Ontario Health
Cancer Care Ontario

Progressing on Quality:

A Report on the Quality Management Partnership Transition – 2020

Progressing on Quality:
A Quality Management Partnership
Transition Report

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Executive Summary

As part of its mandate to improve the quality of healthcare in the province, the Ministry of Health announced the formation of the Quality Management Partnership (the Partnership) in 2013. The Partnership brought Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO) together to work alongside health system partners, including health service users, to develop and implement quality management programs (QMPs) in three health services areas: colonoscopy, mammography, and pathology. The goal of this report is to highlight progress made by the Partnership and to provide insight into how the findings and resources developed within the QMPs will continue, with the potential to grow, within Ontario Health.

The Partnership established three goals for the QMPs:

- enhance the quality of care and improve patient safety;
- increase the consistency in the quality of care provided across facilities; and
- improve public confidence by increasing accountability and transparency.

Each quality management program was comprised of four central components:

- evidence-based standards, indicators and guidelines that apply to all settings where the services are performed;
- quality reporting at the provincial, regional, facility and physician levels;
- a three-tier clinical leadership structure of provincial, regional, and facility leads; and
- resources, tools, and opportunities to support quality improvement.

This report highlights many of the Partnership's accomplishments and advances in colonoscopy, mammography and pathology quality, which serve as a strong foundation for Ontario Health to continue to build on. Potential next steps include:

- Supporting multi-level quality improvement by continuing and enhancing quality reporting at the provincial, regional, facility and physician levels
- Supporting the development and implementation of tools and resources to foster quality improvement at all levels
- Continuing to foster clinical and administrative leadership to enable meaningful quality improvement at all levels
- Building and improving on access to and collection of health data across all types of facilities
- Integrating the health service user voice throughout the development and implementation of quality initiatives

Introduction

Background

The Ministry of Health (the ministry) recognizes the need for a healthcare system that is transparent, is accountable, allows the people in Ontario to be actively involved in their care, and ensures that people across the province receive consistent, high-quality healthcare regardless of where they access services. As part of its mandate to improve the quality of healthcare in the province, the ministry announced the formation of the Quality Management Partnership (the Partnership) on March 28, 2013.

The Partnership brought Cancer Care Ontario and the College of Physicians and Surgeons of Ontario (CPSO) together to work alongside health system partners, including health service users, to develop and implement quality management programs (QMPs). QMPs were considered for a number of different health service areas (e.g., colposcopy). In the end, colonoscopy, mammography and pathology were selected as the first three health service areas. These areas were chosen because they all have foundations of quality management activity that the Partnership could build on (e.g., ColonCancerCheck and the Ontario Breast Screening Program). In addition, there was a perception that quality of care in these areas differed depending on where the services were provided.

The QMPs were designed by three expert advisory panels chaired by provincial clinical leads, one for each health service area. Panel members included physicians and other health professionals who practice in each health service area, administrators and health service users. The QMPs were established on four main pillars including: evidence-based standards and guidelines; quality reporting of indicators and standards at the provincial, regional, facility and physician levels; a three-tiered clinical leadership structure to support the different levels of reporting; and tools and resources to support areas for quality improvement identified by the data (Figure 1)

The Partnership established three goals for the QMPs:

- enhance the quality of care and improve patient safety;
- increase the consistency in the quality of care provided across facilities; and
- improve public confidence by increasing accountability and transparency.

Figure 1: Components of a Quality Management Program

Standards and Guidelines:

Quality Reporting:

Clinical Leadership:

Quality Improvement Resources:

About the Report

In keeping with the Partnership's commitment to transparency, the goal of this report is to highlight progress made by the Partnership and to provide insight into how the findings and resources developed within the QMPs will continue, with the potential to grow, within Ontario Health.

This report follows the release of other public reports that document the evolution of the Partnership, beginning in 2015 with Provincial Quality Management Programs for Colonoscopy, Mammography and Pathology in Ontario, which details the expert advisory panels' design and implementation recommendations for the QMPs. A subsequent report released the same year, Building on Strong Foundations: Inaugural Report on Quality in Colonoscopy, Mammography and Pathology, provided summary information on:

- health professionals and facilities in Ontario that are involved in the three health service areas;
- key provincial quality initiatives that exist in each health service area; and
- provincial performance as measured by the standards and indicators originally identified by the expert advisory panels, where data were available.

After the QMPs were implemented, Advancing Quality: Progress on Key Priorities in Colonoscopy, Mammography and Pathology was released in 2018 to detail progress on the Partnership's key priorities and to provide an update on selected measures of provincial performance in colonoscopy, mammography and pathology.

Progressing on Quality: A Quality Management Partnership Transition Report provides insight into the progress and key accomplishments of the three QMPs to support their transition to Ontario Health.

Progress and Accomplishments

The Partnership's progress was guided by a governance structure (Figure 2) that harnessed the expertise of health system leaders, administrators, clinicians, scientists and, most importantly, health service users. The Partnership's steering committee provided oversight and strategic guidance. The committee was co-chaired by the president and CEO of CCO and the registrar of the CPSO, and had membership from senior executives in both organizations. The steering committee also benefited from the advice and guidance of a number of other committees. The Health System Reference Group, chaired by the president and CEO of Health Quality Ontario, included experts in health system quality. Three Provincial Quality Committees, one for each health service area (colonoscopy, mammography and pathology), included regional clinical and executive leadership, health service users, clinical professional organizations and allied health professionals. These committees were chaired by provincial clinical leads who provided clinical expertise and implementation advice (see Appendix D for membership.)

Health service user input was central to the success of the Partnership. From the beginning of its work, the Partnership obtained health service user input and integrated it into its governance structure. Patients and service users had a Citizens' Advisory Committee (CAC), which was chaired by champions of patient engagement in healthcare. The CAC membership included health service users and family caregivers, all of whom were able to bring their unique perspectives as healthcare system observers and users. In addition to providing their perspective on the overall design and implementation of the QMPs, the CAC gave advice on specific aspects of the QMPs, such as language for quality standards, indicator prioritization and initiating the Partnership's public reporting strategy.

The Partnership also established a clinical leadership structure for each of the three health service areas. The structure included clinical leads at the provincial, regional and facility levels who helped implement the QMPs by providing clinical guidance and oversight. Where possible, existing regional clinical leadership of other provincial programs, such as cancer screening programs, was used. To support their clinical leads, facilities designated QMP executive and administrative contacts that worked with QMP facility leads to implement standards and quality improvement initiatives. This leadership model anchored accountability for quality in the facilities, where care is provided.

The Partnership aimed to build on existing quality initiatives and programs wherever possible. Doing this avoided duplication of efforts and promoted consistency and alignment between programs. For example, the Partnership endorsed standards, indicators and best practice guidelines already recommended or implemented provincially, nationally or internationally. In each QMP, the Partnership worked with key programs (e.g., Cancer Care Ontario's cancer screening programs, CPSO's Out-of-Hospital Premises Inspection Program) and stakeholder groups to ensure that endorsed guidelines and standards were applicable to all providers and care settings.

Figure 2: Partnership Governance Structure

To equip local providers with information on quality improvement, the Partnership released annual quality reports to provincial-, regional-, facility- and physician-level audiences. The uptake and application of these reports were supported by supplementary information on how to review, interpret and act on report findings; teleconferences to facilitate discussion among report recipients; and peer-to-peer support if needed.

The Partnership also developed resources and tools to help report recipients carry out quality improvement initiatives. Examples included resource toolkits for facility recipients, facility improvement plan templates, training on providing peer-to-peer performance feedback and information on clinical guidance. In addition, the Partnership hosted a learning management system (LearnQMP) to provide resources, continuing education, communities of practice and online collaboration among providers across the province.

The QMPs were dynamic programs intended to respond to the needs of the people of Ontario and the healthcare system. Therefore, evaluation was an important component of the Partnership's activities. As the QMPs were being implemented, various activities were evaluated, and the evaluation results were used to improve and refine the Partnership's approach. For example, report design was improved to increase usability, new quality indicators were added to make reports more meaningful, and training opportunities were introduced to address gaps in quality improvement knowledge and skills among report users.

Colonoscopy

Background

The Colonoscopy QMP applied to all facilities and providers of colonoscopy services, including gastroenterologists at hospitals and out-of-hospital premises (OHPs), general surgeons and endoscopy nurses. As of April 2019, 157 facilities in the province provided colonoscopy services across 100 hospitals and 57 OHPs.

Key Accomplishments

Aligning the Colonoscopy QMP with existing provincial programs and quality initiatives helped ensure that providers of colonoscopy services had clear and consistent goals for quality. Starting in 2015, the Partnership worked to implement its quality standards. It measured and reported on adherence to these standards and aligned selected QMP standards with those already accepted by other organizations. For example, QMP standards were aligned with the Out-of-Hospital Premises Inspection Program assessment standards established by the CPSO and facility standards outlined in the ministry's Quality-Based Procedures (QBP) Clinical Handbook for Gastrointestinal (GI) Endoscopy[1].

The Colonoscopy QMP was designed to have many quality indicators in common with the provincial colorectal cancer screening program, ColonCancerCheck, and the GI Endoscopy QBP. These three programs shared several similar indicator methodologies to ensure that reports developed by each initiative provided consistent information.

The Colonoscopy QMP's clinical leadership structure also aligned with other provincial programs and initiatives. The regional leadership for the Colonoscopy QMP shared oversight of ColonCancerCheck and the GI Endoscopy QBP, allowing for centralized regional leadership.

The Colonoscopy QMP established clinical and administrative contacts at each facility to create a direct channel of communication, which has allowed for information-sharing for the Colonoscopy QMP and other Cancer Care Ontario programs. In 2016 and 2017, cross-functional teams from the Partnership and Cancer Screening at Cancer Care Ontario onboarded 103 hospitals so they could submit colonoscopy procedure information to the GI Endoscopy Data Submission Portal (DSP).

The GI Endoscopy DSP was designed to capture data on all colonoscopy services, regardless of indication, performed in hospitals in Ontario. Compared to the previous reporting tool, the DSP provides better data quality, provides a more secure and dynamic channel of data submission, and captures more data elements for measuring and reporting on colonoscopy quality. The DSP supports programs across the province, including ColonCancerCheck and the GI Endoscopy QBP, as part of a provincial endoscopy program.

The Colonoscopy QMP administrative contacts helped onboard facilities to the DSP. This onboarding process allowed for more complete reporting because it was instrumental in introducing the DSP to hospitals that had not previously submitted data to Cancer Care Ontario.

From 2016 to 2019, the Colonoscopy QMP's annual facility survey was sent to all hospitals and OHPs providing colonoscopy services. The survey asked about readiness to provide colonoscopy for those with a positive fecal immunochemical test (FIT). The results from this survey provided a comprehensive picture on FIT readiness that aided regional and provincial planning efforts.

1 Tinmouth J, Kennedy EB, Baron D, Burke M, Feinberg S, Gould M, et al. Colonoscopy quality assurance in Ontario: systematic review and clinical practice guideline. Can J Gastroenterol Hepatol. 2014 May;28(5):251-74

In 2016, the Colonoscopy QMP started releasing annual quality reports at the facility, regional and provincial levels to all facilities at which colonoscopy was performed. In its second year of reporting, with input from the CAC and clinical and scientific leadership, the program prioritized three standards and two indicators to focus quality improvement efforts (see Figures 3 and 3). Please refer to the Appendix for a full list of the colonoscopy quality standards and indicators included in the annual quality reports.

In 2017, the Colonoscopy QMP achieved a major milestone when it released its inaugural physician-level reports to all active endoscopists. This was the first time in Ontario that all physicians in a health service area received a report about their performance from a mandatory provincial program with an established quality improvement mandate. The Colonoscopy QMP physician reports outlined the performance of endoscopists for select quality indicators compared to their peers and any applicable targets.

Based on their performance for certain indicators, physicians were provided with facilitated feedback from their regional leads. Facilitated feedback is a method for having conversations about performance and identifying areas for quality improvement[2]. The regional leads had one-on-one discussions with the physicians about their reports, the context of their practice and, if appropriate, actions for improvement. The facilitated feedback intervention was used for the 2017 and 2018 physician reports, and will continue as part of quality management in cancer screening.

In addition to supporting physician-level improvement, the facilitated feedback model helped build quality improvement capacity across Ontario because it provided the colonoscopy regional and provincial leads with facilitated feedback training that they could apply to all facets of their practice.

Supporting the Partnership's goal to foster ongoing quality improvement through quality reporting, the Colonoscopy QMP also developed and implemented a series of quality improvement tools and resources. These resources are specific to the QMP's standards and indicators, and include a bowel preparation information sheet, a patient discharge template for facilities, and information on courses and videos to support physician improvement.

2 Sargeant, J., et al. (2015) Facilitated Reflective Performance Feedback: Developing an Evidence-and Theory-Based Model That Builds Relationship, Explores Reactions and Content, and Coaches for Performance Change (R2C2). *Academic medicine: journal of the Association of American Medical Colleges, 90(12), 1698-706*

Key Report Findings

Figure 3 compares OHP and hospital adherence to three prioritized standards: informing referring physicians of all procedure results, using the global rating scale (GRS) and providing patients with written information at discharge. Overall, performance for the prioritized standards was mixed, with hospitals and OHPs performing similarly; the lowest adherence was reported for use of the GRS. Compared to 2017, adherence to the three prioritized standards has increased, with the greatest increase being for use of the GRS (data not shown).

Figure 4 shows hospital and OHP performance for the two prioritized indicators: inadequate bowel preparation and wait times from positive guaiac fecal occult blood test (gFOBT) to colonoscopy. The figure shows that while overall facility performance on wait time from positive gFOBT to colonoscopy has remained generally stable, the 75th percentile wait time decreased slightly in hospitals and increased slightly in OHPs since 2014. Performance on inadequate bowel preparation has seen some improvement across hospitals since 2015.

Figure 3: Prioritized Standards: OHP, Hospital and Ontario Adherence, 2019

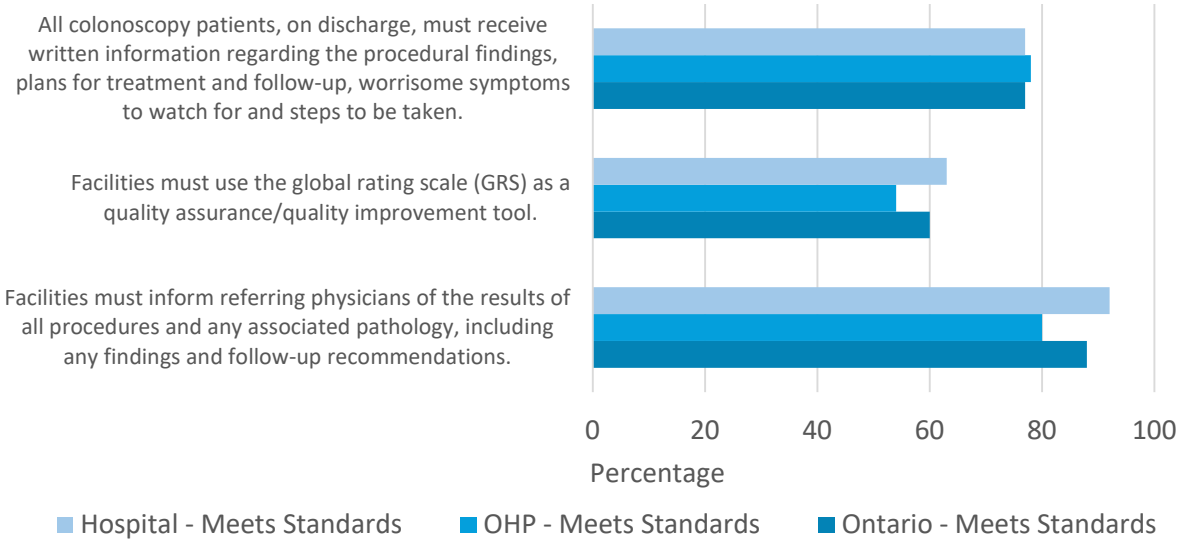


Figure 4: Prioritized Indicators: OHP, Hospital and Ontario Adherence

Abnormal FOBT to Colonoscopy Wait Time	75th Percentile (Days)				
	2014	2015	2016	2017	2018
Hospital total	77	79	77	75	74
OHP total	61	64	62	62	67
Total	72	74	72	70	71

Inadequate Bowel Preparation	Indicator Value (%)			
	2015	2016	2017	2018
Hospital total	3.3	3.0	3.1	2.7
OHP total	-	-	-	-
Total	3.3	3.0	3.1	2.7

Figure 5: Prioritized Standards Regional Summary, 2019

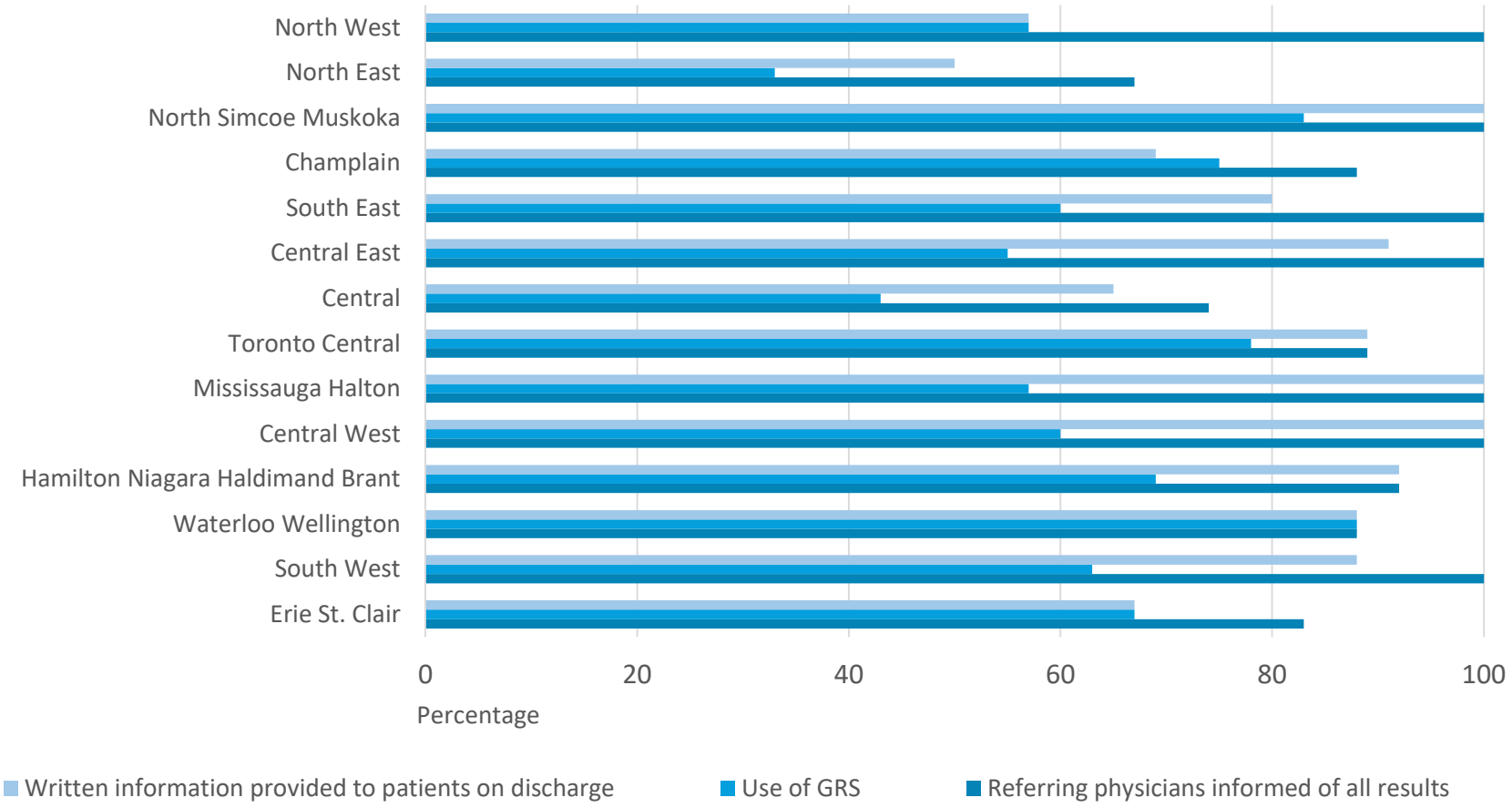
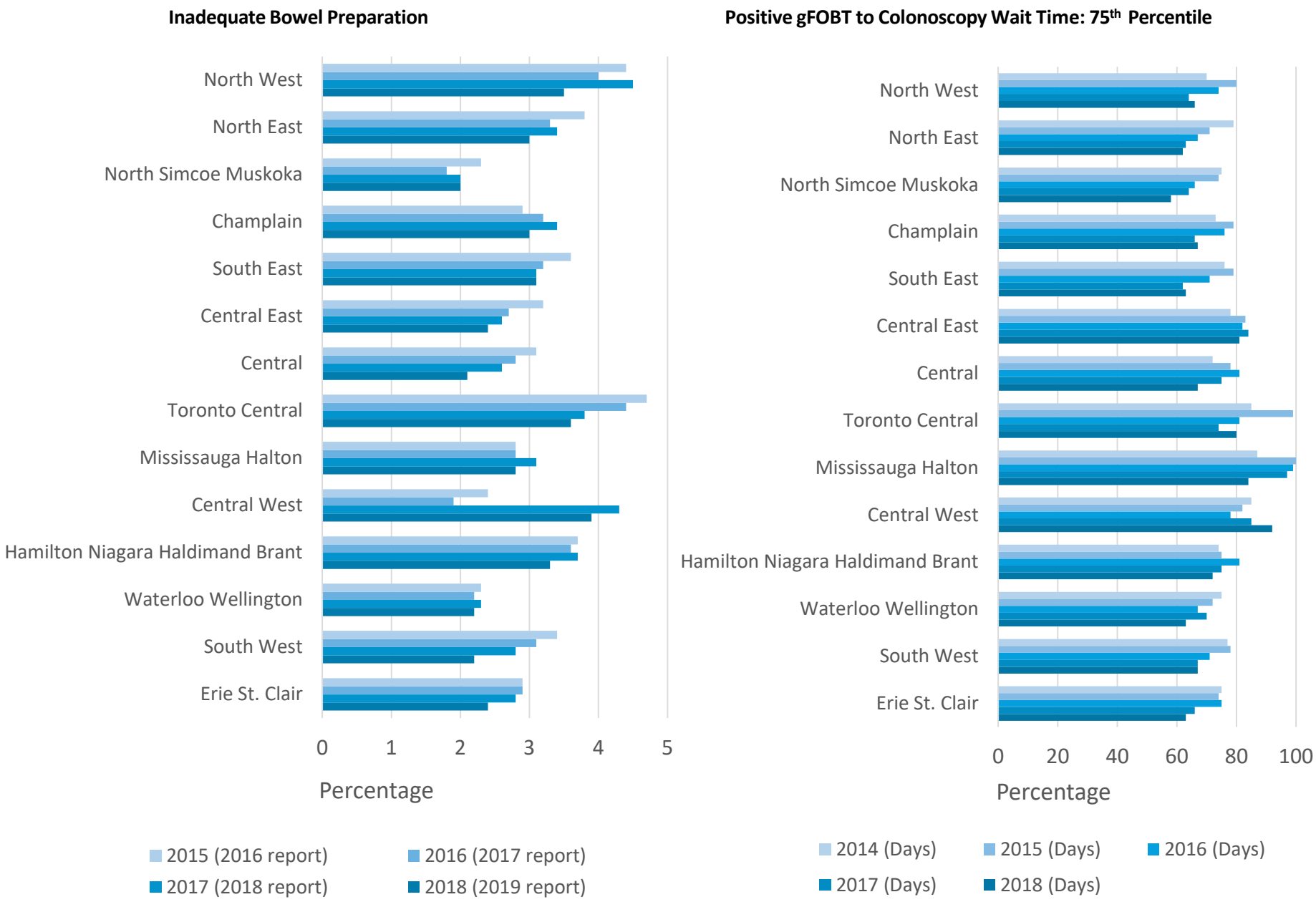


Figure 5 provides a regional summary of performance on the three prioritized standards (2019 data). This figure indicates that while adherence to the standard that facilities must inform referring physicians of all results is highly reported in all regions, there still remains variation in adherence to the three prioritized standards across regions.

Figure 6 provides a regional summary of performance on two prioritized indicators: inadequate bowl prep (data from 2015 to 2018) and positive gFOBT to colonoscopy wait time (data from 2014 to 2018). These figures show that there is regional variation in performance. Based on the selected indicators shown here, endoscopy performance in Ontario is good overall, but there are regional and facility variations that need to be addressed.

Figure 6: Prioritized Indicators Regional Summary



Looking Forward

The Colonoscopy QMP has made several gains in meeting the Partnership's goal of increasing the quality and consistency of colonoscopy services. The integration of province-wide standards and indicators in many system initiatives and quality reporting at the physician level has demonstrated the potential for unifying and reinforcing expectations of care across the system.

Within Ontario Health, there is potential for continued growth in quality reporting at the regional, facility and physician levels. With only two years of the facilitated feedback model, the work is still quite new. Evaluating the 2018 and 2019 reports and facilitated feedback conversations will continue to inform report development and follow-up in 2019/2020 under Ontario Health for colonoscopy and other health service areas. Advancing quality in colonoscopy services will also depend on expanding colonoscopy data collection beyond hospitals to include all facilities.

Mammography

Background

The Mammography QMP applied to all facilities delivering mammography services for all patients/service users and for all indications (e.g., screening and diagnosis). It encompassed all providers of mammography services, including medical radiation technologists who perform mammograms and radiologists who interpret them. In Ontario, mammography is performed in hospitals and independent health facilities (IHFs). As of May 2019, 239 facilities provided mammography services in Ontario: 110 hospitals and 129 IHFs.

Key Accomplishments

The alignment of the Mammography QMP with existing provincial programs and quality initiatives means that it has been able to help ensure that providers of mammography services have clear and consistent goals for quality. The Mammography QMP builds on the excellent foundation for quality established by the Ontario Breast Screening Program (OBSP), the CPSO's IHF Assessment Program and the Canadian Association of Radiology's Mammography Accreditation Program (CAR MAP). The Mammography QMP shares indicators, methodology and targets when available with the OBSP, and recommends that all mammography facilities be accredited by CAR MAP and participate in the OBSP.

The Partnership promoted adoption of its quality recommendations by aligning with the programs noted above, including introducing requirements for IHFs to adhere to the CPSO's *Independent Health Facilities Clinical Practice Parameters and Facility Standards*. These requirements included identifying a facility lead qualified to provide diagnostic services, including mammography, and participating in the OBSP[3]. These requirements supported Cancer Care Ontario's objective of transitioning all screening mammography facilities into the OBSP, which would give all eligible people in Ontario access to organized breast cancer screening. It would also expand the OBSP's ability to collect screening data, which would result in better quality reporting and improvement supports.

The clinical leadership structure for the Mammography QMP was established to reflect its alignment with other provincial programs and initiatives. The regional leadership included regional breast imaging leads for the Mammography QMP and the OBSP, which allowed them to work together on prioritizing quality initiatives and program oversight.

Since 2016, the Mammography QMP has released annual reports at the facility, regional and provincial levels to all facilities providing mammography in Ontario. These reports aligned with other quality reports in the field as much as possible, including the annual physician-level report that has been issued by the OBSP since 2000. In response to feedback from a report evaluation survey, the 2018 report included three new indicators that offered more timely data, including a new breast cancer detection rate indicator. Appendix B contains a full list of the mammography quality recommendations and indicators included in the annual quality reports.

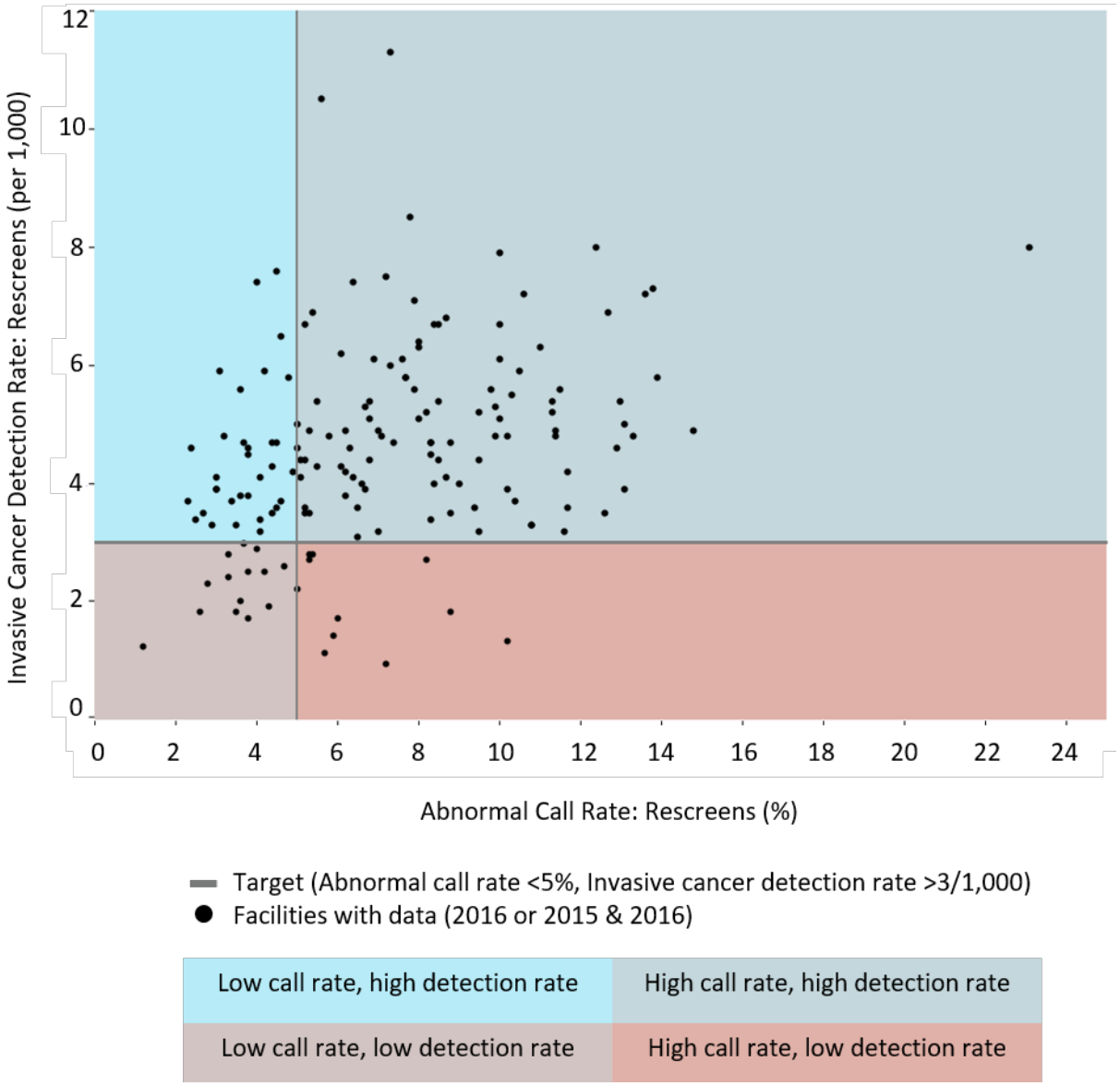
Supporting the Partnership's goal to foster ongoing quality improvement through quality reporting, in 2019, the Mammography QMP facility reports introduced a new visual representation that compared two key quality indicators: invasive cancer detection rate (rescreens) and abnormal call rate (Figure 7). By comparing these two indicators, facilities would be able to better understand their performance and how they compared to other facilities across the province. Accompanying this new visual representation were suggested actions for quality improvement based on where facilities placed on the graph.

3 *Independent Health Facilities: Clinical Practice Parameters and Facility Standards*. Diagnostic Imaging – July 2018 (Revised January 2019). Accessible at: https://www.cpso.on.ca/admin/CPSO/media/Documents/physician/your-practice/quality-in-practice/cpgs-other-guidelines/ihf-standards-diagnostic-imaging.pdf

Since its inception, the Mammography QMP has developed and implemented a series of quality improvement tools and resources. To promote and support high-quality reporting, a multidisciplinary panel developed a standardized screening mammography report template and implementation toolkit that were implemented across all facilities performing mammography.

Other resources, such as the quality report supplementary information document, were designed to help report recipients interpret their report and act on opportunities for improvement identified by the report. In addition, an educational template was developed for regional clinical leads to use in their regional quality improvement activities.

Figure 7: Categorization of Interpretive Performance

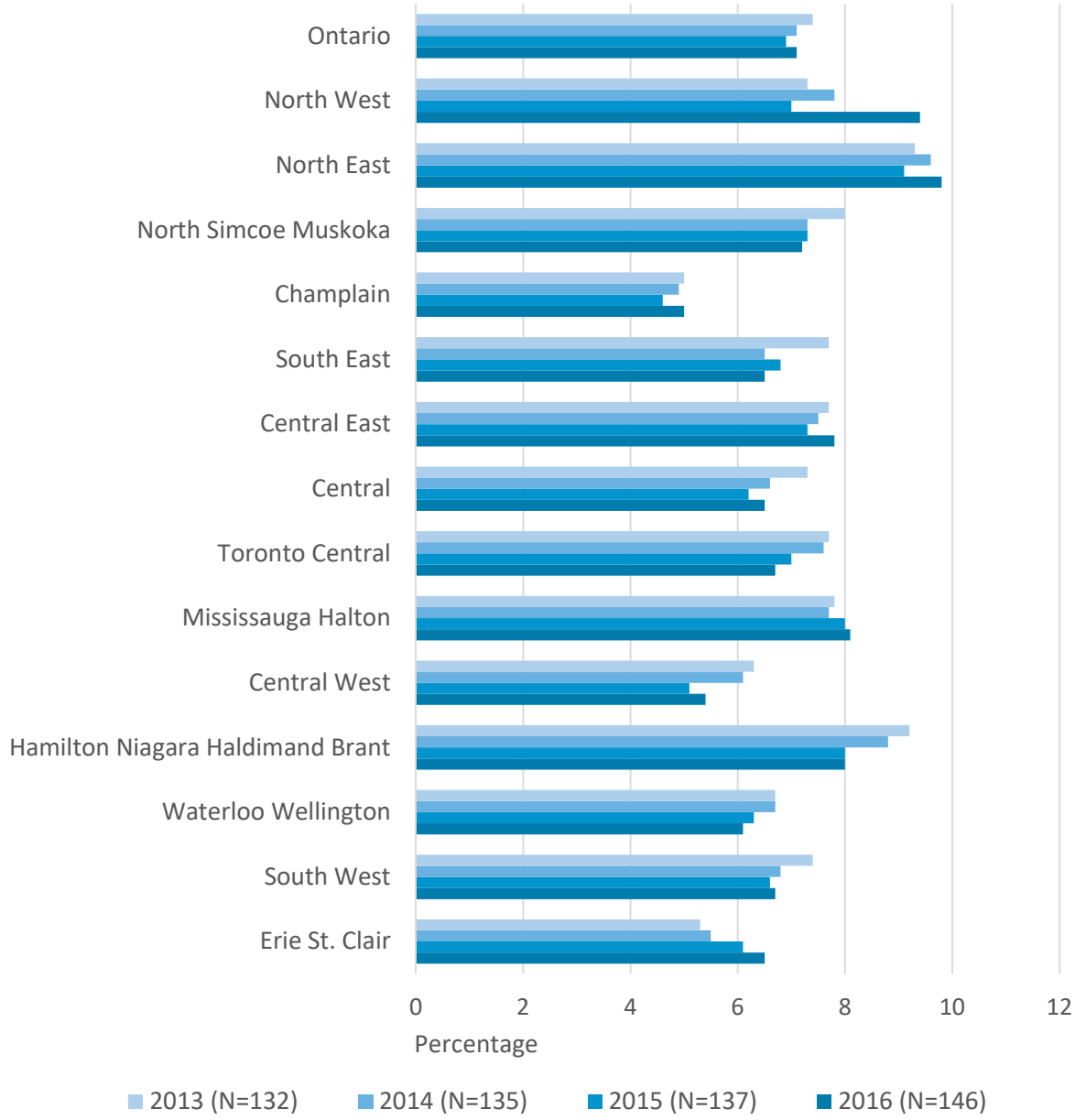


Key Report Findings

Figure 8 shows the percentage of OBSP screening mammograms that were identified as abnormal by radiologists from 2013 to 2016. The national target for this indicator is less than five percent for rescreens[4]. Provincially, the abnormal call rate improved from 2013 to 2016; however, there is variation across regions, with the rate increasing in five of them. It is important to note that having an abnormal call rate higher than the target is not an Ontario-specific phenomenon; abnormal call rates have been increasing in all Canadian jurisdictions and frequently exceed the target.

It is important to interpret abnormal call rate, positive predictive value (Figure 9) and invasive cancer detection rate (Figure 10) in the context of one another because they are interrelated. For example, high abnormal call rates are less concerning if cancer detection rates and positive predictive value are near target or in line with regional and provincial comparators. In contrast, high abnormal call rates paired with low cancer detection rates and low positive predictive value suggests that there may be an opportunity for improvement.

Figure 8: Abnormal Call Rates for OBSP Facilities, Regional Summary



4 Rescreens are subsequent screening mammograms for individuals who had more than one mammogram

Figure 9 shows the positive predictive value, which is the percentage of OBSP screening mammograms with an abnormal result that turned out to be breast cancer (ductal carcinoma in situ or invasive breast cancer). The national target for this indicator is equal to or greater than six percent for rescreens. Most regions met the target, and the majority improved from 2013 to 2016.

Figure 9: Positive Predictive Value for OBSP Facilities, Regional Summary

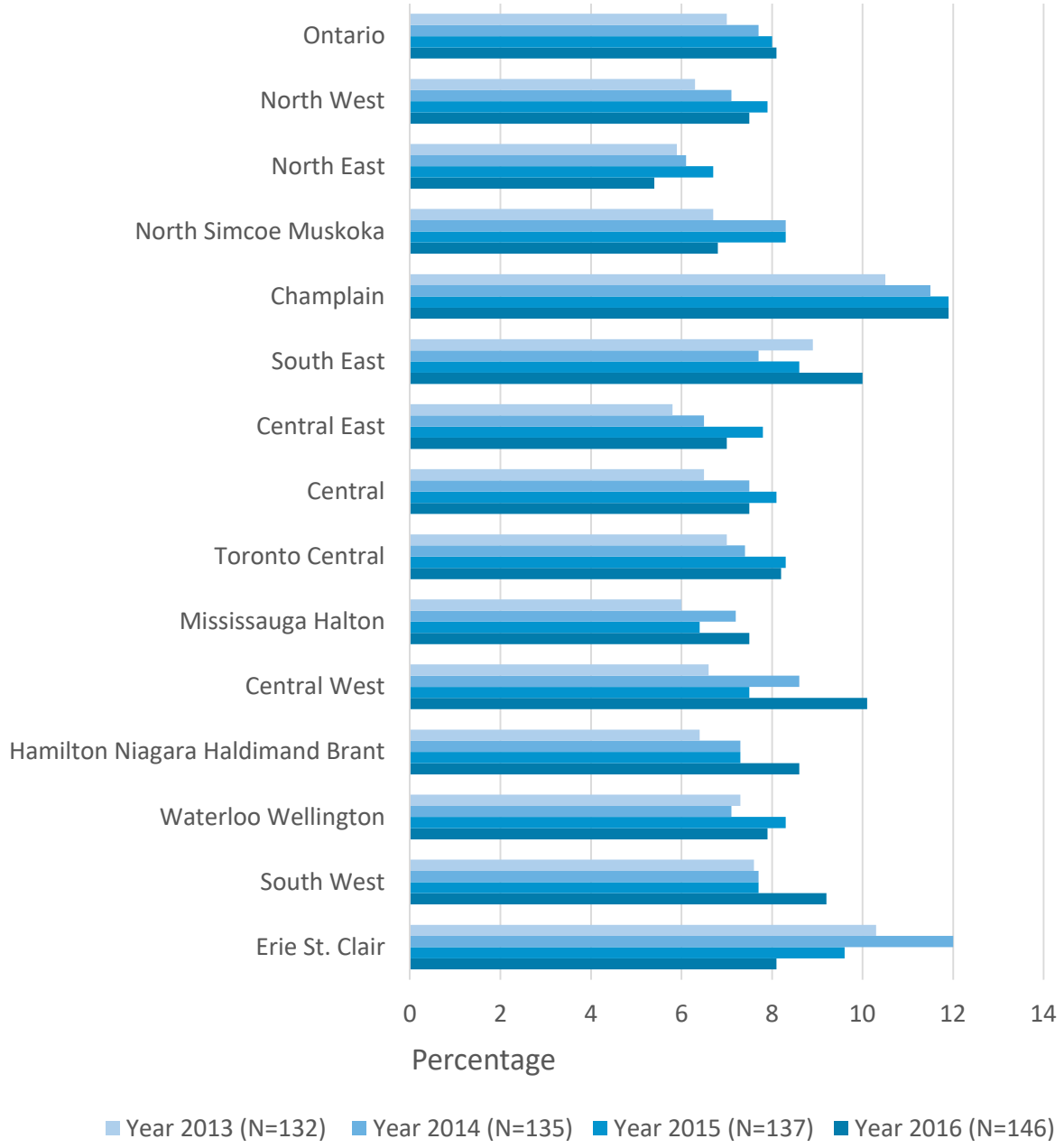
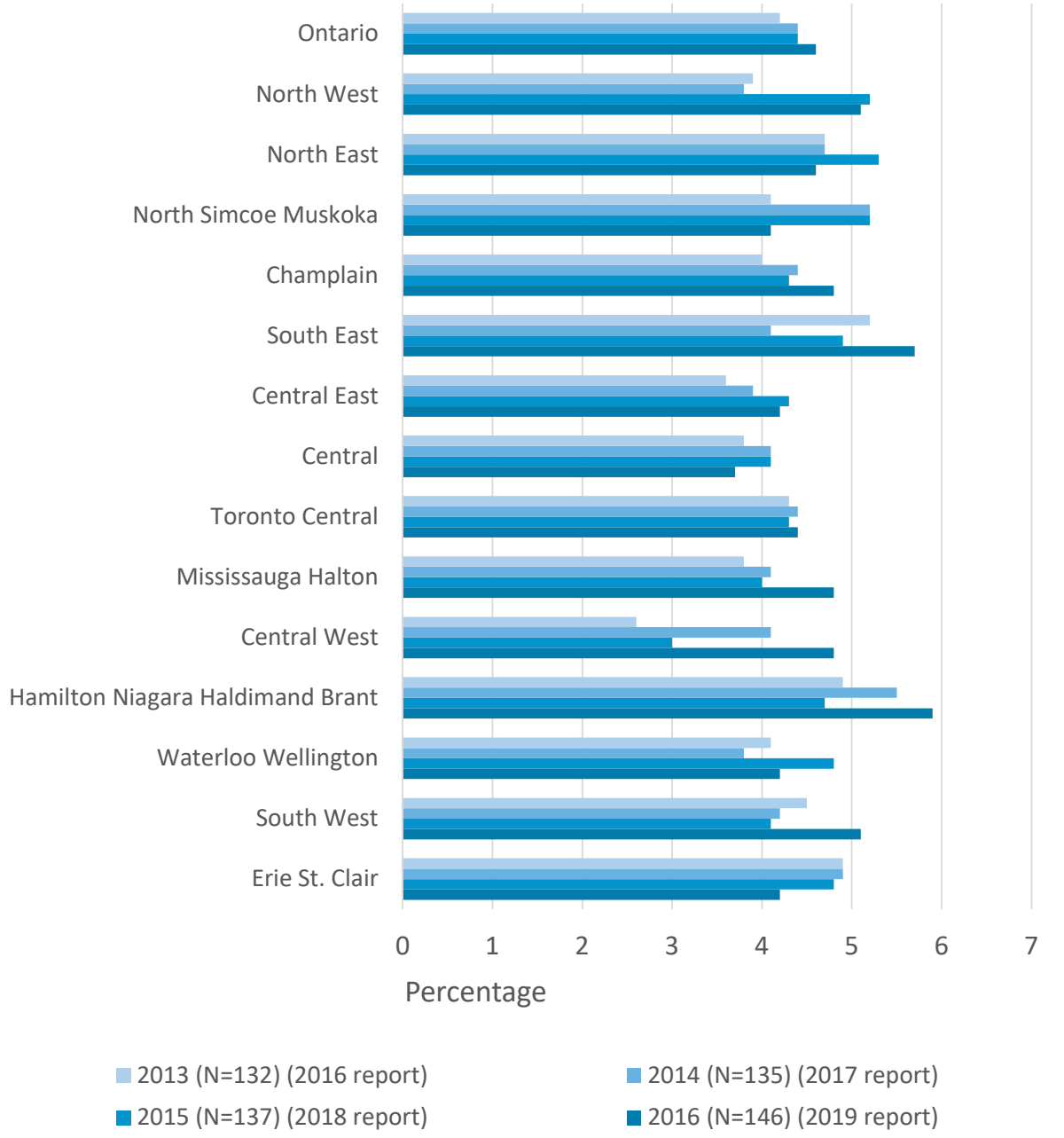


Figure 10 shows the rate of OBSP screening mammograms with an invasive screen-detected breast cancer per 1,000 mammograms. The national target for this indicator is greater than three per 1,000 rescreens. Most regions met the target, and the majority improved from 2013 to 2016.

Figures 8, 9 and 10 show that the quality of screening mammography in Ontario overall is good, but there are regional variations.

Figure 10: Invasive Cancer Detection Rate for OBSP Facilities, Regional Summary



Looking Forward

The Mammography QMP has made several gains in meeting the Partnership's goal of increasing the quality and consistency of mammography services. Integrating the QMP's recommendations with the CPSO's *Independent Health Facilities Clinical Practice Parameters and Facility Standards* helped transition all screening mammography into the OBSP, which has spread the benefits of screening in the OBSP to more women across the province.

Mammography quality reporting at the regional and facility levels can continue to grow within Ontario Health. The knowledge and experience gained from facilitated feedback and individual physician-level improvement in colonoscopy can be applied to radiologist outcome reports, which will further support radiologist performance in screening mammography. Radiologist outcome report design can also be improved and aligned with other similar reports based on learnings from evaluations of mammography facility and colonoscopy physician reports. In addition, Ontario Health has the opportunity to build on and create new quality improvement resources, such as case studies for radiologists to help them improve their interpretation skills. Finally, data collection and standardized reporting for mammography and other breast imaging modalities (e.g., breast magnetic resonance imaging and ultrasound) could be expanded to support more comprehensive, high-quality breast imaging.

Pathology

Background

The scope of the Pathology QMP focused on the analytical or interpretative component of surgical pathology, which involves studying tissue samples for diagnostic and patient management purposes. Quality in surgical pathology encompasses the following domains: accuracy, timeliness, completeness, appropriateness and effectiveness. The Pathology QMP focused on measures of appropriateness, effectiveness and timeliness. In Ontario, diagnostic interpretation of tissue samples is done by anatomical and general pathologists in laboratories. In 2018, surgical pathology services were provided in 53 facilities: 48 hospitals, four community (private) labs and one university-based lab.

Key Accomplishments

One of the Pathology QMP's core goals was to standardize quality assurance processes in laboratories across the province. To further this objective, the expert advisory panel endorsed the work of Path2Quality, a collaborative initiative between the Ontario Medical Association Section on Laboratory Medicine and the Ontario Association of Pathologists. The Path2Quality group's Standards2Quality Guidelines for Quality Management in Pathology Professional Practices - Version 2[5] outlined a core set of standards and indicators based on the workflow processes involved in interpretative work of surgical pathology.

Implementing these standards and key indicators would allow laboratories to monitor accuracy, effectiveness and timeliness, and provide data for quality improvement initiatives, as needed. In 2015, the Pathology QMP prioritized six of these standards for implementation through self-reported annual quality reports, and in 2018, it added two additional standards. In light of resource pressures in pathology laboratories and the diversity of information management systems across the province, there were challenges in collecting indicator data. Despite these challenges, the Pathology QMP worked towards achieving full indicator implementation.

The Pathology QMP found opportunities to align its work with other key stakeholder groups, such as Cancer Care Ontario's Pathology and Laboratory Medicine Program, the Institute for Quality Management in Healthcare, the Ontario Association of Pathologists, and the Ontario Medical Association Section on Laboratory Services. Representatives of these organizations participated in the Pathology QMP's Provincial Quality Committee and were consulted on initiatives of key importance to the Pathology QMP, such as prioritizing standards, developing indicator definitions and methodology, and creating a provincial quality improvement plan.

In 2016, the Pathology QMP started releasing quality reports at the facility, regional and provincial levels to all facilities providing surgical pathology services. The reports contained facility-reported data for compliance with prioritized standards. Appendix C contains a list of the quality standards included in the annual quality reports.

From 2016 to 2018, results from self-reported annual facility surveys showed a progressive increase in implementing these standards (Figure J). Provincially, there was an increase in the number of labs that established pathology professional quality management committees (from 64 percent in 2016 to 90 percent in 2018) and developed pathology professional quality management plans (from 58 percent in 2016 to 87 percent in 2018). Documenting policies and guidelines also improved:

- labs with documented policies for the investigation and/or resolution of report discordances increased from 72 percent (2016) to 94 percent (2018);
- labs with documented guidelines for the classification of report discordances increased from 70 percent (2016) to 94 percent (2018);
- labs with documented policies outlining the process and documentation of comparing intra-operative consultation results with final diagnosis increased from 71 percent (2016) to 98 percent (2018); and

5 Standards2Quality Guidelines for Quality Management in Pathology Professional Practices - Version 2 [Internet]. [Place unknown]: Path2Quality (a collaboration of the OMA Section on Laboratory Medicine and the Ontario Association of Pathologists); 2011 Mar 31 [updated 2013 Sep 3; cited 2016 Apr 8]. 101p. Available from: https://cap-cp.org/cmsUploads/CAP/File/Standards2Quality%20-%20Version%202.pdf

- labs that review data on intra-operative consultation cases with discordances for the surgical pathology professional group grew from 80 percent (2016) to 98 percent (2018).

The marked improvement in adherence to prioritized standards and the 100 percent response rate to the facility surveys demonstrate the Pathology QMP's effective engagement with facilities and pathologists to ensure accurate, timely and effective pathology reporting.

The Pathology QMP also used the facility survey to gather input on the issues facing the field. In 2018, the survey included questions about barriers to implementing standards and improving performance on quality indicators that were proposed for future inclusion in Partnership reports. The most commonly identified barrier was pressures largely related to pathologist resources, availability of pathologists' assistants as well as technologist and decision support resources, signaling an opportunity for future resource discussions.

The Pathology QMP developed and engaged a strong network of regional and facility leads, including facility leads in private and community labs. Based on the expert advisory panel's recommendation, the clinical leadership structure of the Pathology QMP differed in some ways from that of mammography and colonoscopy. While the regional leadership structure largely followed established Regional Cancer Program geographic boundaries, the Pathology QMP also established a regional lead representing the private and community lab sector to ensure that the perspectives of all Ontario lab settings were represented. The regional clinical leads were accountable to the provincial clinical lead, which ensured consistent oversight for pathology quality across the province.

This strong network of clinical and administrative leaders made it possible to overcome challenges. For example, a key challenge for quality reporting in pathology is the inability to report quality indicators from administrative databases, but the Pathology QMP made strides in this area. In early 2019, the Pathology QMP completed a validation study to support the development of a turnaround time indicator for all pathology cases. The study yielded a strong response from facilities (60 out of 63 labs participated, or 95 percent) and demonstrated alignment between data available to Cancer Care Ontario through its data holdings and data collected by labs (data validated for 59 out of 63 facilities, or 94 percent, based on total turnaround time for all specimens). Results from a preliminary analysis of these data found that the average provincial turnaround time was eight days, with a range of two days in the 10th percentile and 15 days in the 90th percentile in the 2018/2019 fiscal year (data not shown). Data variation was expected to be addressed through lab information system updates. Based on this study, the provincial turnaround time data were to be included in future annual reporting.

Supporting the Partnership's goal to foster ongoing quality improvement through quality reporting, the Pathology QMP developed several quality improvement resources, including a toolkit to support facilities when implementing their quality improvement plan. The Pathology QMP developed a provincial quality improvement plan that outlined QI priorities, targets (e.g., for uptake of prioritized standards), improvement methods and measures of success. The program also developed two clinical guidance documents for the field: one on the principles and categorization of discordance in pathology with a focus on patient and clinical impact, and one in collaboration with the Colonoscopy QMP to encourage consistency among pathologists and endoscopists when documenting polyps.

The Pathology QMP also led a number of quality improvement capacity building activities. In partnership with Health Quality Ontario, the Pathology QMP hosted webinars on foundational elements of quality improvement with a focus on pathology. The webinars were very well attended by pathologists across the province. In addition, regional and facility leads completed facilitated feedback training to strengthen their communication skills.

Key Report Findings

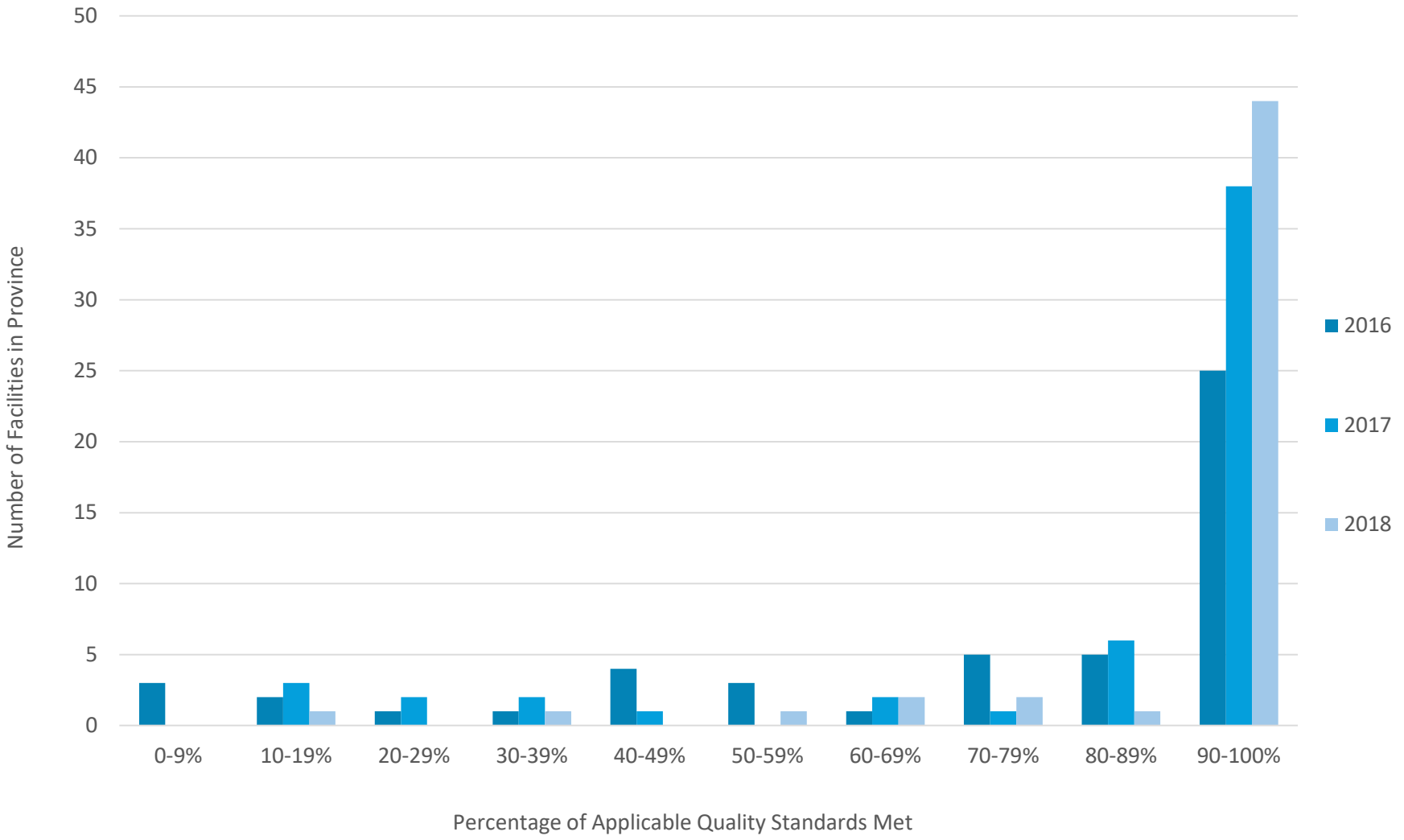
Figure 11 shows the change in facilities' adherence to each of the 10 standards since 2016. There was a consistent increase in self-reported adherence in all 10 standards in 2017 and further adherence increase in nine of the 10 standards in 2018.

Figure 11: Change in Adherence to Prioritized Standards

Figure 12 compares the percentage of overall adherence to the prioritized standards in 2016, 2017 and 2018. This figure shows that there has been progress since 2016.

These data show that the majority of pathology laboratories have internal processes in place to ensure high levels of adherence to the quality standards, and are monitoring data for timeliness and intra-operative consultation discordance and deferral rates.

Figure 12: Percentage of Prioritized Standards



Looking Forward

The Pathology QMP has made important gains in meeting the Partnership's goal of increasing quality and consistency of pathology services. The increased uptake of the pathology QMP standards has contributed to consistent quality assurance processes in facilities that provide pathology services across the province. The Pathology QMP clinical leadership structure contributed to a positive system-wide culture of high quality and enhanced patient safety, while the program laid the groundwork for a culture of continuous quality improvement.

Quality reporting of pathology standards at regional and facility levels is important, and there is an opportunity to continue this work within Ontario Health. There is also an opportunity to expand quality improvement across pathology facilities based on the experience gained in facilitated feedback. Many of the other initiatives started by the Pathology QMP hold significant promise for this service area and present opportunities for Ontario Health to continue the work of strengthening pathology quality in Ontario.

Ontario Health has an opportunity to improve data collection and reporting on quality indicators in pathology to explore clinician level reporting and foster communities of practice.

Looking Ahead

This report highlights many of the Partnership's accomplishments and advances in colonoscopy, mammography and pathology quality. Ontario Health is building on the Partnership's successes by continuing to build on its framework for quality (Figure 1). Opportunities to continue this work are described below:

Support multi-level quality improvement by continuing and enhancing quality reporting at the provincial, regional, facility and physician levels

To support the provincial colorectal and breast cancer screening programs, colonoscopy and mammography quality reporting continues at the physician, facility, regional and provincial levels. Where data availability allows, the reports will add new indicators (e.g., adenoma detection rate, malignant biopsy rate) and support for quality improvement. There will be a continued focus on improving the user experience for colonoscopy and mammography quality reports.

The knowledge and experience gained through colonoscopy and mammography quality reporting will also be used to expand quality reporting to other health service areas. Work is underway to develop colposcopy quality reporting that supports the implementation of human papilloma virus (HPV) testing in the Ontario Cervical Screening Program.

In 2019, the colonoscopy quality physician reports were made available through an online portal. This online access allows physicians to access additional information (e.g., previous years' reports, quality improvement resources) and, in time, will allow for enhanced functionality of the reports.

The importance of local accountability for quality was foundational to the Partnership's work from its inception. As revisions are made to regional structure and resourcing, it will be important to consider the impacts of these changes on quality reporting (e.g., approaches to dissemination, quality improvement activities) so that all levels of these reports may continue to effectively support local quality efforts.

Support developing and implementing tools and resources to foster quality improvement at all levels

As highlighted in this report, the Partnership led a number of initiatives to meet the quality needs of the health system. Ontario Health could advance this work by continuing and expanding the quality reporting and quality improvement processes enacted by the Partnership. For example, facilitated feedback discussions to foster physician-level quality improvement could be strengthened by offering case reviews, support for communities of practice, and more quality improvement capacity building through training opportunities and webinars.

The Partnership's educational tools, templates and resources helped report recipients interpret and take action in response to their quality reports. Continuing this work, will contribute to the culture of quality improvement in provincial healthcare.

Continue to foster clinical and administrative leadership to enable meaningful quality improvement at all levels

Developing tools, distributing reports and facilitating improvement at all levels has greatly improved. The reach of the Partnership's clinical and administrative leadership network across the province enabled more peer-to-peer support for providers, greater reach for the Partnership's initiatives and a greater pool of knowledge to draw on.

In addition, the role of regional leadership in supporting quality improvement interventions will continue to be an important focus for Ontario Health as regional structure, resourcing and accountability evolve.

Build and improve on access to and collection of health data across all types of facilities

The Partnership's mandate promised consistent quality across all providers and care settings in the three health service areas. To meet this goal, some gaps need to be addressed, such as availability of data. Access to all breast imaging data beyond the organized cancer screening program (e.g., indications other than screening and imaging modalities other than mammography) is needed to strengthen breast imaging quality. OHPs need to provide colonoscopy quality data for more comprehensive quality reporting and improvement.

Finally, pathology quality is well-developed, but without a comprehensive pathology data collection strategy there will remain gaps across multiple pathology quality initiatives. If a pathology data collection strategy were developed and implemented, it could serve as the foundation for initiatives to support quality improvement in pathology within Ontario.

Integrate the health service user voice throughout the development and implementation of quality initiatives

Based on the Partnership's experience, embedding the patient/health service user voice throughout the development and implementation of quality initiatives and processes is crucial and help ensure that improvement in quality is clinically meaningful.

Acknowledgements

The Partnership's accomplishments would not have been possible without the dedication of many people, all committed to improving the quality of healthcare services in Ontario. See Appendix E for a listing of staff contributors to the Partnership's work

From the very beginning, the executive leadership from Cancer Care Ontario and the CPSO were integral in championing the Partnership and its work. In particular, we would like to thank:

- Michael Sherar, Former President and CEO of Cancer Care Ontario
- Dr. Rocco Gerace, Former Registrar of the College of Physicians and Surgeons of Ontario
- Dr. Nancy Whitmore, Registrar of the College of Physicians and Surgeons of Ontario
- Dr. Linda Rabeneck, Vice President, Prevention and Cancer Control, Ontario Health (Cancer Care Ontario)
- Dr. Sheila Laredo, Chief Medical Advisor, College of Physicians and Surgeons of Ontario
- Michelle Lloyd, Director, Quality Management, Ontario Health (Cancer Care Ontario)
- Laurie Bourne, Former Director, Quality Management and QMP, Cancer Care Ontario
- Wade Hillier, Former Director, Quality Management Division, College of Physicians and Surgeons of Ontario
- Shandelle Johnson, Director, Quality Improvement and Quality Assurance, College of Physicians and Surgeons of Ontario

We also acknowledge the staff and leadership at CCO and the CPSO who transformed a high-level mandate into the implementation of three provincial QMPs. This work was made possible with the participation of many health system partners, including clinicians, administrators, scientists and patients/health service users who took their time to provide their expert advice.

It is also important to acknowledge our clinical leaders at the provincial, regional and facility levels whose expertise and leadership were invaluable to the development, implementation and ongoing work of the QMPs. Their contributions ensured a comprehensive understanding of quality in each health service area.

Acknowledgements Highlights

For their leadership, vision, and effort in working to achieve the Quality Management Partnership's objectives, and for their ongoing commitment to quality, we would like to extend our thanks to the following people:

Jill Adolphe, Chair, Citizens' Advisory Committee, 2018–2019

Jill Adolphe is the co-founder of Care 2 Collaborate. She is a patient and caregiver engagement specialist and educator with expertise in patient and caregiver experience. She has been involved in healthcare for over 20 years. Her in-depth knowledge and insight from years of working directly with healthcare organizations, providers, academic institutions, policy makers, government organizations, governing bodies, patients and families complement her first-hand lived experience as a patient and family caregiver.

She was a member of the QMP Provincial Pathology Expert Advisory Panel from 2013 to 2015. She also served as the Chair of the QMP Citizens' Advisory Committee and a member of the Pathology and Colonoscopy QMP Provincial Quality Committees. She holds an HBA in economics from the University of Toronto, and graduated with a business degree with distinction from the London School of Economics in the UK. She worked in the investment industry for 17 years.

Dr. Kathy Chorneyko, Provincial Lead, Pathology Quality Management Program, 2013–2019

Dr. Kathy Chorneyko is a pathologist and medical laboratory director at Brant Community Healthcare System and West Haldimand Hospital. In Brantford, she is also the medical co-lead for patient experience and quality outcomes team. Trained in anatomical and general pathologist, she has worked in both academic and community laboratory environments. She is a former Royal College examiner in Anatomical Pathology as well as past president of Brant County Medical Association and the Ontario Association of Pathologists (OAP). She has been involved with Path2Quality for many years contributing to both the Standards2Quality and Work2Quality documents as well as other Path2Quality initiatives. She is an anatomical pathology immunohistochemistry assessor for the Institute for Quality Management in HealthCare (IQMH) program and an Ontario Laboratory Accreditation assessor. She works with the Canadian Society for Medical Laboratory Science (CSMLS) as a cytology exam panel member.

Judith John, Citizen's Advisory Committee Chair, 2016–2018

Judith John served as Vice-President of Communications, Marketing and Public Affairs at United Way Toronto, Mount Sinai Hospital and Foundation, and the Hospital for Sick Children. She volunteers widely, including with University Health Network, Princess Margaret Cancer Centre, SickKids and Mount Sinai, concentrating on the patient experience, partnerships and communications. She is a trained Patient Partner, writer, consultant, facilitator and coach. As a patient advocate, public relations, ethics and marketing instructor and lecturer, she has taught at universities and colleges across Ontario and has been a guest speaker for institutions worldwide, including England's National Health Service. She sits on several arts boards, literacy organizations, the Advisory Board for the Ryerson City Building Institute, as well as The V Generation, which promotes meaningful volunteerism for retirees and senior citizens. She chairs and is an active member of several inter-institutional and government committees and panels, as they work to improve healthcare in Canada.

Dr. David Morgan, Provincial Lead, Colonoscopy Quality Management Program, 2013–2019

Dr. David Morgan, MD, MSc, FRCPC, CAGF, is Head, Service of Gastroenterology, and Deputy Chief, Department of Medicine, at St. Joseph's Healthcare in Hamilton. He also is on Faculty at McMaster University. Dr. Morgan is a previous president of the Canadian Association of Gastroenterology and is currently the Vice-President of the Ontario Association of Gastroenterology. Dr. Morgan's research interests include dyspepsia, including effects of non-steroidal anti-inflammatory drugs. Other research has included colon cancer prevention with COX-2 specific inhibitors and upper GI bleeding secondary to non-steroidal anti-inflammatory drug use. He has published on topics such as GI bleeding, quality of life in cancer care, use of proton pump inhibitors and the prevention of bleeding from GI vascular lesions. Dr. Morgan has participated on several Canadian Association of Gastroenterology consensus panels related to topics such as colorectal cancer screening.

Dr. Rene Shumak, Provincial Lead, Mammography Quality Management Program, 2013–2015

Dr. Rene Shumak received her medical degree and training in Diagnostic Radiology at the University of Toronto. Dr. Shumak is an Assistant Professor of Medical Imaging at the University of Toronto. She is an expert in breast imaging who was the first Provincial Clinical Lead for the mammography quality management program. She previously served as Cancer Care Ontario's Radiologist-in-Chief for the Ontario Breast Screening Program (OBSP) and subsequently served as Special Advisor to the OBSP, focusing on the OBSP High Risk Screening Program. She continues to serve as a Regional Breast Imaging Lead for the OBSP. Through her expertise and leadership, Dr. Shumak has had a tremendous impact on the quality of mammography in Ontario.

Dr. Rola Shaheen, Provincial Lead, Mammography Quality Management Program, 2015–2019

Dr. Rola Shaheen received her medical degree from the University of Jordan in Amman, followed by training in Diagnostic Radiology at the University of Toronto, and completion of a Women's Imaging Fellowship at Beth Israel Deaconess Medical Centre at Harvard Medical School. Dr. Shaheen previously served as Chief of Radiology and Director of Women's Imaging at Harrington Memorial Hospital, a community hospital affiliated with Harvard Medical School. From 2012 to 2015, Dr. Shaheen served as Chief of Women's Imaging at Mafraq Hospital in Abu Dhabi, a major government hospital, where she spearheaded the development of breast imaging programs. In 2015, she returned to Canada and was appointed Chief and Medical Director of Diagnostic Imaging at Peterborough Regional Health Center.

Appendices

Appendix A: Colonoscopy QMP Quality Standards and Indicators

Colonoscopy QMP Quality Standards[6]

1. (OHPs only) Facilities must participate in regular inspections and assessments to ensure they meet appropriate standards

2. Facilities that provide colonoscopy must have the equipment and endoscopists working in those facilities must have the expertise to:
    a. Recognize abnormalities and perform biopsies
    b. Tattoo to identify appropriate abnormalities for follow-up
    c. Remove polyps at least 1cm in diameter
    d. Manage complications resulting from interventions, including knowing when to use clips and/or other hemostasis
    e. Know when transfer to another level of care is required
    f. When transfer is initiated, provide written documentation supplemented by oral communication with the receiving physician

3. Colonoscopies must be performed for an appropriate, clearly documented indication that is consistent with current evidence-based guidelines

4. *Facilities must inform referring physicians of the result of all procedures and any associated pathology, including any findings and follow-up recommendations*

5. Facilities must adopt electronic and standardized reporting

6. Facilities must have equipment to record digital photographic evidence of relevant landmarks and lesions

7. Mechanical irrigators must be available for every case and be used when necessary in order to allow adequate visualization of the mucosa and lesions

8. Facilities providing colonoscopy must use automated endoscope reprocessors (AERs)

9. Personnel involved in reprocessing must participate in a formalized training program beyond that which is provided by the manufacturers

10. Endoscopy units or facilities must provide competency-based orientation to all nursing staff at the time of hiring

11. Every facility providing endoscopy must undertake an annual nursing competency review

12. (Hospitals only) Nurses with experience in endoscopy must be available on-call in facilities where after-hours urgent and emergency endoscopic procedures occur

13. *Facilities must use the global rating scale (GRS) as a quality assurance/quality improvement tool*

14. Facilities providing colonoscopy services must ensure that the environment provides sufficient privacy to patients to maintain their confidentiality. Ideally, the pre-procedure assessment area must be separate from the recovery area

15. *All colonoscopy patients, on discharge, must receive written information regarding the procedural findings, plans for treatment and follow-up, worrisome symptoms to watch for and steps to be taken.*

6 Standards in *italics* represent the three standards prioritized by the CAC, clinical and scientific leadership in order to focus quality improvement efforts

Colonoscopy QMP Quality Indicators[7]

1. Outpatient cecal intubation
2. Outpatient perforation
3. Post-polypectomy bleeding
4. Outpatient polypectomy
5. Colorectal cancer detection
6. Post-colonoscopy colorectal cancer
7. *Inadequate bowel preparation*
8. Percentage of colonoscopies performed by endoscopists meeting volume standard
9. *Abnormal gFOBT to colonoscopy wait time*
10. Abnormal gFOBT with no follow-up within six months
11. Colonoscopies with recent normal findings
12. Adenoma detection rate
13. Total colonoscopy volume
14. Number of endoscopists
15. Number of hospitals
16. Patient age range statistics

For more detail on indicator methodology including data sources, you can access the methodology document for the 2019 Colonoscopy Quality Reports here: http://bit.do/colomethodology2019.

7 Indicators in *italics* represent the three standards prioritized by the CAC, clinical and scientific leadership in order to focus quality improvement efforts

Appendix B: Mammography QMP Recommendations and Indicators

Mammography QMP Recommendations

1. All facilities should participate in the Ontario Breast Screening Program
2. All facilities should maintain CAR-MAP accreditation
3. All mammography units should be digital

Mammography QMP Quality Indicators

1. Abnormal call rate
2. Positive predictive value
3. Invasive cancer detection rate
4. Tumour size
5. Negative nodes
6. DCIS detection rate
7. Post-screen invasive cancer rate
8. Wait time to first assessment
9. Wait time to diagnosis without tissue biopsy
10. Wait time to diagnosis with tissue biopsy
11. OBSP preliminary Indicators
    a. Abnormal call rate
    b. Positive predictive value
    c. Breast cancer detection rate

Detail on indicator methodology including data sources is available on request to cancerscreening@ontariohealth.ca.

Appendix C: Pathology QMP Quality Standards

1. Surgical pathology laboratories that have a Pathology Professional Quality Management Committee.

2. Surgical pathology laboratories that have a Pathology Professional Quality Management Plan.

3. Surgical pathology laboratories that have a documented policy for the investigation and/or resolution of report defects/discrepancies/discordances/errors.

4. Surgical pathology laboratories that have a documented guideline for the classification of report defects/discrepancies/discordances/errors.

5. Surgical pathology laboratories that have a documented policy for handling requests for review of cases by an external source, including the documentation and review of those results.

6. Surgical pathology laboratories that have a documented policy outlining the process and documentation of comparison of intra-operative consultation results with final diagnosis.

7. Surgical pathology laboratories that review data on intra-operative consultation cases with defects/discrepancies/discordances/errors for the surgical pathology professional group.

8. Surgical pathology laboratories that review data on deferral rates of intra-operative consultation cases for the surgical pathology professional group.

9. Surgical pathology laboratories that have a documented policy which outlines how turnaround times are monitored.

10. Surgical pathology laboratories that review data on turnaround times for the surgical pathology professional group.

Appendix D: Partnership Governance and Advisory Committee Membership

Quality Management Partnership Steering Committee

- Michael Sherar, Former President and CEO, Cancer Care Ontario (Co-chair)
- Dr. Rocco Gerace, Former Registrar, College of Physicians and Surgeons of Ontario (Co-chair)
- Dr. Nancy Whitmore, Registrar, College of Physicians and Surgeons of Ontario (Co-Chair)
- Dr. Linda Rabeneck, Vice President, Prevention and Cancer Control, Ontario Health (Cancer Care Ontario)
- Dr. Sheila Laredo, Chief Medical Advisor, College of Physicians and Surgeons of Ontario
- Michelle Lloyd, Director, Quality Management, Ontario Health (Cancer Care Ontario)
- Laurie Bourne, Former Director, Quality Management and QMP, Cancer Care Ontario
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- Dr. Rola Shaheen, Provincial Lead, Mammography Quality Management Program
- Dr. Kathy Chorneyko, Provincial Lead, Pathology Quality Management Program
- Dr. David Morgan, Provincial Lead, Colonoscopy Quality Management Program

Health System Reference Group

- Dr. Joshua Tepper, Former President and CEO, Health Quality Ontario (Chair)
- Dr. Ross Baker, Professor and Program Director, MSc. Quality Improvement and Patient Safety, Institute of Health Policy, Management and Evaluation
- Dr. Adalsteinn Brown, Dean, Dalla Lana School of Public Health, University of Toronto
- Ms. Anne Coghlan, Executive Director and CEO, College of Nurses of Ontario
- Mr. Anthony Dale, President & CEO, Ontario Hospital Association (OHA)
- Dan Faulkner, Former Deputy Registrar, The College of Physicians and Surgeons of Ontario
- Dr. Sholom Glouberman, President & Founder, Patients Canada
- Tom Magyarody, Former CEO, Ontario Medical Association
- Dr. Chris Hayes, Medical Director, Quality and Performance, St. Michael's Hospital
- Dr. John Lavis, Director, McMaster Health Forum
- Dr. James Worthington, Former Executive Vice-President, Medical Affairs, Quality and Patient Safety, The Ottawa Hospital
- Dr. Rocco Gerace, Former Registrar, College of Physician and Surgeons of Ontario
- Michael Sherar, Former President and CEO, Cancer Care Ontario

Appendix D: Partnership Governance and Advisory Committee Membership

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- Ms. Anne Newman
- Ms. Jill Adolphe

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- Dr. Catherine Dube
- Dr. Jill Tinmouth

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- Ms. Judy Knighton
- Ms. Johanne Lin
- Ms. Kay Rhodes
- Ms. Natalia Bubela
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- Dr. Michael Sey
- Dr. Jonathan Love
- Dr. Barry Lumb
- Dr. Andrew Bellini
- Dr. Ian Bookman
- Dr. David Baron
- Dr. Hugh Kendall
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Appendix D: Partnership Governance and Advisory Committee Membership

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- Dr. Allan Wolfsohn
- Dr. Denis Bonin
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- Dr. Simon Raphael
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Regional Administrators and External Partners

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- Mr. Craig Ivany
- Dr. Tim Feltis
- Ms. Debbie Croteau
- Dr. Cathy Ross
- Dr. Celia Marginean
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- Dr. Ralph Meyer

Citizen's Advisory Committee

- Ms. Jill Adolphe (Chair)
- Ms. Judith John (Former Chair)
- Mr. Oren Ben-Shlomo
- Ms. Cassandra Frazer
- Ms. Ivana Marzura
- Ms. Anne Newman
- Ms. Jacquie Brown
- Mr. Owen Litwin
- Ms. Dayna Roberts
- Ms. June Shin

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Quality Management Partnership Staff

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Parts of this material are based on data and information compiled and provided by the Canadian Institute for Health Information (CIHI). However, the analyses, conclusions, opinions and statements expressed herein are those of the author(s), and not necessarily those of CIHI.

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