Building Psychosocial Oncology Services into the New Systemic Treatment Funding Model

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Background

What is Psychosocial Oncology? Psychosocial oncology (PSO) focuses on a whole person approach to cancer care, addressing the social, psychological, emotional, spiritual and functional aspects of the patient journey through a multidisciplinary team and service providers from various care settings. This project focused on the following 7 PSO disciplines:
- Nutrition
- Occupational Therapy
- Physiotherapy
- Psychology
- Social Work
- Speech Language Pathology
- Psychiatry

While it is well documented that there is a high need among cancer patients for psychosocial support, access to PSO services and resources is inconsistent across the province.

Health Care Funding Reform

Under a broader set of health care funding reforms in Ontario, a new, patient-based funding model for systemic therapy is being implemented in the province.

The new funding model aims to:
- Create a per-visit fee for this service
- Increase standardization of care across the province

Under the patient across the cancer journey:

This change in the way that systemic therapy is being funded provided the opportunity to explore the resources and time associated to meet patients’ psychosocial needs.

The Challenge: Building PSO Services into the Funding Model

Under the new funding model, hospitals providing systemic treatment will receive “bundled” payments for services, depending on the patient’s treatment and care needs. To conceptualize the model for the purpose of costing PSO services, the following phases of patient care were considered by the PSO disciplines:

Consultation for Systemic Treatment

- Includes costs of services provided while patient is in consultation for systemic treatment

Systemic Treatment

- Includes costs of services provided while patient is receiving systemic treatment

Post-Treatment (Survivorship/EOl care)

- Includes costs of services provided after patient is no longer receiving systemic treatment

In order to build funding for PSO into the model, it is necessary to identify best practice and associated workload for each phase of care. There is little existing evidence to support the development of workload measures at the system level.

Methods

Expert PSO clinicians from across the province were recruited through the CCO Psychosocial Oncology Program Committee to form advisory groups from each of the PSO disciplines outlined in this poster. Each advisory group consisted of 3-9 members. For each cancer type, type of treatment intent (curative, adjuvant, neo-adjuvant, palliative), and episode of care, advisory groups were asked to answer the following questions via group consensus:

1. Approximately what % of patients in each phase of care need to be seen by a provider from your PSO discipline?

2. On average, how long should a visit with this PSO provider take?

3. On average, how many visits would a patient need with a provider from your PSO discipline?

Group consensus took place over teleconference meetings, ranging from 1-1.5 hours. Groups met formally anywhere from 2-5 times, over a period of 4 months with frequent email correspondence between meetings. For some groups, an online survey was implemented to gather individual’s opinions on the questions outlined above. These values were then averaged and presented back to the group at the meetings to serve as a starting point for consensus building. Literature, evidence, EAMS symptom profiles and best practice was used to inform decision-making when available.

The information gathered through this process was used to estimate the relationship between patient need and service provision for PSO.

Results

Each of the advisory groups produced a set of recommendations for each cancer type and phase of care which included:
- The % of patients who need services
- The average time required to complete clinic visits
- The average number of visits that a patient requires

These recommendations made it possible to identify an average workload per patient for each PSO discipline. This information was used to calculate the amount of PSO funding that should be built into each bundle of the funding model.

Based on this work, funding was built into the consultation bundle for PSO services. The eventual goal is to build funding into the rest of the model over time, pending further refinements in PSO best practice and resource availability.

Limitations and Challenges

Limitations included:
- Tight time constraints to complete the consensus work
- Complexity and nature of the funding model
- Discipline-specific approaches for determining patient need
- Scope of current phase of project – i.e. inpatient, physician services, etc. were not included
- Lack of literature and data on “best practice” and patient need

Challenges identified along the way included:
- Discipline-specific groups made it challenging to identify workload for multi-disciplinary services (e.g. screening, education)
- Accounting for the overlapping scopes of practice for some PSO disciplines
- Regional variation in community resource availability

Conclusion and Next Steps

This work is novel for PSO care and should serve as a foundation for further applied research.

Next steps for this work include:
- Collection of PSO patient visit data
- Further refinement of advisory group recommendations
- Converse experts to identify workload for PSO screening, patient education and group activities
- Quality indicator development based on expert consensus achieved during this process
- Build-in funding for other parts of the model based on these future steps

Contact Info and References

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References:

Note: For the purpose of this work, physician services were addressed separately.