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65

Performance Improvement in Cancer Control: *A Privileged Place for Screening*

Mejora del rendimiento en el control del cáncer: *Un lugar privilegiado para la detección*

Seminario Internacional
Cáncer de Mama: Retos y Respuestas
Noviembre, 2008

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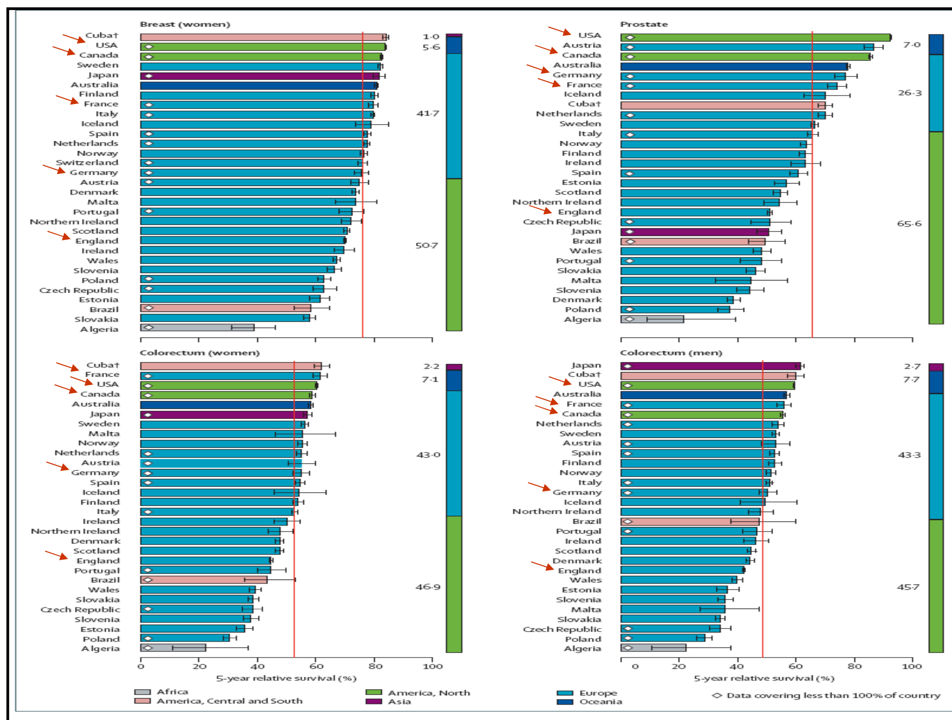
Cancer Care Ontario
Canada



Common Elements of Performance Improvement in Cancer Services*:

1. Performance Knowledge

   1.1 Measures / Performance Indicators of Cancer Care

   1.2 Strategies for Collecting Data/ Sources of Quality Data

   1.3 Performance Reporting

Sullivan T, Dobrow M, Schneider E, Newcomer L, Richards M, Wilkinson L, Borella L, Lepage C, Glossmann JP, Walshe R. Améliorer la responsabilité et l'exécution cliniques et la performance en cancérologie. (Improving clinical accountability and performance in the cancer field).
Pratiques et Organisation des Soins volume 39 n° 3 / juillet-septembre 2008

Common Elements of Performance Improvement :

2. Active Levers for Performance Improvement

   2.1 Institutional and Leadership Alignment on Directions

   2.2 Commitment / Mobilization of Stakeholders
   - Commitment of clinician and clinician leaders
   - Engaging patients
   - Public engagement
   - Engagement of policy/administrative decision makers

Common Elements of Performance Improvement :

3. Active Processes

3.1 Initiatives by Clinicians

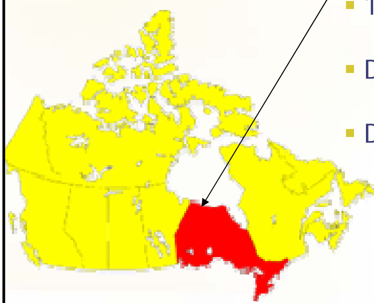
3.2 Payment Mechanisms

3.3 Organizational Standards/Consolidation of Services

3.4 Flexible Work Force Initiatives

Cancer Performance Initiatives in Canada

- National Strategy: Provincial Plans/Execution
- Cancer Services uniquely organized in most provinces
- Ontario: 12.8 million pop; 1.1 million sq kms
- 14 Regional Delivery Systems
- Designated Cancer Leadership (14)
- Dedicated Cancer Funding Envelope



Cancer Care Ontario's model for system improvement

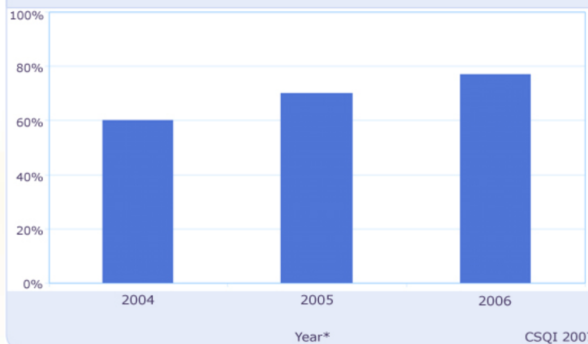
1. Data/Information
   - incidence, mortality, survival
   - analysis
   - indicator development
   - expert input

2. Knowledge
   - clinical guidelines
   - policy options
   - research and evidence
   - planning

3. Performance Management
   - institutional agreements
   - quarterly funding
   - clinical review
   - quality – funding link

4. Transfer
   - publications
   - practice leaders engaged
   - policy advice
   - public reporting

Improving Quality & Program Standards



Source: Cancer Care Ontario, Pathology Information Management System (PIMS). Based on a sample of pathology reports for colorectal cancer resections in each year.
Notes:
1.*Data collection timeframes are Jun.-Aug. 2004, Apr.-Sept. 2005, Sept.-Oct. 2006.

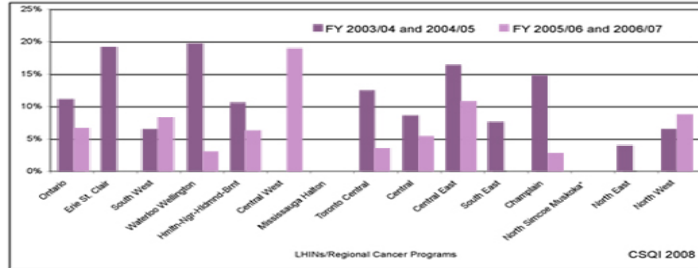
- In the Journal of the National Cancer Institute, Dr. Karl Bilimoria of Northwestern University in Chicago and his team said they found more than 60 per cent of nearly 1,300 hospitals in the U.S. failed to comply with the guideline.

Wright, F et al. BMC Health Serv Res. 2006 Jan 16;6:4.

Performance Reporting

Deaths Following Cancer Surgery

Percent of patients dying in hospital or within 30 days following pneumonectomy
(by LHIN, fiscal years 2003/04 and 2004/05 vs. 2005/06 and 2006/07)



LHINs/Regional Cancer Programs CSQI 2008

Sources:
Canadian Institute for Health Information Discharge Abstract Database
Analysis conducted by scientists in the Cancer Program at the Institute for Clinical Evaluative Sciences (ICES) in Toronto
Notes:
1. Procedures included a small proportion of operations that were not "cancer" cases'.
2. Data included for April 1 2003-March 31 2005 and April 1 2005-March 31 2007.
3. Rates standardized for age and sex.
4. *No surgeries performed in North Simcoe Muskoka

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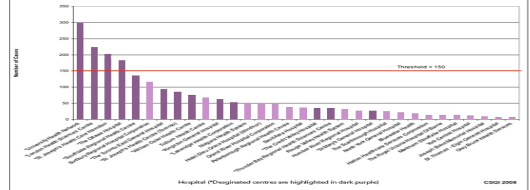
Improving Quality &Program Standards

Adherence to Standards

Number of lung cancer surgeries by hospital, April 1 2006 to March 31, 2007

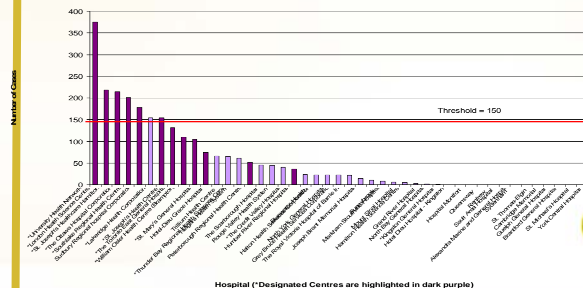


Hospital (*Designated centres are highlighted in dark purple) CSQI 2008

- (06/07) 4 centres meet volume standard

Sundaresan, S., Langer, B., Oliver, t>, Schwartz, F., Brouwers, M., Stern, H. Standards for thoracic surgical oncology in a single payer healthcare system. Ann Thorac Surg. 2008 May:84(2): 693-701.

Number of self-reported Lung Cancer Surgeries by Hospital, April 1 2007 to March 31 2008



Hospital (*Designated Centres are highlighted in dark purple)

- (07/08) 7 centres meet volume standard

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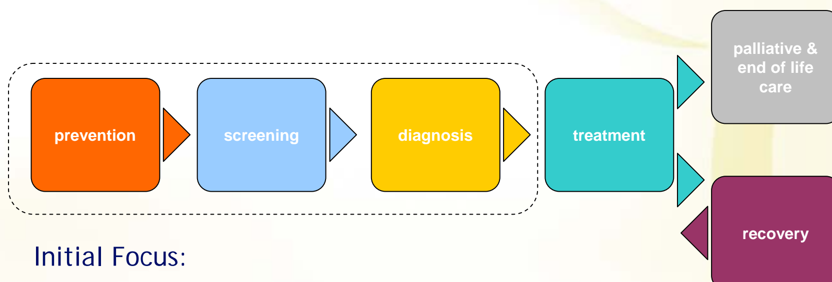
The Place of Screening in The Cancer Journey



Initial Focus:

- Educate patient population on healthy lifestyle and risk reduction
- Encourage target population and increased risk population undergo regular screening
- Streamline diagnostic assessment & support in early phase of care

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What Interventions Are Responsible for the Decline in Breast Cancer Mortality*

- Screening would have no benefit if not followed by effective treatment
- Treatment is more effective if cancer is detected at earlier stage by screening

* Berry DA, Cronin KA, Plevritis SK, Fryback DG, Clarke L, Zelen M, et al. Effect of screening and adjuvant therapy on mortality from breast cancer. N Engl J Med 2005; 353:1784-1792.

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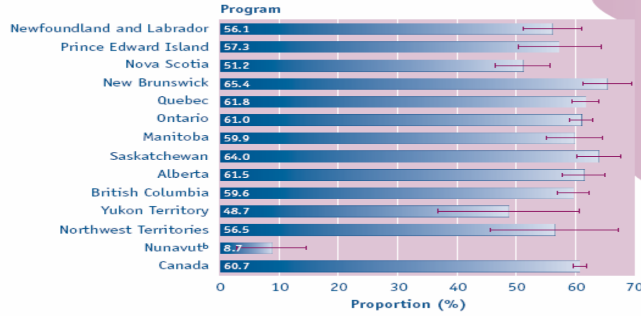
Ontario ranks above the Canadian average in terms of women receiving a mammogram

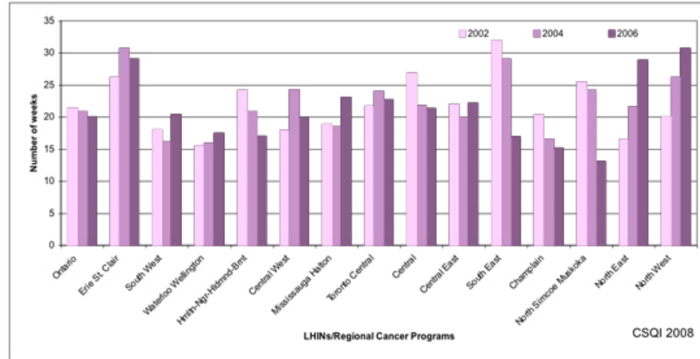
Proportion of women with a self-reported mammogram[a] in the past two years by province, women aged 50-69, 2003 Canadian Community Health Survey (CCHS)



a Diagnostic mammography excluded.
b The CCHS sampling frame covers 71% of the private households in Nunavut.
Source: Health Canada. 2003 Canadian Community Health Survey: share file.

Breast Cancer Test Waits

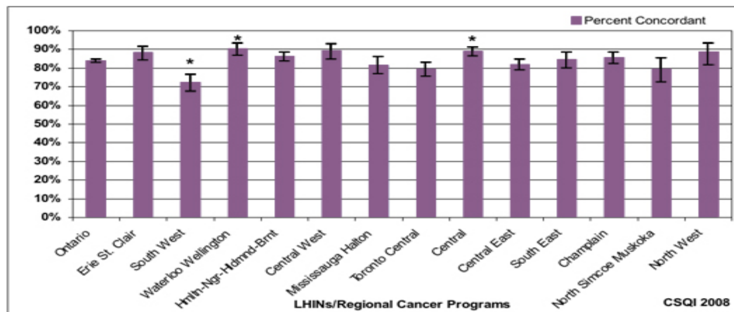
Median waits (in weeks) from abnormal screen to first surgical excision for breast cancer patients, 2002, 2004, 2006



Sources: Cancer Care Ontario, Ontario Breast Screening Program; Ontario Health Insurance Plan database; Canadian Institute for Health Information (CIHI) Discharge Abstract Database; Registered Persons Database
Analysis conducted by scientists in the Cancer Program at the Institute for Clinical Evaluative Sciences (ICES) in Toronto
Note: 1. To measure wait times for this analysis, women were followed for a maximum of 1 year.

Use of Guidelines for Treatment of Breast Cancer

Standardized Percent of Stage I & II Breast Cancer Patients 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. Results are standardized for patient age and stage (I vs. II) and driving distance between patient residence and nearest treatment centre.
2. Confidence interval bars indicate the range (plus or minus) within which the results could vary statistically. Only LHIN-specific results whose interval does not overlap with that of the Ontario average (two horizontal lines) would be considered significantly different from that average (also identified with an asterisk).
3. North East LHIN results are excluded because of data quality issues.
4. * Denotes significantly different from provincial average

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3 Target Commitment: By 2010/2011

Breast Screening	Cervical Screening	ColonCancerCheck
interim goal 70% of women screen regularly by 2011	interim goal 85% of women ages 20-69, screen regularly by 2011	interim goal 40% of Ontarians aged 50–74 screened by 2011
10% increase in 3 years	15% increase in 3 years	23% increase in 3 years

Aggressive but realistic with the right supports

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ColonCancerCheck

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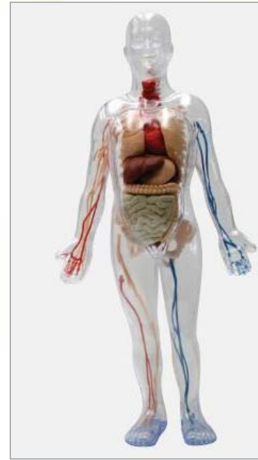
ColonCancerCheck

IF YOU WERE SEE-THROUGH IT WOULD BE EASIER TO SPOT COLON CANCER



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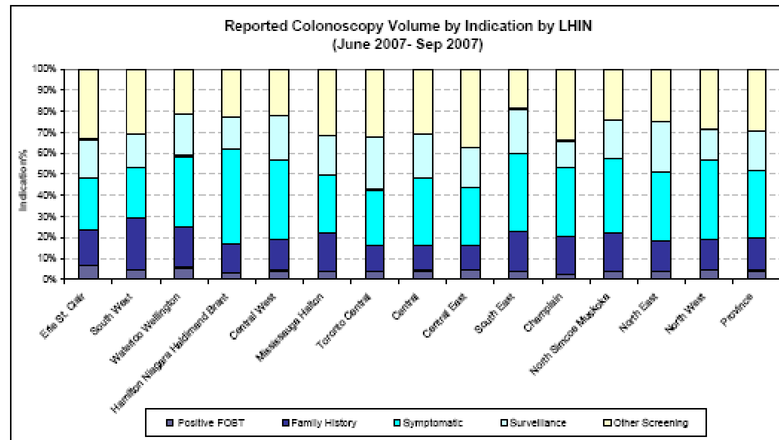
Aligning Data, Quality, Performance, Participation and Funding



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New Approach to Integrated Cancer Screening in Ontario

- Organized and Integrated
- Use new primary care group to link directly to practitioners and deliver tools and incentives
- Education for primary care and other health professionals
- IT to support patient self-care invitations, reminders, follow-on care, monitoring, evaluation and reporting on performance
- Social marketing with target population, customized interventions for hard-to-reach groups
- Innovation in HHR
  - nurse performed flexible sigmoidoscopy
- Regional primary care leadership for cancer screening in every LHIN

Background Material

1 Greenberg, A , Angus, H., Sullivan, Brown, A. Development of a set of strategy-based system-level indicators in Ontario, Canada. Int J Qual Heath Care 2005, 17(2), 107-114.

2 Dobrow, M, Sullivan T., Sawka, C. Shifting clinical accountability and the pursuit of quality: Aligning clinical and administrative approaches. Health Care Management Forum, 2008, Fall, 6-12.

3 Wright, F., Law, c., Last, L., Klar, N., Ryan, D., Smith, A. A blended knowledge translation initiative to improve colorectal cancer staging. BMC Health Serv Rese. 2006 Jan 16; 6:4.

4 Sundaresan, S., Langer, B., Oliver, t>, Schwartz, F., Brouwers, M., Stern, H. Standards for thoracic surgical oncology in a single payer healthcare system. Ann Thorac Surg. 2008 May:84(2): 693-701.

5 Sullivan T, Dobrow M, Schneider E, Newcomer L, Richards M, Wilkinson L, Borella L, Lepage C, Glossmann JP, Walshe R. . Améliorer la responsabilité et l'exécution cliniques et la performance en cancérologie. (Improving clinical accountability and performance in the cancer field). Pratiques et Organisation des Soins volume 39 n° 3 / juillet-septembre 2008

6. Berry DA, Cronin KA, Plevritis SK, Fryback DG, Clarke L, Zelen M, et al. Effect of screening and adjuvant therapy on mortality from breast cancer. N Engl J Med 2005; 353:1784-1792