A Ten-Year History: The Cancer Quality Council of Ontario

Rebecca Anas, Robert Bell, Adalsteinn Brown, William Evans and Carol Sawka

Abstract

One of the longest-established quality oversight organizations in Canadian healthcare, the Cancer Quality Council of Ontario (CQCO) is an advisory group formed in 2002 by the Ministry of Health and Long-Term Care. Although quasi-independent from Cancer Care Ontario (CCO), the council was established to provide advice to CCO and the ministry in their efforts to improve the quality of cancer care in the province. The council is composed of a multidisciplinary group of healthcare providers, cancer survivors and experts in the areas of oncology, health system policy and administration, governance, performance measurement and health services research. Its mandate is to monitor and report publicly on the performance of the Ontario cancer system and to motivate improvement through national and international benchmarking. Since its formation, the council has played an evolving role in improving the quality of care received by Ontario cancer patients. This article will briefly describe the origins and founding principles of the CQCO, its changing role in monitoring quality and its relationship with CCO.

The Origins of Cancer Services Organization in Ontario

Before 2001, Ontario had no integrated provincial system for delivering cancer care, and patients were treated at Cancer Care Ontario (CCO) centres, at Princess Margaret Hospital (PMH), and at other hospitals across the province.

CCO had evolved from the Ontario Cancer Treatment Research Foundation, which had been established in 1943; its name changed officially to Cancer Care Ontario in 1997. Until the late 1990s, CCO managed its delivery of cancer services at regional cancer centres that provided much of the radiotherapy in the province. CCO centres also administered a significant component of systemic treatments (chemotherapy). However, CCO was responsible for none of the cancer surgery that is a crucial part of cancer treatment and had no jurisdiction over pathology, medical imaging or palliative care. As a consequence, CCO coordinated only a relatively small part of the cancer care in the province.

PMH, which had opened its doors in 1958, was the other provider of radiation services in Ontario. PMH also delivered chemotherapy, cancer surgery, pathology, medical imaging and palliative care, as did many other hospitals across the province.

This state of affairs changed in 2001 when the Ontario cancer system was restructured, following a review of cancer services undertaken by a group of CCO and non-CCO cancer experts supported by a CCO secretariat. The report of this Cancer System Implementation Committee led to the devolution of management of the cancer centres from CCO to the host hospitals via a formal Cancer Program Integration Agreement (Ministry of Health and Long-Term Care [MOHLTC] 2001). CCO retained the annual operational funding and established contracts with the host hospitals for their delivery of services on an annual basis. This allowed CCO to attach expectations to the funding for volumes of activity, including data provision and quality improvement initiatives. In return for receiving the capital assets and operational funding for the cancer centres, the host hospitals agreed to maintain their cancer treatment activity at the same quality and volumes of care provided before the asset transfer. CCO developed a new role as an independent, incorporated Schedule A agency of the ministry. With a board appointed by provincial cabinet Orders-in-Council, CCO became responsible for advising the ministry on the provision of an integrated cancer system.

In taking responsibility for advising the ministry, CCO undertook a review of the existing state of the province's cancer

services, engaging outside experts as well as its own. CCO also provided a secretariat function to provide data to inform the analysis. This secretariat extended the usual sources of cancer information available through the Ontario Cancer Registry to include the Discharge Abstract Database (DAD) from the Canadian Institute of Health Informatics. The DAD provided a wealth of new information about the extent of cancer surgery across Ontario as well data describing inpatient chemotherapy provision.

The Cancer System Implementation Committee also signalled a need for an external oversight body to ensure continuous monitoring of quality (MOHLTC 2001). The oversight body was the foundation of one of Canada's first health quality councils, the Cancer Quality Council of Ontario (CQCO). Officially established in 2002 by an announcement by Health Minister Tony Clement, the council was positioned at arm's length from CCO and challenged the provincial agency to improve the documentation of the quality of care in cancer services. The council's mandate was to monitor and publicly report on the quality of Ontario's cancer system.

First, the council focused on the quality issues of existing cancer services in Ontario. It published its findings in a book, *Strengthening the Quality of Cancer Services in Ontario*, in 2003 (Sullivan et al. 2003). The council's first product, the book describes the challenges inherent in creating an integrated provincial cancer system. Michael Decter, a former Ontario deputy minister of health, was recruited to chair the council and provided the book's executive editorial leadership.

The council's governance is a self-renewing body, with members meeting as a whole to nominate new members, achieving a skill mix matrix. CQCO members recognized that expertise was required from clinical experts in and out of the CCO system, as well as from members of the public knowledgeable about healthcare and cancer services, cancer patients and their families, and health service experts. Throughout its ten-year lifespan, the Council has recruited members who fit this skill and experience matrix. It has also retained a secretariat administered by CCO and has an agreement that data sources available to CCO should be provided to the council. This "inside–outside" relationship provides the council with sophisticated expertise and access to extensive data holdings, while maintaining an independent oversight role with respect to CCO performance.

The council's initial work emphasized just how little was known about the quality of cancer treatment, especially outside the treatment centres previously managed by CCO and PMH. Indeed, the CQCO recognized that complete information about the extent of cancer care was available only for radiation therapy. Cancer surgery was essentially a black box, with treatment provided at virtually every hospital in Ontario, and with little information about quality of service. Similarly, information about chemotherapy provided outside previous CCO centres, as well as pathology, imaging and palliative care services, was not available.

In its early days, the CQCO held CCO accountable to develop a cancer control strategy for Ontario. The groundwork began in 2003, with CCO working with system stakeholders to redefine its vision, mission and guiding principles and to lead the development of a three-year provincial cancer plan encompassing a full range of cancer services. Subsequently, CCO published its first Ontario Cancer Action Plan, for the years 2005–2008 (Cancer Care Ontario 2005). The CQCO challenged CCO to develop an outcomes-based strategy and emphasized the use of verifiable quality metrics. This approach culminated in the council's most important product, a North American first in 2005 – the Cancer System Quality Index (CSQI) (CQCO 2012a).

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CQCO's Cancer System Quality Index

The CSQI is a web-based, interactive public reporting tool that presents comprehensive information on key indicators of cancer system performance, including data on mortality and survival. The CSQI is structured as a matrix reflecting the seven dimensions of quality as well as the patient's cancer journey from prevention and screening to active treatment, survivorship and end-of-life care. A valuable system-wide monitor that tracks the quality and consistency of key cancer services delivered across Ontario's cancer system, the CSQI is one of the most comprehensive reports of its kind in its breadth of measurement, jurisdictional comparisons and international benchmarks.

As such, the CSQI is an important tool for health professionals and cancer organizations, planners and policy makers in identifying cancer trends and in planning and making improvements in all areas of cancer control. Indicators within CSQI are a specific measure of progress against one of the seven quality dimensions:

- Safe (avoiding, preventing and ameliorating adverse outcomes or injuries caused by healthcare management)
- Effective (providing services based on scientific knowledge to all who could benefit)
- Accessible (making health services available in the most suitable setting in a reasonable time and distance)
- 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)
- Equitable (providing care and ensuring health status does not vary in quality because of personal characteristics (gender, ethnicity, geographic location, socioeconomic status, age)
- Integrated (coordinating health services across the various functions, activities and operating units of a system)
- Efficient (optimally using resources to achieve desired outcomes)

The CSQI has evolved since its inception and most recently reflects CCO's vision of "creating the best cancer system in the world" (Cancer Care Ontario 2011: 16). International comparisons of quality in cancer care are achieved by comparing cancer survival and patient experience across developed countries that maintain well-documented cancer registries. In 2011, an international comparison of cancer outcomes in several developed countries was published in *The Lancet*; it reported that Ontario's cancer survival was among the best in the world (Coleman et al. 2011).

The progressive measurement of cancer quality metrics generated by the CSQI has resulted in many improvements and has been incorporated within CCO's performance improvement cycle and clinical governance structures (Duvalko et al. 2009). Improvements include decreased surgical 30-day mortality related to consolidation of complex care in Ontario founded on evidence-based standards (i.e., thoracic surgery for lung and esophageal cancer as well as hepato–pancreatic–bilary surgery for pancreatic and liver cancer). Survival compares favourably with that of other jurisdictions; this is attributed to many factors, including oversight, accountability and the use of evidence to drive practice (e.g., pathology reporting being submitted in a standardized synoptic electronic format with discrete data fields that improve quality and readability).

In addition to ensuring accurate measurements of wait times for cancer treatment, CCO now reports wait times for more than 190 procedures and diagnostic exams for cancer and other conditions. Public reporting of these wait times has shown where bottlenecks are in the system and where quality improvement initiatives are needed.

The CSQI has also documented improvement in both modifiable cancer risk factors and improved uptake of cancer screening. Non-clinician members of the council have focused on ensuring there are indicators that measure the patient experience in the journey across the cancer. Indicators related to system integration and customer service are difficult to develop and measure, but doing so remains a goal of the Council.

The annual CSQI serves as an important benchmarking exercise that holds CCO accountable for progress in the quality of cancer services across Ontario. The CSQI also tracks Ontario's progress toward better outcomes in cancer care and highlights where cancer service providers can advance the quality and performance of care.

CQCO Products: Signature Events, Programmatic Reviews and Quality and Innovation Awards

The council not only measures CCO's progress, using the CSQI, it also suggests which elements of the cancer system require CCO's focused attention. The vehicle for council's annual focus on strategic priorities became known as the Signature Event. These one-day events are action-oriented and bring national and international expertise to the province, providing practical solutions and identifying areas of opportunity to improve the quality of health service delivery within the Ontario context. Annually since 2003, the Signature Event series has brought together practice leaders, policy makers, providers and patient representatives to solve pressing quality challenges in Ontario's cancer system. Subsequently, these events have been used as a catalyst to shape strategic directions and models to implement globally recognized best practices, helping CCO realize its vision of being the "best cancer system in the world" (Cancer Care Ontario 2011: 16).

Signature Events have explored topics such as cancer wait times and access to cancer services, palliative cancer care and colorectal cancer screening. They have explored using technology to improve the patient experience in cancer care, innovative models of care, the patient experience and, most recently, a system approach to preventing chronic disease (a collaborative engaging the Council, CCO and Public Health Ontario) (CQCO 2012b). These Signature Events are particularly important to quality improvement, since CCO's clinical council chair reports back to the CQCO on changes in program provision and initiatives undertaken by CCO as a result of the event recommendations.

A more recent CQCO product is the Programmatic Review, undertaken at the request of the clinical programs that are represented in the CCO Clinical Council. The first was a formative review focused on disease pathway management, in 2010. For these reviews, the CQCO invites international experts to Ontario to review progress, analyze the effectiveness of CCO programs and provide the programs with international expert advice on best practices. The result of the Programmatic Review is a set of recommendations on the strategic directions and improvements that the CCO program should undertake.

Finally, the CQCO sponsors annual Quality and Innovation Awards, which are provided to recipients at an event following the annual Signature Event. Since their inception in 2006, the Quality and Innovation Awards have recognized significant contributions to quality or innovation in the delivery of cancer care within Ontario. The 2011 awards expanded to include

contributions to cancer prevention, and the 2012 awards will include primary care integration with cancer. The awards are hosted and co-sponsored by the Council, CCO and the Canadian Cancer Society – Ontario Division.

These awards serve to recognize and promote front-line quality improvement. They complete the CQCO's quality improvement strategy, which includes measurement of cancer system performance (CSQI), identification of areas of opportunity (Signature Events) and analysis of program progress (Programmatic Reviews). The work of the CQCO is fundamental to CCO's quality agenda and will remain a central aspect of that agenda for the foreseeable future.

Conclusion

Over the last decade the CQCO has consistently improved its role in monitoring and reporting on quality, as well as providing tools to improve system performance and the quality of care that Ontario cancer patients received. The CQCO's next chapter is to ensure that the quality of the patient's experience is given equal weight in the quality agenda as clinical outcomes.

The source of the CQCO's success is directly linked to the commitment of its volunteer members, as well as to its productive working relationships with CCO, the regional cancer programs and other measurement/performance organizations locally, nationally and internationally. The shared beliefs in transparency, dedication to quality improvement and the perspective of the patient have been the critical success factors that will continue to serve the CQCO in its future work. HQ

About the Authors

Rebecca Anas, BSc, MBA, is the director of the Cancer Quality Council of Ontario (CQCO) Secretariat. In her current role, she leads a team to support the work of the CQCO, a quality oversight council that provides advice to Cancer Care Ontario and the Ministry of Health and Long-Term care in their efforts to improve the quality of cancer care in the province.

Robert Bell, MDCM, MSc, FACS, FRCSC, is president and CEO of the University Health Network (UHN) in Toronto, ON and is chair of the CQCO. From 2000 to 2005, he served as chief operating officer of UHN's Princess Margaret Hospital where he was responsible for leading Canada's largest comprehensive cancer centre. From 2003 to 2005, he served as regional vice president and chair of the Clinical Council of Cancer Care Ontario.

Adalsteinn Brown, DPhil, is the director of the Institute for Health Policy, Management and Evaluation at the University of Toronto. He is also leads the Division of Public Health Policy at the Dalla Lana School of Public Health and is a scientist at the Keenan Research Centre in the Li Ka Shing Knowledge Institute at St. Michael's Hospital. Dr. Brown is a member of the CQCO.

William Evans, MD, FRCPC, is the president of the Juravinski Hospital and Cancer Centre at Hamilton Health Sciences and Cancer Care Ontario's regional vice president for the Hamilton Niagara Haldimand Brant LHIN. Dr. Evans is a vice chair of the CQCO.

Carol Sawka, MD, FRCPC, is vice president, clinical programs & quality initiatives and co-chair, clinical council, Cancer Care Ontario. In that role, she works with clinical leaders across the province to improve the quality and coordination of the full spectrum of cancer care and is an ex-officio member of the CQCO. Dr. Sawka is a medical oncologist with a special interest in the management of breast cancer.

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