Toronto	ON
87	Loiselle	Carmen	Poster Presenter	Associate Professor	McGill University	Montreal	QC
88	Loutfi	Antoine	Speaker/Presenter	Directeur	Direction de la lutte contre le cancer	Québec	QC
89	Manii	Diane	Planning/Steering Committee	Clinical Manager Psychosocial Oncology Program	The Ottawa Hospital	Ottawa	ON
90	Marshall	Denise	Speaker/Presenter	Assistant Dean	McMaster University	Hamilton	ON
91	McBride	Mary	Poster Presenter	Senior Scientist	BC Cancer Agency	Vancouver	BC
92	McCormack -Speak	Pat	Speaker/Presenter	Program Manager	CancerCare Manitoba	Winnipeg	MB
93	McMullen	Alison	Poster Presenter	Director Preventive Oncology	Regional Cancer Care	Thunder Bay	ON
94	Mehta	Anita	Poster Presenter	Clinical Nurse Specialist	McGill University Health Center	Montreal	QC
95	Meyer	Louise	HHR-AG Network	Senior Policy Analyst	Health Human Resource Strategies Division	Ottawa	ON
96	Miller	Carol	HHR-AG Network	Director, Practice and Research	Canadian Physiotherapy Association	Ottawa	ON
97	Morarescu	Diana	Poster Presenter	Program Manager	Oncology Nursing e-Mentorship Program	Hamilton	ON
98	Ng	Amy	Speaker/Presenter	Health Program Coordinator	Calgary Chinese Community Service Association	Calgary	AB

## Appendix C List of Symposium Delegates *Continued*

#	Last Name	First Name	Registration Type	Title	Company	City	Prov
99	Normandin	George	Planning/Steering Committee	Chief Human Resource Officer	CancerCare Manitoba	Winnipeg	MB
100	Norton	Femma	Speaker/Presenter	Council Member	Canadian Cancer Action Network	Colborne	ON
101	O'Grady	Rosemary	Attendee	Nurse Manager Palliative Care Services	McGill University Health Centre	Montreal	QC
102	Padmos	Andrew	Speaker/Presenter	CEO	The Royal College of Physicians and Surgeons of Canada	Ottawa	ON
103	Palmer	Dal	Planning/Steering Committee	Account Executive	PRIME	Vancouver	BC
104	Paquet	Louise	Attendee	Agent de planification	Ministère de la Santé et des Services sociaux	Montréal	QC
105	Park Dorsay	Jan	Speaker/Presenter	Nurse Practitioner	Hamilton Health Sciences	Hamilton	ON
106	Parmar	Monica	Speaker/Presenter	Clinical Nurse Specialist	Segal Cancer Centre, Jewish General Hospital	Montréal	QC
107	Petrella	Jill	Attendee	Quality Coordinator	Cancer Care Nova Scotia	Halifax	NS
108	Plante	Anne	Poster Presenter	Clinical Nurse Specialist	Hôpital Charles Lemoyne	Longueuil	QC
109	Poirier	Sylvie	Attendee	Chef de service	CSSS de Laval	Laval	QC
110	Proulx	Hélène	Attendee	Coordonnatrice en oncologie	CHA Québec	Québec	QC
111	Rapp	Dorothy	Attendee	Provincial Leader, Support and Development	Saskatchewan Cancer Agency	Saskatoon	SK
112	Richer	Marie-Claire	Attendee	Director	McGill University Health Centre	Montreal	QC
113	Rivard	Chantal	Poster Presenter	Coordonnatrice des services à domicile par intérim	CSSS de l'Énergie	Shawinigan	QC
114	Robson	Sheila	Poster Presenter	Manager, Radiation Therapy	Odette Cancer Centre	Toronto	ON
115	Roche	Lise	Attendee	Conseillère	Coalition Priorité Cancer au Québec	Montréal	QC
116	Rochon	Murray	Poster Presenter	President, CEO	Oncology Interactive Navigator	Toronto	ON
117	Rodrigue	Nathalie	Attendee	Présidente	Ordre professionnel des technologistes médicaux du Québec	Montréal	QC
118	Rompré	Annie	Attendee	Administrative Associate	Segal Cancer Centre, Jewish General Hospital	Montreal	QC
119	Roy	Denise	Attendee	Technologiste Médicale	C.S.S.S Gatineau	Gatineau	QC
121	Saucier	Andréanne	Planning/Steering Committee	Associate Director of Nursing	McGill University Health Centre	Montreal	QC
122	Sawka	Carol	Speaker/Presenter	Vice President, Clinical Programs & Quality Initiatives	Cancer Care Ontario	Toronto	ON
123	Schacter	Brent	Planning/Steering Committee	Professor	CancerCare Manitoba/ University of Manitoba	Winnipeg	MB
124	Secord	Scott	Poster Presenter	Manager Breast Cancer Survivorship Program	Princess Margaret Hospital	Toronto	ON

#	Last Name	First Name	Registration Type	Title	Company	City	Prov
125	Sellar	Carol	Poster Presenter	Research Assistant	PEI Cancer Treatment Centre	Charlottetown	PE
126	Serediuk	Fidelda	Speaker/Presenter	Chief of Physiotherapy	Hamilton Health Sciences	Hamilton	ON
127	Serrano	Elena	Attendee	Professional Practice Leader in Nursing	BC Cancer Agency	Vancouver	BC
128	Sevean	Pat	Planning/Steering Committee	Professor	Lakehead University	Thunder Bay	ON
129	Shibata	Henry	Attendee		McGill University	Montréal	QC
130	Simard	Isabelle	Poster Presenter	Conseillère clinicienne en soins infirmiers	Institut de cardiologie et de pneumologie de Québec	Quebec	QC
131	Skillen	Aaron	Speaker/Presenter	Director, Oncology Clinical Systems	Thunder Bay Regional Health Sciences Centre	Thunder Bay	ON
132	Skrutkowski	Myriam	Attendee	Clinical Nurse Specialist	McGill University Health Centre	Montreal	QC
133	St-Pierre	Isabelle	Planning/Steering Committee	Nurse Consultant - HHR	Canadian Nurses Association	Ottawa	ON
134	Sullivan	Victoria	Attendee	Program Director	Capital District Health Authority	Halifax	NS
135	Sullivan	Linda	Attendee	Chef, clinique dialyse	Hôpital général du Lakeshore	Pointe-Claire	QC
136	Swidzinski	Marika	Attendee	Nurse Manager Hematology -Oncology Services	MUHC	Brossard	QC
137	Thomas	Bejoy	Attendee	Assistant Professor	Tom Baker Cancer Centre / University of Calgary	Calgary	AB
138	Tremblay	Dominique	Attendee	Chercheur	Centre de recherche - Hôpital Charles LeMoyne	Longueuil	QC
139	Turner	Fran	Attendee	National Program Director	Ovarian Cancer Canada	Toronto	ON
140	Udarchik	Natalia	Speaker/Presenter	Primary Care Asthma Program Coordinator	Stonegate Community Health Centre	Toronto	ON
141	Von Zweck	Claudia	Attendee	Executive Director	Canadian Association of Occupational Therapists	Ottawa	ON
142	Watanabe	Sharon	Poster Presenter	Director, Department of Symptom Control and Palliative Care	Cross Cancer Institute	Edmonton	AB
143	Weir	Linda	Speaker/Presenter	Manager, Community Oncology	Saskatchewan Cancer Agency	Regina	SK
144	Wexler	Sharon	Attendee	Program Director	McGill University Health Centre	Montreal	QC
145	Wiernikowski	Jennifer	Speaker/Presenter	President	CANO - Canadian Association of Nurses in Oncology	Hamilton	ON
146	Woodward	Graham	HHR-AG Network	Director	Cancer Care Ontario	Toronto	ON
147	Wortsman	Arlene	HHR-AG Network	Principal	Arlene Wortsman & Associates	Ottawa	ON
148	Wright	Janice	Speaker/Presenter	Nurse Practitioner	University Health Network /Princess Margaret Hospital	Toronto	ON

## Appendix D Service Delivery Models Featured through Breakout Sessions and/or the Service Delivery Models Poster Showcase\*

### Advanced Practice Nurses in Oncology and Palliative Care

#### Poster

Advanced Practice Nurses include Clinical Nurse Specialists and Nurse Practitioners. In Ontario, Nurse Practitioners have protected title and are required to write additional licensing exams in order to practice with an expanded scope of practice that includes: diagnosis; ordering diagnostic and other tests; prescribing medications and treatments; and making referrals to other health care professionals. These are nursing roles, not physician extender roles. Advanced Practice Nurses have five domains in their roles: comprehensive clinical practice; education; research; professional and scholarly practice; and organizational leadership. For Advanced Practice Nurses, research may include the application of evidence to practice, the development of research questions and/or participation on a research team.

**Esther Green, RN BScN MSc(T)**  
*Provincial Head, Nursing and Psychosocial Oncology*  
Cancer Care Ontario

### Bone Marrow Transplant Virtual Clinic

#### Breakout Session 2A, Poster

The Bone Marrow Transplant Virtual Clinic brings the expertise of Princess Margaret Hospital staff to patients almost on their doorstep. Led by an Oncology Nurse Practitioner, the virtual clinic provides acute and long term follow up care to patients treated for malignant hematology disease. Following a bone marrow transplant, patients are able to receive complex continuing care in their home communities as long as the community has access to the Ontario Telehealth Network. Blood work is obtained locally at the community hospital, and supportive care treatments are arranged locally. The virtual clinic changes how the ambulatory clinic needs to be staffed. If most visits are virtual, the space and human resources at the physical site are reduced.

**Janice Wright, RNC MS**  
*Nurse Practitioner, Lymphohematopoietic Stem Cell Program*  
Princess Margaret Hospital/University Health Network

### Breast Health and Cancer Prevention Program for the Chinese and Asian Communities

#### Breakout Session 1C, Poster

The Breast Health and Cancer Prevention Program is a community-based health program designed primarily for both Chinese Canadians and new Chinese immigrants. It is specifically designed to raise awareness of the need for breast cancer screening in the Asian population. The model involves three main areas: a) development and provision of information regarding breast health; b) outreach activities for disseminating the information; and c) networking with health care professionals to sustain the program in a non-profit organization and establish trust among professionals in order to broaden the community health base. The model includes Chinese family physicians, surgeons for breast cancer disease, providers from the Tom Baker Cancer Centre, representatives from the Canadian Cancer Society and volunteers.

**Amy Ng, BA MA Doctorate in Healthcare**  
*Health Program Coordinator*  
Calgary Chinese Community Service Association

### Cancer Care Pathways and Programs

#### Breakout Session 3C, Poster

The Cancer Care Pathways and Programs model attempts to connect all parts of the new Alberta Health Services in order to improve efficiencies. The objective of the model is to ensure that the trajectory for cancer patients is well understood and followed. The model is based on a theoretical tool called "care pathways" that are the basis for coordinated approaches to diagnosis, treatment delivery, and surveillance of cancer patients. Through the model, the scope of practice of radiation therapists, nurses and pharmacists is being altered so that they fit into a team based approach to providing care. In addition, the reporting relationship within the organization is being modified. All caregivers report to a provincial and local authority. The provincial authority is important for setting standards and policy.

**Peter Craighead, MBChB FFRad(T) FRCPC**  
*Medical Director, Tom Baker Cancer Centre*  
Cancer Care, Alberta Health Services

### Cancer Nutrition Rehabilitation Program

#### Breakout Session 3B, Poster

The Clinical Nutrition Rehabilitation Program at the McGill University Health Sciences Centre functions at two sites - the Jewish General Hospital and the Royal Victoria Hospital. Through expertise in medical and nursing care, nutrition, physiotherapy, occupational therapy and psychology, the program facilitates and develops focused strategies for cancer patients with Anorexia-Cachexia Syndrome. The majority of patients seen at the Jewish General Hospital's program have lung or gastrointestinal cancers. A high proportion of patients are on active treatment. There is no-predetermined standard term for the program. Visits are scheduled according to the needs of individual patients.

The McGill University Health Centre Cancer Nutrition Rehabilitation Program at the Royal Victoria Hospital in Montréal provides ambulatory patients who have received a diagnosis of cancer with an eight week individualized program designed to improve their functioning and well-being. The global objective of the rehabilitation program is to empower individuals who are experiencing loss of function, fatigue, loss of appetite, weight or muscle loss, psychological distress and/or other symptoms (as a result of cancer or its treatment) to improve their own quality of life. The program is provided by an interdisciplinary team composed of a physician, a nurse, a nutritionist, an occupational therapist, and a physiotherapist.

**Margaret Eades, N MSc(A) CON(c)**  
*Clinical Nurse Specialist - Oncology*  
Co-Administrator of the MUHC Cancer Rehabilitation Service  
McGill University Health Centre

**Monica Parmar, N MSc(A)**  
*Clinical Nurse Specialist - Cancer Nutrition - Rehabilitation Program*  
Jewish General Hospital

**Cancer Treatment at Home Pilot Project***Breakout Session 3A, Poster*

The Cancer Treatment at Home Pilot Project is designed to improve access to services by providing cancer treatment in the patient's home. The program is innovative in that the patients are not all "home bound" patients; rather, they are relatively healthy patients who wish to receive chemotherapy at home. As a result, precious space is freed up in the hospital for sicker patients and those on clinical trials, potentially reducing wait lists. Currently, a pharmacist is completing medication reconciliation for all patients enrolled in the program and certified oncology nurses have the expanded role of providing care in the patient's home setting. The latter creates a hybrid of specialized oncology nurses with home care skills.

**Cathy Duong**  
Clinical Network Officer  
Alberta Health Services

**CanWell***Breakout Session 1C, Poster*

CanWell is a collaborative, community based exercise program involving the YMCA, Hamilton Health Sciences Centre, Juravinski Cancer Centre and McMaster University. The program is different from many other exercise programs for people with cancer in that it is provided fully in the community (i.e., not located in a university or hospital) and the exercise supervisors (who are YMCA staff) have some understanding of cancer and the disease process.

**Oren Cheifetz**  
Physiotherapist  
Hamilton Health Sciences

**Genevieve Hladysh, BKin YMCA**  
Canada Training Educator  
General Manager Community Health  
Program Development

YMCA of Hamilton/Burlington/Brantford  
**Jan Park Dorsay, RN(EC) MN NP-Adult CON(C)**  
Nurse Practitioner, Inpatient Oncology  
Rehabilitation Program  
Hamilton Health Sciences

**Fidelma Serediuk, BSc PT MA Health**  
(Candidate)  
Chief of Physiotherapy  
Hamilton Health Sciences

**Clinical and Administrative Coordination of Palliative Home Care Services***Poster*

Following a three year pilot project, the clinical and administrative coordination of the palliative home care interdisciplinary team of the Centre local des services communautaires (CLSC) du Centre de santé et des services sociaux (CSSS) de l'Énergie is now carried out by a team of three nurses, rather than two - an assistant head nurse (clinical and administrative) and two palliative care nurses (clinical). As a result, the care and services are now dispensed in a more integrated, structured and efficient manner, and patients are accompanied throughout the continuum of services. The reorganization of the service resulted in no additional budget requirement.

**Chantal Lehoux, Inf BSc MSc(C)**  
Conseillère à la direction des services  
de santé et des affaires médicales  
Agence de santé et des services sociaux  
de la Mauricie et Centre-du-Québec

**Chantal Rivard**  
Coordonnatrice par intérim des  
services à domicile  
CSSS de l'Énergie

**Clinical Specialist Radiation Therapist***Breakout Session 1B, Poster*

A new role for radiation therapists is being pilot tested across Ontario in an effort to increase the efficiency of radiation therapy centres by using advanced roles to bridge some of the gaps in service delivery as well as enhance the patient experience. The Clinical Specialist Radiation Therapist (CSRT) role involves an advanced scope of practice with new skills and competencies in clinical practice in Radiation Oncology. The CSRT is responsible for patient assessment, triage of referrals, ordering of additional tests (within a prescribed range), determining the treatment site and volume, marking the patient, etc. Eventually, the CSRT will be prescribing radiation for a defined subset of patients and may also be able to prescribe medications from a limited formulary.

**Nicole Harnett, MRT(T) BSc MED**  
Project Manager, CSRT Demonstration  
Project  
Cancer Care Ontario

**Sheila Robson, MRT(T) ACT BSc**  
Manager, Radiation Therapy  
Odette Cancer Centre

**Community Cancer Support Networks***Breakout Session 1C, Poster*

The Community Cancer Support Networks use strong collaborative approaches to connect rural and urban cancer care providers with existing resources, other providers, and services. Dedicated human resources are used to administer the networks to nearly 600 professional partners. A strong professional development program has helped raise awareness of the roles professionals play in cancer care delivery. It has also helped enhance and refine the skills involved in cancer care delivery.

**Vivian Collacutt, BSc(Ed) BSW MSW RSW**  
Provincial Manager Community Cancer  
Support Networks  
Alberta Health Services - Cancer Care

**Community Health Centres Peer Tobacco Educators Program***Breakout Session 3A, Poster*

The Community Health Centres Peer Tobacco Educators Program is an initiative of the Toronto Tobacco Control Area Network. Funded by the Smoke-Free Ontario Strategy, the program is designed to support the development, implementation, and evaluation of a peer-to-peer smoking cessation strategy that meets the needs of participating community health centres' ethno-cultural populations. The program is unique in that it builds the capacity of local community residents and offers them an opportunity to learn a new skill and add an employment experience to their resume that will help them in their career development. The local community benefits from having access to services at the local level.

**Natalia Udarchik, Certified**  
Respiratory Educator  
Primary Care Asthma Program  
Coordinator  
Stonegate Community Health Centre

## Appendix D Service Delivery Models *Continued*

### Community Oncology Program

#### *Breakout Session 3A, Poster*

The Community Oncology Program of Saskatchewan provides cancer patients with care, treatment and support in or near their home communities. The program is managed in Regina, but delivered in rural areas. The program includes a full-time Program Manager supported by one full-time Administrative Assistant as well as two full-time Community Liaison Nurses. The Community Liaison Nurses are front-line nurses who are responsible for liaising between Cancer Agency staff and community staff to enable patients to be treated as close to home as possible. Major components of the Community Liaison Nurse position include coordinating safe and efficient chemotherapy delivery at community oncology centres, facilitating communication and problem solving, attending site visits, and assisting with the education of community oncology staff.

**Linda Weir, RN BScN**  
*Provincial Manager, Community  
Oncology Services*  
Saskatchewan Cancer Agency

### Comprehensive Breast Care Program

#### *Poster*

The Comprehensive Breast Care Program is designed to support family physicians and their patients through often complex and time-consuming diagnostic and care processes, and ensure seamless, integrated, patient-centered, high quality care. A simple referral process provides access to a range of diagnostic and support services in a timely manner. The program is a virtual program that provides professional breast nurse navigation support to patients over the phone with benign and positive breast conditions. In addition, the program offers support from a social worker with clinical expertise. The program involves a lot of partnerships rather than employees. The partnerships include access to medical breast expert services, medical consultants that provide input to the program and other services that the model impacts (such as private diagnostic imaging clinics).

**Janice Chobanuk, RN BScN MN CON(C)**  
*Manager CBCP*  
Comprehensive Breast Care Program  
AHS Cancer Care

### e-Mentorship

#### *Breakout Session 2A, Poster*

The e-Mentorship program was initiated through a grant on inter-professional mentorship and preceptorship from the Ontario Ministry of Health and Long Term Care. The program involves the development of mentor-mentee relationships. It was introduced to address some of the barriers advanced practice nurses were experiencing as professionals in a new area (e.g., lack of support, mentoring experiences and referent groups as well as multiple reporting relationships) which were resulting in poor job satisfaction and a desire to seek other employment. Mentors have included: administrators; psychiatrists; social workers; nurse researchers; and expert advanced practice nurses. Mentees are primarily advanced practice nurses working in a variety of sites in Ontario.

**Esther Green, RN BScN MSc(T)**  
*Provincial Head, Nursing and  
Psychosocial Oncology*  
Cancer Care Ontario

**Diana Morescu, PhD**  
*Program Manager*  
Oncology Nursing e-Mentorship Program

### Follow-Up Care for Childhood, Adolescent and Young Adult Cancer Survivors

#### *Poster*

The Follow-Up Care for Childhood, Adolescent and Young Adult Cancer Survivors program is intended to improve the coordination of care for child cancer survivors among oncologists, family physicians and specialists. The program addresses existing gaps in knowledge or risks and resource issues related to survivors of a cancer diagnosed before the age of 25. It is anticipated that the program will result in: enhanced effectiveness of, and access to, care; the development of strategies for follow-up care; and policies to support follow-up care among cancer survivors.

**Mary McBride, MSc**  
*Senior Scientist*  
BC Cancer Agency

### Healing Beyond the Body Volunteer Program

#### *Breakout Session 3B, Poster*

New skills and competencies have been developed for volunteers in the hospital setting with an expectation that they will be able to provide emotional support to patients and their families and assist patients and caregivers in their navigation through the health care system. The volunteers focus on reducing distress, improving the ability of patients to access hospital and community systems, and increasing patients' capacity to self-manage the complexities of treatment. The volunteers accomplish this by providing emotional support, information, and system navigation assistance. This type of volunteer service is typically not found in hospitals.

**Margo Kennedy**  
*Social Worker*  
Princess Margaret Hospital

### Home Telecare for Colorectal Cancer Patients with New Stomas: Pilot Testing a Multidisciplinary Intervention Protocol

#### *Breakout Session 2A, Poster*

The Home Telecare for Colorectal Cancer Patients is a three year project designed to connect colorectal patients with new stomas with a multidisciplinary team via telehealth. A video conferencing system is used to connect patients (who are at home) with their health care providers (who are at a hospital). Patients are able to save travel and waiting time as well as money; health care providers are also able to save time. An initial report indicated that there was a high level of satisfaction with the model. A more formal evaluation is planned for late 2009.

**Antonia Arnaert, RN MPH MBA PHD**  
*Associate Professor*  
McGill/St. Mary's  
**Zoumanan Debe**  
*Telehealth Research Coordinator*  
McGill/St. Mary's

### Let's Take a Stand Against...Colorectal Cancer!

#### *Breakout Session 1A, Poster*

The Let's Take a Stand Against...Colorectal Cancer! model is intended to provide First Nations communities with an understanding of colorectal cancer prevention and screening, to build capacity in First Nations communities, and to provide Ontario's colorectal cancer screening program with information regarding this type of cancer in First Nations communities. Cancer Care Ontario has been successful in securing one-time funding to support the procurement of an Aboriginal Provincial Educator who will be responsible for training both professional educators (e.g., nurses, dietitians, and social workers) and lay educators (e.g., community health representatives, community health promoters, and life long care workers) to provide information regarding colorectal cancer to First Nations communities. The training sessions strongly encourage cross-collaboration and support between and among these service providers, depending on what is available within their catchment areas.

**Rina Chua-Alamag**  
*Manager, Aboriginal Cancer and Prevention Team*  
 Cancer Care Ontario

### Mobile Breast Screening Program

#### *Poster*

As part of the Mobile Breast Screening Program, a mobile coach travels 10,000 km annually to visit over 56 locations in northwestern Ontario. The program works with rural and remote communities to increase access to breast screening. The program is supported by a small administrative office located in Thunder Bay. A Registered Nurse and a Mammography Technologist share duties related to the mobile service. The nurse has additional training in clinical breast examination. The technician is responsible for the operation of the digital mammography unit. Images are transferred to radiologists at the hub office who read the mammograms daily.

**Alison McMullen**  
*Director Preventive Oncology*  
 Regional Cancer Care, Thunder Bay  
 Regional Health Sciences Centre

### Model of Cancer Care

#### *Poster*

The Cancer Care model of Le Centre intégré de cancérologie en Montérégie (the integrated cancer centre of the Montérégie; CICM) at L'hôpital Charles LeMoine is innovate in that all the professionals are trained to work in an interdisciplinary manner using a patient and family centered approach. The CICM was the first health institution in Québec to have introduced the pivot nurse with specialized training in oncology into its oncology program. The pivot nurse is a member of the multidisciplinary team, accompanies the patient and his/her family throughout the trajectory of the illness, and acts as a link with the different health care providers. The pivot nurse provides coordination of care and services based on the personal needs of each patient.

**Anne Plante, MSc Inf**  
*Infirmière conseillère spécialisée en oncologie*  
 Centre de lutte contre le cancer de la Montérégie

**Brigitte Brabant**  
*Responsable du programme régional de lutte contre le cancer*  
*Gestionnaire du Réseau Cancer Montérégie*  
 Agence de la santé et des services sociaux de la Montérégie

### Niagara West Shared Care Model

#### *Breakout Session 3B, Poster*

The Niagara West Shared Care model is a comprehensive, population based model for palliative care patients. The purpose of the model is to improve the quality of end-of-life care through the implementation of a shared care model that integrates primary care services with specialized palliative care services. The model focuses on continuity of care, provides seamless care, and reduces the need for patient transitions in care. Palliative/end-of-life clinical care is provided with an emphasis on the primary care role - what the family doctor and bedside nurses provide. Consultative palliative care is provided by an expert palliative care consult team that works with the primary care team. Together they provide shared care to patients in a variety of care settings - private homes, retirement homes, long term care facilities, hospices, hospitals, etc.

**Denise Marshall, MD CCFP FCFP**  
*Assistant Dean, Faculty of Health Sciences*  
 McMaster University

### Northern Cancer Control Strategy

#### *Breakout Session 1A, Poster*

The Northern Cancer Control Strategy is a comprehensive strategy which encompasses the entire continuum of cancer control programs and services. The strategy is designed for the relatively small population living primarily in rural and remote communities in the large northern British Columbia geographic area. A number of additional services and specialized staff resources are being put into place to support improved cancer control in the region through enhanced services, increased coordination, multidisciplinary collaboration and partnerships.

**Dan Le, BComm BSc MHA MD(c)**  
*Project Manager, Special Projects*  
 Northern Health Authority

### Nunavik Pivot Nurse in Oncology Pilot Project

#### *Breakout Session 1A, Poster*

Nunavik, a remote arctic region in Québec, has limited specialty medical care and no oncology specialty care. Inuit suspected of having cancer are sent to the McGill University Health Centre in Montréal for a work up of their diagnosis, surgery, and medical and/or radiological treatment, as required. The Nunavik Infirmière pivot en oncologie (IPO) meets cancer patients in Montréal as close to the time of diagnosis as possible and maintains contact with the patient throughout his/her stay in Montréal. The presence of Inuit interpreters facilitates communication with the patient. As well, the IPO collaborates with nurses in the northern communities and supports them in acquiring knowledge/information about the different treatment plans for cancer patients who return to their communities following their stay in Montréal.

**Mary Lou Kelly**  
*Infirmière Pivot en Oncologie*  
 Centre de Santé Tulattavik de l'Ungava/ McGill University Health Centre

## Appendix D Service Delivery Models *Continued*

### Oncology Clerical Navigator

#### *Breakout Session 1B, Poster*

In the PEI Cancer Treatment Centre, the role of clerical navigator has been developed out of need. For both the Medical and Radiation Oncology departments, clerical staff are used to follow patients' schedules throughout their treatment at the centre in order to aid patient flow, increase time efficiencies, and minimize treatment delays. Scopes of practice for these navigators have been broadened and abilities have been used to their maximum potential.

**Liz Dobbin, RT ART**  
*Manager*  
PEI Cancer Treatment Centre

### Oncology Interactive Navigator

#### *Poster*

A person-centred care (PCC) model involves a fundamental shift in the ways the healthcare workforce operates and the ways individuals interact with each other and the system while dealing with acute or chronic health issues. An essential element within this model is an informed, engaged patient who actively participates in their care with an enhanced sense of competence and empowerment. The Oncology Interactive Navigator (OIN) was conceived according to the values of this promising model. As a patient-centred web-based tool that fuses technology with rigorous content and full clinical integration the OIN provides timely psychosocial and pragmatic informational support throughout the cancer trajectory from prevention to long-term survivorship. The OIN complements the healthcare workforce by providing clinical information and training that seamlessly supports hospital and community-based PCC interventions.

**Murray Rochon, B.Arch**  
*President, CEO*  
Oncology Interactive Navigator  
**Carmen Loisel, N PhD**  
*Associate Professor, Faculty of Medicine*  
McGill University

### Oncology Service with Dietitian Services at HealthLink BC

#### *Poster*

Through a partnership between Dietitian Services at HealthLink BC and the BC Cancer Agency, oncology nutrition services in British Columbia have expanded. The BC Cancer Agency provides nutrition care during the time of cancer care for those most at risk for malnutrition. Dietitian Services at HealthLink BC provides nutrition care during the entire cancer continuum from primary prevention, prevention or recurrence, to palliation. Positioning the service outside of the traditional hospital model changes the emphasis from a focus on care during treatment to a focus on care throughout the entire cancer continuum (from prevention to palliation). It also allows dietitians working in the hospital setting to focus on the needs of those undergoing treatment. A referral matrix was developed with the Oncology Nutrition department at the BC Cancer Agency to ensure that patients are referred to the correct service.

**Andrea Holmes, RD**  
*Tele-Dietitian, Oncology*  
HealthLink BC  
**Barb Leslie, RD**  
*Director, Dietitian Services*  
Emergency and Health Services Commission

### Organized Screening, Monitoring and Evaluation Research Program

#### *Poster*

The Organized Screening, Monitoring and Evaluation Research Program evaluates the services of population based screening programs that target populations at risk of diseases such as breast, cervical and colorectal cancer. It provides a single evaluation, monitoring and research framework, as well as a venue for collaborative action. Thus, participating jurisdictions are not burdened with having to develop their own approaches individually. This results in increased efficiency without a loss of jurisdictional independence.

**Heather Limburg**  
*Epidemiologist*  
Public Health Agency of Canada

### The Ottawa Hospital Cancer Centre Psychosocial Oncology Program

#### *Poster*

The Psychosocial Oncology Program is based on comprehensive research, consultation, and a financial sustainability analysis developed over a two year period. Its Business Plan provided a cost-benefit analysis related to psychosocial services and the chronic care management services required to reduce the number of emergency visits and address the higher than average length of stay for oncology patients. As a result, the program includes a number of specialized rehabilitation staff (e.g., Psychiatry, Social Work, Psychology, Nutrition Management, Physiotherapy, Occupational Therapy, Speech Language Pathology and Kinesiology). The majority of psychosocial oncology programs do not include these professions within their program.

**Diane Manii, MSW RSW**  
*Clinical Manager Psychosocial*  
Oncology Program  
The Ottawa Hospital Cancer Centre

### Palliative Day Care Centre

#### *Poster*

La Maison Michel-Sarrazin's Palliative Day Care Centre (le centre de jour en soins palliatifs de la Maison Michel-Sarrazin) is innovative in that it is independent from the hospice and provides, on an outpatient basis, biomedical and psychosocial support to cancer patients who are at the palliative stage of their life and who wish to remain at home as long as possible (even until death). The model is also innovative in terms of human resources. There is much versatility in the organization of the work. Health care professionals and volunteers provide care as well as complementary services such as hairdressing, relaxation and esthetician treatments to palliative care patients.

**Michel L'Heureux**  
*Directeur général*  
Maison Michel-Sarrazin  
**Lynda Beaudoin**  
*Coordonnatrice du Centre de jour*  
Maison Michel-Sarrazin

**Provincial Family Physician Initiative***Breakout Session 1C, Poster*

The goal of the Provincial Family Practice Initiative is to establish and enhance effective strategic and collaborative relationships with family physicians and oncology services across Alberta in order to provide the population at risk and people living with cancer with current, accessible and responsive information and care. The three priority areas of the initiative include: access to cancer specialists and resources; oncology education for family physicians from the expert community in order to support the care of cancer patients across the cancer care spectrum and closer to home; and communication between and among care providers through system improvements and organized dialogue sessions (including educational opportunities and collaborative development of system improvements).

**Patti Taschuk**  
*Senior Leader, Medical Affairs  
and Community Oncology  
Alberta Health Services, Cancer Care*

**Provincial Pediatric Oncology/Hematology Network***Breakout Session 3C, Poster*

The Provincial Pediatric Oncology/Hematology Network is an interdisciplinary organization which functions under the guidance of the BC Children's Hospital and the BC Cancer Agency. The goals of the network are to ensure appropriate diagnosis, management, follow-up and end-of-life care for children and adolescents with cancer and hematological disorders across the province. The network supports community hospitals and practitioners and develops partnerships with other health care facilities to enable seamless and integrated care for patients and families. Community health care professionals are able to gain knowledge and skills to deliver safe care and treatment as close to the patient's home as possible. They are supported by health care professionals at a tertiary care centre.

**Christopher Fryer, FRCPC**  
*Pediatric Oncologist/Radiation Oncologist  
BC's Children's Hospital*

**The Psychosocial Oncology Program***Poster*

The Psychosocial Oncology Program was created as part of the McGill University Health Centre's Cancer Care Mission. The mission and mandate of the Psychosocial Oncology Program are to: a) offer professional psychosocial services to oncology patients and family members; b) offer continuing education for providers by providing in-services or conferences on topics in psychosocial oncology; c) conduct psychosocial research in oncology; d) provide cancer teams at the McGill University Health Centre with brief interventions; and e) offer clinical training to PhD students in psychosocial oncology.

**Marc Hamel, PhD**  
*Director, Psychosocial Oncology Program  
McGill University Health Center  
Montréal General Hospital*

**Anita Mehta, MSc(A) PhD**  
*Clinical Nurse Specialist  
Associate Director, Psychosocial  
Oncology Program  
McGill University Health Center  
Montréal General Hospital*

**Pulmonary Investigation on an Outpatient Basis***Poster*

The Outpatient Pulmonary Investigation Program is comprised of a number of rigorous and organized activities for patients who are suspected of having lung cancer or a recurrence of lung cancer. Clinic staff follow patients from the moment of suspected cancer right up to the time when a decision is made regarding the required treatment. The nurse responsible for the Pulmonary Investigation Outpatient Clinic ensures that multidisciplinary team members are available to respond to the needs of each patient and his/her family in a timely manner. In the Pulmonary Investigation Clinic, the contribution and productivity of the care team has been optimized, especially with respect to "taking charge" of patients.

**Mélanie Anderson**  
*Infirmière clinicienne  
IUCPQ*

**Isabelle Simard**  
*Conseillère clinicienne en soins infirmiers  
institut de cardiologie et de pneumologie  
de Québec*

**Rapid Access Palliative Radiotherapy Program***Breakout Session 3B, Poster*

Palliative-intent radiotherapy is an effective treatment for painful bone metastases. It is generally underutilized, possibly because the traditional approach is to have multiple clinic visits for consultation, planning and treatment. In addition, consultations with other health care disciplines, such as Occupational Therapy or Social Work, usually occur at separately scheduled visits. With recent evidence showing that one palliative radiotherapy treatment is as effective as multiple treatments for analgesia, the Rapid Access Palliative Radiotherapy Program was born. The main goals of the program are to provide: timely and efficient palliative radiotherapy; and timely and efficient access to a patient-centered, holistic, multidisciplinary health care team specialized in addressing symptom control and quality of life concerns. Secondary goals for the program include: involvement in cancer research; academic teaching; maintenance of continuity of care; and inter-professional communication and education.

**Alysa Fairchild, MD FRCPC**  
*Clinical Lead, Rapid Access Palliative  
Radiotherapy Program  
Cross Cancer Institute*

## Appendix D Service Delivery Models *Continued*

### Rapid Response Oncology Clinic

#### *Breakout Session 1B, Poster*

The goals of the Rapid Response Oncology Clinic are to: provide rapid access to care for active oncology patients with cancer related problems; improve continuity of care for patients from the R.S. McLaughlin Durham Regional Cancer Centre; reduce the number of oncology patients presenting to emergency departments in Durham; relieve pressure on follow up clinics at the Regional Cancer Centre; reduce readmission rates for oncology patients; and improve relationships with emergency departments. As a result of the model, the readmission rate for oncology patients has been reduced. In addition, the relationship between the Oncology and Emergency departments has improved. Registered nurses, with increased scopes of practice assess oncology emergencies and triage patients in the clinic and a hospitalist (a family physician) works collaboratively with medical and radiation oncologists.

**Tamara Dus, RN MN CON(c)**  
*Manager, Clinical Trials & Systemic Therapy*  
R.S. McLaughlin Durham Regional Cancer Centre

**Leta Forbes, MSc MD FRCPC**  
*Head, Medical Oncology*  
R.S. McLaughlin Durham Regional Cancer Centre

### Regional Systemic Treatment Program

#### *Breakout Session 3C*

Thunder Bay is a medium sized city surrounded by a vast rural area. Regional patients can travel between one to six hours to get to the Thunder Bay Regional Cancer Centre. In addition, patients from Northwestern Ontario must travel to larger urban centres for care not offered in the region. The Thunder Bay Regional Cancer Centre tries to reduce the amount of travel required by providing a variety of services close to patients' homes. As part of the Regional Systemic Treatment Program, cancer services offered to patients at both the local and regional levels are enhanced through telemedicine and the support of visiting physicians. The contributions of the clinicians support nurses, pharmacists, pharmacy technicians, and general practitioners in 13 satellite sites.

**Aaron Skillen, HBC BEd MBA**  
*Director, Oncology Clinical Systems*  
Regional Cancer Care  
Thunder Bay Regional Health Sciences Centre

### Registered Nurse (RN) Performed Flexible Sigmoidoscopy Project

#### *Breakout Session 1B*

The Registered Nurse Performed Flexible Sigmoidoscopy Project is a pilot project which involves RNs performing flexible sigmoidoscopy. Ontario is the first jurisdiction in Canada to provide this screening test through non-physician resources. RNs perform flexible sigmoidoscopy for referred clients, with oversight provided by a gastroenterologist. Follow-up involves a biopsy when polyps are detected and referrals for a colonoscopy when one or more neoplastic polyps are present. Studies from the UK and the US have shown no clinically significant differences between gastroenterologists or general surgeons and nurses or other appropriately trained non-physician endoscopists in terms of outcomes. They have also shown that the use of non-physicians is cost-effective and does not impact negatively on patient satisfaction or safety.

**Esther Green, RN BScN MSc(T)**  
*Provincial Head, Nursing and Psychosocial Oncology*  
Cancer Care Ontario

### Single Entry Point - Coordination of Lung Cancer Investigation

#### *Poster*

The Single Entry Point - Coordination of Lung Cancer Investigation at the Institut universitaire de cardiologie et de pneumologie de Québec (IUCPQ - Hôpital Laval) was first implemented as a one year pilot project in February 2008. The program is targeted at family physicians and specialists, who practice in rural areas near Québec City and in the central and eastern regions of Québec, who want to rapidly refer their patients who are suspected of having lung cancer to the specialized pulmonary clinics at the IUCPQ for investigation.

**Mélanie Anderson**  
*Infirmière clinicienne*  
IUCPQ

**Isabelle Simard**  
*Conseillère clinicienne en soins infirmiers*  
Institut de cardiologie et de pneumologie de Québec

### Survivorship Empowerment Model for Integrated Cancer Care

#### *Poster*

The Survivorship Empowerment Model for Integrated Cancer Care focuses on breast cancer survivors and connects them to the services and supports they need. The model assumes that many survivors can benefit from navigational support and can work within a self-management framework. The model is innovative as it challenges the way supportive care is delivered within a cancer facility and involves the integration of multiple disciplines and agencies. With respect to health professions, the model includes occupational therapists, physiotherapists, nurses, social workers, manual lymph drainage therapists and physicians. New skills are acquired by the health care professionals who are delivering holistic care in a standardized way from a framework of empowerment. The model also involves peer volunteers and volunteers with intensive training in providing support to patients. These individuals work under Social Work supervision.

**Scott Secord, MSW RSW**  
*Program Manager, Breast Cancer Survivorship Program*  
Princess Margaret Hospital

### SYMO

#### *Poster*

Le Centre de santé et de services sociaux (CSSS) (Health Care Centre) du Haut-Richelieu-Rouville has implemented a new and unique computer application in Québec which supports the work of the palliative home care nurse in providing home care. SYMO, a distinctive computer application, optimizes the process by which clinical activities taking place in patients' homes are organized. Specifically, it captures patient data at the source (by the home care nurse) and immediately sends the information to other care providers involved in the care of the patient. Its use has resulted in an increase in the number of visits by home care nurses, a reduction in the amount of time the nurses need to allocate to clerical functions, an increase in the time spent with patients and an improvement in the quality of the nurses' interventions with the patients.

*Model informant information not available at time of print.*

**Teleoncology (Sudbury)***Poster*

Many challenges exist in providing access to care for oncology patients living in a large rural geographic area of 310,000 square kilometers. The availability of telemedicine through the Ontario Telehealth Network has provided the Regional Cancer Program at the Hôpital Régional de Sudbury Regional Hospital with the opportunity to be innovative in how they offer oncology services to patients living a distance away from a tertiary care centre. Here, teleoncology is used by radiation and medical oncologists as well as primary nurses for patients who require monitoring while receiving treatment, follow-up care and palliative care. It may also be used for selected new cases and to consult with patients regarding treatment decisions. Other health care professionals also use the technology for one-on-one patient consultations and group work.

**Mark Hartman, MRT(T) MBA**  
*Administrative Director, Northeast  
 Regional Cancer Program*  
 Hôpital Régional de Sudbury Regional Hospital

**Terry MacKenzie, RN CON(C)**  
*Interim Administrative Director, RCP*  
 Hôpital Régional de Sudbury Regional Hospital

**Teleoncology Model (BC)***Poster*

The Teleoncology model replaces the traditional face-to-face model of health care delivery. The model focuses on cancer patients in smaller communities who need to be seen by a medical and/or radiation oncologist for a new patient assessment/consultation, medical management during treatment, or follow-up care post-treatment. The model also provides group education sessions for patients regarding nutrition.

**Helen Anderson, MBChB FRACP MD FRCPC**  
*Medical Oncologist*  
*Assistant Professor, UBC*  
*Regional Professional Practice Leader*  
*Medical Oncology*  
 BCCA, Vancouver Island Cancer Centre

**Two Day Treatment (Day Before Bloodwork)***Breakout Session 3C, Poster*

The R.S. McLaughlin Durham Regional Cancer Centre is committed to: ensuring ongoing safe chemotherapy treatment; making the treatment process efficient and relatively easy to navigate; and eliminating very long wait lists in the waiting room. In order to meet their mandate, the Regional Cancer Centre introduced the Two Day Treatment model. In this model, patients come into the regional cancer clinic for blood work the day before their chemotherapy treatment. As a result of the model, several efficiencies have been realized: physicians are able to see patients without delays and everyone is treated at their scheduled appointment time. Sick time for nurses and overtime costs have been reduced, patient wait times have decreased and activity volumes have increased. Finally, there is less waste of prepared, expensive chemotherapy drugs.

**Tamara Dus, RN MN CON(c)**  
*Manager, Patient Care Systemic  
 Therapy & Clinical Trials*  
 R.S. McLaughlin Durham Regional  
 Cancer Centre

**Leta Forbes, MSc MD FRCPC**  
*Head, Medical Oncology*  
 R.S. McLaughlin Durham Regional  
 Cancer Centre

**UPCON: Uniting Primary Care and Oncology***Breakout Session 2B, Poster*

The UPCON model facilitates ongoing communication and collaboration between Cancer Care Manitoba and primary care providers regarding services related to secondary prevention, treatment, follow-up rehabilitation, supportive care and/or palliative care. UPCON has 25 partner primary care clinics/centres each of which work through a Lead Clinician (i.e., a family physician or nurse practitioner). The Lead Clinician in each clinic coordinates liaison between Cancer Care Manitoba and other family physicians and primary care providers in their clinics/centres. The Lead Clinicians have an interest in cancer/palliative care and assist their colleagues with questions that arise in the care of cancer patients. The program focuses on communication, education and technological initiatives to expand and strengthen collaborative measures and extend the network of participating clinics/centres.

**Pat McCormack-Speak, RN MBA**  
*UPCON Program Manager*  
 CancerCare Manitoba

**Virtual Pain and Symptom Control/  
Palliative Radiotherapy Clinic***Breakout Session 2A, Poster*

The Virtual Pain and Symptom Control/Palliative Radiotherapy Clinic delivers specialist multidisciplinary pain and symptom control and palliative radiotherapy consultation to patients who do not have local access to these services. The clinic team, which is based in an urban tertiary cancer centre in Edmonton, provides services to patients in rural northern Alberta via telehealth connections to Associate and Community Cancer Centres. The model is innovative in the inclusion of rural oncology and palliative care nurses in the specialist multidisciplinary team.

**Sharon Watanabe, MD**  
*Director, Department of Symptom  
 Control and Palliative Care*  
 Cross Cancer Institute, Alberta Health  
 Services Cancer Care

**Well Follow-Up Breast Cancer Clinic***Poster*

In the Well Follow-Up Breast Cancer Clinic, care is transferred to, and delivered by, a General Practitioner in Oncology and an Advanced Practice Nurse. The clinic sees women who have been diagnosed with breast cancer. Once they have completed surgery, chemotherapy and/or radiation, patients may be referred to the clinic by their oncologist for ongoing follow-up care. Having a clinic dedicated solely to the needs of a patient on follow-up enables oncologists to have the opportunity to see more new patients, more complex patients, participate in research, etc. It also helps other clinics run more smoothly.

**Margaret Forbes, RN BScN CON(C)**  
*APN Intern Breast Disease Site Team*  
 Juravinski Cancer Centre

*\*Based on information available at time of print. Service delivery model summaries are based on the model summary descriptions developed for the Service Delivery Models Project.*

## Appendix E World Café: Analysis of Recommendations

George Eisler; Facilitator

### 1. Overview

Participants at the World Cafe session of the Symposium were asked to identify strategies with positive impact on human resource challenges. Randomly assigned to discussion tables of 4-6 individuals during 'round one', participants identified 38 strategies for consideration as identified in the attached table. In 'round two and three', participants, in collaboration with new table partners, chose 20 of these strategies and identified associated challenges as well as a series of action areas to address these strategies.

Conference organizers separated the recommended strategies into the following seven categories:

- Shifting Care
- Role of Healthcare Providers
- Changing the Way We Work
- Patient Empowerment
- Education
- Technology
- System Management

### 2. Shifting Care

The challenges have to do with lack of knowledge and confidence and standardization of approaches between the various providers and patients.

Collaborative action would address the creation of and support for a 'community of practice' (COP) for all partners, including content such as standards, models of approaches, links to education opportunities, and networking opportunities. Cost-benefit analysis of selected innovative models is recommended, with respect to financial and human resources.

A COP or network administrative structure, an oversight committee and resources for consultants with broad program and economic evaluation expertise would be advisable.

### 3. Role of Healthcare Provider

The broadening of provider roles is being addressed at many levels in the healthcare system. Regulatory bodies, legislators, and healthcare managers throughout the continuum of care are engaged in this development across the country. It could be most useful to fund a review of status and developments in this area across the healthcare system combined with an analysis of how best to harness the findings and developments for the continuum of cancer care.

#### **4. Changing the Way We Work**

Moving toward interprofessional patient-centered collaborative practice has become a national and international priority. Provincial, institutional, and national bodies focused on this goal are in existence.

Initiatives involving educators and practice leaders exist and major funding programs over the past three years have generated a considerable body of knowledge. The cancer community could form a partnership with or take on a leadership position within the established provincial, national, and international networks.

Investment in an analysis of the landscape of organizations and initiatives as well as funding for associated networking and knowledge transfer could move this agenda forward quite quickly within the cancer care community.

#### **5. Patient Empowerment**

A major conference on this issue with a focus on cancer care could bring significant benefits quite quickly as the expertise and the appropriate body of knowledge are well developed in Canada. This could be a high priority next step as it would drive many of the other improvements and innovations presented at the symposium.

#### **6. Education**

Rather than developing education resources, a closer partnership with educators should be established, including undergraduate, graduate, work place based, for profit or cost-recovery continuous education operators, etc. An inventory of needed and innovative education approaches and materials could be produced and disseminated, as resource challenges in education could serve as incentive for broader sharing or collaboration.

#### **7. Technology**

The application of information and communication technology (ICT) to overcome barriers in distance, knowledge, access, and culture could become a demonstration project or living laboratory, addressing all the networking and communication needs identified at the symposium.

#### **8. System Management**

It is assumed that other forums exist to deal with this issue.

#### **9. Conclusions**

Continued investment in a combination of cost-benefit studies of various approaches, partnerships with existing national efforts, a strong ICT based communication infrastructure, a network and COP administration office, and additional symposia on special topics would be valuable contributions to enhanced human resource deployment and development in cancer care.

## Appendix F Summary of the Symposium Evaluations

Nearly 50% of attendees completed an evaluation form, providing valuable feedback moving forward. Over 90% of respondents found the symposium to be both relevant to their work as well as timely. Similarly, over 97% found the symposium to be instrumental in helping forge connections with others across the country who are working with the same issues and challenges.

The responses received for two open-ended questions speak to the value and significance of the symposium as well as the Service Delivery Models Project in working towards its overall goal of **promoting the application of leading, innovative and promising models of service delivery that can be shown to be effective in overcoming existing and future human resource challenges faced by the cancer control system.** Hence, the responses are shared below.

### Question #8 List one thing you will do in your organization/work place as a result of attending the symposium.

#### Making Connections

- Work with new contacts; contact some of the innovative models presented
- Follow-up to get more information on some models
- Continue to work on partnering with our colleagues and developing relationships
- I will be in touch with a couple of presenters to find out more about their projects
- Look at how to create the partnerships to bring the various stakeholders together to develop seamless patient-centred cancer care access - the patient's journey from screening to follow-up.
- Develop partnerships to proceed with our work
- Consult with experts in patient education, survivorship and electronic psychosocial support from Princess Margaret Hospital

#### Sharing the Learnings

- Share the information on relevant models with colleagues
- Share the model concepts that seem very applicable and usable to our province.
- Make sure we share the information that we felt can be used in our facility.
- Disseminate the opportunity to access the information about models through Cancerview Canada
- Encourage staff to look at on-line resources and presentations from the symposium
- Provide information from symposium to rest of professionals in office
- Share info with colleagues in regional offices.
- Contribute ideas from this symposium to our Agency strategic planning and my research work
- Share information with Manager to explore ways to seek «sponsor» support for workforce in clinical trials

### Adopting Innovation

- Better knowledge of models of care
- Apply knowledge gained about BC's pediatric oncology/haematology network
- Apply knowledge gained about follow-up care initiative
- Network with Durham RCC regarding the urgent care clinic they described in their breakout session as we are also trying to determine how best to deal with similar pressures at our centre
- Push for more home-based chemo but stress impact on hospital pharmacy, etc.
- Use some of the ideas presented on care pathways and rapid response clinics.
- I will follow up with a couple of presenters to see how their project can be adapted
- Review possibility of 2-day chemotherapy plan. Review educational information available locally.
- Implement a variation of rapid response team. Modify our models of care by including patients in the decision of what their needs are and address them in our models of care.
- Look at implementing a 2 day chemo program
- We will look at 2 day chemo and work more with role clarification and pathways.
- I will attempt to establish a Rapid Response Clinic in my centre.
- Evaluate where models presented may be applicable - seek collaborative networking to facilitate implementation possibilities
- Continue with care pathways
- Start a 2 day treatment program
- Looking at 2 day treatment plan
- Shared-care clinic (transition from Cancer Centre to Primary Care/Family Physician)
- Use select examples (eg. Alberta pathways, Niagara West Shared Care model) to illustrate options paper for next steps in our province
- Push for more home-based chemo but stress impact on hospital pharmacy, etc.

### Exploring/ Adopting other Enhancements

- We will continue to push forward to develop innovative models of care that meet the needs of cancer patients and their families and ensure that these are patient-centred, not discipline-centered models.
- Identify the role of nurses in weekly clinical case conferences as part of the process's quality agenda
- Make effort to better understand the rural context
- Communicate better
- Define better our roles within the system
- We feel encouraged to continue work on scope of practice issues
- I'm going to network more with our other practitioners. I'm going to ask every patient «How can I help you today?» and «Have I answered your questions today?»
- Hope that there are professionals who want to change and move forward
- Adjust a local program taking into account some innovations found here

## Appendix F Summary of the Symposium Evaluations *Continued*

- Look for opportunities for greater collaboration (particularly rehab survivorship). Be «respectively provocative»
- I will continue to look for new opportunities regarding technology to improve access to service and education for patients and providers
- Involve patients more in planning projects
- Speak to our SW department regarding utilizing volunteers to expand supportive care to patients.
- Work with local cancer experts to bring innovations into the workplace
- Look at more opportunities with technology
- Try to determine how laboratories can do even more to make their role in cancer more relevant to policy makers and physicians.
- More evidence-based service delivery
- More performance measurements
- Look into guidelines for surveillance of survivors of childhood cancer
- Look at ways to use infoway and telehealth
- Advocate to appropriate levels to increase/maximize all professions scope of practice
- Utilize concept of «World Cafe» for group discussions at our centre
- «Listen» to others

### Question #10 - What would you like to see happen as a follow up to the Service Delivery Models Project?

- Further work on World Cafe as to actual actions that can be undertaken.
- Another symposium
- More co-operation across areas and provinces.
- Pilot projects
- Select 3 to 5 models and move to implement them across the country. That will make a huge difference for patient care.
- Not sure, very anxious to see the repository on line. I think CPAC HHR AG will need to take all of the information and then determine what the vision and goals will be for this group going forward. I think it is more than a repository although that will be very helpful.
- National follow-up guidelines for cancer care are developed
- Progress reports
- List of to come forward to assist others on a consultative basis when implementing new projects.
- make available to participants a copy of each poster
- Ensure the repository is updated on a yearly basis
- How can my program be included in the repository?»
- Ask people to present a brief (5 min) project they started after attending this conference

- One thing that would be interesting is to ensure that people responsible for delivery of service are the ones in attendance. There were not that many front line managers or directors there. There were physicians, researchers, academics.... all good but more operational people would be good too
- The provinces can talk to each other
- Discussions at the level of my institution to really brainstorm about strategies for now and the future.
- Follow-up/update on projects presented. How is it going? This would provide some opportunity to learn about outcomes
- Repository of models
- Follow-up symposium to show new models in 2 years»
- I would like to see a template for service delivery models prepared at a national level to facilitate communication. A framework for outlining elements of service delivery that would allow common language
- Definitely would like follow up symposium to update on any changes, adaptations or evolutions to the models. Also would be great to hear about how models were applied to other centers/provinces and how the process was.
- I would like more information on some of the projects.
- More service delivery models in organizations that aren't represented, as our organization implements projects, but little research before or evaluations done.
- Increased sharing of info
- Feedback on how the strategies identified at World Cafe will be moved forward.
- More exposure of some of the models within Canada
- Perhaps regular workshops on a smaller scale
- Progress report from the recommendations from the World Cafe
- That people in health care across Canada use the models within their own area. That this leads to greater collaboration. Administrators and decision makers recognize the innovation and reward it.
- National initiatives - informatics, guidelines, education
- I'd like to see some national (CPAC) support in helping us to maintain some of the connections we've made here Eg. I have met people who have similar roles to mine and it would be nice to stay in touch. Some of my colleagues across the country and I are beginning to organize ourselves as an «interest» group however, at this point it is my assistant doing the organizing and coordinating
- Maybe another conference in a couple of years
- Sharing information
- Coaching opportunities for the innovative models shared here
- I would like to see action to recommendations made. Lets move the agenda forward and not pack it into a little box and store on a shelf... would be a pity.
- I would like to see CPAC help to influence/lobby/ support providers in lobbying policy makers to translate several of the relevant pilot projects into sustainable programs to demonstrate the financial implications of doing things differently.
- This conference should be annual and focus on key areas identified in this symposium for next year.

## Appendix F Summary of the Symposium Evaluations *Continued*

- This symposium should not be regarded as a snapshot, but should become the beginning or a continuum of activities to support knowledge transfer in the context of service delivery models
- A report on common successes
- A cost benefit template for models to use in future»
- Action - we now need to demonstrate to policy makers we can do a better job by moving from traditional silo structure to an integrated model. Mandates, timelines and financial remuneration needs to be put in place. Excellent examples.
- Information sharing on models or frameworks that could be implemented (why re-invent the wheel)
- More models and possibly a website with such ideas (more of them) would be an interesting idea.
- Education of lay team survivorship by the different service delivery models
- Mode of evaluation in term of effectiveness
- That there be a clear body of experts to direct and advise the Federal Health Minister on policy decisions regarding Cancer control and that these be shared with provincial health ministries.
- Work on Strategies and Recommendations
- A strong emphasis/support of remote communities as part of CPAC national strategy
- «Updates on the service delivery models --> how they continue; what works, what doesn't work well
- ongoing continuity of «»shareing»» interprofessional models
- Showcasing fewer models to help facilitate a national focus on one or two models that can be easily integrated or at least understood by other professionals
- Ensure accessibility of information - ensure that information is distributed to all parties
- Create a networking site for future reference as new issues develop in local/regional»
- Update on strategies in development at another annual symposium
- information shared online forum for discussion / q&a on CPAC or chat session?
- Transfer of symposium ideas to decision makers, HCP associations, for discussion and evaluation in regard to system structural change to meet future needs in a sustainable system. Increased ideas and dissemination of successful service delivery models.
- Focus on special needs of growing population (different ethnic groups) and aging population
- CPAC to fund national/pan-canadian groups to develop patient experience or other pt outcome measure to be able to evaluate impact of new models. Patient satisfaction (NRC-Picker) is not doing the job
- Follow up/update on projects presented. How is it going? This would provide some opportunity to learn about outcomes»
- Publication of top ideas, follow up symposium
- Incentives for Provinces to adopt comparable or compatible standards of care, record keeping, etc. due to national requirements and funding



