Care to Plan, Plan to Care: Diving into the Regional Cancer Plan 6

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help when you really need it.

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Welcome to the cancer assist podcast. I'm your host, Dr Bill Evans, and today I'm welcoming two guests to the podcast. Anil Johnson, who's the vice president of oncology and regional VP Oncology at Ontario health and for the Hamilton Ira Haldeman, Brandt Lin, that's such a mouthful, but it's not a Lin anymore, but it's the region. I think we get that. And Jennifer Smith, who's the director of the Regional Cancer Program for the same region, and also you have responsibilities in hematology, I gather, seems like double duty, and must be stretching people very rather thinly at the jurors key these days. But I think that is a challenge across the system in terms of numbers of leaders and practitioners and nurses and so everybody's working very, very hard. What we want to talk today about is actually how Cancer Care Ontario plans for the services it delivers. And just as a way of background. I'm old enough to have been around for the very first Ontario cancer plan, which was done in 2005

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and these are rolling three year plans, and I actually have a copy of it. So since we're on YouTube these days, I can actually hold it up, and you can see this nice, glossy booklet here that laid out a whole series of priorities. And in those days, the priorities were very much around a system that was under resourced. It didn't have enough machines, it didn't have enough cancer centers, and it didn't have enough people, and it didn't have enough guidance for how to deliver quality patient care. And so the action plans built around all of those items. And subsequent to that, a progress report came out in 2008 2009

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which actually showed that there was significant progress made against all of these issues, or plans for six more cancer centers, for example, in the province of Ontario. So there's been a lot of benefit out of these plans, which now we're up to plan six, and I think it's one of the features that makes the cancer system in Ontario one of the best in the world.

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So but there's always room for improvement, right? And so plan six is what we want to talk about, and what some of those improvements will look like, and how they might be implemented in our region. So

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you've led through a number of these plans as well, Neil, and you might want to give your own impression of how effective they've been before we just dive into plain plan six and some of the topic areas there that are flagged for future development? Yeah, happy to Bill, and it's always great to meet with you, Bill. We always have Bill and I sat at the provincial leadership table for a number of years together, and so it's always good to reconnect with you, and obviously with your listeners on the podcast. You know you're right. I mean, you can't improve a system, whether it's a cancer system or healthcare system, if you don't have a plan. And I believe Cancer Care Ontario has been very successful, really, over the last two decades. Right about organizing plans, but also executing on them. I mean, a plan without execution is nothing. Is nothing. You know, it might take a little baby step back and just say to people, there is a Cancer Care Ontario. What is that? And has morphed a bit now into a bigger organization called Ontario health. But maybe just step back, yeah, let me give you a little bit of a background. I love the history of this, because I think if you don't know the history of organizations, you can't sort of understand the culture and how they've come so if you go back into the 1900s seems like a long time ago, but it is, I guess, now. You know, in the 1930s and 40s, I mean, there was very limited cancer treatment available. Radium was just coming online, and there was the need to create centers around radium, because there's very little radium to be had in radiation. And so, you know, there was a royal commission struck, or an Ontario commission that was struck that said that we needed a cancer system, and that's really what gave birth to the Ontario Cancer Treatment and Research Foundation. Now, your listeners may want to know that the the inimitable Dr Bill Evans actually has a role in naming the current Cancer Care Ontario. Now I'm I'm led to believe. And you can tell the story later if you want, Bill, but the name change from OC T or F or the Ontario cancer research and treatment foundation to Cancer Care Ontario, Bill had some small dealing with that, but I'll leave that for later in the podcast, maybe.

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But over time, Cancer Care Ontario ran cancer centers and.

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But didn't really have oversight to things like cancer surgery, recovery, palliation and so forth. And so in 2004

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or there about Cancer Care Ontario changed. It became a really a planning organization, an improvement organization, and the hospitals took over the operations of the cancer center. So for instance, the jarvinsky Cancer Center here that Hamiltonians will be well familiar with. And so over that period of time, though, we've launched cancer plants, the full measure of the cancer treatment journey from screening and prevention all the way through to treatment, be it surgery or chemotherapy or hematology and malignancies that Jen oversees at our center and and as well radiation. So really a whole continuum of of services. And so one of the principles, though, that we operate on is to develop plants and execute plants at the provincial level. And your good friend of mine, Mary gospoderwitz, Dr Mary Gosper Edwards, who's an international, internationally recognized leader in cancer services. I was at a at a meeting with hospital executives two years ago, and she talked about this very thing, what's the state of the art with cancer planning across the world? And of course, all the developed nations have cancer plans. Even a lot of the developing nations in the world have cancer plans. So no matter where you are in the world, there is a planning mechanism to improve services for cancer patients, because the impact of cancer on our society is so large, and so Ontario is not alone, but it's been very successful in doing its plans. And

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the last comment I would have on this part of it, Bill is that the plan is really developed with three component parts, or the inputs of three component parts. First of all, it has to be oriented in what the patients need, what the patients want. And so we make a specific emphasis on engaging patients about what's important to them. And so, for instance, I sat on the plan that developed for the committee that developed the sixth Ontario cancer plan, which we're going to talk about today, and a patient was co chairing that work right there. And so it's really important to have that feedback there. Secondly, and you'll you'll appreciate this from your experience, it's got to be evidence based. We have to be using the best evidence to inform what we're going to be investing in. The example that I would use more recently is lung cancer screening. So we've launched lung cancer screening across the province, and based on your professional experience, you'll understand this quite

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well. And in Hamilton, we've launched it at St Joseph's, and are going to be expanding that out that was based on key clinical research that was done probably less than a decade ago that really showed that screening in a certain way will lead to improvements in length of time that people are live with the disease and the survival, survival and the morbidity, mortality rates of that right? So it's got to be anchored in good evidence. And then the third component really is making sure that those who are providing the care. Have voice in the process, right? Because they're the ones, the oncologists, the nurses, the pharmacists, the dietitians, social workers, who see the challenges day in, day out, and so that's a really important part, to have them give voice to that, what they see, and see that into the plan. So those are all the inputs. Lots of other things go into it, but that's sort of how we approach the planning process, and I think it's really important for our listeners to hear because one of the outputs is, in fact, that this is a provincial system. So in the end, the care given in each of the cancer centers, and there are 14 of them, is pretty much the same. There are some specialty areas. Things have been rationalized to some centers just because they're infrequent and the volume is important to have to have the expertise concentrated and produce the best outcomes. But I want people to know that there's planning for the whole system and that there's quality built in across the whole system, so they can be confident whether they're seen in Niagara seen in Hamilton, seen at Princess Margaret Hospital. At a care level, they're going to get equivalent care because it's all evidence based, and we're all trying to drive towards better psychosocial supports and and other quality elements that would make for an excellent care system. I just noticing at the bottom of the 2005 plan that's driving quality, and I think that that driving quality, that idea, has been there from the beginning, and we're still driving quality, accountability and innovation throughout the Ontario system. So, and I think that's what each of the successive plans have tried to do, and and identify the next area where we can innovate, or the next area where we can add quality to the whole system, so the patient experienced and and the provider experience are enhanced. So that's really behind the idea of having this podcast is to try and make our listeners more aware of just how how things happen. It's not by happenstance, or one doctor over here thinks that this is a good, best way to treat cancer and.

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So we don't have that. We have a system that's based on evidence and that there's very careful planning that's gone into it. And I think there's interesting evolution in the planning, because I think

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we can always use more resources, and certainly more funding for the resources, but we we have cancer centers that are well distributed across our province now they weren't before. So that was addressed from the very first cancer plan that we needed to have more centers and distribute them appropriately, the human resource planning is much more sophisticated than ever before,

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and there's a really excellent mechanism of generating evidence, not just around treatments, but on organization of systems through our program in evidence based care that's based here at McMaster, those things as you were referencing, the evidentiary base is so important that we don't do things just because somebody thinks it's a good idea. It's based on solid research. And so I think we've seen successive improvements in the cancer system in each of the plans, and we won't review all five plans that get us to

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have a six part series or something, but Ontario cancer plan, I find interesting because of where it's emphasizing things are. Some of the things that are are kind of become top of mind within not just health care, but I think more generally, the whole notion of equity, I think some of it comes out of our discussions around

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what we've done as colonists to our indigenous people and but then we also recognize we're a pluralistic society, and we have many different groups here. And are there groups that are being disadvantaged in any way and don't have access to the cancer center? So

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that's really the first block in this new cancer plan. I'm sort of interested to hear your thoughts on the relevance of that to the Hamilton, nigra,

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Brandt area, Haldeman Brandt area is we clearly have pockets of marginalized communities in terms of so called Cold red areas and in Hamilton, but Branford and and st Catherines have their similar areas, maybe smaller, but they're nonetheless there. We have a large Aboriginal population, six nations. So what does equity? What does improving equity kind of look like

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in our region? Yeah, maybe you can start. And then I know Jen has a lot of good examples of her work more directly with her teams across the region, you know, going back to the plan. So if I could just for a minute, Bill, you know, you talk about plans one through five, each one of them had a different thematic emphasis, right? So first one was around, sort of back to basics, because we didn't know what cancer surgery wait times were as an example, right? Building the foundations of new cancer centers and so forth, right? Somewhere down the road, I think it was three or four, we got into person centered care, and advancing that notion that patients have to have voice in the system, right? And, and you're right. The next theme, really is around equity. And, you know, here I am talking about scientific evidence base, but I'm going to make a non scientific comment, and you can challenge me on that, but, you know, it, I think it's helpful for effect. You know, I think the issue of equity is even bigger in the cancer system, in terms of impact, than smoking is and tobacco use is. You know, when you think, explain yourself,

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the inequities in our society leave many people behind. And so that health outcome is really we see that every day. We see people who fall through the cracks, people who can't, you know, who are diagnosed at end stage disease, who could not even get to a screening site, or don't know, have a family doc, or have some other impediment in their life from a social determinants of health perspective, and and so, you know, We're leaving them behind. We plan the system historically, or many times, it feels like we plan the system for well off white guys like me. And you know, the reality is, is that I can navigate the system. A lot of people can't. And so, you know, what does that mean? Well, you know, kudos to the work that you did when you were in my chair in my office, or what is now my office, I guess, with the mobile coach that we have that travels this region and takes cancer screening to these groups. But more than that, I think it's not only taking the services there, but it's the relationships that we're building with those community groups that represent and advocate for and deal with very sub, specialized communities in our areas, that might be an immigrant community, it might be a very impoverished area of our of our society, you know, and we're building those relationships with them so that we can better understand, you know.

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I tell our team, you know, the first thing that you can do is seek to understand and then develop the services around those things. But Jen, maybe you can share some of the things. I mean, in six months you've seen on the on the job here, well, I think the mobile coach is such a great example of that. And it's not only about screening, you know, underserved populations, but under screened populations, and really using, you know, a spirit of health promotion as a way of, you know, providing information about why you should get screened. And then, even more so, when we speak of having that present voice and really making sure that either our indigenous communities or underserved communities are really helping with that CO design. It's developing those follow up pathways for for them, should something be identified through screening. So that's definitely something that we've continued to focus on, and we've recently formulated new partnerships with some of our indigenous communities and arranged some very robust follow up pathways for them through Brantford or wherever the closest screening site or assessment site might be for them following that assessment. So I think that's really something that we're very committed to in utilizing our indigenous cancer team, our navigator, our patient coordinator, to really help continue to strengthen those partnerships and bring that voice forward. A lot of it's building trust with these communities. If you come from a foreign country, you have no idea of what the health system is like in this country, how you're going to be treated, how to begin to use it. How do you present yourself to whom with your complaint should you present yourself? So it's a very I'm sure it's a very frightening experience for them, and the fact that the coach goes out and visits these different areas, and people talk to each other, and they start to realize that they you know, they're good people. They're there to be helpful. They answer questions, etc, etc, and they don't just promote the screening. I know they promote smoking cessation, which I'm very pleased with.

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Someone who has to lead that in the province. I'm happy to hear that. So it's terribly important. But you know, one of the failings of the healthcare system, it seems to me, is the failure to reach out. It's been healthcare organizations, hospitals, medical arts buildings, doctors, private offices. They sit there and wait for people to come to them. It's worked pretty well in the small population. We weren't perhaps, as as multicultural and so on, but we have to go the reverse direction, because we don't we leave people behind, and they're the marginalized people, and I saw that quite dramatically in moving between Ottawa and Cancer Center here in Hamilton, because the population we serve In Ottawa is a pretty well educated, pretty well insured, pretty information, avarice, group of people, very demanding, and the results that cancer center gets in terms of the outcomes of treatment are better than are seen in Hamilton, not because of any failings of people or equipment or knowledge In Hamilton, every bit as good as in Ottawa. The difference is that people come later, and it's because there's a large group in the inner city and elsewhere that don't know that spitting up blood's a bad thing, or that those cramps they're having in their belly should be looked into and having a coach going out, maybe it needs to be more than a screening coach. Maybe there's another kind of model of similar but reaching out to those communities that helpful anyway, it's just No, I think Bill fingers add to that, like, I think you're right. I mean, I think it's a philosophical approach that needs to change, in which we're trying to initiate change, and that's cultural, too. In the health system, right? You know, people come to a cancer center, they come to a hospital? Well, the destination should not be the hospital. Now, there are some things we have to have in the hospital. And radiation equipment is not going to go on every corner, but we need to be thinking about, how do you best take care to those individuals? And you know, Bill, this is not just an equity issue. It's a it's a quality issue as well to a capacity issue. Some of the things in that we're starting to talk about in in one of our physicians as a major, almost $5 million research grant, to take a look at this is, how do we do major treatments in people's homes with remote monitoring? So in Jen's area of hematology, which is, again, the jurors key, is one of only three centers in the province that offers full service blood cancer treatments. How can we do things like stem cell treatments, car T infusions in people's homes? Now you know exactly your eyes are going, Wow, that's internal but, but that's not so much an equity issue, but it is an issue of maximizing the capacity of our system. But it just illustrates that we do have to think differently, whether we're approaching equity or sustainability or capacity. We need to be thinking that the hospital is not the only place to provide care, or the doctor's office or the clinic, as you will go think outside the box and back to driving innovation here. Yeah. So.

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Yes, very important discussion. And clearly the equity issue is prominent in OCP six, as are a number of other issues. And maybe move on to the one that is next to it on this little place mat of it says, improve patient care. Patient care care, partner and provider experience. It seems to me, I continue to hear very positive feedback of the patient experiences at the jurors key some of it starts with, you know, having somebody at the at the front door, someone opens the car door and and welcomes you. And if you're a newcomer, first visit takes you to the information desk, gets you started. Some of those little things really do improve the care experience. And I like to put a pitch in for the cancer assistance program. I think it improves the care experience by providing some free transportation, by providing equipment needs that help people be safe in their homes and so on and other supports. But what else are we thinking about now in terms of innovations improve that patient experience. What do you hear from patients and their and their care providers, their family members, that they feel would be a better make a better experience for them? Jen and I are trying to figure out who's going to go first, or I'll drop it at the bit on this one. Go ahead. Jen, yeah, so this is a big one, and was one of the things that we first turned our attention to, is we started looking at utilizing some of the feedback we had received from our engagement sessions that had actually started before I began in the role, and I just got the fun task of formulating all that data together to try to organize it into some themes. And one of the things that came across

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very loud and clear, both from our patients and from the providers, was that, you know, the biggest pressures that they face is that two week wait before they actually see an oncologist. And you know, our practitioners in the supportive care side psychosocial oncology, they say that they're fielding large volumes of cars calls where patients are just feeling lost and they're feeling anxious and they're just waiting for that unknown. And then from the patient perspective, you know their descriptions of their experiences while they're waiting for that initial consult. It sticks with you. And you know, if you've ever been the loved one or a patient yourself in that waiting period, it's tough. So what we're looking at from that perspective while we're trying to improve the experience for both patient and provider is, how do we create some more peer to peer type support mechanisms? And you know, we think about our partnerships with cancer Assistance Program or or Wellwood, or any of our other community agencies. You know, how do we, how do we leverage those external partners, bring them in house, look at how we can actually formulate some really robust pathways for patients to get support from patients who may have experienced something similar to what they are currently going through. One to alleviate some of the pressures on the teams, to make sure that they have capacity to really wrap around patients once they've had that appointment and they receive their diagnosis, and for the patients that are in that waiting period as well. So that's definitely something that we're turning our attention to, that would hopefully have a two fold impact. Just building on that like I think the healthcare system has underplayed the resources and the importance of patients who are people, people who have a disease,

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finding community. And so I use the word tribal. You know, humans are sort of tribal creatures, right? We're part of a team. We're part of this. And when you get a cancer diagnosis, all of a sudden, you're isolated, on your own, because you have no one that you know, perhaps, who has the same issue that you have. Yet, there's hundreds and 1000s of people out there who have the very same issue that most of these patients have, right? So how do we build that connection healthcare, I think, has has said hands off. You know, we're the experts. We're going to do all that for you. But yet, patients want to talk to somebody about their experience. Want to know that there's somebody like me, and I think that's where, you know, we're thinking about, how do we we're not going to build those relationships, but how do we facilitate that occur?

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And you know, I think the other part in this around experience is, how do you make it easy for a patient or an individual community member who has cancer to find those services, right? So, you know, as an example, cap is just down the road. We've got some services in the building, like I'd love to have a community mall in the jurors key where people you know who are facing a diagnosis, first off, can see, oh, here's the 10 different programs. Here's the 10 different community agencies that I can tap into, right? And so how do we do that in an integrated way? How do we integrate the services of the well woods and the caps and the other folks into our operations? Because right now it's all handoff based. Go down the street, talk to Deb and her team, go down to well would see what they are, right? How do we integrate that better? Right? And, you know, I think that's a philosophical approach that we have to have in the cancer system that weren't we don't need to do everything for everyone. We can't. We do good at radiation and surgery and chemotherapy, but we're not good at the stuff that other agencies do. And so how do we integrate them better? How.

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Do you have that chopping ball that makes it easy for people to find their way? Well, it also touches on another component of the plan, the integration of the various care partners. And actually, I think integration, or integrated, or some variation on that word, appears like five times on this plan. So clearly

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those who drafted the plan thought that that was an essential direction. And I, I agree, because what you constantly hear from patients is that the system, it's a non system, is fragmented, and just as you're describing is, is kind of this disjointed piece, your idea of some sort of mall where all the different players that could provide various supports were were visible, easily accessible, could be registered to the services that that particular group provides. Is a great one. It just takes a bit of money and time and collegial relationships, which I'm sure are already built. One of the other things that I recall from my experience of the jurorsky is that in that two week period, people, they have no concept of what a cancer center looks like. They also have no concept of what radiation if they were going to get it was going to be like what a radiation machine looks like, no concept of these things. And we actually created a like a virtual tour, but it was a guided tour. I don't know where that's still available on your website. We've got to, we've got to redo that bill. And you know, I've had some experience with this and past lives, and one of the most powerful things that I've found is having patients, both present and past, do the education of other patients. So this is the tour through the center. This was my experience in my past life. In our nephrology program, a dialysis program, right? We would have patients teach other patients around the different types of dialysis treatments, which you usually know as a clinician, they're very different, right? And they have to, patients have to make a wise choice

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in the same situation. And it was well received. And you know, patients love to hear from other people who have lived that experience. And so how do we have patience be the conduit of education and orientation as an example? Because I can tell them, Jen, can tell them what the experience is like and how it is designed to occur. But the reality is, they're going to be talking with people in the waiting room anyways, and they're going to be hearing about this experience or that experience. So how do we build that in at the front so that people have a more an easier onboarding time? It's challenging because maybe it's very specific, specific to the type of cancer you have. What's going to happen to you if you have a lymphoma, it's going to be different than you have a colon cancer that's metastatic. So, but just even getting oriented to the building, what it's like. So it's not frightening when you arrive the first time and and you have a concept that of the kinds of services that you're likely to receive, but getting all that information sometime in that two week gap sounds like a good idea, if it isn't a problem of information overload. Because, as you know, some patients can handle the diagnosis of cancer and the diagnostic tests and all this avalanche of information coming at them. So it is a sensitive thing to do, but different things work for different folks. So you have to have a menu of options as well. I think that's you have to have a menu of options. So it's there if you want it, if you want to use it, but if you don't, then later on, you may want to go back to that. It's available there. And every experience is different. Every family experience is different. So it may not be the patient, it may be a caregiver, a loved one again, if there's language barriers, potentially, right? An elderly immigrant person who has language difficulties. Maybe it's the son or the daughter that's doing it. So we have to think about, I hate to sound like a marketing person, but multi channel, type of environment that we can serve our clients better. Well, for our listeners, you can see that there are a lot of things on this cancer plan six that are going to be challenging to implement, but it's great that people are thinking about it. We're going to take a little break now, but we'll be back and talk about some other aspects of the plan in a few minutes. We'd like to take a moment to thank our generous supporters, the Hutton Family Fund and Banco creative studio, who make the cancer assist podcast possible. The Cancer Assistance Program is as busy as ever providing essential support to patients and their families. We remain committed to providing free services for patients in our community, including transportation and equipment, loans, personal care and comfort items, parking and practical education.

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We're back with Neil Johnson and Jennifer Smith talking about the Ontario cancer plan six, and we've talked.

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Got several of the pillars in that plan, and what plans are unfolding in our own region to implement some of the aspects of the plan. And one of the things that's

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is a challenge facing care providers in the cancer area is the incredible increase in new therapies that are effective and the need to adopt them, but at the same time, there's resource impacts, there's cost of drugs or new radiotherapy or other approaches the demands of training individuals be able to deliver the care closer to home. So it's a complicated issue, and all of this is informed by cancer clinical trials, which we've talked about in podcasts previously. But basically clinical trials are simply testing new therapies, first for their toxicity, what's their tolerance in human beings, in an early phase, so we call it phase one, then moving on to see where it's effective what type of cancer, and then comparing it to the current best therapies to see if it's an improvement on them, by either combining it with the existing best or perhaps it's singularly better treatment than anything we've had before, and then be a phase three trial. So there's a way of introducing these new treatment approaches, and it's wonderful that they're happening, but it's also really hard for cancer centers currently to

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get up to speed quickly and integrate

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them into existing, already very Busy chemotherapy suites, radiotherapy suites, etc, and have sufficient people trained and available to administer them, so that, I'm sure is heavy on your minds right now, and how you do that and and maybe hear your thoughts, because I know expanding access to clinical trials is important to the jurors key, And it always has been in Hamilton. I think that's part of McMasters philosophy of being an innovation area,

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but that creates

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certain stresses on the institution as well, so expanding clinical trials and adopting new approaches

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and while maintaining a system that's sustainable. Boy, what a challenge you guys have. I'm glad I'm just asking questions at the office. Bill, just another day at the office, maybe I can take a stab at shedding some light on that. And then Jen and her role of overseeing our complex malignant hematology program has, I think, some really good case examples. You know, Bill, you've grown up in academic hospitals your whole career.

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I have worked in academic hospitals my whole career as well, too. And we know the value that teaching hospitals have in carrying on research. And you know, the clinical trials one is really important to me and to our program, I, you know, I said to our teams, we are a research intensive Cancer Center, full stop, edge of sentence. And so that means really doing things seriously around that. And so our transformation plan for our clinical trials, we'll hope to see it grow by 100% in the next couple of years, right? So in terms of the numbers of trials, the number of staff, the numbers of researchers, the number of projects that are going on, and that takes a lot. There's a lot of moving parts to that. It's not all working well right now, but we want to do that for a couple things. You know, there is the contribution to science and research and that that's, you know, that's fair, but it's beyond that as well too. This is also a quality of care issue for our patients, right? Sometimes, you know, there are diseases that don't have effective treatments, and the only way that a person can get a hope of a longer life and a better life is through clinical trials of a new agent. You know, when I was in London, I met with our patient family advisory group. And I asked him, what do we really need to be good at as a cancer center? And everyone had their own interesting answers, but one of our patients, who was a myeloma patient, said, Neil, you need to be really good at research and clinical research and clinical trials. And I asked him about that afterwards, and he said, there's no cure for my disease, and my life depends on your doing well in clinical trials. So that that has always motivated me, Bill, and you know, it does you in our teams. But then that leads into the interesting conundrum that you're talking about, right? You know, we have successfully

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treated or studied different agents, different molecules, and now they're in practice. How do you cope with every every second week we get emails with this agent has been improved, and this indication and so forth. And it's not just like writing a prescription

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for the drug. There's training involved. There's resources involved as well too. And we also have the capacity issues, because previously cancer treatment, you know, you'd go through.

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Treatment, and then you'd stop treatment, and you'd wait to see how things went and follow up. Most of our treatments now are ongoing for the rest of someone's life. And so that's a good thing, because people are living longer and better, but it's also research resource intense. So our system, our systemic treatment suite, as an example, has grown in volume by 50% over the last four years, 50% and so, you know, I can't build a building big enough or quick enough to actually cope what to accommodate it on. So that goes back to that other, other philosophy. But how do we not only adopt but do treatments differently, not in the cancer center, perhaps somebody's home in a different, alternate environment and so forth, right? So, but I, Jen has some really good examples with the products I can never remember the name of, but yeah, I would, thanks to clinical trials and the access to it. I mean, we've learned a lot locally on the hematology side of the house about T cell engaging antibodies, or bispecifics, as it used to be known as, and you know, it was through clinical better try and explain that a little bit to our listeners. I know what you're talking about. Yeah, they may not T cell engaging antibodies. So it is a type of therapy that helps for a number of different indications, for patients with blood cancers. You know, it's a type of treatment that's innovative, and it does have some nuance in terms of some of the side effects that come post infusion of these medications that require some very specialized training and education for our staff and for our providers in terms of the administration of these drugs. So we actually, through clinical trials, were able to get some first hand experience with the adoption of some of these therapies. And what I think it also did, while it was it was resource intensive at the beginning, and we really had to be very purposeful in our planning for how we would provide them, what it also did was it gave us an opportunity to be leaders across the region and even amongst other regions, in terms of how we could continue to adopt this therapy now that it is as more and more of these types of drugs are becoming approved lines of therapy for patients. So I think it's one of those. It was a key learning for me about how we really need to be

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make sure that we're mindful of how much we're promoting access and ensuring that we do have very robust processes in place and are doing a thorough impact analysis about what the pathway should be for patients as they receive these types of therapies, and lean on our partners to be able to help with some of that capacity once the drugs then do become approved and become those regular lines of therapy. So it's a good learning that I think can be applied to other clinical trials as well, and it's something that we need to continue to turn our attention to as we plan so these agents bill as an example, you know, the monograph or the instructions would be that you, when you get this medication, you've got to be admitted for a week or five days, right? And that's all well and that's all well and good, but when you don't have any beds, it's hard to do that right? But through our clinicians, who are part of the research team who are doing this gain familiarity with it, they've adopted a practice that doesn't require that level of admission, that requires a different way of doing things, right? So this is where being upfront in the clinical trials, gaining the experience with these molecules and the real life treatments helps us opt to transition. And then also other other partner sites, like trillion health partners in Mississauga and and other cancer centers around rely on us to give them that advice, because they don't have that experience. They've not done the clinical trials. So there is a, you know, there is a, I think, a virtuous pathway between research and adoption. And to what extent can we use some of the virtual technology to facilitate like so, much of monitoring can be done remotely these days. And I know there's a project going on, and I've forgotten what the name of it is, predict or prevent or something that BJ Devereaux, well, it's close.

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Was a P word

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to monitor,

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starting with cardiology, but to move into oncology to try and, I guess, minimize the necessity of patients coming and being seen in a cancer center, and hence freeing up some resource, but also making it better for the patient and they don't have to travel, worry about parking, etc, etc. So creative use of technology applied to situations like that, with all the remote monitoring kinds of aids that we have, the wearables that will beat off your blood pressure, your oxygen, what have you can be helpful in that regard. So I guess we just have to keep looking for the innovative approaches to implement the really exciting changes that are coming in in treatment and bill. I think, I think that also helps with the patient experience as well too. A couple of weeks ago, we were on a provincial call, and one of the husband of a patient who unfortunately had to go to the states for or for stem cell treatment, I believe, talked about his experience, right? He had to live in Cleveland in a sort of a hotel

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for 100 days, and couldn't be, you know, with or.

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Far away from his wife, who was his, who was the patient, you know, couldn't be more than 100 feet away from her, right? So you think about the disruption of that massive disruption to your life, and the cost, and the cost 100 days in hotels somewhere, yeah, and, and, and. So, you know, you think about the opportunity to reside in your own room, your own suite, but also have the backup of the experts at the jurors key. It's pretty amazing to think about what that future could hold. So, you know, we've got some active research trials underway with that. We want to make sure it's safe and effective, obviously. But you know, these are the types of things we got to think differently

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about. Well, it's a huge challenge to think differently about, but how do you think differently about something like car, T cell, delivery, the whole manufacturing process, time it takes to manufacture, the time it takes to get it back, the infusion, the risk of some pretty serious consequences,

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you know? How do you how do you manage that differently? What are the what are the hematologists thinking of doing about that? Yeah, I think the biggest challenge right now with car T is staying on top of what's coming next, right? We meet provincially, we meet locally to talk about what's in the pipeline, not only of what we currently have approved, but what's coming and, you know, there's new drugs that will potentially be approved coming in. You know, early 2025

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that represents car t as an option for patients for multiple myeloma that hasn't been introduced before, that's going to be from a capacity perspective, from a planning perspective, that's huge for us locally and across the province as well. Right now. I think the way that we're thinking differently about it is we're really, really relying on our partnerships with some of the other hospitals, Trillium Health Partners like Neil, mentioned Grand River Hospital and their cancer center as they tried to develop their own cellular therapy programs and really strengthening those partnerships we have for transferring patients of care,

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you know, whether it be on day one post transplant, so that we can really keep some of that specialized care for Car T local while we continue to manage those patients and then figure out how we can expand and support them in their onboarding and learning. So that's where we're really across the province, trying to create some level of integration. We keep coming back to that word,

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but integrating across the programs, you know, our three leading centers being Princess, Margaret, Ottawa and Hamilton, and then supporting our partner sites in their development of their programs as well to help build that capacity. So I think that's really how, on the hematology side of the house, we're trying to reimagine how we can deliver care while also keeping up to date with all of the new therapies and and being ready locally as well. And Bill, I mean, this summer, when we launched the Grand River program in partnership with Grand River, that was the first stem cell, new stem cell program in over a dozen years in the province of Ontario, right? So, and this is the type of work that we need to do with our regional centers. If they're doing those types of treatments for the patients that reside or the people that reside in their communities, they don't have to come to the jarvinsky and then we're able then to do more of other things. And right? So, it's a continual what's next? Type of approach. For many years, the Kitchener Waterloo area referred their complex hematology here. And so the extent that they can have capacity locally, offloads our center. It's good for patients to have the care in their own, own region. And so it's a win win.

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I guess it's we usually think about integration as more of a local phenomena or regional phenomenon, that you're really talking about a provincial integration of of of programs. There's multiple levels to the integration, word on the on the place mat here. So that's a good example of a provincial one. Maybe just wrap up with some talk about the quality of a life of Ontarians being improved. That's the fourth of the pillars in this cancer plan, and what that sort of means at the local the regional level. What are the things you're thinking about, or what fits into that pillar, from a jarovinsky cancer center point of view.

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I mean locally, what we think about. So some new, new reports, new data has been coming available from Oh CCO that really looks at each of the regions and their survivorship data. And this is new as of June, and now they're actually seeking some feedback in terms of how we can utilize that data to inform practice. And it's, it's really interesting to see, you know, how we compare against our other regions from a survivorship perspective, when we really look at that, you know, quality of life and providing care for patients beyond their you know, their acute cancer journey as they continue to live, live with it. And you know, the one thing I think about locally at JCC, how we can help with that, is really continuing our partnerships with our Ontario health teams and the greater health Hamilton Health Network to really make sure that we are engaging our primary care providers as part of this as well. You know, I think historically, sometimes when patients receive that cancer diagnosis, their their oncology team wraps around them, when we kind of keep the primary care provider just waiting in the wings, if informed of.

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All, and I think that that has been a key learning to us, that, you know, they're so important at that screening side of the house, and you know, in that those initial early diagnosis stages, well, how do we continue to leverage them and engage them as part of that, knowing that these patients are going to continue to have complex needs, you know, beyond that acute treatment phase.

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So I think that's one thing that comes to mind for me in terms of how we can really focus on the quality of life for Ontarians is really taking a multi provider approach and ensuring that we are engaging at all levels our providers to make sure that they're informed and able to support the patients. I think the other one bill, and it's funny, we've not even mentioned artificial intelligence in this conversation. I was afraid to go down, I know, but I, but I will bring that up. You know, when you when you think about quality of life, when you're in the in the cancer journey, you know, you know, this is a very complex treatments, and everyone comes with a different background, right, a different issue. We talked about social determinants of health a little while ago as an example, and so, you know, we're starting to collect more data around people's individual circumstances right in their health record. So it's their record, not ours. But then, how do we use artificial intelligence tools to identify people who are at risk in their cancer journey, a risk of being lost to follow up, or maybe risk for we talked about with car T with, you know, specific side effects. How do we make sure that we're thinking about those and then designing the services around them? I've got limited resources. I don't have unlimited resources. So the way I think about this is I need to make sure that the resources that I do have are prioritized to those with the highest needs. And, you know, we've always thought that that would be a great thing to do, but I think with AI and collecting some data around that, we can think about that differently, and we can better predict and identify patients who are going to have challenges. We know we're doing some work at the jurors key, taking a look at patients who come through our emergency department, and our AI tools can that predict people or identify people at higher risk of readmission after they come back after they get discharged, as an example. So I think there's lots of things on that. The other piece that strikes me is, you know, it's a digital world. We have MyChart app, which connects patients, and we are just scratching the surface of that. And I think there's, I was just in the states a couple of months ago with our IT vendor, and the things that are going on the states, with people connected on a real time basis, with their care teams, just transformative, and that can also improve the experience, but also the outcomes as well too. So we're just really scratching the surface of those things. Those things might be more of a jarvinsky specific intervention, but those are some things that you know down the road, we're going to have to integrate into our thinking, the things that comes to mind. And I was frustrated by when I was in the role was trying to fully implement the power of the E SaaS, which is the Symptom Assessment Scale, which, you know, gives you some rating of how much pain, discomfort, anxiety, depression, a patient's experiencing. If you're not aware of those things, you can't begin to address them or direct them to services. And there was, sort of seemed to be a reluctance to partly on patient side to complete the instrument, partly on the side of providers to use the instrument. And it seemed like an opportunity lost to augment the quality of care of patients. I don't know how it's going across the system right now, or specifically in jurors, but it may be an area where AI could also be applied to make, you know, flags appear that really directed people quite automatically to services so that there, there's an opportunity to address whatever is impairing the quality of life in a more effective way. So, yeah, I hope you're doing better than I did. Well, I think the whole province has taken a dip, but we're at the top of that bad province where we're doing, not too bad. But, you know, it's interesting, Bill. I mean, East house is a great tool, and it's really just a data collection tool, right? How's the patient doing? Right? And I think in this day and age, as this day and age, there's only 10 years ago that we started this, right? But, you know, in this day and age, there are different ways to get at that data. But to your point, it's we need that data to effectively serve those that are seeking our care. That's what it comes down to. Can't just collect the data for the sake of the data. You've got to be using it so it has an impact on the outcomes. I feel like a bit in a Cancer Care Ontario planning session in this podcast here, maybe you felt Vancouver having to replan the OCP six, but to me, this has been a great discussion. I hope our listeners have benefited from it and got a greater sense of a lot of the hard work that goes into thinking about how to continually improve the system. And it has improved hugely since the very first cancer plan was done back in 2005

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and.

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Will continue to improve as it evolves and but there will be the continued challenges, and that's why we need to continue to plan and make things

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better. Nino Johnson, Jennifer Smith, thank you so much for your time. Thanks for your ideas and for being here today for the podcast. Thank you so much. Enjoyed it. Thanks.

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