Improving quality and performance in health services: Reflections from CCO

Terrence Sullivan PhD
President and CEO
Cancer Care Ontario

Alf Nachemson
Lecture, 2010
The Design Exchange
Overview

1. A Short Biography of Cancer Services
2. Genuine Burning Platform + Crisis
3. Building a Common Culture of evidence to practice
4. Alignment of Leadership (Clinical/Administrative)
5. Instrumenting the Cancer Journey
6. Quality and Performance Measurement and Reporting
Where Have We Been:
Thumbnail History of Cancer Control in Ontario

1922 Government of Quebec purchases radium

1931–32 Study by Ontario Royal Commission on the Use of X-Rays and Radium in the Treatment of the Sick (Cody Commission)

1935 British Columbia Cancer Foundation established

1936 Harvey Sellers, Chief Medical Statistician Appointed to begin work on Ontario Cancer registry

1943 Ontario Cancer Treatment and Research Foundation established


1997 OCTRF Becomes CCO (Conservative Era) to promote better integration of Cancer Services

1998 - 2001 Second Crisis of waiting times: Round 2: Cancer Services Implementation Commission, Outlined problems of integration, ownership and quality

2002-2003 Start of Cancer Quality Council and restructuring of CCO

January 2004: Integration of Existing Cancer Programs into regional Host hospitals with mandate for regional coordination

2005 Wait Times Begins/Access to Care

2009 Province ask CCO to take on CKD
Burning Platform # 1:
Aging & Growing Population Driving Increased Cancer Incidence

Note: Based on individuals diagnosed at ages 15-99.
Source: Cancer Care Ontario (Ontario Cancer Registry, 2009)
Prepared by: Surveillance, Population Studies and Surveillance, Cancer Care Ontario
More people live with cancer

The number of people living with cancer will increase by 40% over the next ten years.

Provided by: Surveillance Unit, Cancer Care Ontario
Source: Ontario Cancer Registry
U.S. cities to treat Ontario's cancer victims

Plan aims to cut patient backlog

BY RITA DALY
HEALTH REPORTER

Ontario cancer patients will be sent to Buffalo and other American cities as soon as next month for radiation treatment, in an attempt to reduce waiting times.

As part of a plan to cut the backlog, Cancer Care Ontario has given the go-ahead to send patients to the United States. The government-funded agency, which co-ordinates cancer services, approved the out-of-province proposal yesterday.

The patients who are referred to other centres will start treatment at the end of February, but it’s expected to take a year or two to clear the backlog of between 1,300 and 2,000 patients.

It’s estimated to cost taxpayers between $15,000 and $20,000 per patient for travel, accommodation and treatment in the United States. A central office in Cancer Care Ontario, with support from the health ministry, will manage the referrals of patients.

Exactly who will be sent south depends on a number of factors, including the patient’s condition and willingness to travel. Some women recovering from breast cancer and men with prostate cancer have been mentioned as likely candidates.

"If we don’t address the backlog, the waiting list is going to get progressively worse. That’s why we want to deal with it now," Dr. Tom McGowan, the organization’s co-ordinator of radiation treatment, said yesterday.

The Toronto Hospital board of trustees went ahead and approved a motion this week similar to the one endorsed yesterday.

Now, physicians at Princess Margaret Hospital — Ontario's busiest cancer hospital — will be allowed to refer patients to other centres in Ontario and to

THE SICKNESS IN OUR HEALTH SYSTEM

U.S. clinics jostle for Ontario cancer patients
Tories want to silence critics, board members say

Cancer agency facing the axe

Centre created to co-ordinate treatment for Ontario patients

BY CAROLINE MALLAN AND RICHARD BRENNAN
QUEEN'S PARK BUREAU

The Conservative government is quietly trying to gut the cancer care agency that it created in 1997 to co-ordinate “world-class” treatment for Ontario patients.

Critics of the government and several members of the board of Cancer Care Ontario say the move to strip the agency of all power is meant to silence members of the agency who have openly questioned the direction taken by the government in delivering cancer care and funding.

“The government wants to dismantle the cancer system and put it into the hospitals so that any criticism towards the cancer system is defused,” said a board member, who asked not to be identified.

Another board member, again speaking on condition of anonymity, said there was no opportunity to object to the plan, which he said is clearly a retaliation against the agency for its sometimes public disagreements with the health ministry.

“At this point in time, the ministry has delivered a fait accompli, without consultation… the fait accompli is you are going to cease to exist, so cooperate with us on how you cease to exist.”

The move to shift care from Cancer Care Ontario to regional hospitals was announced quietly Wednesday morning after board members were summoned to an emergency meeting to hear the news delivered in a letter from Health Minister Tony Clement.

As it exists now, Cancer Care Ontario directly runs eight regional cancer centres, with independent budgets and services, although the centres are physically attached to hospitals.

Under the plan to shift cancer care, patients will be admitted to the hospitals and come under their budgets. The current heads of each cancer centre will become vice-presidents in the affiliated hospitals and will report to the hospital administration, whereas Cancer Care Ontario reported directly to the government.

Another board member, who also asked for anonymity, said the board was stunned by the government’s move, which he says came out of no-
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

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, venal 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 time for patients needing treatment.

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 Clement told the directors of Cancer Care Ontario not to offer patients more resources to cope with their illness.

The government's 2003 budget introduced a $175 million deficit and pending legislation making deficits illegal.

Exhibit 3: On Wednesday, a city committee will consider a report on ambulance services. It says crowding...
Cancer agency escapes the Tory axe

Province has backed off merger plans, sources say

BY THERESA BOYLE
QUEEN'S PARK BUREAU

The provincial government has abruptly abandoned plans to gut Ontario's cancer agency after what one source described as an "all-out, behind-the-scenes war" with the health ministry.

The Harris government backed off the decision yesterday after a flurry of phone calls and high-level meetings that saw advocates of Cancer Care Ontario bypass bureaucrats and go directly to politicians, sources said.

The government, meantime, is trying to downplay any strife with the agency that co-ordinates cancer-care services in the province.

It denies there was any plan to merge the agency's eight regional cancer centres with local hospitals and insists the agency and the health ministry have been working together.

But several agency advocates, including board members and advisers to the agency, have painted a different picture.

Last night, Dr. Bill Evans, vice-president of Cancer Care Ontario, said the ministry presented the board with a "directive" for a "forced merger" during an emergency meeting convened, via teleconference, Wednesday.

Cancer Care Ontario would have still existed under the ministry's plan with funding flowing through it to hospitals, but Evans said the agency would have lost control of where the dollars were spent.

"To be left as a standard-setting, policy-setting organization with no ability to assure that the resources would be used to meet those standards ... that would have been a dereliction of our responsibility to ensure equitable care across the province," he said.

"We don't see the point of giving away all the resources so that we can't enforce standards and ensure that people get equitable access to care. ... If you just lose that in a general hospital somewhere, you're going to find very uneven care occurring across a jurisdiction," Evans said, adding hospitals are already strapped for cash.

Gord Haugh, spokesperson for Health Minister Tony Clement, denies a forced merger was in the works.

"That was never the plan," he said.

"It was never a forced merger. It's always been an integration of services. We just don't know what model it will be," Haugh said, adding that an implementation team is being created to determine that.

Haugh said better integration is needed so that a patient, for example, doesn't have to go to a cancer centre to get diagnosed, a hospital for surgery and then back to a cancer centre for radiation therapy.

Cancer Care Ontario was established by the Conservative government with much fanfare in 1997.

At the time they described it as a "world-class" institution.

It was because of Cancer Care Ontario that Ontarians began to hear about long waits..."
Pressure and Change in the New Millennium in Ontario…

• **Restructuring**
  - 2004 Cancer Care Ontario shift from direct service delivery to purchasing, information management, quality improvement for all cancer services
  - Regional cancer centres + affiliated hospitals → Integrated Cancer Programs
  - Next stage → Regional Cancer Programs → Local Health Integration Networks

• **Quality monitoring & reporting**
  - Cancer Quality Council of Ontario established in 2003
  - Quasi-independent public reporting

• **Performance management**
  - Performance agreements & contracts with Integrated Cancer Programs
Cancer Care Ontario: Delivery at a Glance

Mission: To improve the performance of the cancer system by driving quality, accountability and innovation in all cancer-related services.
## Shift to the New Cancer Care Ontario

<table>
<thead>
<tr>
<th>2001</th>
<th>2010</th>
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<tbody>
<tr>
<td>provider of patient care</td>
<td>purchaser of services</td>
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<td>managing service delivery</td>
<td>managing system performance</td>
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<tr>
<td>treatment orientation</td>
<td>prevention and reducing burden</td>
</tr>
<tr>
<td>radiation and systemic therapy programs</td>
<td>prevention and screening, primary care, stage capture, pathology and laboratory medicine, radiation treatment, systemic treatment, surgical oncology, palliative care, psychosocial oncology, oncology nursing, patient education</td>
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<tr>
<td>measuring volumes</td>
<td>measuring access and quality</td>
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<td>patient based approach</td>
<td>population based approach</td>
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<tr>
<td>opinion based decision making</td>
<td>evidence based decision making</td>
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<tr>
<td>professional accountability</td>
<td>integrated clinical and administrative accountability</td>
</tr>
<tr>
<td>fragmented care</td>
<td>integrated and coordinated care</td>
</tr>
<tr>
<td>Limited internal reporting</td>
<td>Extensive public reporting; some internal reporting</td>
</tr>
<tr>
<td>limited information management systems</td>
<td>mature and comprehensive information technology (data) systems</td>
</tr>
<tr>
<td>8 regional cancer centres + Princess Margaret Hospital</td>
<td>14 integrated cancer programs</td>
</tr>
<tr>
<td>single disease agency</td>
<td>multi-service agency (cancer, access to care, chronic kidney disease)</td>
</tr>
<tr>
<td>$284 million funding</td>
<td>$~800 million funding</td>
</tr>
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</table>
2009-2010: The Cancer Journey by the Dollars

- Prevention: $8,080,985
- Screening: $65,195,516
- Diagnosis: $7,732,000
- Treatment: $548,780,779
- Palliative and end-of-life care: $2,350,627

*Fiscal year ending March 31, 2010

2010 Annual General Meeting
Explicit System-wide Strategy since 2005

Quality Improving Use of Evidence: Two Key Components

Performance improvement cycle & Clinical accountability framework

Extensive clinical engagement and joint clinical/administrative accountability for quality at provincial and regional levels.
Clinicians engaged in all components of Performance Improvement Cycle

1. Data/Information
   - Incidence, mortality, survival
   - Analysis
   - Indicator development
   - Expert input

2. Knowledge
   - Research production
   - Evidence-based guidelines
   - Policy analysis
   - Planning

3. Transfer
   - Publications
   - Practice leaders engaged
   - Policy advice
   - Public reporting
   - Technology tools
   - Process innovation

4. Performance Management
   - Institutional agreements
   - Quarterly review
   - Quality-linked funding
   - Clinical accountability

Monitoring performance

Identifying quality improvement opportunities

Horizon-scanning and championing innovation

Developing and implementing improvement strategies

Standardizing development and guidelines

Clinicians engaged in all components of the Performance Improvement Cycle include data/information, knowledge, transfer, and performance management. Each component is crucial for continuous improvement in healthcare.
Clinical accountability structures (cont.)
Synoptic Pathology Reporting: Implemented in 74% of Ontario Hospitals

% of hospitals implemented as of April 2010

<table>
<thead>
<tr>
<th>LHIN</th>
<th># of hospitals implemented discrete synoptic reporting</th>
<th>Total # of hospitals</th>
<th>%</th>
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<td>0%</td>
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<td>13</td>
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<td>19</td>
<td>74%</td>
</tr>
<tr>
<td>14</td>
<td>1</td>
<td>6</td>
<td>17%</td>
</tr>
<tr>
<td>All</td>
<td>81</td>
<td>110</td>
<td>74%</td>
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</table>
Use of Guidelines for Treatment of Breast Cancer

Percent treated with guideline recommended radiation following breast conserving Surgery by LHIN of patient residence (patients having surgery from April 2005 to March 2007)

Sources: Cancer Care Ontario, Activity Level Reporting and Ontario Cancer Registry
Notes:
1. Includes only cases referred to a cancer centre with valid stage reported to CCO.
2. “No Treatment Reported” does not necessarily mean inappropriate care. Some patients may not be medically fit for the guideline treatment due to factors we are not currently able to adjust for. Many patients may also refuse treatment for personal reasons. Others may have been treated outside Ontario.
3. North East LHIN results are excluded because of data quality issues.
4. * Denotes significantly different from provincial average
Embedding Guidelines in Policy - Drugs

• Ontario New Drug Funding Program
• Created to ensure that Ontario patients have equal access to high-quality intravenous drugs
• Provides ~80% of the overall funding for intravenous cancer drugs in Ontario
• Every drug funded is supported by clinical guidelines, which ensures they are delivered according to the best standards of care
• National Table now following this model
Radiation delays hit 65% of patients

Moving beyond ‘wait times’ focus

Radiation Ready to Treat To Treatment Percent Treated within 28 Days April 2005 - October 2010

96.2% in July 2010

Data Source: ALR/DataBook
Prepared by: Informatics
Date: October 22/2010

Radiation Ready to Treat To Treatment Percent Treated within 28 Days April 2005 - October 2010

FPT Target

Percent Treated Within 28 Days
Linear (Percent Treated Within 28 Days)
Lifetime Utilization: Proportion of new cancer cases treated with radiotherapy at any time over the course of their illness, by LHIN

LHINs/Regional Cancer Programs

Proportion of Incident Cases Treated with Radiotherapy

Recommended Rate: 48%

2003-2004
2004-2005
2005-2006
2006-2007
2007-2008
2008-2009
Determining the appropriate Utilization rate

Evidence-based

• Identify all indications for RT by systematic review
• Estimate the incidence of each indication in the cancer population
• Integrate this information to estimate overall requirement for RT

Criterion-based Benchmarking

• Set criteria for identifying communities where access likely to be optimal, i.e. no barriers to access
• Identify communities which fit those criteria, and which have appropriate case mix
• Measure rates of use of the service in several such communities
• Develop a Benchmark

Potential “care gap” - Stable versus Increasing utilization, 2010-2010

Episodes of treatment refer to CCO treated cases (R21) inflated by re-treatment rate (15%). Includes cases of breast, in-situ diseases, non-melanoma skin cancers, and cases from other provinces.
% of Radical IMRT courses: Where we are now

** Preliminary data
Provincial Average: % of Radical IMRT Courses

Q1 - 2010-11 – Preliminary data
Prostate Margin Rate – 2008 to 2010

- Guideline for Optimization of Surgical and Pathological Quality Performance for Radical Prostatectomy in Prostate Cancer Management Released 2008
  - “... a positive margin rate of <25% for pT2 disease should be an achievable goal.”

- Implementation of synoptic pathology reporting, near-real time reporting

- KT Initiatives:
  - provincial workshops (2) numerous regional workshops

- Provincial positive margin rate for pT2 patients:
  - 31% (2005 & 2006) to approx 20% (FY10/11, Q1)
Guideline for Optimization of Surgical and Pathological Quality Performance for Radical Prostatectomy in Prostate Cancer Management


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

The full Evidence-based Series #17-3 is comprised of 3 sections and is available on the CCO website (http://www.cancercare.on.ca)
PEBC Surgery page at:
http://www.cancercare.on.ca/toolbox/qualityguidelines/clin-program/surgery-ebs/

Section 1: Surgical and Pathological Guidelines
Section 2: Evidentiary Base
Section 3: EBS Development Methods and External Review Process
Positive margin Rates for Radical Prostatectomy, for pT2 and >pT2 patients, FY08/09 to FY10/11

Source: Cancer Care Ontario, Pathology / Stage Capture program; PIMS
Thoracic Cancer Surgery Standards
Number of lung cancer surgeries by hospital, fiscal years 2004/05 to 2008/09

Ontario surgery volume 2004/05: 1863
Ontario surgery volume 2008/09: 2119

Threshold: 150

Report date: January, 2010
Data source: Discharge Abstract Database (CIHI)
Prepared by: Cancer Care Ontario, Cancer Informatics
Notes: 1. *Data not shown due to low volumes
Percent of thoracic cancer surgeries performed (esophageal and lung) performed in designated thoracic surgery centres, by fiscal year 2006/07 to 2009/10

<table>
<thead>
<tr>
<th>Disease site</th>
<th>FY 2006/07</th>
<th>FY 2007/08</th>
<th>FY 2008/09</th>
<th>FY 2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Esophageal</td>
<td>79.2%</td>
<td>82.5%</td>
<td>85.8%</td>
<td>88%</td>
</tr>
<tr>
<td>Lung</td>
<td>76.7%</td>
<td>77.8%</td>
<td>81.4%</td>
<td>87%</td>
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</table>

Note: Erie St. Clair not included in data
Percentage of patients who died in hospital or within 30 days following thoracic cancer surgery (by surgery type, fiscal years 2003/04 + 2004/05, 2005/06 + 2006/07, and 2007/08 + 2008/09)

<table>
<thead>
<tr>
<th>Surgery Type</th>
<th>FY 2003/04 + 2004/05</th>
<th>FY 2005/06 + 2006/07</th>
<th>FY 2007/08 + 2008/09</th>
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</thead>
<tbody>
<tr>
<td>Lung Lobectomy</td>
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<tr>
<td>Esophagectomy</td>
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<tr>
<td>Pneumonectomy</td>
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Report date: February 2010
Data source: Distract Abstract Database (CIHI)
Prepared by: Institute for Clinical Evaluative Sciences, Cancer Program
Our Quality Framework

Our Quality Framework
Aligned with those of key Ontario organizations

Patient Journey
Prevention
Screening
Diagnosis
Treatment
Recovery
End-of-Life Care

Quality Dimensions
Safe
Effective
Accessible/Timely
Patient-Centred/Responsive
Equitable
Integrated
Efficient
IM Tools ‘Instrumenting’ the Disease Journey

**Prevention**
- Risk factor surveillance

**Screening**
- In Screen
- Integrated Cancer Screening

**Diagnosis**
- Diagnostic Assessment Programs

**Treatment**
- Wait Times
  - Computerized Physician Order Entry
  - Multi-disciplinary Case Conferences
  - Stage Capture
  - Quality Indicators

**Follow Up Long-term Survival**
- Palliative & end-of-life care

**Symptom Management**
- Robust data systems

**Recovery/Survivorship**
- Structured care plans

Supported by IM/IT
- Cancer System Quality Index
- Disease Pathway Management
- Regional/Corporate Scorecard
# Cancer System Quality Index: Instrumenting Quality

<table>
<thead>
<tr>
<th>Patient Journey</th>
<th>Safe</th>
<th>Effective</th>
<th>Accessible/ Timely</th>
<th>Patient Centred/ Responsive</th>
<th>Equitable</th>
<th>Integrated</th>
<th>Efficient</th>
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</thead>
<tbody>
<tr>
<td>Prevention</td>
<td></td>
<td>Guideline production; Quitting smoking; Second-hand smoke</td>
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<tr>
<td>Screening</td>
<td></td>
<td>Guideline production; Population FOBT rates; Population breast cancer screening; Cervical screening; Composite screening</td>
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<tr>
<td>Diagnosis</td>
<td></td>
<td>Guideline production; Completeness of pathology reports; Stage capture</td>
<td>Wait times for breast cancer assessment; Colonoscopy wait time (positive FOBT)</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Treatment</td>
<td>Deaths following surgery; Thoracic standards; HPB standards; Admission or ER visit within 4 weeks of IV chemo; Safe handling of cytotoxics; CPOE</td>
<td>Guideline concordance- lung cancer; guideline concordance – CRC; Guideline production</td>
<td>Wait times for cancer surgery; Wait times for radiation treatment; Wait times for systemic treatment; Clinical trials</td>
<td>Patient experience</td>
<td>Availability of MCCs; Radiation therapy utilization; IMRT utilization</td>
<td>Radiation efficiency composite</td>
<td></td>
</tr>
<tr>
<td>Recovery</td>
<td></td>
<td>Guideline production</td>
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<tr>
<td>End-of-Life Care</td>
<td></td>
<td>Guideline production</td>
<td></td>
<td>Hospitalization in the last 6 months of life; In-hospital death from cancer; Chemo in the last 2 weeks of life</td>
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</table>

Gaps guide future work
Internal Reporting

Target Setting

- Provincial Targets set by Provincial Programs for each yearly priority.

- Regional Targets negotiated through the RVP.

- Performance against targets monitored through the CCO Regional Scorecard and quarterly performance reviews.

- Regional Scorecard is a central component of RVP performance review.

- Progress against targets reported publicly through CSQI, and in annual OCP update.
Provincial performance against lung cancer targets

Percent of ‘Lung’ Cancer Patients who were Screened at Least Once with ESAS
Regional Cancer Centre Patients Only
July YTD 2009/10 vs 2010/11

Provincial performance against lung cancer targets
Upward momentum: Greater than 250,000 ESAS screens in past year
Patients value ISAAC approach to symptom assessment

- Thought ESAS was important to complete as it helps health care providers know how they are feeling (89% (85% in 2007))
- Preferred the kiosk/internet version of ESAS over the paper tool (70%)
- Agreed that their pain and other symptoms have been controlled to a comfortable level (78% (62% in 2007))
- Agreed that their providers took into consideration ESAS symptom ratings in developing a care plan (79% (61% in 2007))

ESAS Satisfaction Survey 2009/10 (Sample of 8 RCCS - 844 patients completed)
## Regional Score Card of Performance Reviewed Quarterly With All Centres in Each Region

### Performance Indicators

- **WT Ref-Con (% w/in 14 days)**
- **WT RTT-Tr (% w/in target)**
- **Vol (C1R) % of Budgeted Vol in the Province**
- **WT Ref-Con (% w/in 14 days)**
- **WT Con-Tr (% w/in target)**
- **Vol (C1S) % of Budgeted Vol in the Province**
- **WT (% w/in target)**
- **WT (POB+)**
- **Vol (Family History)**
- **RTT-Tr (% w/in target)**
- **Vol (cases) % of Budgeted Vol in the Province**
- **WT (FOBT+)**
- **WT (Family History)**
- **Vol % of Budgeted Vol in the Province**
- **Combine Rate**
- **% Hosp.-Collaborative Staging**
- **% Hosp. Discrete Path Report**
- **% Complete-ness**
- **Lung**
- **All Other**
- **MCC Q1 10/11**
- **RSTP Safe Handling as of April 2010**
- **IMRT Q4 09/10**
- **Overall Provincial Rank**
- **Change from Previous Rank**

### Performance Data by Region

<table>
<thead>
<tr>
<th>Region</th>
<th>Radiation Apr-Jun 10/11</th>
<th>Systemic Apr-Jun 10/11</th>
<th>Surgery Apr-Jun 10/11</th>
<th>Colonoscopy Apr-Jun 10/11</th>
<th>Stage Rate</th>
<th>Pathology</th>
<th>Thoracic Apr-Dec 09</th>
<th>Hepat B Apr-Dec 09</th>
<th>MCC Q1 10/11</th>
<th>RSTP Safe Handling as of April 2010</th>
<th>IMRT Q4 09/10</th>
<th>Overall Provincial Rank</th>
<th>Change from Previous Rank</th>
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<td>PROVINCE</td>
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EXCELLENT CARE FOR ALL:
Are the Lessons and Levers for better quality in decision making based on cancer?

- Align leadership/ promote clinical accountability
- Designate Provincial and Regional Clinical Practice Leaders by specialty
- Support Clinical Indicator Development and Reporting
- Support Clinical Communities of Practice Initiatives
- Build Culture of evidence, quality improvement
- Volume and quality linked to $$ funding
- Pay for Participation, Pay for volumes, Pay for Quality in Hospital Level Agreements;
- Quarterly Performance Reviews with each Region, Regional Scorecards (with AnnualTarget Adjustment)
- Public Reporting on 30+ access and quality measures; Annual Provincial Quality Scorecard
- Chief Advisor to Government

...Better Cancer Services Every Step of the Way
King Hammurabi B.C. 1795-1750
....Early Quality Champion
“If a doctor has opened with a bronze lancet an abscess of the eye of a gentleman and has cured the eye, he shall take ten shekels of silver”

“If a doctor has opened with a bronze lancet an abscess of the eye of a gentleman and has caused the loss of the eye, the doctor’s hands shall be cut off”
Woman undergoes mastectomy only to learn a week later, she never had cancer. Now another patient claims the same fate.

Friday, June 4th, 2010

Janice Laporte
Thank You/Questions

Ontario Cancer Plan
2008–2011

Better cancer services every step of the way