

ARCC

Canadian Centre
for Applied Research
in Cancer Control

ARCC Program Area Webinar: Dr. Craig Earle

Friday January 29th, 2016



BC Cancer Agency
CARE & RESEARCH
An agency of the Provincial Health Services Authority



**Canadian
Cancer
Society** **Société
canadienne
du cancer**



Cancer Care Ontario
Action Cancer Ontario

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Cancer
Quality
Council
of Ontario

Public reporting through Ontario's Cancer System Quality Index (CSQI)

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Sunnybrook Health Sciences Centre, University of Toronto

Co-Chair (with Monika Krzyzanowska) of the CSQI Project Leadership Team

Outline

- Overview of the CSQI
- Focus on some specific initiatives:
(time permitting)
 - Efficiency measures
 - Patient-reported symptoms
 - Physician-level reporting

EDITO

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The sorry tale of Cancer Care Ontario

The Mike Harris government's ham-handed handling of Cancer Care Ontario has to be seen in the context of what else is happening.

Last week, Health Minister Tony

jected deficit of \$175 million and pending legislation making deficits illegal.

Exhibit 3: On Wednesday, a city committee will consider a report on

PRIVATE PRACTICE: Dr. Tom McGowan, former head of radiation oncology for Cancer Care Ontario, set up a private company to run the new after-hours clinic.

Cancer Care Ontario should be shut down

Agency couldn't figure out how to run an evening shift at its Sunnybrook centre

THOMAS WALKOM



For two weeks, Premier Mike Harris' government has been embroiled in a furor over its plans for **Cancer Care Ontario**, a crown agency that runs eight of the province's nine cancer treatment clinics.

The battle has been painted in Goliath and David terms - a monolithic, vengeful government moving to silence a feisty, independent agency devoted to serving the interest of cancer patients.

Agency board members, speaking under the cloak of anonymity, charged that Health Minister Tony Clement was trying to punish Cancer Care Ontario for publicizing the lengthy waiting

newspaper by New Democrat MPP Frances Lankin. It is a remarkable document.

First, the new private company is promised a so-called performance bonus. Public cancer treatment centres receive \$3,000 per patient no matter how many they treat. But if McGowan's firm treats more than 500, its subsidy will lo-

“The First Law of Improvement”

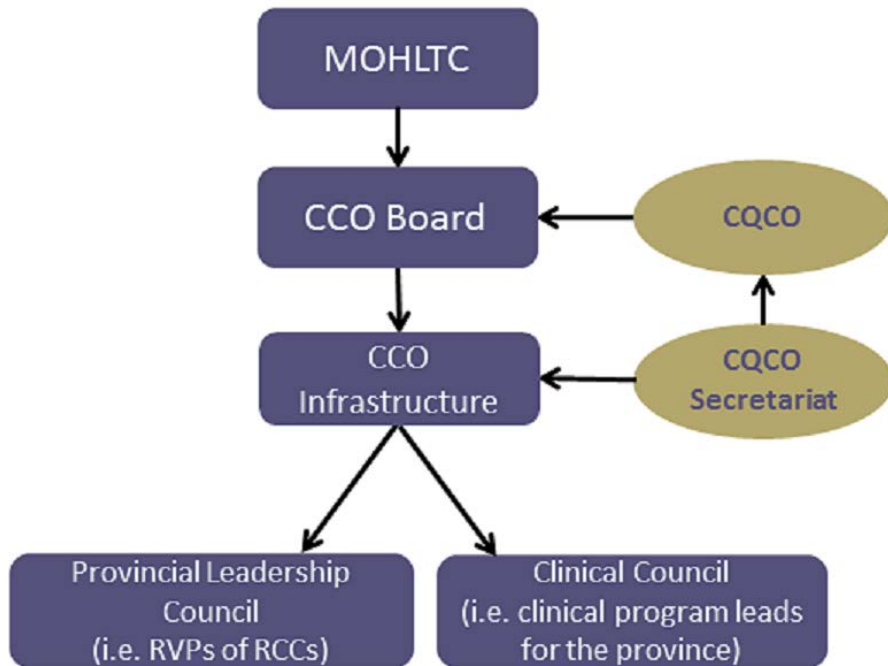
Every system is perfectly designed to achieve exactly the results it gets.

History of CQCO: Where we started in 2000



- 2000:** Challenges with variability in quality; Radiation Therapy wait times too long; public concerns about the cancer care system
- 2001:** Cancer System Implementation Committee review recommends integration of the regional cancer centres with the hospitals, a new role for CCO and the creation of a Cancer Quality Council
- 2002:** Minister of Health and Long-Term Care announces establishment of Cancer Quality Council of Ontario - an arms-length, quasi-independent body; mandate to monitor and publically report on the quality of cancer services. First task - develop a set of quality indicators.

Relationship with CCO



CQCO:

- A quasi-independent body, and the first of its kind in Canada, given a mandate to **monitor** and **report publicly** on cancer system performance, and to **make recommendations** for targeted quality improvement to the minister of Health and Long-Term Care via CCO's Board of Directors.

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- 2005:** Cancer System Quality Index (CSQI) launched →



CQCO and the CSQI

Original context

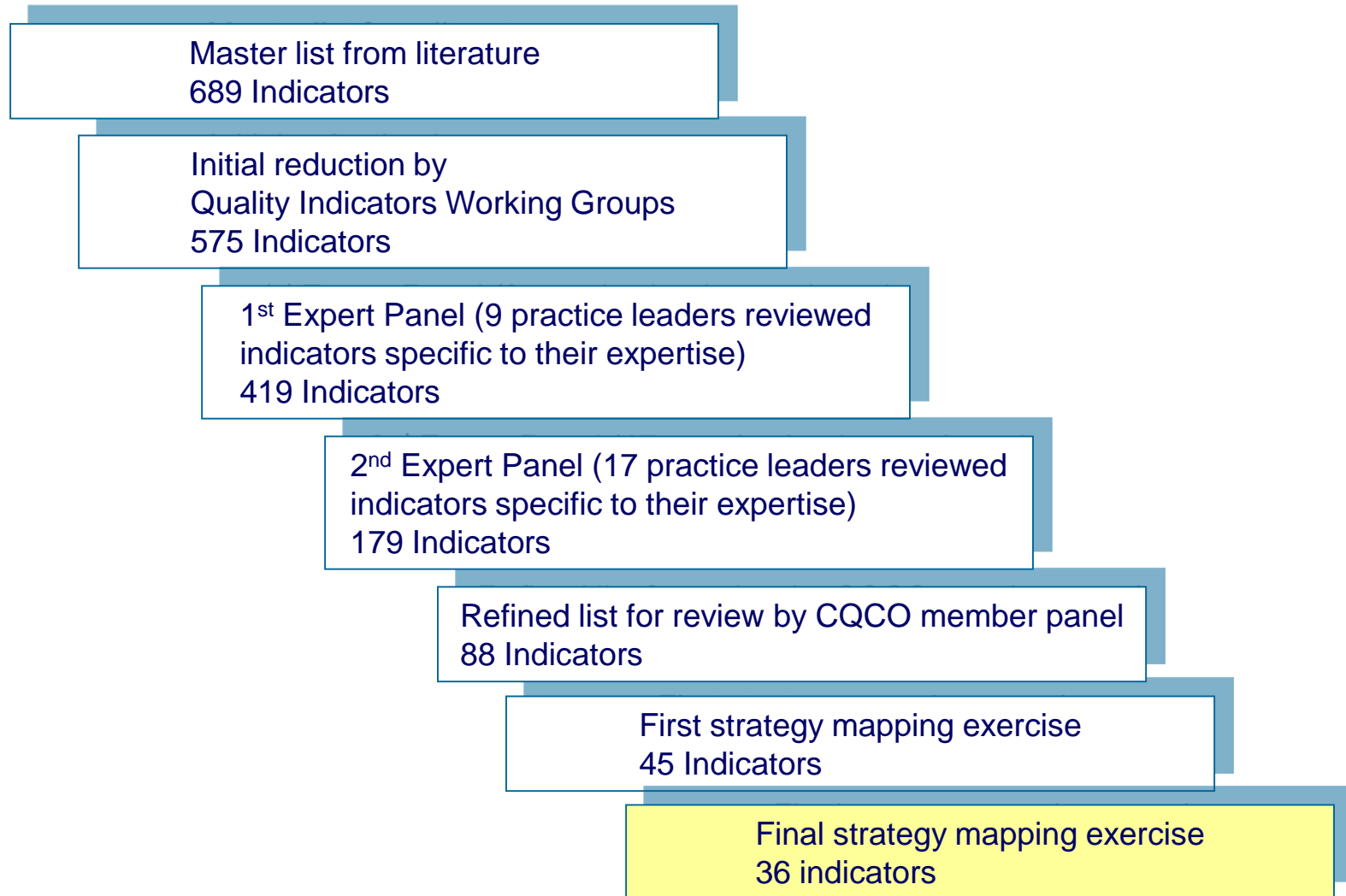
- Original goal: To develop a set of scientifically sound and managerially useful system-level cancer care performance indicators for routine public reporting in Ontario



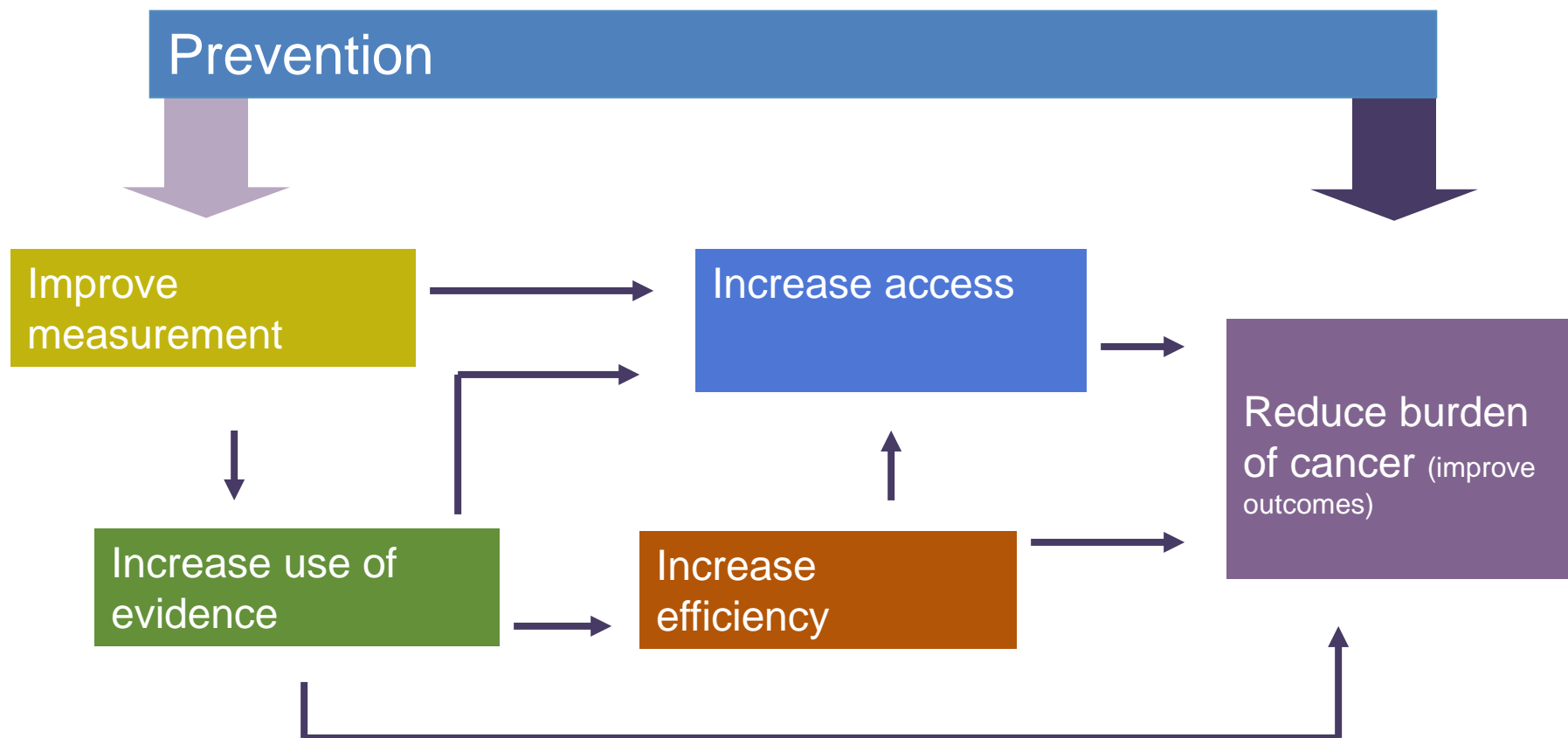
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“If you can’t measure it, you can’t
monitor/manage/improve it”

Original CSQI 2005: Performance Indicator Identification & Selection



Back in 2005 – until 2009, the CSQI followed dimensions of cancer system strategy map





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“Not everything that counts can be counted, and not everything that can be counted counts”

Albert Einstein

History of CQCO: Where we started in 2000



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- 2002:** Minister of Health and Long-Term Care announces establishment of Cancer Quality Council of Ontario - an arms-length, quasi-independent body; mandate to monitor and publically report on the quality of cancer services. First task - develop a set of quality indicators.
- 2005:** Cancer System Quality Index (CSQI) launched →
- 2010:** CSQI moved from strategy map to quality dimensions framework with 7 dimensions
(*Safe, Effective, Accessible, Responsive, Integrated, Equitable, Efficient*)



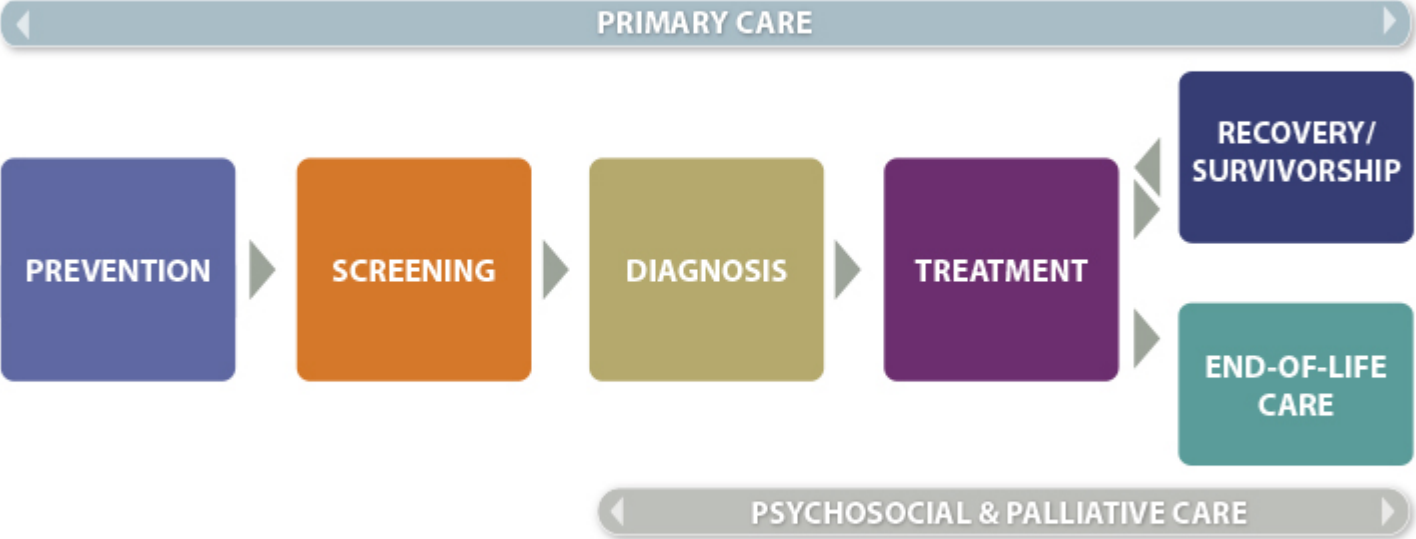
Quality Dimensions since 2010: Each indicator is a specific measurement of progress against one of seven dimensions of quality

Safe	Avoiding, preventing, and ameliorating adverse outcomes or injuries caused by health care management (Source: OECD, Baker).
Effective	Providing services based on scientific knowledge to all who could benefit (Source: IOM)
Accessible	Making health services available in the most suitable setting in a reasonable time and distance (Source: Alberta, HQC).
Responsive (Patient-Centred)	Providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions (Source: IOM).
Equitable	Providing care and ensuring health status does not vary in quality because of personal characteristics (gender, ethnicity, geographic location, SES, age) (Source: IOM) .
Integrated	Coordinating health services across the various functions, activities and operating units of a system (Source: Gillies et al).
Efficient	Optimally using resources to achieve desired outcomes (Source: Alberta, HQC).

The Patient Journey has many steps and involves many locations...

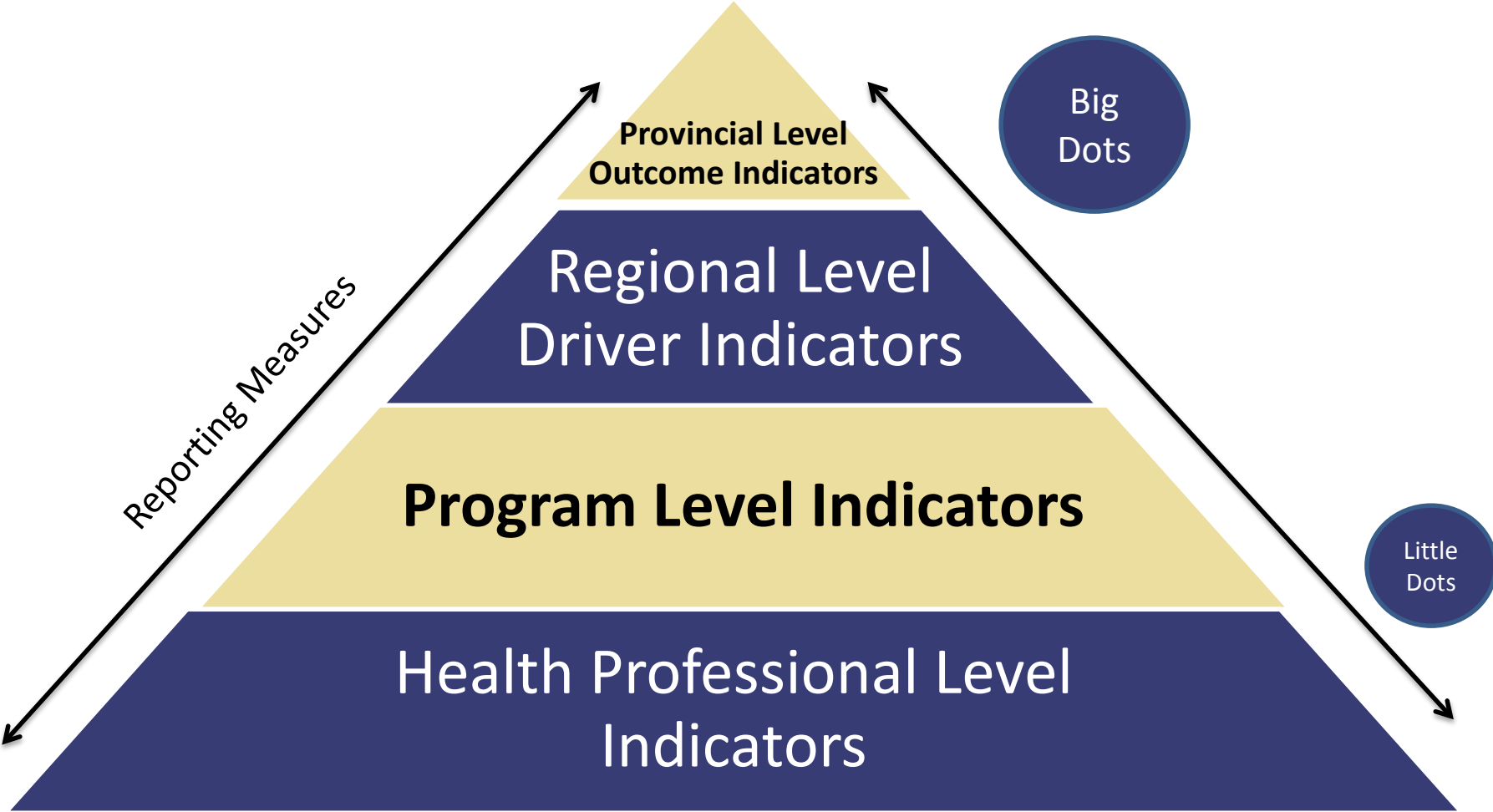
The cancer journey

Better cancer services every step of the way



	Safe	Effective	Accessible	Responsive	Equitable	Integrated	Efficient
Prevention							
Screening							
Diagnosis							
Treatment							
Recovery							
End-of-life care							

Big Dot Quality Cascade Pyramid



Adapted from Heenan, M. Khan, & Binkley, D. (2010). "From boardroom to bedside: How to define and measure hospital quality." *Healthcare Quarterly*, 13(1): 55-60.

CSQI 2015 Indicator Results

CSQI 2015 Ratings

Safe



Good. Many processes for a safe cancer system are in place. However, more system supports for patients are required, especially during the active treatment phase, as shown by the use of emergency room visits.

Effective



Good. More cancer patients are receiving care based on the best available evidence. Guidelines selected for CSQI are system focused and require effort to achieve targets and ensure consistency across regions.

Accessible

Responsive

Equitable

Integrated

Efficient



Cancer survival in Australia, Canada, Denmark, Norway, Sweden, and the UK, 1995–2007 (the International Cancer Benchmarking Partnership): an analysis of population-based cancer registry data



M P Coleman, D Forman, H Bryant, J Butler, B Rachet, C Maringe, U Nur, E Tracey, M Coory, J Hatcher, C E McGahan, D Turner, L Marrett, M L Gjerstorff, T B Johannesen, J Adolfsson, M Lambe, G Lawrence, D Meehan, E J Morris, R Middleton, J Steward, M A Richards, and the ICBP Module 1 Working Group*

Summary

Background Cancer survival is a key measure of the effectiveness of health-care systems. Persistent regional and international differences in survival represent many avoidable deaths. Differences in survival have prompted or guided cancer control strategies. This is the first study in a programme to investigate international survival disparities, with the aim of informing health policy to raise standards and reduce inequalities in survival.

Methods Data from population-based cancer registries in 12 jurisdictions in six countries were provided for 2·4 million adults diagnosed with primary colorectal, lung, breast (women), or ovarian cancer during 1995–2007, with follow-up to Dec 31, 2007. Data quality control and analyses were done centrally with a common protocol, overseen by external experts. We estimated 1-year and 5-year relative survival, constructing 252 complete life tables to control for background mortality by age, sex, and calendar year. We report age-specific and age-standardised relative survival at 1 and 5 years, and 5-year survival conditional on survival to the first anniversary of diagnosis. We also examined incidence and mortality trends during 1985–2005.

Findings Relative survival improved during 1995–2007 for all four cancers in all jurisdictions. Survival was persistently higher in Australia, Canada, and Sweden, intermediate in Norway, and lower in Denmark, England, Northern Ireland, and Wales, particularly in the first year after diagnosis and for patients aged 65 years and older. International differences narrowed at all ages for breast cancer, from about 9% to 5% at 1 year and from about 14% to 8% at 5 years, but less or not at all for the other cancers. For colorectal cancer, the international range narrowed only for patients aged 65 years and older, by 2–6% at 1 year and by 2–3% at 5 years.

Interpretation Up-to-date survival trends show increases but persistent differences between countries. Trends in cancer incidence and mortality are broadly consistent with these trends in survival. Data quality and changes in classification are not likely explanations. The patterns are consistent with later diagnosis or differences in treatment, particularly in Denmark and the UK, and in patients aged 65 years and older.

Funding Department of Health, England; and Cancer Research UK.

Lancet 2011; 377: 127–38

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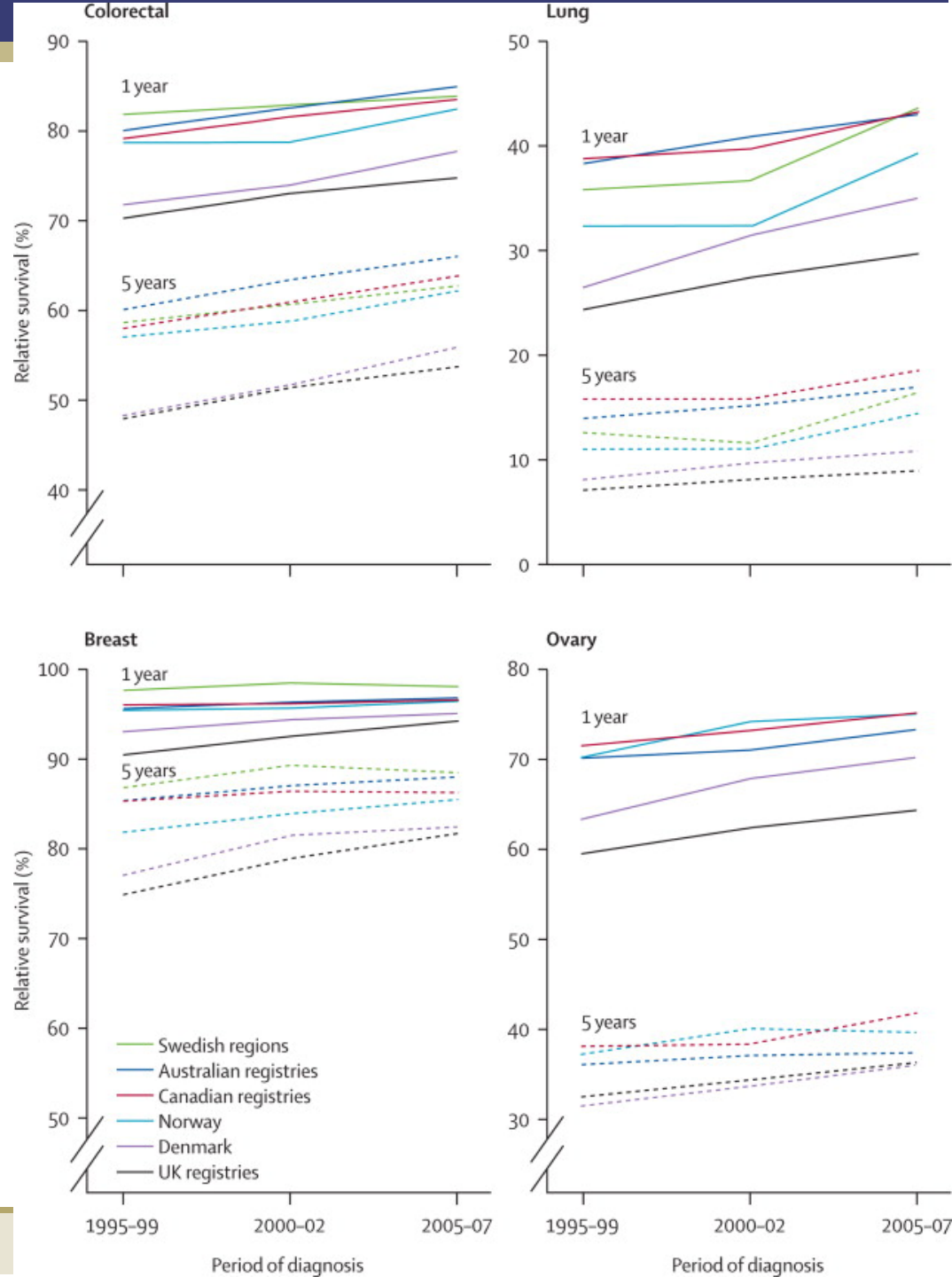
See Comment page 99

*Members listed at end of Article








Cancer Research UK Cancer Survival Group, London School of Hygiene and Tropical Medicine, London, UK (Prof M P Coleman BM BCh, B Rachet PhD, C Maringe MSc, U Nur PhD); Section of Cancer Information, International Agency for Research on Cancer, Lyon, France (D Forman PhD); Canadian Partnership Against Cancer, Toronto, ON, Canada (Prof H Bryant MD); Department of Health, London, UK (J Butler MRCCG); Cancer Institute New South Wales, Sydney, NSW, Australia (E Tracey MPH); Cancer Council Victoria, Melbourne, VIC, Australia (M Coory PhD); Alberta Health Services, Edmonton, AB, Canada (J Hatcher PhD); British Columbia Cancer Agency, Vancouver, BC, Canada

Age-standardised 1-year and 5-year relative survival trends 1995–2007, by cancer and country

- *Lancet* 2011; 377: 127–38



CSQI 2015 Ratings

Safe		Good. Many processes for a safe cancer system are in place. However, more system supports for patients are required, especially during the active treatment phase, as shown by the use of emergency room visits.
Effective		Good. More cancer patients are receiving care based on the best available evidence. Guidelines selected for CSQI are system focused and require effort to achieve targets and ensure consistency across regions.
Accessible		Good. More Ontarians are accessing the services they need within the appropriate timeframe. Wait times for services such as testing and supportive care are being measured so that areas for improvements can be identified.
Responsive		Fair. More emphasis is needed on the quality of life of patients during and after active treatment. Patient care should be structured so that it aims to improve the overall health and wellbeing of the cancer patient.
Equitable		Fair. Inequity exists, however, for some measures in the cancer system, equitable care is being realized. More work is needed using a holistic approach across the system to ensure equal health status is achieved across Ontario.
Integrated		Fair. More efforts are required to increase the level of coordination within Ontario's cancer system to support seamless, effective and person-centred care transitions regardless of location or provider.
Efficient		Incomplete Data. There is a lack of meaningful measures to determine value for money for all services, while maintaining good health outcomes and seamless patient care. Currently only radiation equipment utilization is measured and the results are moving in the right direction.



Safe: Systemic Treatment Safety: Best Practice Drug Ordering

Figure 1: Percentage of outpatient intravenous systemic treatment visits supported by ST CPOE, 2004-2013



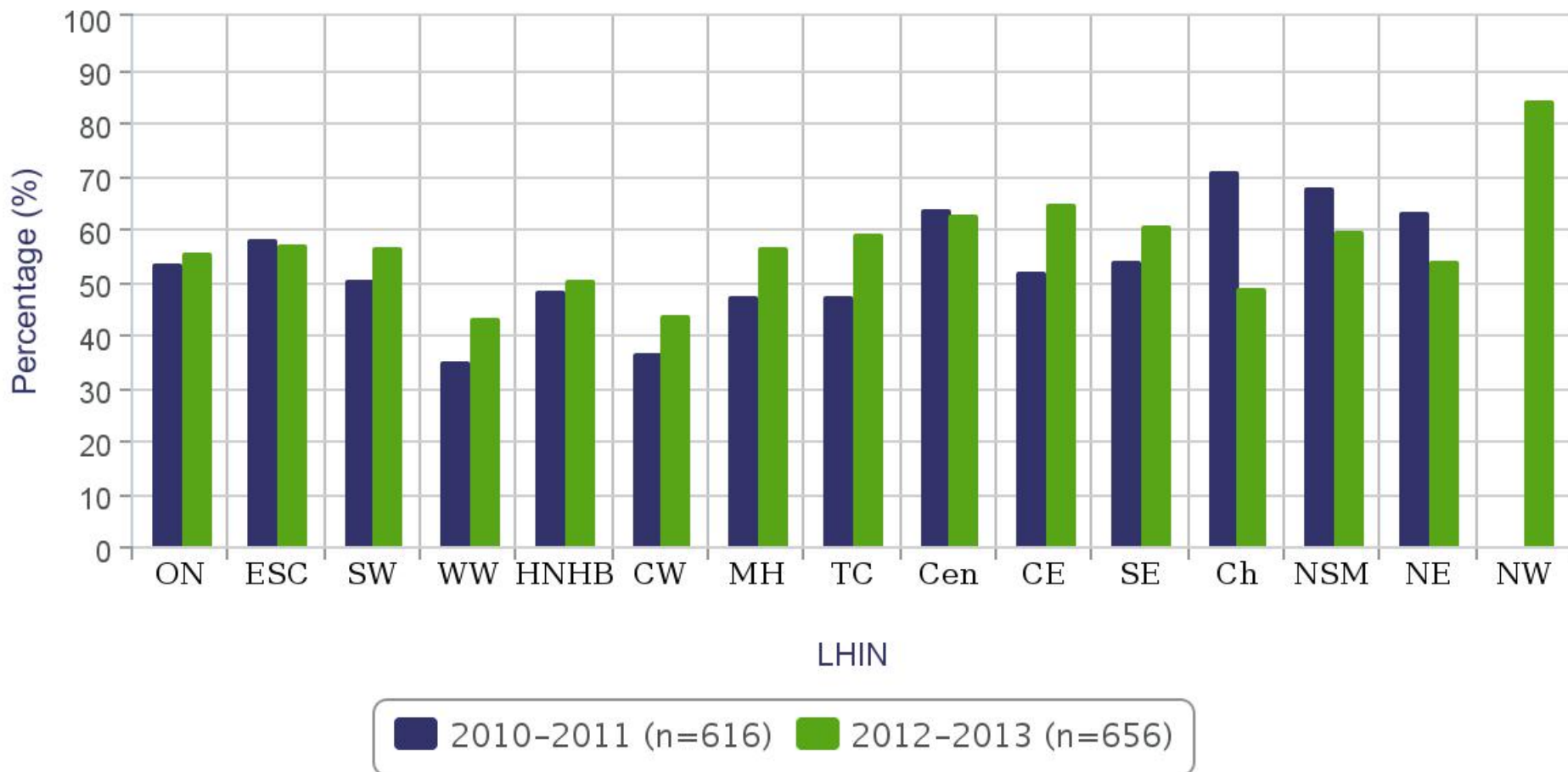
Report Date: January 2015

Source: NACRS – CIHI, Self-Reported CPOE Use

Prepared by: Analytics and Informatics, Cancer Care Ontario

Effective: Treating NSC Lung Cancer According to Guidelines

Figure 1: Percentage of resected Stage II or IIIA NSCLC patients treated with guideline-recommended adjuvant chemotherapy following surgery, by Local Health Integration Network (LHIN), 2010-2013



By geographic region (LHIN)

Report Date: January 2015

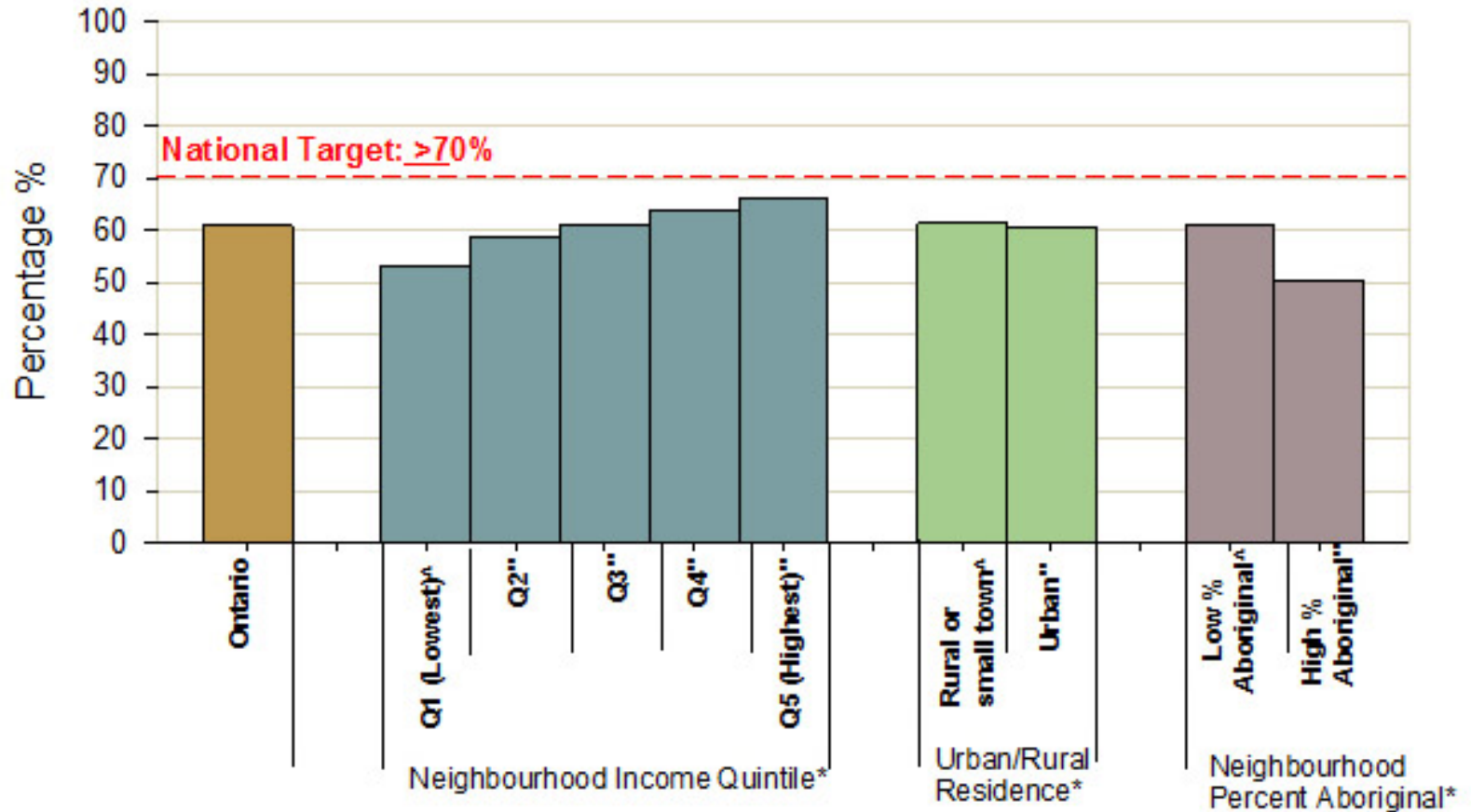
Source: OCR, ALR, DAD, NACRS, STAGE

Prepared by: Cancer Analytics, Cancer Care Ontario

Accessible:

Breast Cancer Screening Participation Rate

Age-adjusted percentage of Ontario women, 50-74 years old, who completed at least one mammogram within a two-year interval, by socio-demographic factor, 2010-2011

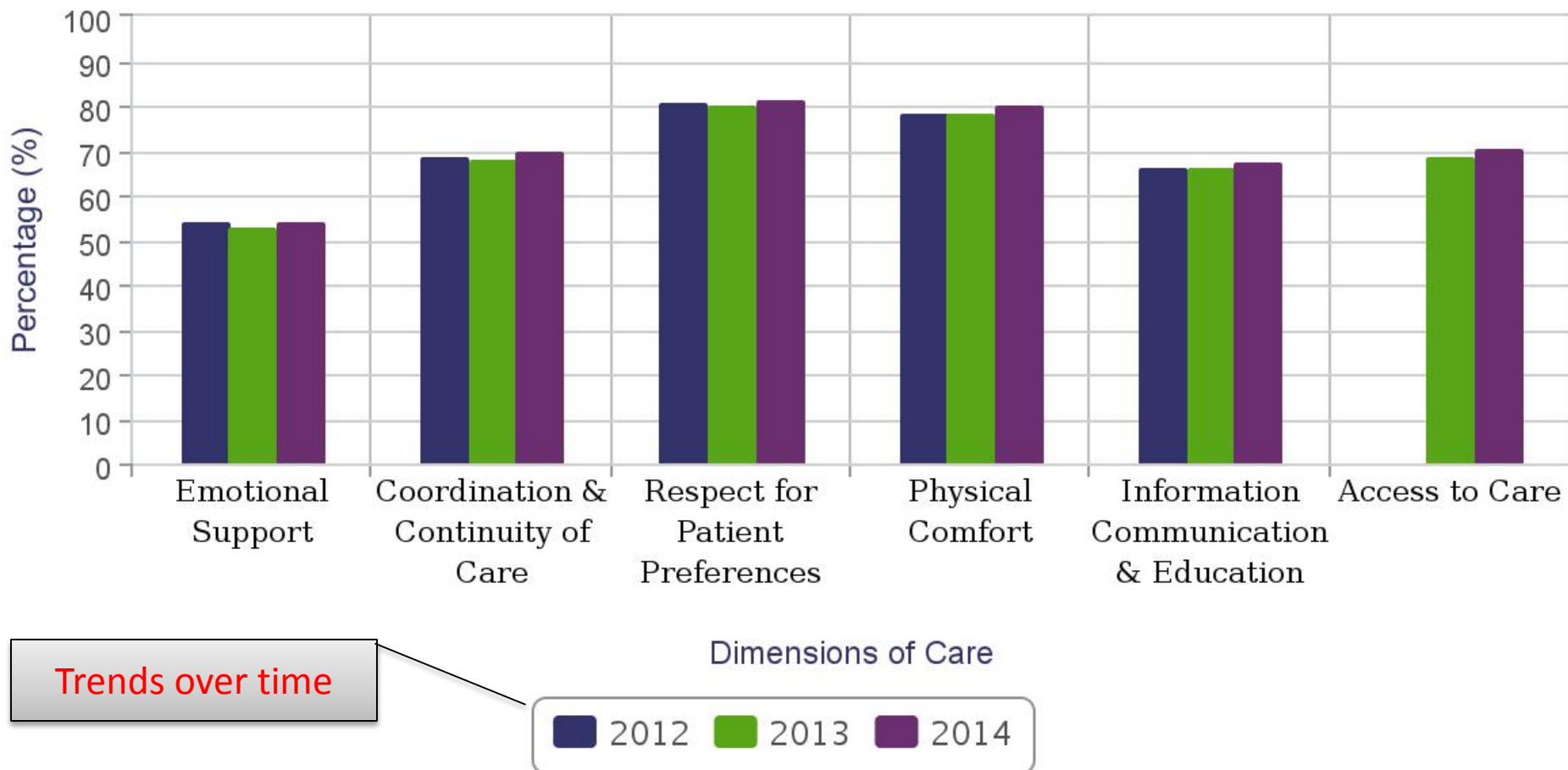


An 'equity' lens: Socio-demographic Factor

Responsive:

Patient Experience

Figure 1: Average cancer patient satisfaction scores for outpatient care, Ontario, 2012-2014



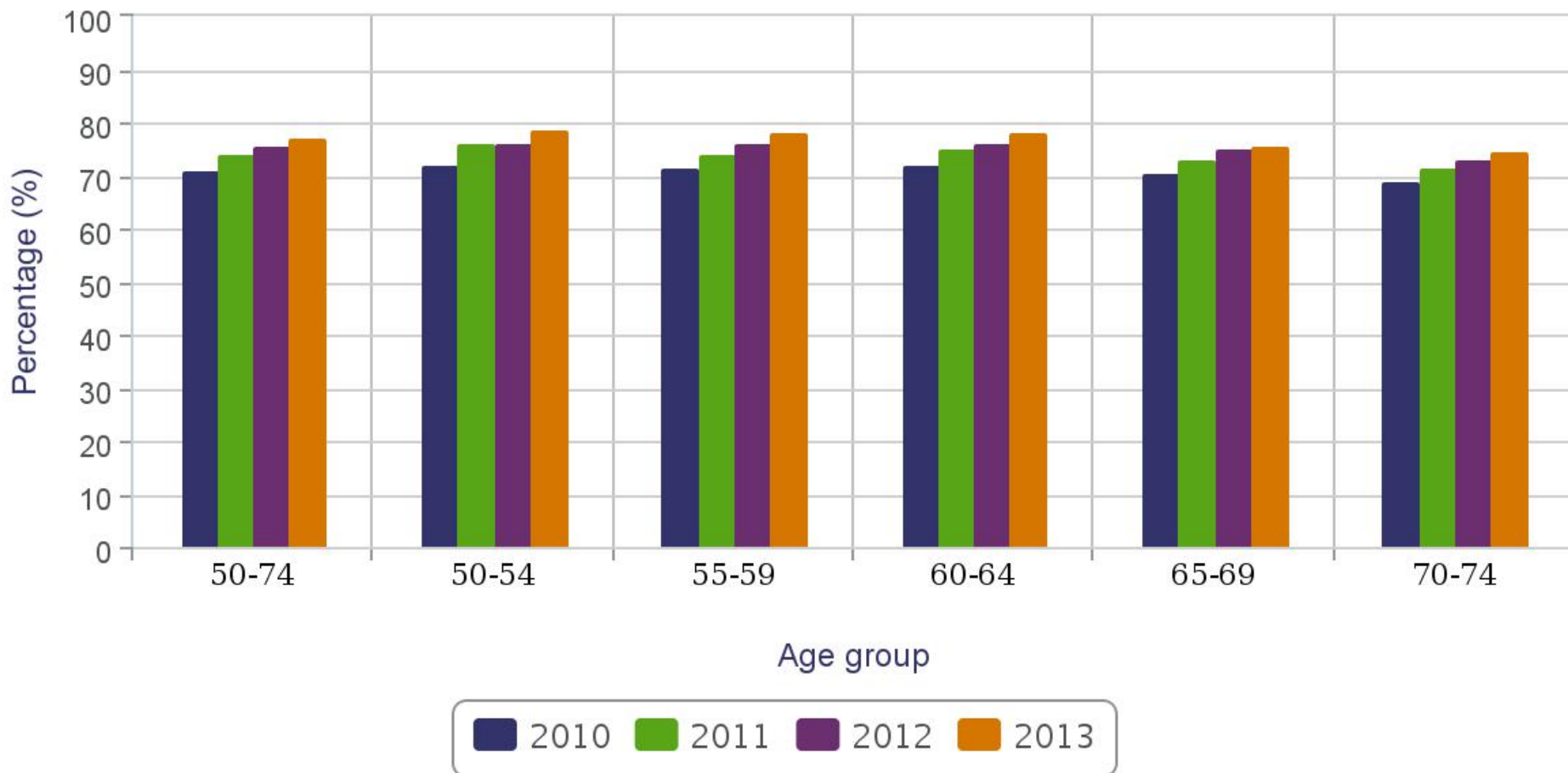
Report Date: February 2015

Source: Ambulatory Oncology Patient Satisfaction Survey (AOPSS)

Prepared by: Analytics and Informatics, Cancer Care Ontario

Equitable: Colorectal cancer screening follow-up rate

Figure 2: Percentage of Ontario screen-eligible individuals with an abnormal FOBT result aged 50-74 who underwent colonoscopy within six months of the abnormal screen date by age group 2010-2013



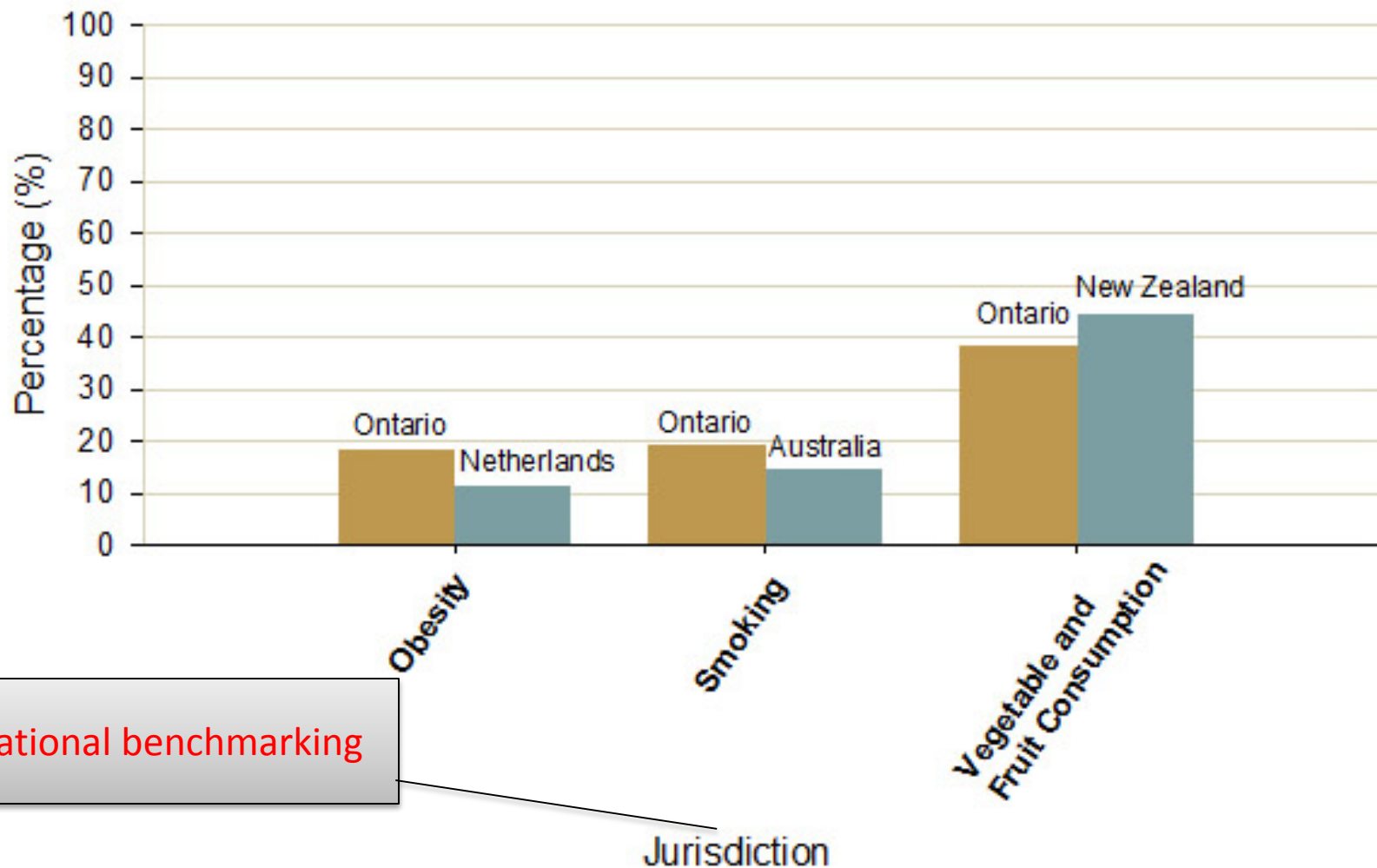
Report Date: February 2015

Source: OHIP CHDB, LRT, CIRT, OCR, RPDB, PCCF+ version 6A

Prepared by: Cancer Screening Evaluation and Reporting, Cancer Care Ontario

Modifiable Risk Factors

Percentage of Ontarians with select modifiable risk factors, compared to the best jurisdiction, 2011

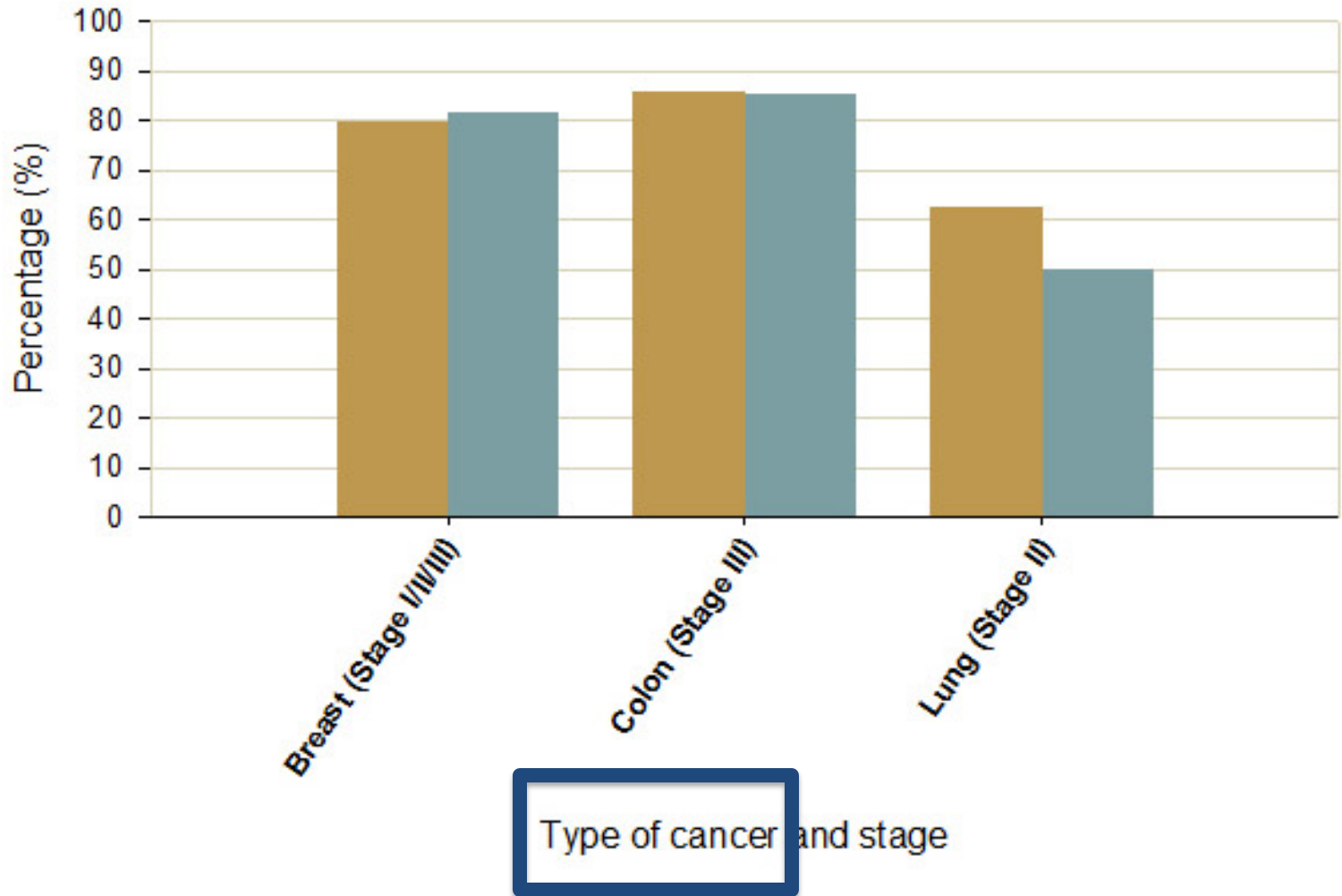


International benchmarking

Integrated:

Wait Time between Diagnosis and Adjuvant Chemotherapy

Percentage of patients who received adjuvant chemotherapy within 120 days of diagnosis, Ontario, for patients diagnosed in 2009 and 2010, by type of cancer and stage



Efficient Domain:

Optimally using resources to achieve desired outcomes

System is efficient if there is an appropriate use of resource allocation based on evidence across the cancer system and where there are no unnecessary treatments, diagnosis, screening or follow up tests based on evidence.

How are we doing?

Incomplete Data



There is a lack of meaningful measures to determine value for money for all services, while maintaining good health outcomes and seamless patient care.

E-mail me with your ideas or suggestions!

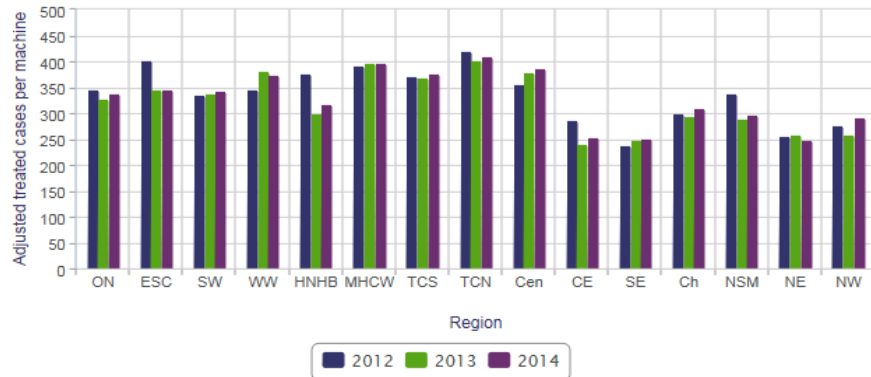
This is a challenging area to measure

craig.earle@ices.on.ca

Spotlight on: Radiation Equipment Utilization

Radiation Equipment Utilization

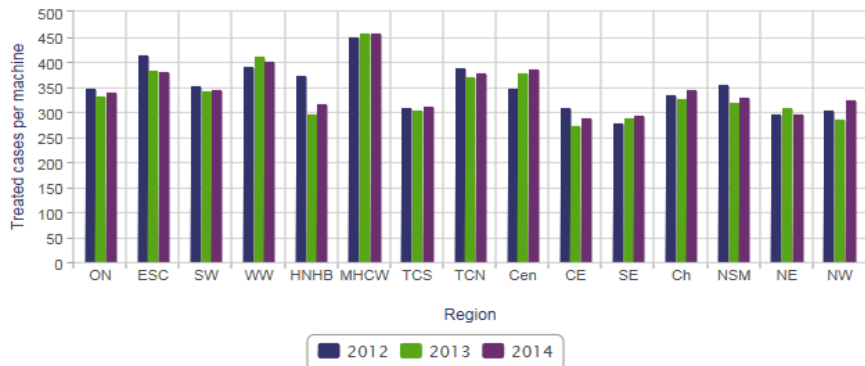
Figure 1: Adjusted treated cases (for complexity) per megavoltage machine, 2012, 2013 and 2014, by region



Report Date: January 2015
Source: ALR
Prepared by: Analytics and Informatics, Cancer Care Ontario

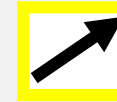
Radiation Equipment Utilization

Figure 2: Treated cases per megavoltage machine, 2012, 2013 and 2014, by region



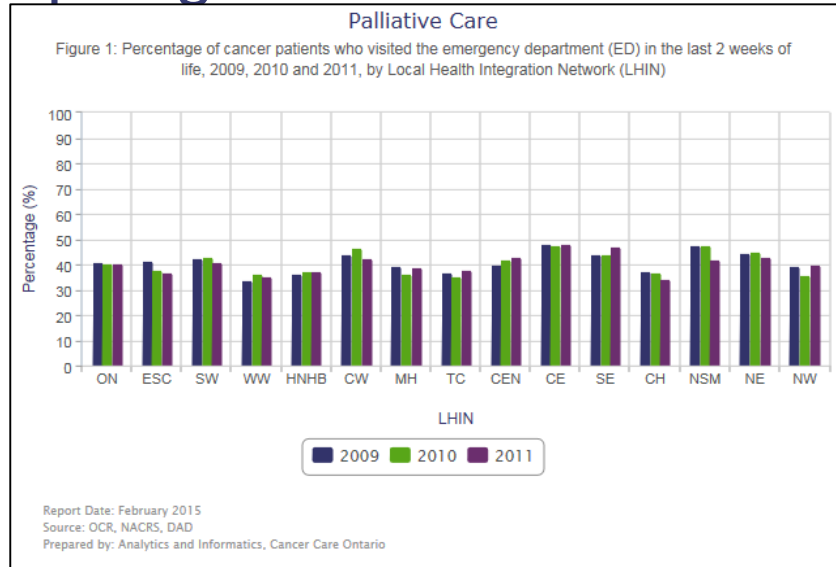
Report Date: January 2015
Source: ALR
Prepared by: Analytics and Informatics, Cancer Care Ontario

KEY FINDINGS

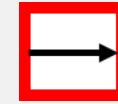


- Medical evidence has shown that not using radiation treatment when it is needed could lead to serious adverse outcomes, such as a higher chance of recurrence and reduced survival time.
- Highly efficient use of megavoltage machines will improve timely access to radiation and, in turn, signals whether the cancer system is making efficient and effective use of resources and capital investments. One factor in measuring utilization is the complexity of the case treated in a cancer centre.
- The efficient use of radiation treatment machines has increased slightly over the past year. Cancer centres' equipment utilization ranged from **252 to 394** patients treated per machine in 2014. This compares with a range of **212 to 351** for patients treated per machine but adjusted to incorporate the complexity of patients' cases.
- The measure is moving in the right direction.

Spotlight on: End-of-Life Care



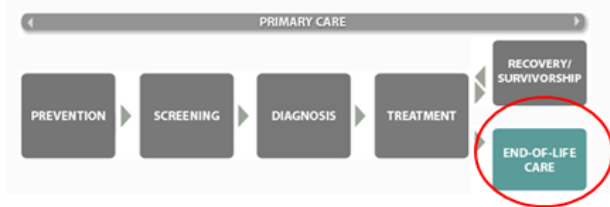
KEY FINDINGS



- The rates of **ED visits** for cancer patients in the last 2 weeks of life have continued to remain high with minimal regional variation ranging from **34% to 47%** indicating a reactive, rather a responsive approach to palliative care.
- Possible contributing factors include a lack of timely advanced care planning, a lack of physician or nurse practitioner care in their community and a lack of after hours support for these patients.
- Evidence suggests that there is a need for a better way to provide Palliative Care in Ontario as the current model is associated with sub-optimal outcomes for patients.
- Earlier access to palliative care services, at the point of diagnosis and of course, prioritizing also as patients near the end of life to ensure they and their families have the appropriate supports, to ensure patients are able to have their end-of-life experience in the location of their choice.

Image 1: Current understanding of palliative care in Ontario compared to future direction of palliative care

Previous understanding of palliative care was synonymous with end-of-life care:



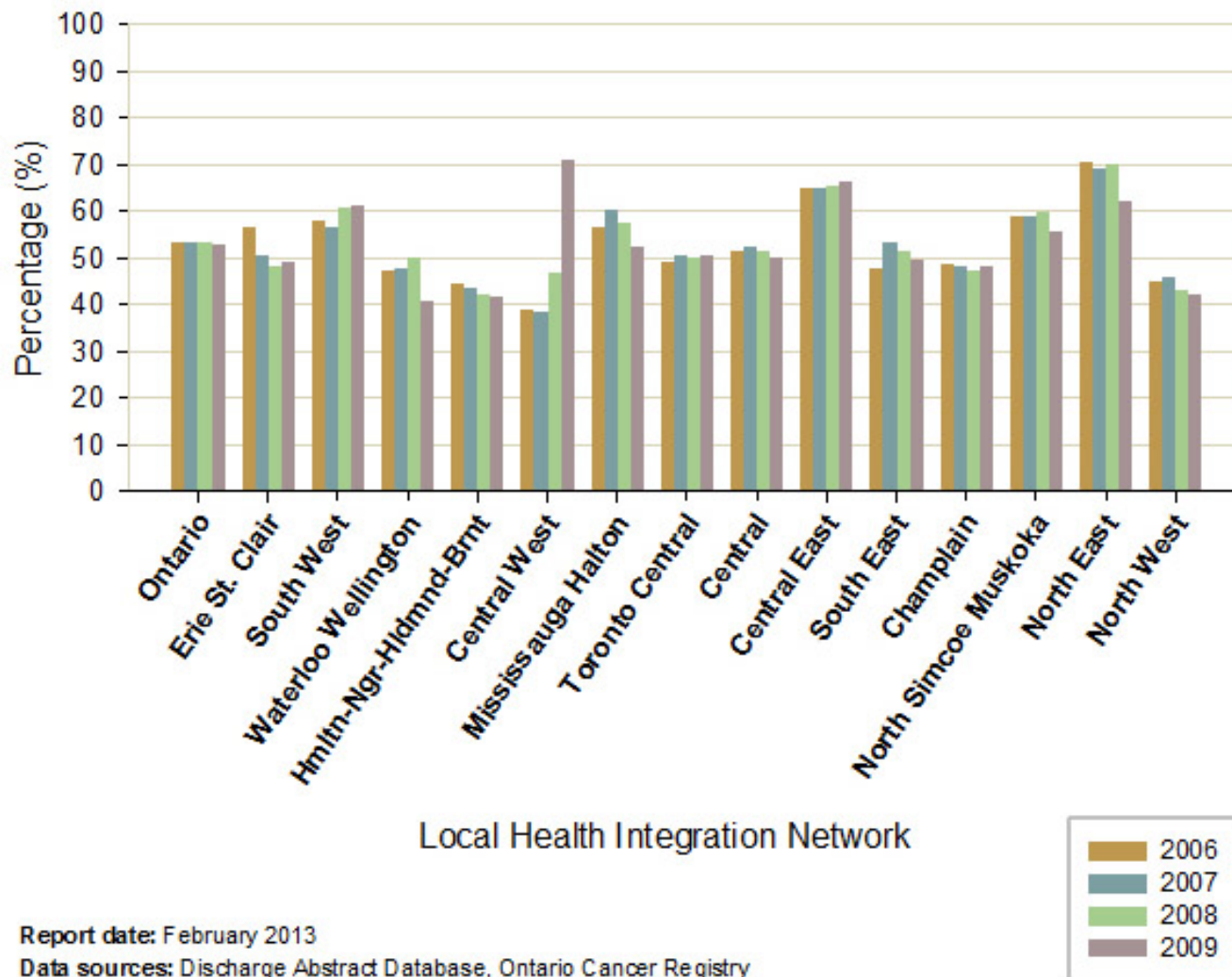
Future direction: palliative care is available to patients facing a serious illness



Efficient:

End-of-Life Care

Percentage of cancer patients who died in an acute care hospital, 2006, 2007, 2008 and 2009, by Local Health Integration Network (LHIN)



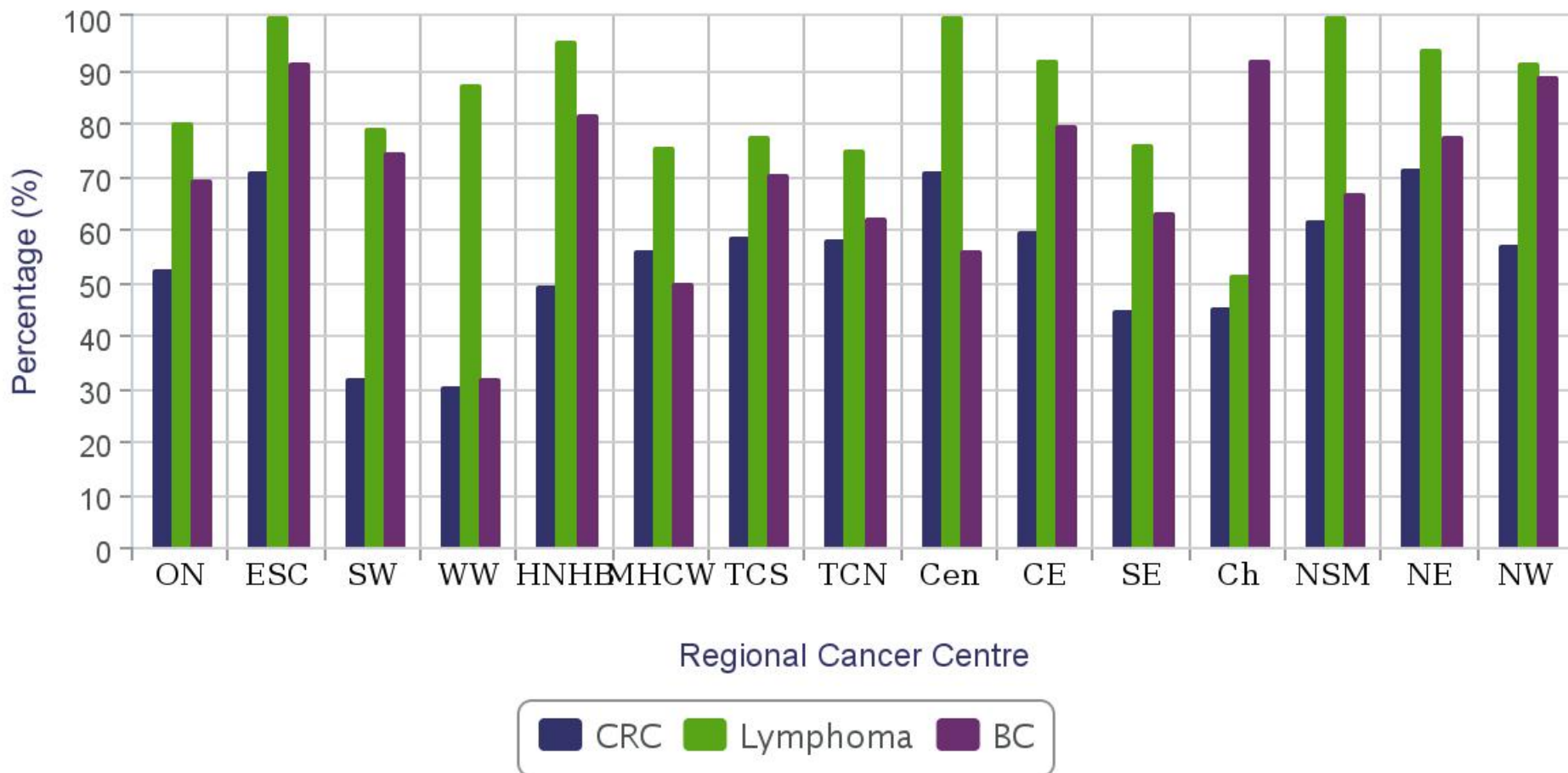
Report date: February 2013

Data sources: Discharge Abstract Database, Ontario Cancer Registry

Prepared by: Institute for Clinical Evaluative Sciences

Survivorship

Figure 6: Percentage of breast, colorectal cancer and aggressive NHL patients diagnosed in 2011 who received at least one routine follow-up from a specialist at an RCC in the first follow-up year (13–24 months from diagnosis), by RCC



Report Date: February 2015

Source: OCR, ALR, DAD, NACRS, OHIP, RPDB, CSI

Prepared by: Analytics and Informatics, Cancer Centre Ontario

Guiding principles and criteria for the selection of CSQI Indicators

Overall guiding principles for CSQI Indicators (i.e. basic expectation of measures)

Credibly measures quality at the level of the cancer system	Is important and/or relevant to stakeholders	Linked to mission of CCO: <i>To be the best cancer system in the world</i>	Has clear owner within CCO that will maintain accountability	Has a clear directionality	Has credible evidence basis	Meets data quality standards
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Criteria for CSQI Indicator selection (i.e. how to select one vs. another)

Strategically Increases the breadth of measurement across the CSQI quality framework	Can be used to describe outcomes from a patient perspective and/or as a "big dot" indicator	Helps shape the message of each quality dimension and aligns with their definitions	Aligns with disease site focus	Has evidence of an existing target, benchmark and/or comparison (CCO, national and international)	Can be collected feasibly, for a reasonable cost and on a timely basis
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	Safe	Effective	Accessible	Responsive	Equitable	Integrated	Efficient
Prevention	Occupation and environment	MRFs: <i>Healthy weights, Healthy eating, Active living report, tobacco & alcohol</i> <u>See Modifiable Risk Factors in the Métis People of Ontario</u>	CSQI 2015 Quality Framework		Modifiable Risk Factors (by SES) Occupation and environment (by geography) Modifiable Risk Factors – MNO Report	Returning from 2014 New for 2015 Indicators for rotation Retired indicators	
Screening	Quality of screening (breast) <u>Perforation rates (colorectal)</u>	Follow-up abnormal results (Breast, Cervical, CRC) <u>Screening for high risk population (breast)</u>	Screening Participation (Breast, Cervical, CRC) FOBT only	Retention rates (Breast, Cervical, CRC)	All screening <u>by age</u> : <i>Quality of Screening Follow Up Abnormal Results</i> <i>Participation rates</i> <i>Retention rates</i> <i>Integrated screening</i>	Integrated cancer screening participation <u>Primary care and screening</u>	
Diagnosis		Reporting of Cancer Stage at Diagnosis (Stage capture)	Point-in Time Waits for PET Turnaround times for pathology (All sites) Wait times for DAP (Lung/Thoracic)	Patient Experience with DAP	Access to PET by geography Access to DAP by geography		
Treatment	Unplanned hospital visits after chemo (breast/colon lymphoma)	Treating NSC Lung and Colon Cancer by guidelines MCCs	WT for cancer surgery (<u>wait 1</u> and wait 2)	Patient experience (satisfaction) with outpatient care plus composite	See <u>Unplanned hospital visits after Chemo</u> (age, income) See <u>Treating NSCLC by Guidelines</u> (by age)	WT from diagnosis to chemo (lymphoma, breast, colon, lung)	Radiation Equipment Utilization
	Systemic Treatment Safety Best Practice Drug Ordering (CPOE)	Radiation utilization- Breast, Prostate, Lung and Rectal	See <u>integration for integrated waits</u>	Symptom assessment (and symptom management)	See <u>Treating Colon by Guidelines</u> (age, income)	WT Surgery to chemo interval (colon)	
	Unplanned ED visits after radiation (oropharynx)	IMRT <u>Head and Neck Centres</u>	<u>Access to Stem Cell Transplant</u> <u>(Wait times from apheresis to transplant)</u>	ESAS Symptom Severity (all and Lymphoma)	See <u>RT Utilization</u> (by geography – see map) See <u>WT from Diagnosis to Chemo</u> (age)	Integrated WT for RT (oropharynx)	
	Appropriate peer review (radiation) ALL Diseases <u>Unplanned hospital visits after lung/thoracic surgery</u>	<u>Gynecology Oncology Centres</u>	<u>Mortality 100 days after stem cell treatment</u>	<u>Perception of pain management (AOPSS)</u>	See <u>WT Surgery to Chemo</u> (age)		
Recovery		Utilization of mammography by breast cancer follow-up patients Concordance with CRC survivorship guidelines		Symptom Screening in Recovery Care [ESAS one year (and two years) after primary treatment]			Breast & CRC survivors routine visit to Primary Care & RCCs in first year of follow-up
End-of-life care		<i>Referrals to CCAC</i> <i>Median Time between CCAC referral and death</i> <i>First house call in last 4 wks of life</i>			See <u>End of Life Care</u> ED visits in last 2 weeks of life (income)	<i>Patients connected to palliative care prior to death</i> <i>Palliative assessment in the last 2 wks of life</i>	End of Life Care (In hospital death, ICU admission, LOS, ED visits in last 2 wks) <i>Place of death</i>

New efficiency measures

New for 2016:

- Screening: over/under utilization in breast, colon, and cervix screening
- Screening: in patients with advanced cancer (Choosing Wisely)
- Diagnosis: Overuse of staging tests in early breast cancer (Choosing Wisely)
- Diagnosis: Gallium scanning in lymphoma (data capture issues with PET)

Being considered/developed for beyond 2016:

- Diagnosis: Overuse of staging tests in early prostate cancer (Choosing Wisely)
- Treatment: ROI for radiation machines
- Treatment: Chemotherapy chair efficiency
- Treatment: Funding model (bundled payments to centres) effects (evidence-informed treatment, care close to home...)
- Other Choosing Wisely: surveillance intensity, early palliative care

- Overarching: Regional variation in costs of care, by phase of cancer journey

SYMPTOM REPORTING

Background:

Ontario Cancer Symptom Management Collaborative

- Since 2007 cancer centers in Ontario have been systematically collecting
 - Edmonton Symptom Assessment System (ESAS) scores
 - Palliative Performance Scale (PPS) scores
 - ⇒ ECOG PS since 2014
- Goal is to improve symptom screening and assessment, symptom control and coordinated palliative support

Edmonton Symptom Assessment System

Please circle the number that best describes:

No pain 0 1 2 3 4 5 6 7 8 9 10 Worst possible pain

Not tired 0 1 2 3 4 5 6 7 8 9 10 Worst possible
tiredness

Not nauseated 0 1 2 3 4 5 6 7 8 9 10 Worst possible nausea

Not depressed 0 1 2 3 4 5 6 7 8 9 10 Worst possible
depression

Not anxious 0 1 2 3 4 5 6 7 8 9 10 Worst possible anxiety

Not drowsy 0 1 2 3 4 5 6 7 8 9 10 Worst possible
drowsiness

Best appetite 0 1 2 3 4 5 6 7 8 9 10 Worst possible appetite

Best feeling of 0 1 2 3 4 5 6 7 8 9 10 Worst possible feeling
wellbeing of wellbeing

No shortness of 0 1 2 3 4 5 6 7 8 9 10 Worst possible
breath shortness of breath

Other problem 0 1 2 3 4 5 6 7 8 9 10

Symptom screening kiosks



The screenshot shows the ISAAC (International Symptom Assessment) interface. At the top right, the text "ISAAC" is displayed. Below it, a "Quit" button is visible. The main instruction reads: "Please select the number that best describes the symptom **pain**".

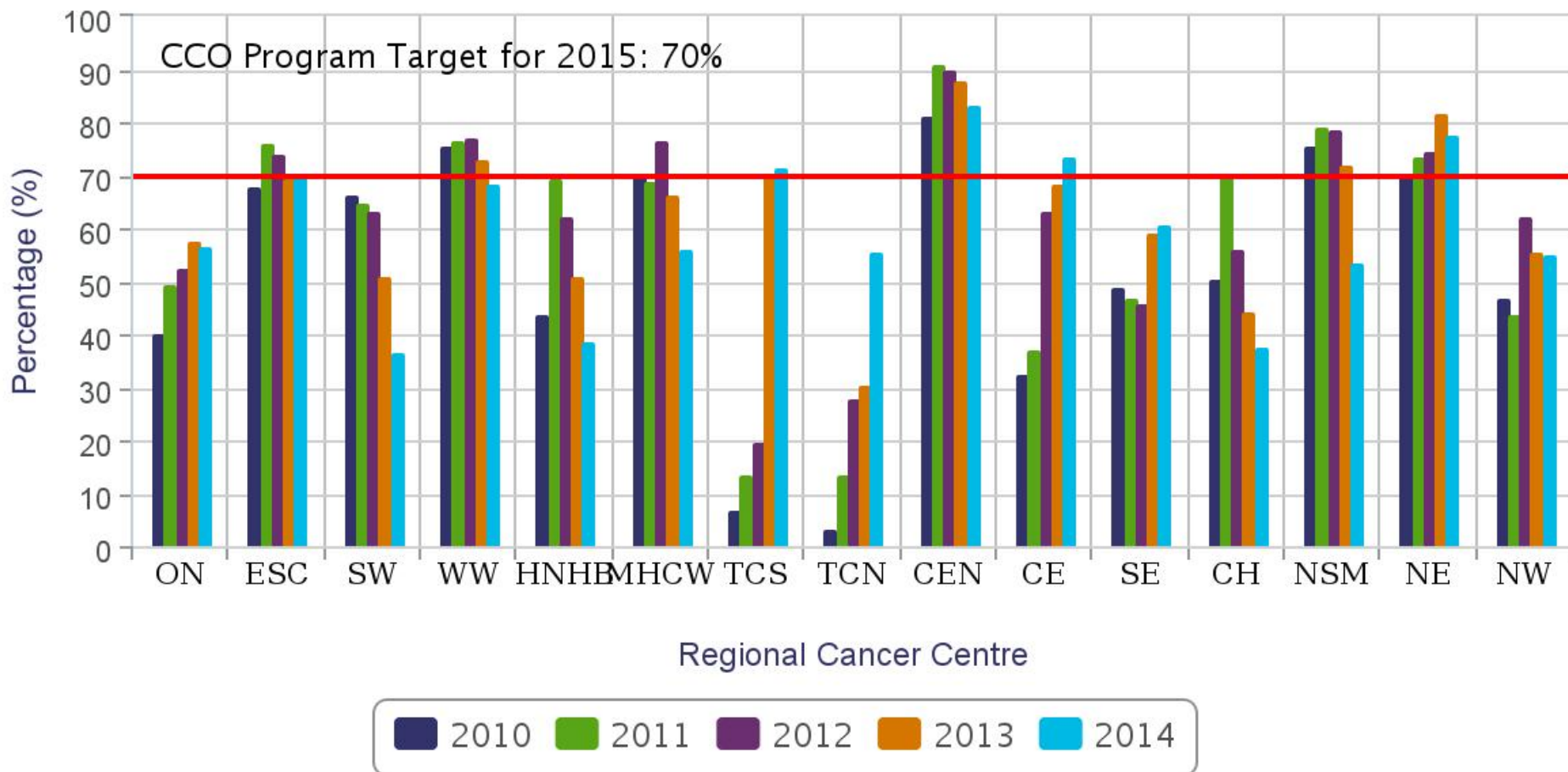
A horizontal row of ten circular buttons, numbered 0 through 10, is shown. The button for "1" is highlighted in red, while the others are grey. Below this row, there are two labels: "No pain" on the left and "Worst possible pain" on the right. A light blue horizontal bar is positioned below these labels.

At the bottom of the interface, there are two navigation buttons: "Go Back" with a left-pointing arrow and "Continue" with a right-pointing arrow.

In the bottom left corner, the logos for "cancer care ontario" and "action cancer ontario" are displayed. In the bottom right corner, the text "ESAS" is visible.

ESAS Indicator Rate (All Disease Sites)

Figure 1: Percentage of cancer patients who were screened at least once per month for symptom severity, all Ontario, 2010-2014



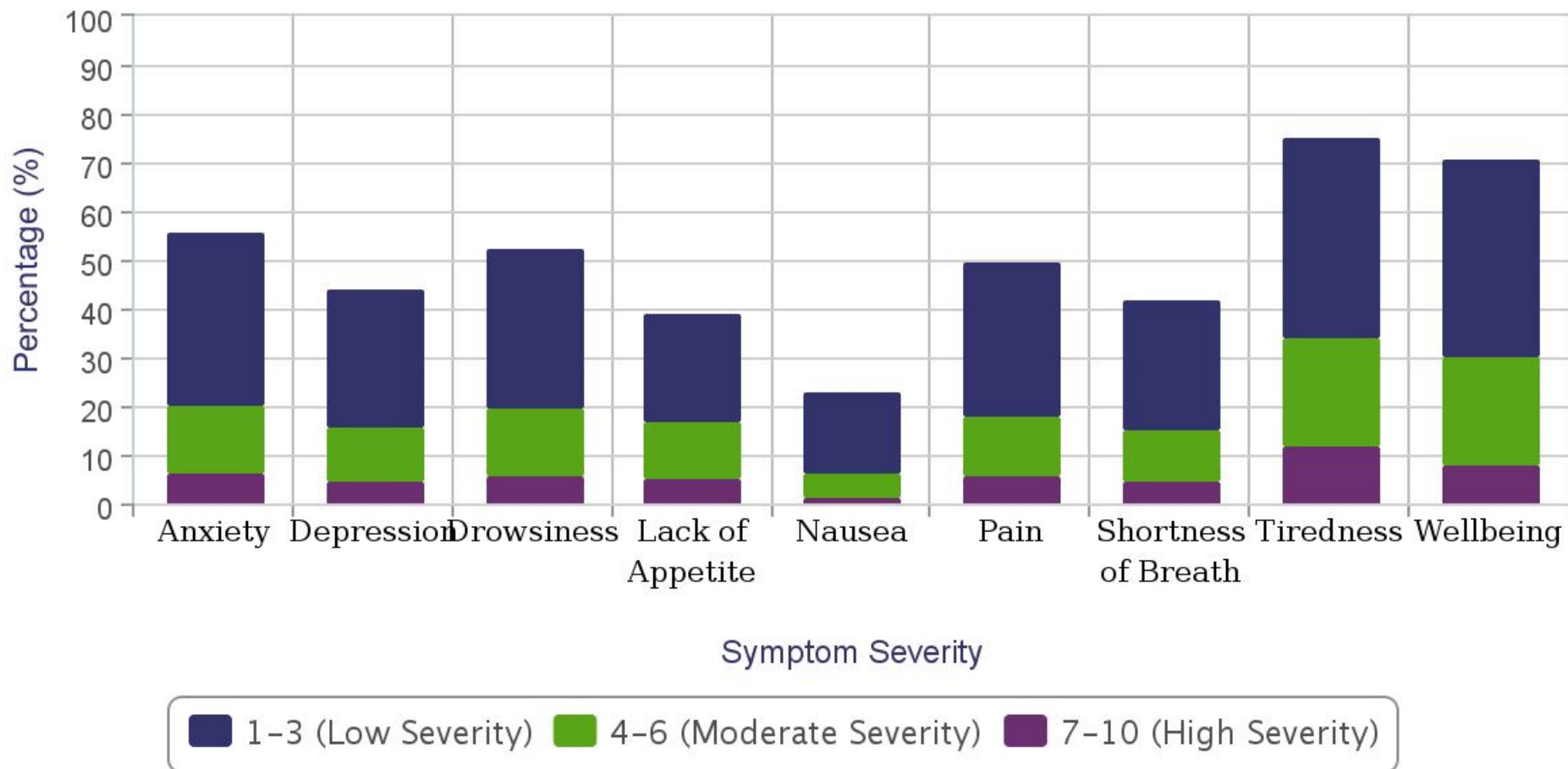
Report Date: January 2015

Source: Ontario Cancer Symptom Management Reporting Database, Activity Level Reporting

Prepared by: Cancer Analytics, Cancer Care Ontario

ESAS Symptom Severity- All Cancers

Figure 4: Symptom severity for patients with all types of cancer, all Ontario, January 2014–December 2014



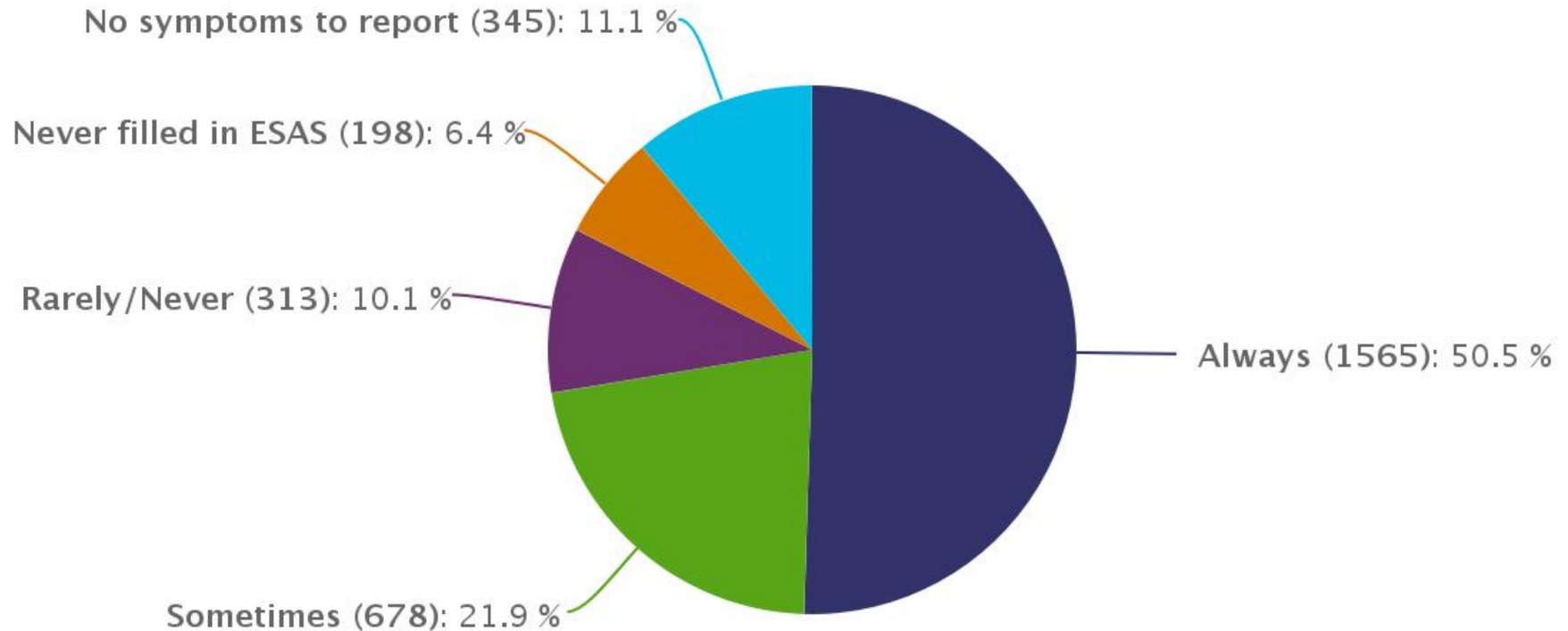
Report Date: February 2015

Source: Ontario Cancer Symptom Management Reporting Database, Activity Level Reporting

Prepared by: Analytics and Informatics, Cancer Care Ontario

Patient Experience with Symptom Management

Figure 5: [Theme: communication] Percentage of patients who report that their health care team talked to them about symptoms on their ESAS that concern them, all Ontario, January 2015



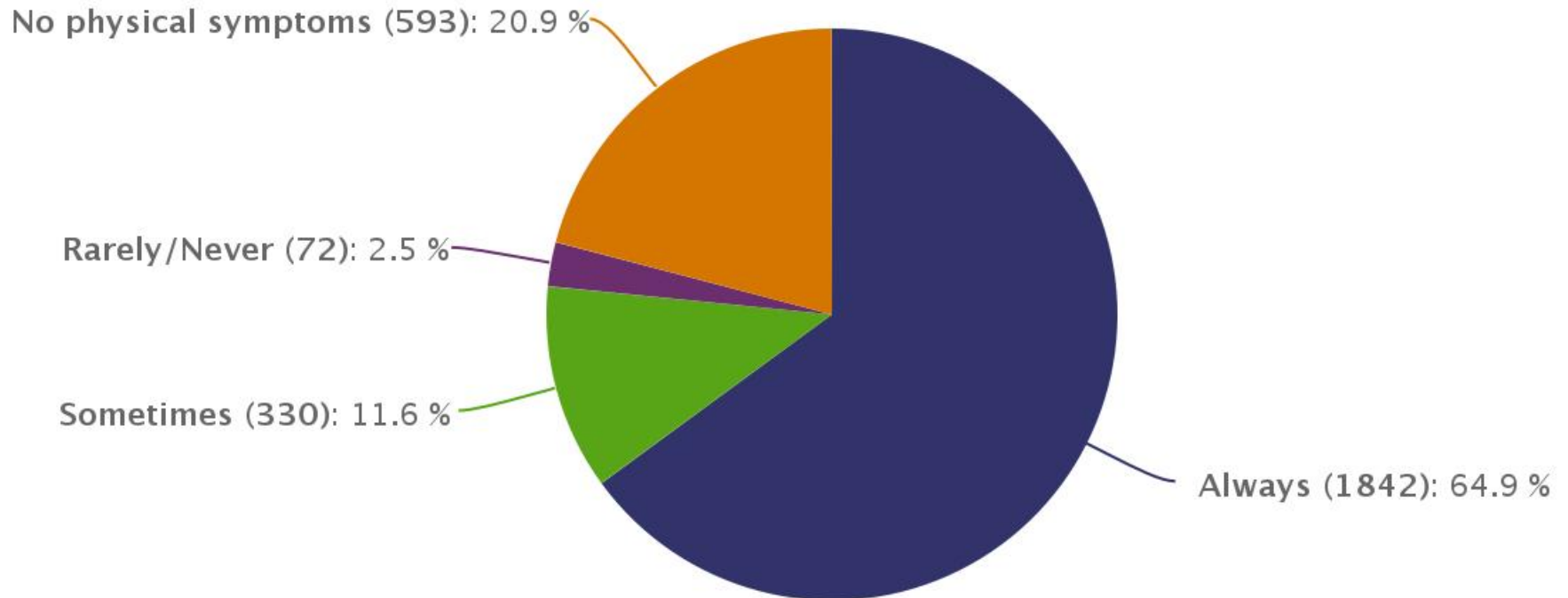
Report Date: February 2015

Source: Symptom Management Patient Experience Survey

Prepared by: Cancer Care Ontario

Patient Experience with Symptom Management

Figure 7: [Theme: response to symptoms] Percentage of patients who report that their health care team treats/manages their physical symptoms, all Ontario, January 2015



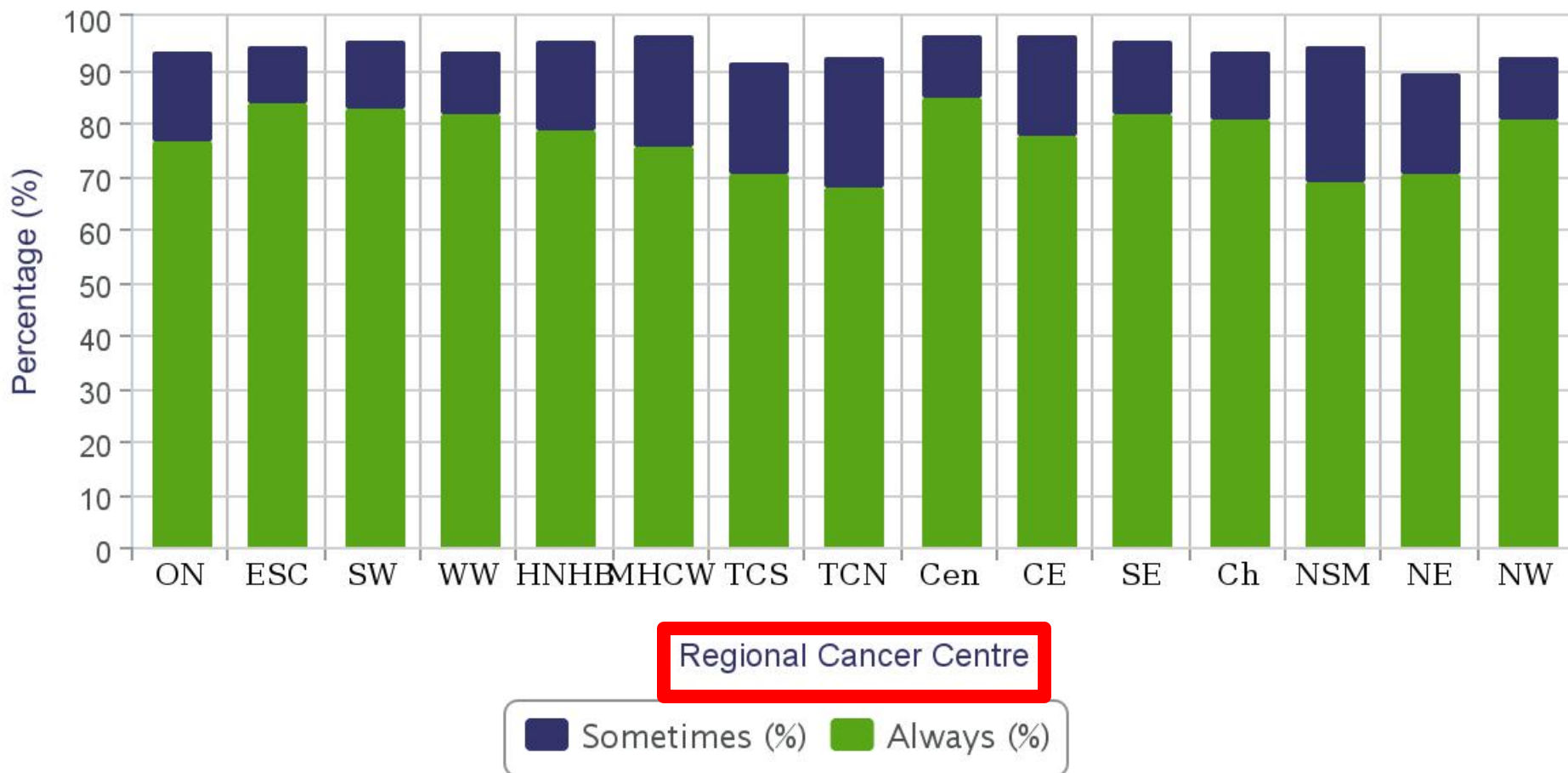
Report Date: February 2015

Source: Symptom Management Patient Experience Survey

Prepared by: Cancer Care Ontario

Patient Experience with Symptom Management

Figure 10: [Theme: response to symptoms] Percentage of patients (adjusted) who report that their health care team responds to their worries, concerns or feelings of sadness, January 2015, by RCC



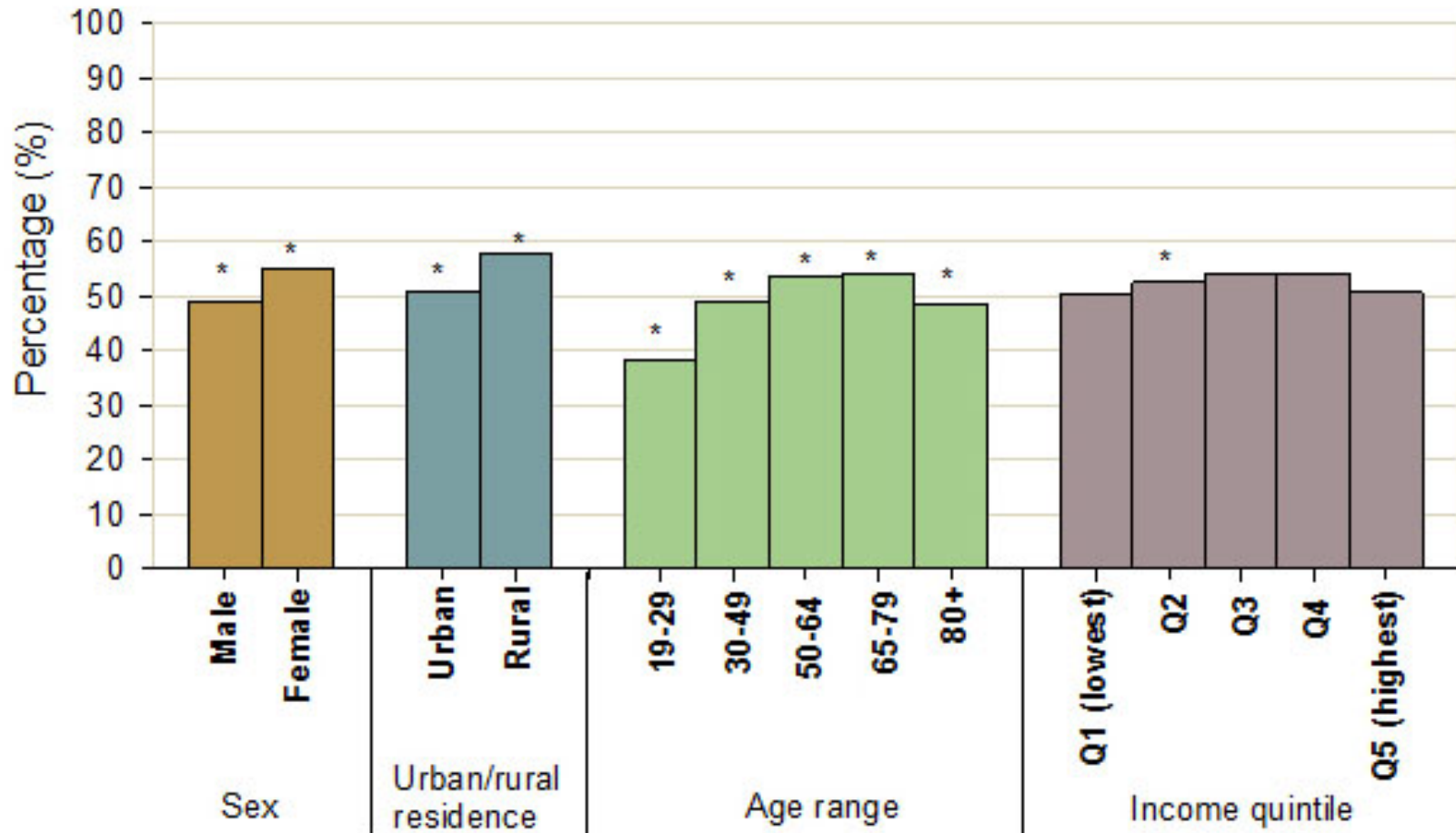
Report Date: February 2015

Source: Symptom Management Patient Experience Survey

Prepared by: Cancer Care Ontario

Symptom Assessment and Management

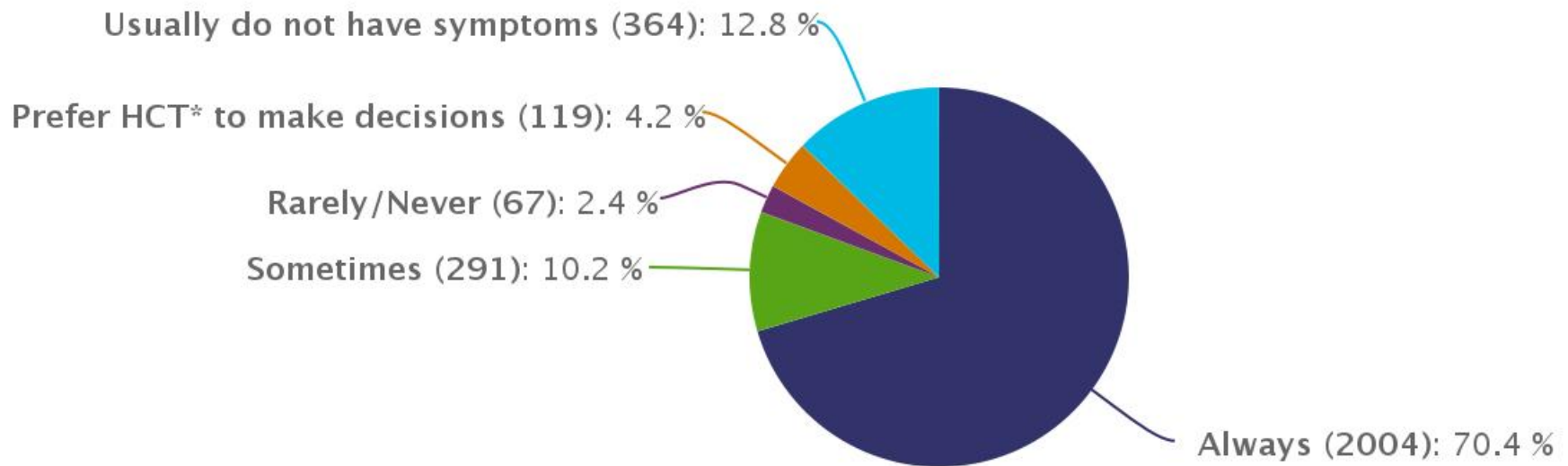
Percentage of patients who were screened at least once per month for symptom severity, 2012, by sex, residence, age and income



Sociodemographic factors

Patient Experience with Symptom Management

Figure 11: [Theme: shared decision-making] Percentage of patients who report that their health care team includes them in decisions about how to treat/manage their symptoms, all Ontario, January 2015



Report Date: February 2015

Source: Symptom Management Patient Experience Survey

Prepared by: Cancer Care Ontario

PHYSICIAN-LEVEL REPORTING

Surgical Pathology Quality Indicators



Evidence-Based Series 17-4 IN REVIEW

Optimization of Surgical and Pathological Quality Performance in Radical Surgery for Colon and Rectal Cancer: Margins and Lymph Nodes

*A.J. Smith, D.K. Driman, K. Spithoff, R. McLeod, A. Hunter, R.B. Rumble, B. Langer,
and the Expert Panel on Colon and Rectal Cancer Surgery and Pathology*

A Quality Initiative of Cancer Care Ontario (CCO)'s
Program in Evidence-Based Care (PEBC) and CCO's Surgical Oncology Program (SOP).
Developed by the Expert Panel on Colon and Rectal Cancer Surgery and Pathology

Report Date: April 17, 2008



Evidence-Based Series #17-3

Guideline for Optimization of Surgical and Pathological Quality Performance for Radical Prostatectomy in Prostate Cancer Management

*J. Chin, J. Srigley, L.A. Mayhew, R.B. Rumble, C. Crossley, A. Hunter,
N. Fleshner, B. Bora, R. McLeod, S. McNair, B. Langer, A. Evans,
and the Expert Panel on Prostate Cancer Surgery and Pathology*

A Quality Initiative of the Surgical Oncology Program, Cancer Care Ontario
and the Program in Evidence-based Care, Cancer Care Ontario
A Special Project of the Expert Panel on Prostate Cancer Surgery and Pathology

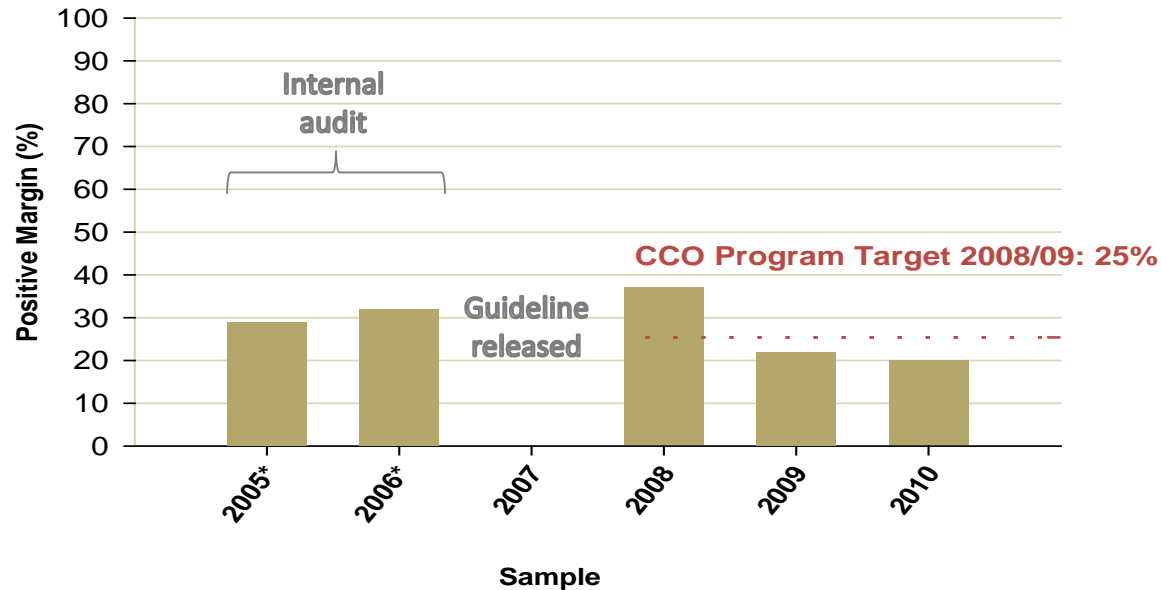
Report Date: September 11, 2008

A Quality Improvement Example:

Cancer Care Ontario's Performance Improvement Cycle in Action

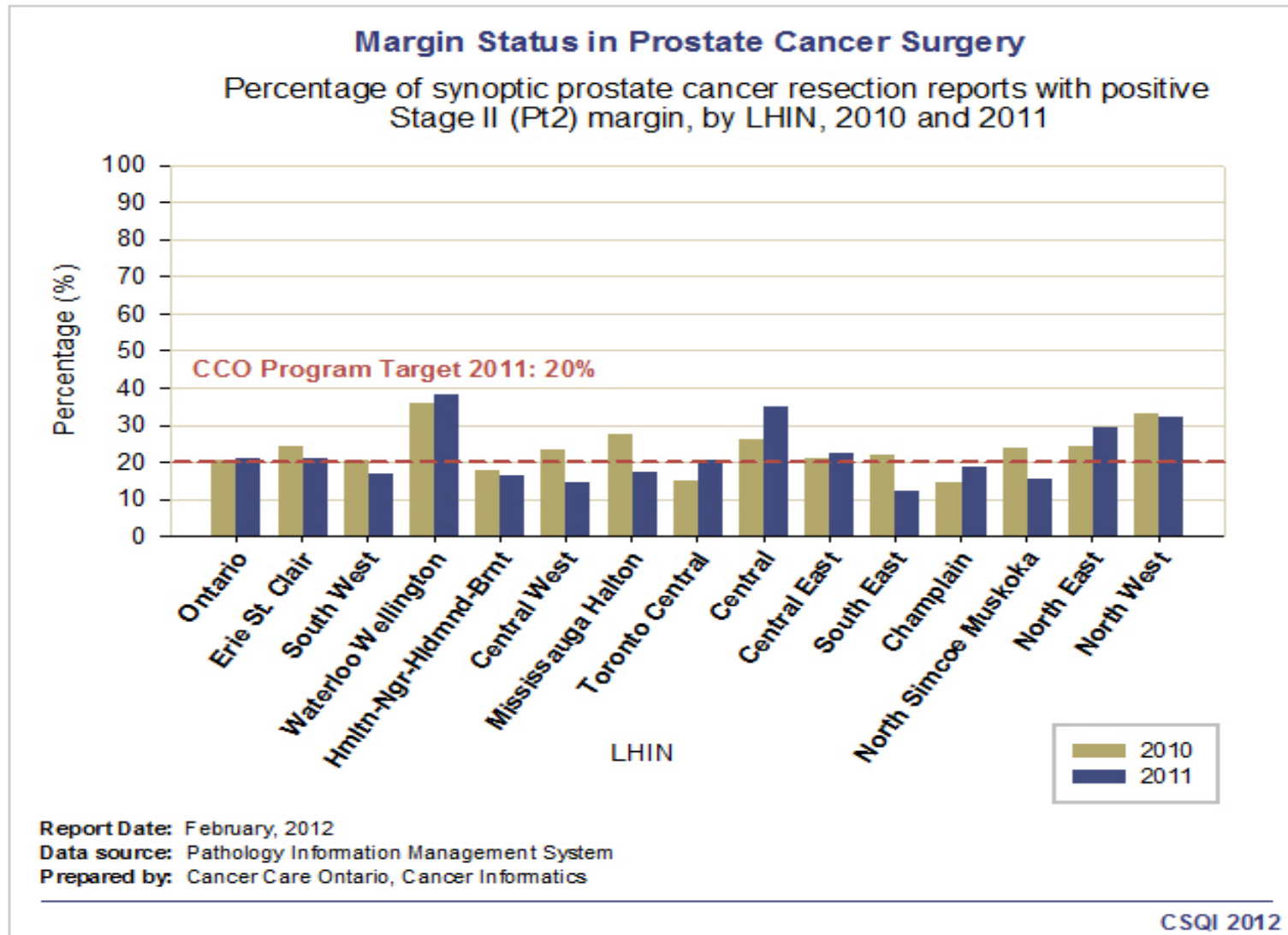
Radical Prostatectomies

% Positive surgical margin (PSM) rate for Radical Prostatectomies for pT2 patients in Ontario



Data Sources : *Y2005-2006 - CCO Pathology Audits; Y2008-2010 PIMS, ePATH
Prepared by: Cancer Care Ontario, Informatics

Public Reporting – focus on regional variation



Physician-level quality audit

PURPOSE

- To improve the quality of prostate and colorectal cancer surgery and pathology with regards to sharing individual level data in a **non-punitive culture**
- To assess the process and impact of providing timely, physician-level quality indicator reports via regional clinical leaders

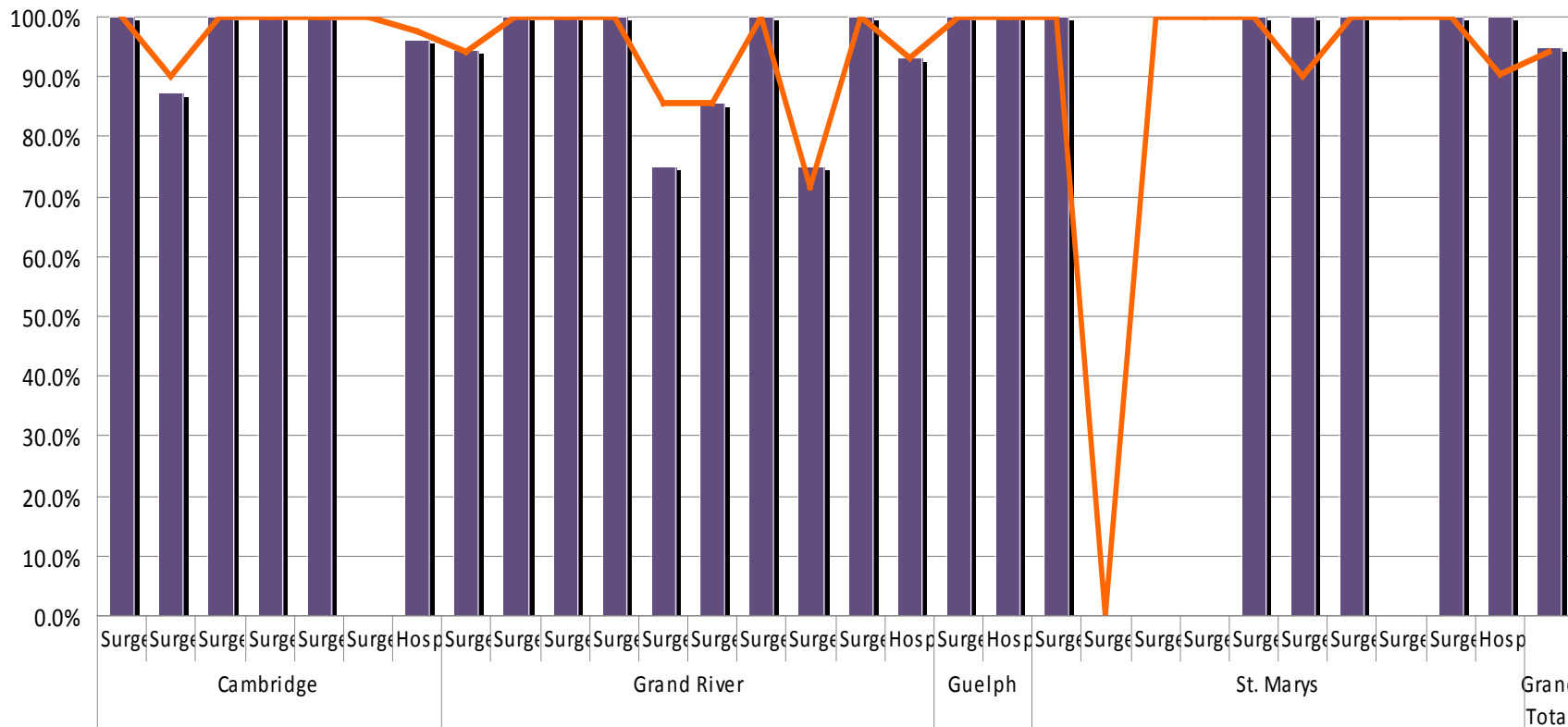
OBJECTIVES

- Develop & test process (including logistics, legal, privacy)
- Identify /address the operational resources (provincial, regional)
- Identify / address clinical issues (data validation)
- Understand physician response to the Project, (acceptance of data and receptiveness to the principles of quality assurance)
- Determine impacts on practice

Percent of Discrete Synoptic Colon cancer resection reports with 12 or more nodes examined for all live LHIN 3 Reporting Hospitals in Q3/Q4 for fiscal year 2009/2010

Surgeons

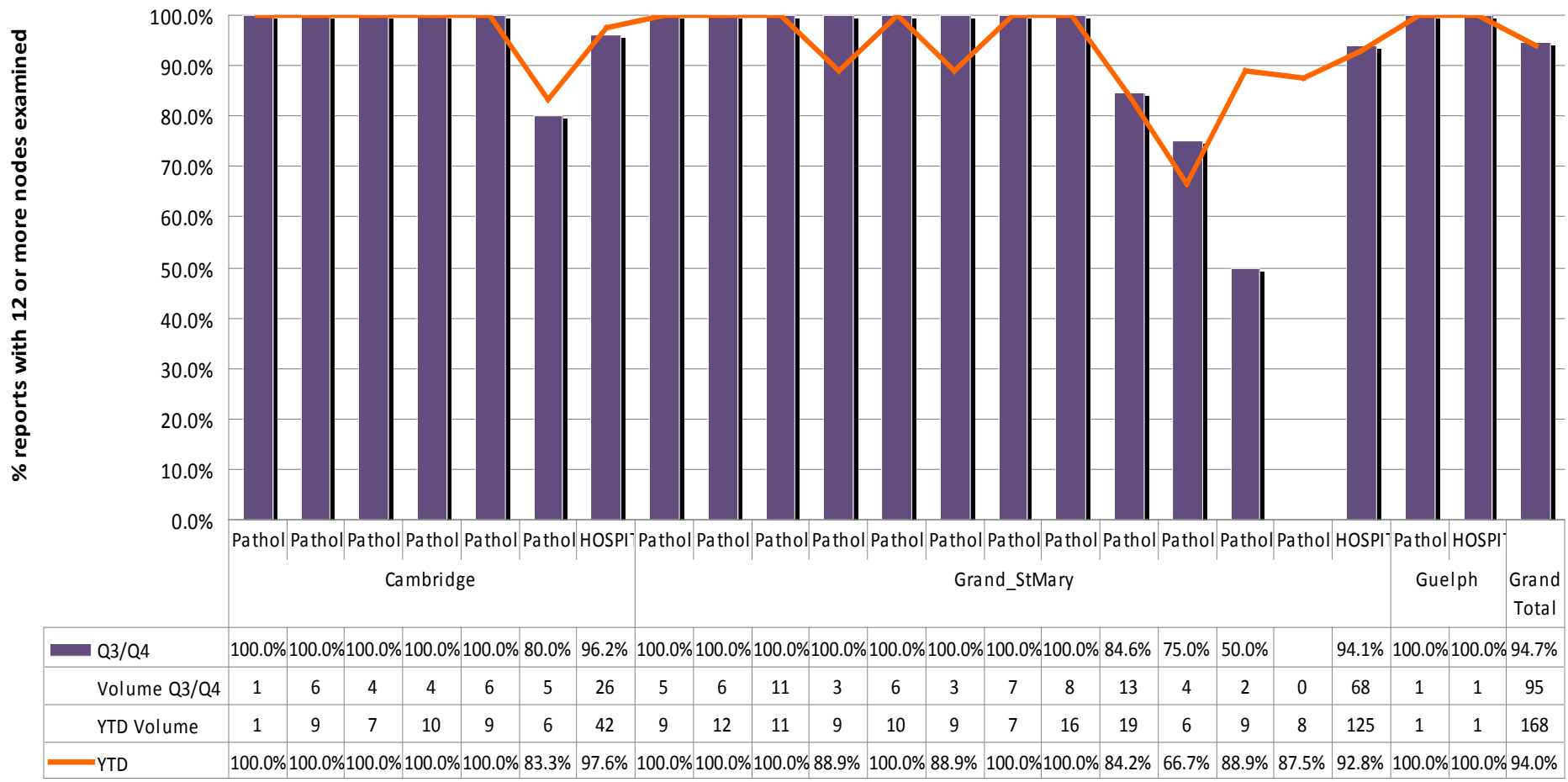
% reports with 12 or more nodes examined



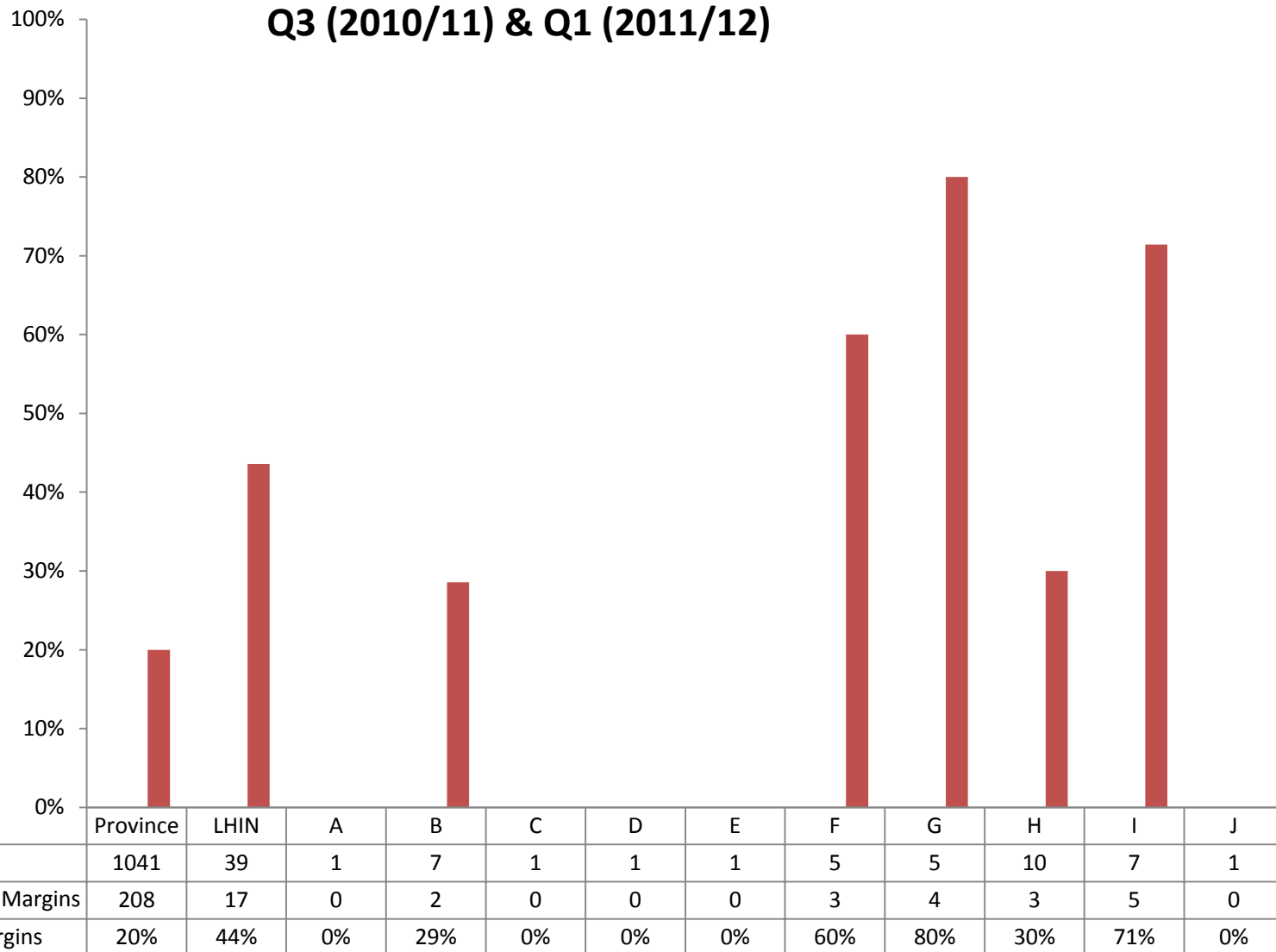
Q3/Q4	100.0	87.5	100.0	100.0	100.0		96.2	94.4	100.0	100.0	100.0	75.0	85.7	100.0	75.0	100.0	93.1	100.0	100.0	100.0				100.0	100.0	100.0		100.0	100.0	94.7
Volume Q3/Q4	5	8	5	5	3	0	26	18	7	3	9	4	7	2	4	4	58	1	1	1	0	0	0	2	5	1	0	1	10	95
YTD Volume	8	10	9	8	6	1	42	35	8	7	16	7	14	4	7	6	104	1	1	1	1	3	1	2	10	1	1	1	21	168
YTD	100.0	90.0	100.0	100.0	100.0	100.0	97.6	94.3	100.0	100.0	100.0	85.7	85.7	100.0	71.4	100.0	93.3	100.0	100.0	100.0	0.0%	100.0	100.0	100.0	90.0	100.0	100.0	100.0	90.5	94.0

Pathologists

Percent of Discrete Synoptic Colon cancer resection reports with 12 or more nodes examined for all live LHIN 3 Reporting Hospitals in Q3/Q4 for fiscal year 2009/2010



Percent of pT2 Prostate Cases with Positive Margins LHIN 3 Surgeons Q3 (2010/11) & Q1 (2011/12)

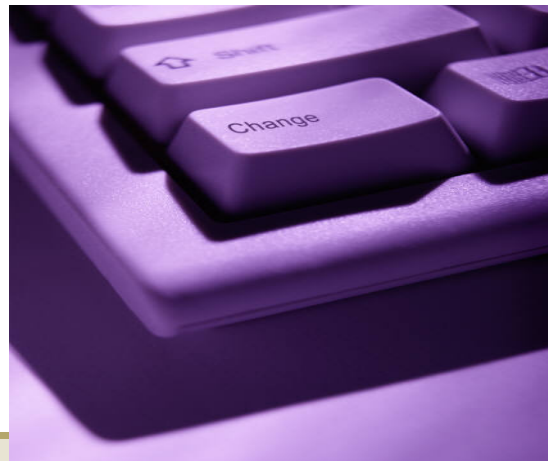
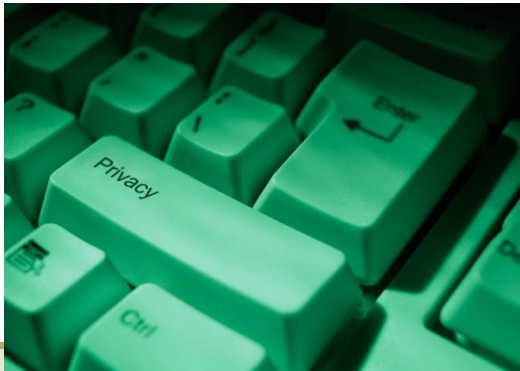


If We Looked at Individual Data

- How would surgeons and pathologists react?
- What is an acceptable variation in practice?
- Would surgeons or pathologists be receptive to mentorship programs, if they are required?
- How would hospitals react to this information?

Pre-implementation Change Management Strategies

1. Presentations to MAC at each Hospital site
2. Presentations to Disease site specific meetings (Communities of Practice)
3. Conversations with individual physicians as required



Potential Conflict

- CCO has the data
- The hospital, and ultimately the Board of Directors, has responsibility for quality
- Would a hospital use the data punitively and not as part of an effort to improve quality?

Memorandum of Understanding

- The data will remain blinded to the hospital
- Except in cases where the 'Surgical Oncology Quality Committee' sees a clear danger to patient safety no immediate action will be taken against individuals
- Hospital will agree to allow a remediation process directed by the Chiefs and Regional Leads

Clinical Validation Process: Case Assessment



Prostate Margins:

Pathology criteria

- ✓ Margins not inked
- ✓ En face shaved technique of distal apical margin or base (bladder neck) margins not acceptable for margin assessment.
- ✓ Submission Protocol not documented
- ✓ Subtotal submissions- no evidence of systemic approach to include posterolateral peripheral zone

Surgery criteria

- ✓ Intra operative finding or events that forced a change on operative strategy

Colorectal (12 nodes assessed):

Pathology criteria

- ✓ No Evidence of secondary gross examination for lymph nodes
- ✓ Nodes not submitted in entirety

Surgery criteria

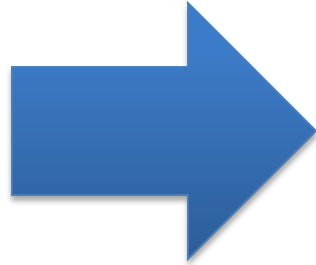
- ✓ Patient received neo-adjuvant long course radio-therapy
- ✓ Emergency or palliative surgeries
- ✓ Resection for locally recurrent disease

The Report to the Physicians

- Individual physician data
- Comparison data with regional peers (anonymized)
- Comparison data with provincial peers (un-validated)

RESULTS

- 54 surgeons and pathologists
- 437 cases
 - 78 prostate
 - 241 colon
 - 118 rectal



- 50 cases (11%) were “suboptimal”
 - 30 prostate
 - 9 colon
 - 11 rectal
- 21 (42%) of those were excluded from scores after validation

Of the remaining 29 cases:

- 7 (25%) were pathologist-related
- 22 (75%) surgeon-related

Physician Perceptions

Pre-implementation N=31(57%)		Post- implementation n=32 (56%)	
Item	Response (Agree ; Strongly Agree)	Item	Response (Agree ; Strongly Agree)
I have confidence that the quality indicator data provided will be valid	19 (65.5%)	The data provided in the quality indicator report was valid .	19 (66.7%)
I have confidence that the methods used for sharing the indicator reports will maintain confidentiality	23 (79%)	The methods used for sharing the indicator reports maintained my confidentiality	24 (80%)
I have confidence that this information will not be used in a punitive manner	20 (64.5%)	The information provided in my individual report was not used in a punitive manner	23 (76.6%)
		I am confident that any information in my individual report will not be used in a punitive manner in the future	14 (47%) *Not sure = 14 (47%)


Pre-implementation N=31(57%)		Post- implementation n=32 (56%)	
Item	Response (Agree ; Strongly Agree)	Item	Response (Agree ; Strongly Agree)
I see the relevance of having access to my personalized report to my practice	29 (94%)	I believe that having access to my personalized report can improve the quality of my practice	23 (77%)
I see the relevance of having access to indicator reports to organizational performance	28 (90%)	I believe that indicator audits can improve organizational performance	26 (87%)
I see the relevant of having access to indicator reports to patient outcomes.	28 (90.4%)	I believe that indicator audits can improve patient care outcomes.	24 (83%)
		The results provided in my individual was useful to me in my practice	14 (53.3%) * Not sure = 11 (37%)
		The display of my results in comparison to my peers was useful	23 (77%)

HEALTH & WELLNESS

Life / Health & Wellness / Diseases & Cures

Cancer survival in Ontario ranks among best in the world

Ontarians diagnosed with common types of cancer are living longer than patients in Norway, Denmark, Sweden and the United Kingdom.

  Tweet { 0 }  +1 { 0 }  reddit this!  + save to my star 

By: [Megan Ogilvie](#) Health Reporter, Published on Tue Dec 21 2010

Ontarians diagnosed with common types of cancer are living longer than patients in Norway, Denmark, Sweden and the United Kingdom, new research shows.

The study, the most up-to-date comparison of cancer survival rates to date, suggests the province's cancer strategy is more effective at catching and treating lung, ovarian and colorectal cancers than health care systems in similar countries.

Among the 12 health jurisdictions included in the study, Ontario ranked second for ovarian and lung cancer survival and third for colorectal cancer survival. For breast

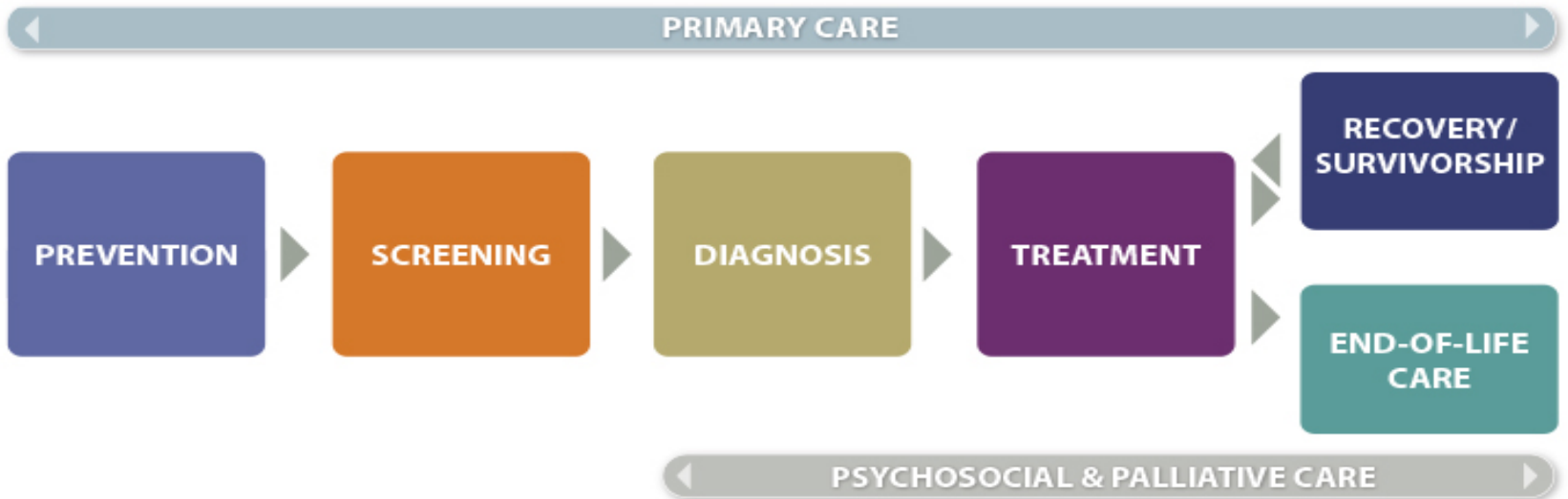
For more information go to:

www.csqi.on.ca

www.cancercare.on.ca

The cancer journey

Better cancer services every step of the way



Ontario Cancer Plan IV

<http://ocp.cancercare.on.ca/>

