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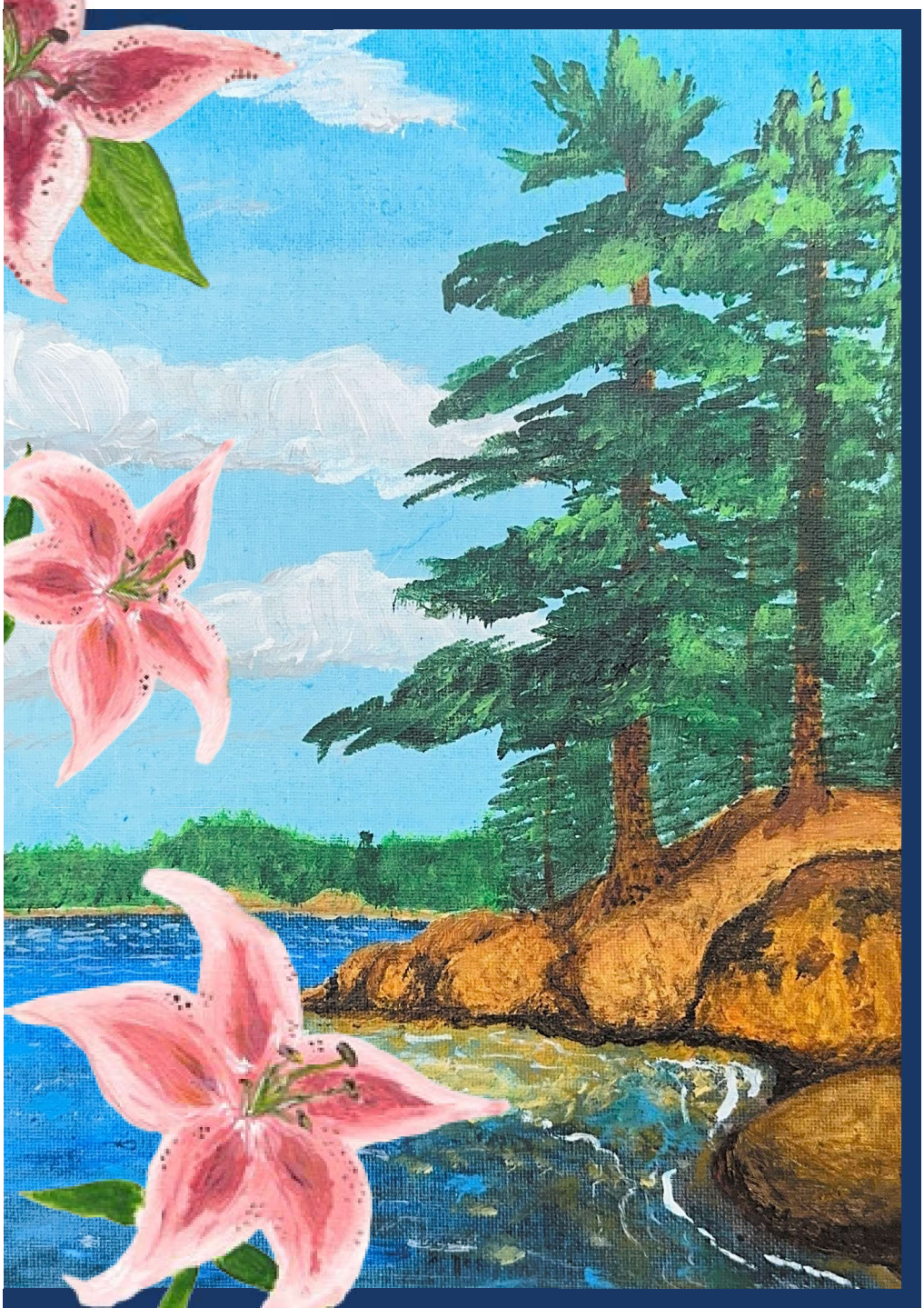
All Nations Health Parnters Ontario Health Team "Screening and Prevention On Time for Cancer (SPOT-Cancer)" Advocacy Document



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Paige Stevenson BHSc,
Charlie Compton
Barbara Zelek, MD
Brianne Wood, PHD

Illustrated by Charlie Compton

All Nations Health Partners Ontario Health Team "Screening and Prevention On Time for Cancer (SPOT-Cancer) " Advocacy Document

This report was developed in collaboration with the All Nations Health Partner OHT Cancer Screening Working Group, with final drafts completed in October 2025. Since the completion of this report, and as of July of 2026, the ANHP OHT Cancer Screening Working Group and the SPOT-C (Screening and Prevention on Time for Cancer) focus group have continued to advance this work, further refining and adapting the framework to best align with patient needs and the realities of available resources, including human resources, infrastructure, and community-specific considerations. We recognize and appreciate the significant and ongoing work carried out by these teams to continue to support equitable cancer screening access across the region.

Please see the below statement from the ANHP OHT's Cancer Screening Working Group and SPOT-C Focus Group, highlighting the work undertaken, advancements achieved, and future directions for this initiative.

SPOT-Cancer Planning – Update July 2026

The All Nations Health Partners OHT Cancer Screening Group developed an initiative to advance the scheduling of collaborative clinics, aligned with the 2024 Equity in Cancer Screening recommendations for the 2025–26 cQIP. Early progress was slow, largely due to the team's initial focus on recruiting licensed practitioners.

During this period, the group also partnered with NOSM on a research opportunity that resulted in several advocacy documents supporting the ANHP OHT Screening and Prevention for Cancer (Spot-C) initiative. Following the release of these documents—and in response to the early challenges—the group broadened the scope of the initiative to reflect the recommendations outlined in the NOSM advocacy guides.

To begin this expanded work, the team held two brainstorming sessions to review the logistics and engagement categories identified in the guides, along with locally identified challenges. This process generated a comprehensive list of requirements, constraints, and knowledge gaps. These elements were documented in a project workbook, and the group has been systematically working through each requirement while also identifying and collecting baseline demand and supply data.

The group initially met monthly but shifted to bi-weekly meetings to maintain momentum. Most of the identified challenges have now been addressed or resolved, and sufficient data has been

gathered to begin developing recommendations for partner organizations, including a draft schedule and workflow guidelines.

Once the recommendations are finalized, the group will engage service provider partners for feedback and approval. Following partner approval, the initiative will be shared with potential providers and community partners for broader implementation.

All Nations Health Partners Ontario Health Team "Screening and Prevention On Time for Cancer (SPOT-Cancer) " Advocacy Document

Authored by: Paige Stevenson, Charlie Compton, Barbara Zelek, Brianne Wood, on behalf of the All Nations Health Partners OHT ("The Research Team")
Dr. Gilles Arcand Centre for Health Equity, NOSM University

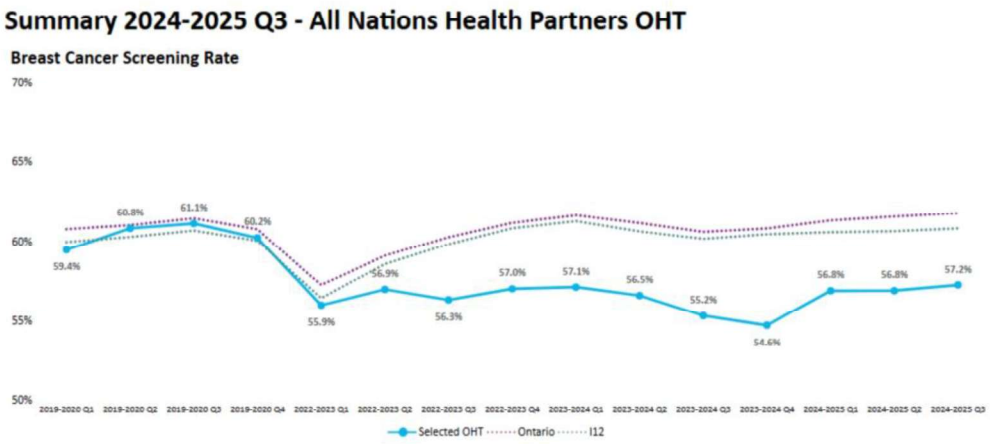
Introduction

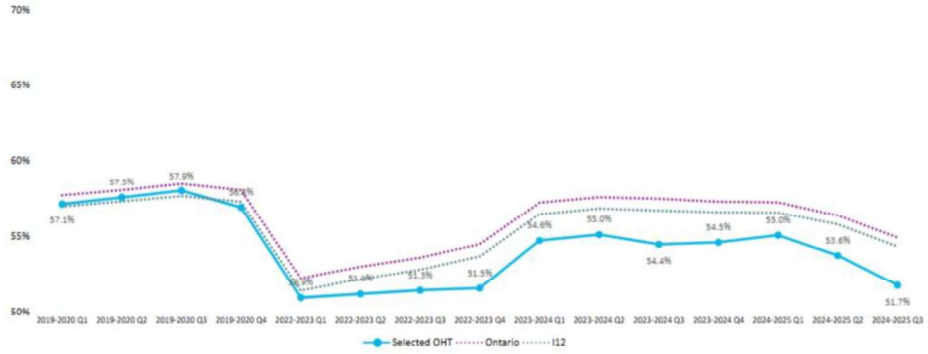
Access to primary care has become an increasingly challenging issue across Canada, particularly in northern, rural, and remote regions, where it often serves as the first and sometimes only point of contact with the healthcare system (1). This gap in access to primary healthcare services includes a lack of access to proactive and preventative care services, including cancer screening. Within the All Nations Health Partners Ontario Health Team (ANHP OHT) region, cancer screening rates remain significantly lower than the provincial average (2). These lower screening rates contribute to delayed diagnoses and poorer health outcomes (3) for rural and remote populations.

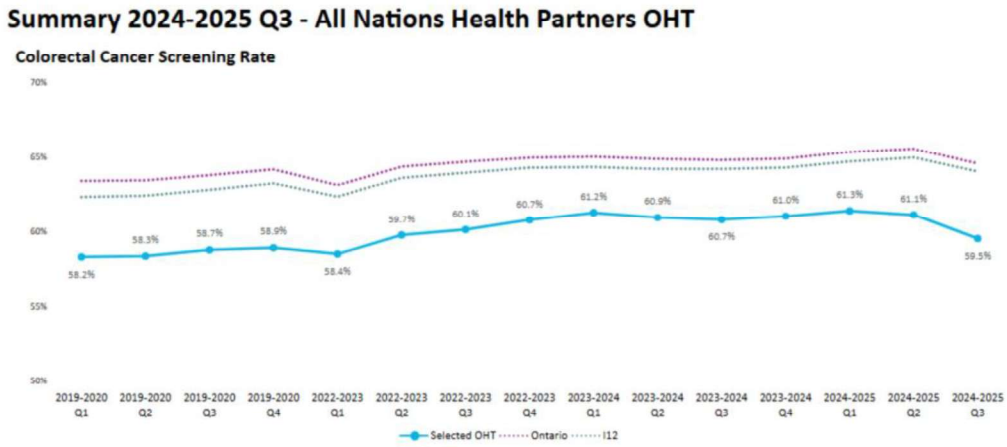
The Cancer Screening Working Group has continued to be dedicated and passionate about improving cancer screening rates in the region, demonstrating this commitment through its leadership of multiple research initiatives. Research conducted by the ANHP OHT's Cancer Screening Working Group within the ANHP OHT region has highlighted the lasting impacts of the COVID-19 pandemic, barriers to accessing preventive care services, including both patient- and system-level factors, and the unique needs of the population within the ANHP OHT (4,5,6). Collectively, these findings point to the need for a more unified, sustainable, and targeted approach to cancer screening. The Cancer Screening Working Group has identified that the ANHP OHT is uniquely positioned to respond to this need. Through the leadership of the Cancer Screening Working Group and the shift to a new model of care delivery, the Rural Generalist Council Care model, the ANHP OHT has the infrastructure and momentum to support innovative, community-based screening solutions. The proposed Screening and Prevention On Time for Cancer (SPOT-Cancer) model is a proactive strategy to address cancer screening rates in the region and improve access to preventative care services for all patients, those attached and unattached, across the ANHP OHT region.

Cancer Screening Rates: ANHP OHT, 12 Accelerated OHTs, and Ontario

As of the most recent reporting period (Q3 2024-2025), the ANHP OHT reports screening rates of 57.2% for breast cancer, 51.7% for cervical cancer, and 59.3% for colorectal cancer. The infographic below presents trends in cancer screening rates from Q1 2019-2020 to Q3 2024-2025, comparing data across the ANHP OHT region, the 12 accelerated Ontario Health Teams, and the province of Ontario overall for all three cancer screenings discussed (2).







Potential Contributing Factors to Cancer Screening Rates

Disparities in cancer screening rates exist, and several factors may contribute to these differences. The following potential causes are based on insights gathered from discussions within the ANHP OHT Cancer Screening Working Group meetings and informed by three key documents: “Primary Health Care

Utilization in All Nations Health Partners Ontario Health Team: Assessing Preventative Services, Covid-19 Impacts, and Recommendations for Improving Access" (2024), "Equity in Cancer Screening Quality Improvement Project with the All Nations Health Partners Ontario Health Team" (2025), and the "Wequedong Lodge Cancer Screening Research Report: Full Research Report" (n.d.), (4,5,6). Please note that confounding factors make it difficult to determine the exact cause(s) of the changes in cancer screening rates observed.

Patient Specific Factors:

Some individuals may be unaware they are due for screening or unsure where to access these services. Others may choose to opt out of screening altogether due to deep-rooted barriers such as intergenerational trauma, fear or mistrust of the healthcare system, and past experiences of sexual abuse. Various life circumstances, such as housing instability, financial stress, and other competing priorities, can understandably place preventive health measures like screening lower on the list of immediate concerns, resulting in patients not getting cancer screening.

System Specific Factors:

Limited availability of healthcare providers can affect timely access to cancer screening. In rural and remote areas, such as the First Nations communities surrounding the Kenora region, long travel distances and limited local services exacerbate the challenge.

Inaccurate Data:

Cancer screening rates may appear lower than they are due to gaps in data collection.

Often the Screening Activity Report (SAR) is not consistent with the Electronic Medical Records in use, as some patients on the SAR that are signalled to be screened have been shown to no longer be eligible for screening (ie, hysterectomy), no longer live in the region or province, or have since deceased. Additionally, when patients receive follow-up cancer screening care in Manitoba, these visits are not captured in Ontario Health's database. As a result, out-of-province screening follow-up information/data is not recognized within the Ontario screening programs.

Recent Changes In Systems:

Several recent system-level changes, including adjustments to physician incentives, the transition to the Rural Generalist Council Care (RGCC) model, and updates to cervical screening guidelines, may have contributed to fluctuations in cancer screening rates. While it is not always possible to directly link these changes to specific outcomes, it is important to acknowledge them as they may serve as potential confounding factors when interpreting screening data.

Changes in Physician Incentives for Cancer Screening. As of April 1, 2025, Ontario's physician incentive structure changed so that physicians no longer receive preventative care bonuses for completing colorectal, breast, lung, or cervical cancer screenings (7). It is essential to note that these changes only apply to physicians working under a rostered patient model. Many providers within the ANHP OHT are not affected by this change, including nurse practitioners offering cancer screening and those working outside of a rostered care model.

Transition to the RGCC Model. The ANHP OHT has recently adopted a new funding structure known as the Rural Generalist Council Care (RGCC) model. While it is not yet clear how this shift may

impact screening rates, the change is notable and could influence service delivery in ways that are not yet fully understood, potentially leading to improved cancer screening rates in the region.

Changes to Cervical Screening Guidelines. Ontario transitioned from Cervical Cancer Screening Pap Testing for people with a cervix aged 21 - 69 with a recommended follow-up in three years for those with a history of normal test results, to HPV-based Cervical Screening for people with a cervix aged 25 - 69 in 5 years for those with a history of normal test results, as of March 2025 (8). It is plausible that some practitioners may have delayed screening in anticipation of these new guidelines, particularly if patients were previously eligible under the old screening criteria but would not be eligible under the new ones. This pause in screening may have contributed to temporary decreases in cervical screening rates.

Efforts Taken to Improve Cancer Screening Rates

Improving cancer screening rates has been a key priority for the ANHP OHT and many of its practitioners. A variety of initiatives, both direct and indirect, have been implemented to support increased participation in screening across the region.

ANHP OHT Cancer Screening Working Group

The ANHP OHT's Cancer Screening Working Group is a dedicated task force focused on improving cancer screening rates within the region. The group brings together practitioners, administrators, data analysts, and regional cancer screening leads from across ANHP OHT partner organizations. Recognizing the importance of this work, the ANHP OHT initially formed the group in response to the inclusion of cancer screening as a Collaborative Quality Improvement Plan (cQIP) deliverable in Ontario Health starting in 2019/2020. The working group remains active and committed to advancing screening rates and reducing disparities across the region.

Cervical Screening Trained Nurses

Organizations across the ANHP OHT have supported some of their Registered Practical Nurses (RPNs) and Registered Nurses (RNs) to complete Cervical Screening Training, where they have acquired the course-based education and, through practical experience, demonstrate the competency to perform inspection of the cervix, cervical screening testing, and testing for STIs. The expectation for this Cervical Screening Training education is that nurses complete several supervised cervical screenings with a practitioner, who will then sign off to confirm that the nurses are competent and able to work independently. Currently, there is not a specific number of supervised exams, or a specific number that must be completed annually for competency; therefore, current medical directives and organizations' competency requirements vary.

Despite completing the initial education and training, many of the Cervical Screening Trained nurses have been unable to advance to independent practice due to difficulties in fulfilling the required supervised screenings. Coordinating time between supervising practitioners and Cervical Screening Trained nurses is often challenging, as both providers have their own clinical duties, often in environments affected by staffing shortages. Further complicating this process are patient-related factors, including some patients' reluctance to receive screenings from the nurses.

Screen For Life Coach with the Thunder Bay Regional Health Science Centre

The Thunder Bay Regional Health Sciences Centre's Screen For Life Coach is a mobile coach and cancer screening unit that provides breast, cervical, and colorectal screening services. The Coach supports access to care for both attached and unattached patients, with no referral required. Travelling to over 40 communities across Northwestern Ontario, the Coach helps reach individuals who may otherwise face barriers to accessing cancer screening services. These locations include many First Nations communities within the ANHP OHT region, where the Coach plays a key role in increasing cancer screening rates in the region.

Cancer Screening Working Group

The ANHP OHT's new Rural Generalist Council Care Model aims to improve access to care, including preventative services such as cancer screening, for all patients in the region, whether attached or unattached. Further details on this model are provided below.

Rural Generalist Council Care (RGCC) model

On January 7th, 2025, it was announced that Municipal and Indigenous leaders, healthcare providers, the Ontario Medical Association (OMA), the Ministry of Health, and the All Nations Health Partners Ontario Health Team (ANHP) had come together to introduce a new model of rural health care delivery in Northwestern Ontario, the Rural Generalist Council Care (RGCC) model (9).

The RGCC model focuses on improving equitable access to both primary and emergency care for all residents in the region, regardless of whether they are attached with a specific provider (9). It represents a shift from reactive to proactive care, with an emphasis on timely, culturally safe, and community-driven services (10). By supporting both the City of Kenora and regional First Nations communities, the model aims to strengthen critical health infrastructure such as the Lake of the Woods District Hospital Emergency Department and regional primary care clinics, while enhancing provider recruitment, retention, and long-term sustainability (10).

Before the RGCC, the region faced several system challenges. Physicians were often overwhelmed by complex, multi-level contracts and heavy administrative duties, which created confusion and acted as a barrier to recruitment (10). These structural inefficiencies contributed to persistent physician shortages and widened existing gaps in healthcare delivery and health equity. The RGCC addresses these issues by streamlining processes, reducing administrative burdens on providers, and coordinating more effective recruitment and retention strategies (9,10).

Under the RGCC model, all Nurse Practitioners in the ANHP OHT region are now rostering patients and working in a salaried framework. Physicians have also transitioned to a single, unified contract, replacing the former system of multiple agreements and contracts. This has significantly reduced administrative complexity, as both physicians and nurse practitioners now receive salaries and complete shadow billing. While patients remain attached to individual providers, providers' schedules now also include dedicated time to care for unattached patients. This ensures broader, more flexible access to care for everyone in the region, helping to meet diverse health needs in a timely and culturally safe way.

With this shift in the region's healthcare delivery model, there is a unique opportunity to implement a new, dedicated cancer screening initiative to support all patients in the region.

Proposed Solution of the ANHP OHT: Screening and Prevention On Time for Cancer (SPOT-Cancer)

Driven by the need to address the identified challenges and presented with emerging opportunities, the ANHP OHT's Cancer Screening Working Group has developed a proactive and strategic solution titled "Screening and Prevention On Time for Cancer (SPOT-Cancer)". The objective of SPOT - Cancer is to increase cancer screening rates in the region by implementing a phased approach, beginning in Kenora and expanding to surrounding First Nations communities, where a nurse practitioner or physician, supported by a Cervical Screening Trained nurse, provide a cancer screening clinic, for a full day, once-a-month, focused on improving access, capacity, and quality of care for both attached and unattached patients.

Background Literature on the Successful Implementation of a Dedicated Cancer Screening Practitioner

Please see the Appendix for reference.

Proposed Solution of the ANHP OHT: Screening and Prevention On Time for Cancer (SPOT-Cancer)

The primary objective of this initiative is to enhance cancer screening outcomes across the ANHP OHT region by addressing gaps in access, equity, and capacity. Specific objectives include increasing overall cancer screening rates, improving timely access to screening services, expanding access for unattached patients, and strengthening the local healthcare workforce by enhancing the competency of Cervical Screening Trained nurses. By dedicating a full day each month to cancer screening, led by a practitioner supported by trained nursing staff, this initiative creates a consistent and focused opportunity to deliver high-quality, accessible preventive care.

To support this, the project will follow a phased approach: Phase 1: Planning and Operational Readiness, focused on logistics planning, cross-organization coordination, and funding; Phase 2: Initial Implementation, which will launch the *One Day, Once a Month* cancer screening clinic at the SCFHT in Kenora, and Phase 3 Expansion to the First Nation communities in the ANHP OHT region, which will continue Phase 2, and introduce the model to surrounding First Nations communities based on capacity, evaluation, and lessons learned.

Phase 1: SPOT-Cancer Planning

The first phase of this initiative focuses on engaging organizations and key stakeholders, determining logistics such as timeline, location, personnel, and other details, as well as patient recruitment, funding advocacy, and evaluation planning, to ensure the proper infrastructure is in place for the successful implementation of SPOT-Cancer.

Engaging Organizations

The partnered organizations across the ANHP OHT, including the Sunset Country Family Health Team, Waasegiizhig Nanaandawe'iyewigamig Health Access Centre, Kenora Chiefs' Advisory, CMHA Kenora, the Lake of the Woods District Hospital, and The Thunder Bay Regional Health Science Centre Screening for Life Coach Team, can be actively engaged through the collaborative ANHP OHT Cancer Screening Working Group meetings, which foster cross-organization collaboration across the ANHP OHT. Early involvement of these partners is essential to align goals, clarify roles, and ensure coordinated planning, reducing confusion and duplication of efforts.

Logistics: Timeline, Location, Personnel, and Additional Logistics

Timeline

Through collaborative discussions with involved organizations and stakeholders, an appropriate start date for the initiative can be determined. A consistent day each month (for example, the second Friday of each month) will be agreed upon for SPOT-Cancer to take place. Creating a detailed calendar that outlines the schedule for six months enables organizations to align internal resources and ensure that practitioners can be signed up for dedicated or specific days, supporting advanced planning and promoting consistent participation.

Location

Collectively, the team must agree upon a location for each phase of SPOT-Cancer. For Phase 2, the preliminary goal is to host the monthly clinic at the Sunset Country Family Health Team, offering a centralized and accessible site for initial implementation. It is essential to initiate early conversations with surrounding First Nations communities to understand their local interests, readiness, and capacity for future participation in Phase 3. Engaging these communities from the onset will help ensure that the expansion of SPOT-Cancer is grounded in partnership, trust, and tailored to the unique needs of each community.

Personnel

At the core of each SPOT-Cancer Day is a team of dedicated cancer screening practitioners and cervical screening-trained nurses. When determining who will facilitate these days, it is necessary to identify which practitioners (nurse practitioners and physicians), and which nurses (with Cervical Screening Training) from which organizations, are eligible and expected to participate. Sharing the preliminary SPOT-Cancer calendar and relevant information in advance will help facilitate scheduling and enable providers to plan accordingly. To ensure role clarification and consistent delivery of care, it is important to establish clear expectations and roles for each provider. This can be done by creating a detailed document that is attached to the preliminary schedule outlining responsibilities.

As discussed, the Cervical Screening Trained nurses involved in SPOT-Cancer come from various organizations, each with different training backgrounds. To promote consistency and cohesion across the ANHP OHT, it is necessary to establish a "Cervical Screening Trained Competency for the ANHP OHT", a shared agreement on the number of training hours and supervised cervical screenings required for a nurse to be considered competent and able to practice independently. This agreement may also outline the frequency of competency reviews or renewals. Creating this streamlined, competency-based process across the ANHP OHT offers an opportunity for nurses outside of the SPOT-Cancer initiative who may be interested in building their skillset, such as those on the Sexual Assault Team at Lake of the Woods District Hospital, to receive additional training, skill development, and recognition of competency in alignment with ANHP OHT guidelines. For SPOT-Cancer nurses to carry out cervical screenings both under supervision and independently, appropriate medical directives must be in place to support their scope of practice and facilitate effective collaboration with the assigned practitioners.

Other Logistics

Early conversations and planning may bring about several other logistical considerations that must be addressed to ensure a smooth rollout of SPOT-Cancer. This may include logistical considerations

related to administrative staff, walk-in appointments, and new information provided by the new screening activity reports (SAR) for Grand Council Treaty Three.

Administrative staff will need to be notified well in advance of designated SPOT-Cancer days, with clear guidance on how to book patients for these sessions appropriately. Establishing consistent processes for communication, referral management, and data tracking will also be crucial in ensuring effective coordination across teams.

In addition to scheduled appointments, walk-in appointments should be offered to patients. Considerations and planning regarding time slots and scheduling for the SPOT-Cancer Day will need to be reviewed to ensure efficiency and optimal clinic flow. This opportunity for patients offers improvements in accessibility for patients who face barriers to pre-planning and provides insight into patient preferences and attendance patterns, which may help inform future planning.

A new and upcoming initiative involves the production of SARs specifically for Grand Council Treaty Three Members. These reports will support patient recruitment by identifying individuals in need of screening and highlighting communities with the lowest screening rates, allowing for more targeted outreach and intervention. It will be important to consider how this data captures mobile populations who frequently move between communities, as well as individuals without a health card or fixed postal code, who may be underrepresented in the SAR.

Patient Recruitment

Developing a clear and coordinated patient recruitment process is essential to ensure strong community uptake and maximize the use of the dedicated time and resources allocated to each SPOT-Cancer Day. All participating organizations should have the opportunity to provide input into the design of recruitment materials, supporting a unified and collaborative approach across the region. Advertisement and promotional materials must be accessible, culturally safe, and reflective of the diverse populations being served. To reduce confusion and improve access, materials should clearly outline the booking pathways for both attached and unattached patients and provide details about walk-in options if available.

In addition to SPOT-Cancer Day advertisements, culturally safe cancer screening promotion and education should be streamlined and continued throughout the ANHP OHT region. Resources developed by the ANHP OHT organizations, the Thunder Bay Regional Health Science Centre, and Ontario Health should be utilized in addition to the Indigenous-specific FIT promotional resources currently being developed by the Sunnybrook team in partnership with KCA.

Funding Advocacy

Identifying and confirming in-kind contributions from partner organizations and funding models, including but not limited to the Rural General Council Care Model, WNHAC, and KCA, is required to support early implementation. These contributions may include clinic space, administrative support, staffing, or training resources. Leveraging these existing pathways and strengths within the current ANHP OHT system is key to building early momentum.

Early conversations around external funding are necessary to ensure long-term viability. This document, which outlines the background, data, and purpose of SPOT-Cancer, can serve as a funding advocacy brief and tool to be shared with governing bodies and potential funders.

Evaluation Planning

Collectively determining how success will be measured via creating an evaluation plan with specific performance indicators and data collection methods outlined is essential to assess the success and effectiveness of SPOT-Cancer. Some examples of key performance indicators may include change in screening rates across the region, number of patients screened, and uptake among unattached patients. Some examples of data collection methods include analyzing Ontario Health Team data, examining de-identified patient characteristics, and distributing surveys to both patients and providers following each SPOT-Cancer Day to gather feedback on the experience, access, and satisfaction.

Evaluation findings will play a key role in informing program improvements, ensuring SPOT-Cancer remains responsive to community needs and system priorities. These findings can also serve as formal deliverables to Ontario Health, providing evidence of progress and accountability and can support funding advocacy by demonstrating impact and identifying areas of continued need.

Phase 2: SPOT-Cancer Introduction

Phase 2 of SPOT-Cancer will be the initiation of SPOT-Cancer. As outlined in Phase 1, this will include one full day each month dedicated exclusively to cancer screening. This designated day will be promoted in advance to patients to encourage participation and increase awareness of screening opportunities. Each SPOT-Cancer Day will be staffed by a dedicated cancer screening support practitioner and a Cervical Screening Trained nurse, providing focused, team-based care that supports timely and accessible preventive services.

Dedicated Practitioner: Nurse Practitioner or Physician

As discussed, the dedicated cancer screening support practitioner, a physician or nurse practitioner, will be assigned or allowed to sign up for each SPOT-Cancer Day. This practitioner will support the training of the RPNs and RNs, via signing relevant requisitions, reviewing abnormal findings, answering related questions and supervising and providing guidance on hands-on skills. To promote broad engagement and shared ownership, the role will rotate monthly among practitioners. This approach fosters cross-organizational support by involving multiple practitioners and distributing responsibilities more evenly across the region. Additionally, it helps reduce the cancer screening workload, including but not limited to result follow-up, on any single provider, promoting a more sustainable and balanced system.

Cervical Screening Trained Nurse

The nurses eligible/selected to support SPOT-Cancer days will be those who have completed the Cervical Screening Training, positioning them as key contributors to both the immediate and sustained success of the initiative. In the short term, these nurses will enhance clinic workflow by providing essential hands-on support and expanding the screening capacity within the limited time available on each SPOT-Cancer Day. In the long term, the initiative offers a valuable opportunity for Cervical Screening Trained nurses to deepen their skills and gain additional supervised experience, particularly in cervical screening, enabling them to meet their competency requirements and ultimately perform screenings independently. This will strengthen the local healthcare workforce and prepare the team for Phase 3 of SPOT-Cancer.

Types of Screening Opportunities

When patients call the clinic to book their screening appointment, they will be asked about their current screening history to determine which cancer screenings they are eligible for or require. Based on this information, SPOT-Cancer will offer five distinct types of cancer screening visits to meet individual patient needs:

New Patient Screening Visit: Patients new to cancer screening or unsure of their screening history. This visit includes a review of screening eligibility and planning for appropriate next steps. Administrative and scheduling staff may be able to support this process by reviewing the new streamlined cancer screening toolbar in the electronic medical record.

FIT (Fecal Immunochemical Test) Visit: During this visit, the FIT test will be ordered, accompanied by education, test distribution information, and follow-up instructions.

Mammogram Visit: A mammogram will be scheduled during this visit and will include education, system navigation, and follow-up instructions. As self-referral for mammograms is an option, patients will also be provided with information to self-refer through the Ontario Breast Screening Program (1-807-684-7777).

Cervical Screening Visit (Practitioner-Led or Nurse-Led): Patients will be booked with the dedicated cancer screening practitioner. Cervical Screening-Trained nurses may assist during these visits as part of their supervised training hours or lead the appointment independently once competency requirements are met, according to their organization's medical directive or policy.

Walk-In Appointments: To improve accessibility for patients who are unable to schedule appointments in advance, a walk-in option will be provided during the designated SPOT-Cancer Day.

This flexible visit structure ensures patient needs are met efficiently while optimizing the skill sets of the care team.

Evaluation

Conducting formal evaluations of SPOT-Cancer at the 6-month and 1-year marks will be crucial to assess the initiative's effectiveness, identify areas for improvement, and make any necessary adjustments. These checkpoints will ensure the model continues to meet patient and system needs while maintaining quality and efficiency. Evaluation findings will also help determine readiness for regional expansion in Phase 3.

Phase 3: SPOT-Cancer Expansion to First Nation Communities

Phase 3 will continue the monthly SPOT-Cancer clinics established in Phase 2 while expanding services to First Nations communities. Nurses who have completed the Cervical Screening Trained Competency for the ANHP OHT will travel to a different community each week on a rotating basis, bringing screening services directly to patients and improving access in remote communities. Findings from the evaluation of Phase 2 will inform the development of Phase 3 planning.

Screen For Life Coach

There is an opportunity and a need for synergy between the SPOT-Cancer program and the Screen for Life Coach, operated by the Thunder Bay Regional Health Sciences Centre. Introducing conversations with the Coach team early in Phase 1 and Phase 2 creates the foundation for coordinated planning in Phase 3. Collaboratively developing screening lists will help ensure efforts are aligned, avoid duplication, and maximize outreach and efficiency across communities.

Community Engagement

As outlined in Phase 1, meaningful community engagement remains paramount throughout Phase 3 to ensure that all efforts are culturally safe, respectful, and responsive to local needs. Building trust through early and ongoing collaboration with community leadership, healthcare staff, and residents is essential to the success of SPOT-Cancer days. It is also crucial to collaborate closely with local healthcare systems to raise awareness, encourage participation, and facilitate patient navigation. Community-driven advertisement strategies will play a key role in motivating patients to attend and feel comfortable accessing screening services.

Organizations, Personnel, and Medical Directives

Different First Nations communities are served by various organizations, making it essential to establish clear plans for assigning roles and responsibilities to each partner. Aligning nurses with their respective organizations ensures accountability and smooth operational flow. As emphasized in Phase 1, having up-to-date medical directives in place is critical to support nurses' scopes of practice and enable seamless collaboration with assigned practitioners, regardless of the organization they represent. This foundation is essential for delivering safe, effective, and integrated care across communities.

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Appendix: Literature Review for ANHP OHT "Screening and Prevention on Time - for Cancer" Initiative

Background:

In support of the All Nations Health Partners Ontario Health Team "Screening and Prevention on Time - for Cancer (SPOT - Cancer) initiative", this literature review aims to provide a comprehensive understanding of the uptake of dedicated cancer screening clinics impacting overall cancer screening trends across North America and to examine the successes and challenges associated with the implementation of dedicated cancer screening clinics within rural, remote and Indigenous populations in Northwestern Ontario. Specifically, this literature review aims to determine whether this model of care has been previously used and to what extent it has been effective or ineffective, as well as how it has incorporated culturally safe and traditional practices. Additionally, any potential barriers and limitations associated with this type of initiative will be identified, along with proposed solutions to address and overcome them.

Common themes were analyzed across 10 peer-reviewed articles published between 1995 and 2025, which comprised a compilation of case studies, systematic reviews, qualitative research, and observational studies. Several themes emerged, including barriers to appointment-based care, the need for innovative models, a focus on Indigenous and marginalized populations, and the effectiveness of nurse practitioner-led programming. It is hoped that the findings from this literature review, including both successes and limitations, will support the "SPOT-Cancer" initiative.

Themes:

One of the most common themes found across all articles highlighted that there are barriers to appointment-based care. Whether that is at the geographical, social, cultural, or systemic level. Wiseman et al. (2025) reported that many patients had previously experienced difficulties scheduling appointments with their local physicians, faced long wait times, and lacked access to female physicians. The patients were thrilled to have services come directly to their communities. Furthermore, in Canada, First Nations,

Inuit, and Metis peoples experience the most limited access to and utilization of cancer screening services due to demographic and geographic characteristics (Kerner et al., 2015). More specifically, in Canada, Indigenous peoples experience inequitable access to healthcare and oncology care because of social, economic, historical and political influences as well as experiences of racism, stigma and discrimination within healthcare (Horrill, T., 2022). However, the most significant barrier to accessing preventative cancer care for Indigenous peoples in Canada is the lack of culturally safe care (Horrill, T., 2022).

A dire need for a focus on underserved and marginalized populations, as well as a need for equity-oriented interventions, is another recurring theme identified. Kerner et al. (2015) highlight that a one-size-fits-all approach is ineffective. The demographic and geographic characteristics of the "hard-to-reach" populations require careful examination, and intervention approaches developed for similar populations should be reviewed and adopted. Additionally, there is a need to adopt evidence-based screening promotion interventions that are integrated into their organized cancer screening programs. Horrill (2022) suggests that the key pathway to addressing inequities in access to oncology care involves integrating approaches into the design and delivery of oncology care that purposefully address the barriers highlighted previously.

Bottorff et al. (2001) attest to the need for changes in health policy and the structure of health services to deliver patient-centred care and address barriers beyond cervical cancer screening. Kerner et al. (2015) highlight that in Canada, First Nations, Inuit, and Metis peoples experience the most limited access to and utilization of cancer screening services due to demographic and geographic characteristics. More specifically, it is emphasized that Indigenous peoples in Canada experience inequitable access to healthcare and oncology care as a result of social, economic, historical and political influences, as well as experiences of racism, stigma and discrimination within healthcare (Horrill, T., 2022). However, the most significant barrier to accessing oncology care for Indigenous peoples in Canada is the lack of culturally safe care.

Another prominent theme identified across the review was that innovative models enhance screening uptake, and delivering care to the community is needed. The literature review suggests a wide variety of successful models, including mobile clinics, weekend clinics, NP student-led models, and long-term NP-led programs. Several articles specifically discussed that nurse practitioners can be key providers for cancer screening. Schlabach et al. (2022) found a 60% increase in the number of completed scans observed after the inception of the NP-led lung cancer screening clinic. It was highlighted that nurse practitioner training prepares graduates in multidimensional roles parallel to those required to lead a successful cancer screening clinic, and that nurse practitioners are educated in primary prevention, risk reduction and diagnostic interpretation, inherent pieces of cancer screening. They contend that a program led by a nurse practitioner with oncology experience supports successful cancer screening, as NPs are well-positioned to address commonly identified challenges associated with cancer screening, such as the recognized clinician and individual barriers, compliance with insurance requirements, and complexity of patient monitoring. They also state that using a combination of evidence-based practice, quality improvement, and research will lead to the best healthcare and patient outcomes. Wiseman et al. (2025) highlight another successful implementation of nurse practitioners delivering cancer screening directly to rural or remote communities. They noted that adding a nurse practitioner increased the efficacy of the screening pathway and provided continuity of care. Previous research has shown that integrating NPs into cancer screening increases participation of under-screened patients by removing barriers to screening and providing on-the-spot primary cancer care for people in underserved communities. This study emphasized that the cancer screening clinic was not designed to replace existing local primary care services, but to

complement them in rural and remote communities. Strelow et al. (2024) also demonstrated successful results of improving access to cervical cancer screening by establishing a clinic delivered by nurse practitioners. A study done in Texas (Weston et al., 2018) had excellent results from implementing a student-led cancer screening clinic. 73% of patients reported not having a consistent primary care provider. The patients reported a 95% satisfaction rate, and 100% reported they would refer their family and friends, as they wouldn't have had access to a Papanicolaou (Pap) test without this service. The researchers argue that, with a focus on value-based care, expanding opportunities through NP student-led clinics improves access to cancer screening, combining high-quality, cost-effective healthcare delivery with the education of the next generation of healthcare providers. Another study (Strelow et al., 2024) emphasizes its results that cancer screening rates improved when women attended non-primary-care outpatient clinics using lay health advisers and a nurse practitioner to perform screenings, and that the effect was most substantial in women who were in the greatest need of screening.

According to Waheed & Linthacum (2013), a successful rural, comprehensive cancer screening program with 25-year participation rates, a total of 51,223 visits, and a 94% return rate has the evidence to support the statement that screening programs are effective at decreasing cancer mortality and morbidity through education, prevention and early detection. They state that nurse-run clinics offer a satisfying and cost-effective approach, providing competent expertise in the specialized field of cancer prevention. Kottke & Trapp (1998) found that nurses can also close the gaps between current cancer screening rates. Their study aimed to determine whether nurses can collect high-quality Pap tests. After one week of training, they determined that nurses could collect Pap test specimens that are the same quality as those collected by physicians.

Summary:

This literature review examines the common themes associated with the implementation of dedicated cancer screening clinics within rural, remote and Indigenous populations. Several key themes emerged, including barriers to appointment-based care and the identified need for innovative models, a focus on Indigenous and marginalized populations, and the strength of nurse practitioner-led primary care programming. Despite promising results, some limitations and gaps in the literature were identified. There is an underrepresentation of Indigenous populations in cancer screening programs, and there is also limited long-term data available. **There were also limitations in context to government restrictions, which led to issues such as difficulty securing spaces in rural facilities (Wiseman et al., 2025).** While many of these studies demonstrate successes, there remain opportunities for improvement. These gaps underscore the need to increase capacity by incorporating other practitioners, including nurse practitioners and cancer-trained nurses. The screening models need to cater to the demographic, geographic, social and cultural needs of the specific population.

The findings from this literature review support the development and implementation of a dedicated cancer screening clinic in Northwestern Ontario. By reviewing and integrating these identified themes, we can work to address the challenges faced in the communities served by the All Nations Health Partners OHT and aim to develop an effective model that meets the specific needs of our members.

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