The Opportunity and Strategy for Quality and Health-System Improvement Now and in the Future

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Abstract

Since 2004, Cancer Care Ontario (CCO) has played a leadership role in linking funding to quality of care, and in using evidence and administrative and clinical data to drive performance and quality improvement. This article describes how CCO has used its cancer and renal health system strategies to establish an environment of continuous health system improvement. The article also describes how CCO's Corporate Strategy is driving organizational improvement: evolving CCO's capacity and capability to drive quality and value across healthcare settings, and its ability to advance broader health system transformation in support of cancer and renal patients.

We began this special issue by looking back in time to the 1990s and early 2000s when wait times for radiation therapy created a crisis and a platform for change in the Ontario cancer system. We end this issue by looking forward and contemplating how CCO is evolving to meet the emerging challenges in Ontario's healthcare systems. These challenges include reducing the rate of growth in healthcare spending, a distributed governance structure, a patchwork of information technology and funding for providers not well-aligned with quality. And this is on a backdrop of rising need for services due to an aging demographic and increasing exposure to risks for chronic disease including alcohol consumption, unhealthy eating and physical inactivity, and a decline in smoking rates that has stalled.

CCO can play an important role in meeting these challenges for cancer and renal care while contributing more to broader health-system improvement in Ontario, by building on the approaches it has established for quality improvement. This article will summarize CCO's quality improvement approaches and achievements (until 2011), and then describe the corporate strategy that was developed and implemented over the past three years to position CCO to tackle broader quality improvement objectives that will enable cancer, renal and support broader health-system improvements.

Background

Prior to 2004, CCO was the major provider of cancer services in Ontario through a system of regional cancer centres and with a focus on providing outpatient radiation and chemotherapy services. As a result of a provincial review in the wake of a crisis in access to radiation therapy (Hudson 2001), CCO ceased to be a provider of healthcare services, handing over operation of the cancer centres to the local hospitals with which they were co-located. CCO was to become a quality improvement organization combined with its role as a purchaser of cancer services. The intent was to maintain oversight of the budget for cancer services and through the development of a provincial quality plan, tie the provision of funding to quality of care. In 2005, CCO embarked on the implementation of the first Ontario Cancer Plan (OCP). The plan went beyond radiation and chemotherapy in hospitals, and took a population approach to cancer control and quality of care throughout the cancer journey

from prevention to survivorship or end-of-life care. Although initially CCO did not fund cancer services outside of radiation and chemotherapy, the Ministry of Health and Long-Term Care in Ontario (MOHLTC) began providing CCO the funding needed for growth in other cancer services (e.g., cancer surgery) as well as funding for quality improvement initiatives included in the OCP.

The first OCP (2005–2008) focused on establishing guidelines and standards for quality of care, the establishment of Regional Cancer Programs across the province and the gathering and use of information for performance measurement and quality improvement. The second OCP (2008–2011) broadened the scope of the work to strengthen Ontario's cancer screening programs, to streamline diagnostic assessment processes and to improve the patient experience. Throughout this period (2008–2011), several new cancer centres were built to improve access to services.

Significant improvements as measured through an annual Cancer System Quality Index were achieved through this approach, mostly in the quality of cancer care provided in hospitals. (www.csqi.on.ca). As CCO embarked on consultations to develop the third OCP to begin implementation in 2011, it was recognized that more work was needed to improve the cancer system beyond the care provided during active treatment in hospitals. The effectiveness of prevention initiatives, cancer screening, diagnostic assessment, survivorship and palliative care all needed strengthening.

At about the same time, the MOHLTC asked CCO to develop and implement a plan for quality improvement in the care of patients with chronic kidney disease (CKD). To deliver on this new mandate, CCO established the Ontario Renal Network (ORN) in 2009. The rationale was that the approaches and infrastructure used to improve the cancer system could be leveraged to improve renal care. This was not without its challenges, including a renal care community suspicious of engaging with a cancer care organization and a cancer care community worried about a loss of focus. Nevertheless, four years later, improvements are now being made in renal care in Ontario while the breadth of work in cancer continues to expand. One example is the expansion of access to independent dialysis (dialysis provided outside of hospitals). Although much work remains, this access is now increasing.

A Strategy for the Future

Once the third OCP was written, the ORN established and the first Ontario Renal Plan developed, CCO recognized in 2011 the need to plan strategically as to how best to achieve broader gains for the cancer and renal care systems in Ontario. Since 2005, CCO had focussed on the quality of care provided in hospitals. This involved working with a few hundred specialist providers in surgical, radiation and medical oncology. To improve the system for prevention, screening, diagnostic assessment, survivorship and palliative care, a much wider group of providers including primary care and community organizations needed to be engaged. As CCO does not directly fund this broader set of services, we recognized that stronger partnerships were needed with other organizations that play a role in funding and quality improvement.

CCO's corporate strategy, developed in consultation with partners in 2011 and launched in 2012, was based on a recognition that CCO should retain a focus on cancer, CKD and access to care, while responding to opportunities for the use of CCO's assets and quality improvement approaches beyond these areas. We also recognized that to fully realize our vision for cancer and renal care, we must partner in or even lead broader health-system quality improvement. To leverage CCO's programs more generally in the health system to address quality issues, we decided to concentrate on developing those areas where there is a substantial cancer, renal or access to care footprint. As an example, it was recognized after a review of the quality of pathology services in some Ontario hospitals (Mclellan et al. 2011) that a broad (not just cancer) approach to quality improvement in pathology was needed in Ontario (this example will be discussed in more detail later).

The CCO corporate strategy identifies five areas of strategic focus:

1. Person-centred care
2. Prevention of chronic disease
3. Integrated care
4. Value for money
5. Knowledge sharing and support

Person-centred care for CCO represents a shift to more indicators and measures of system performance based on the patients' view of their care, and involving patients and families more directly in our planning for system improvement. Measurements of quality from the patient's perspective include patient-reported outcomes such as quality-of-life indicators, how patients are supported throughout their care including emotional and physical supports and asking patients about their experience. The work to expand measurement of person-centred care is underway, and the more robust engagement of patients and families is having a significant influence on the development of OCP IV (2015–2019), which is being co-chaired by a member of CCO's Patient and Family Advisory Council.

However effective and efficient the healthcare system is, it does little to slow the increase in need for care due to the rising incidence of chronic disease including cancer and CKD. CCO's strategy recognized we could have a greater positive

impact on the incidence of disease, which links directly to the sustainability of our healthcare system. Through a focus on prevention of chronic disease, CCO can catalyze improved public policy with respect to exposure of the population to risk factors for chronic disease. Through this strategic focus, CCO will develop, assemble and analyze evidence and, on this basis, propose policies that the Ontario Government can enact to reduce the exposure of the population to the four most important risk factors for chronic disease: tobacco, alcohol, unhealthy eating and inactivity. An example of such policy advice includes a recent report on the effects of alcohol consumption that calls for a moratorium on increasing the density of sales outlets for alcohol. This report generated significant publicity at a time when the Ontario Government is considering increasing the number of premises licensed to sell alcohol in order to increase revenue. Part of the policy advice is based on a business case as to why foregoing increased revenue from alcohol sales makes economic sense for the province. There is now an opportunity, based on this report, to engage with the government to influence policy in areas such as alcohol sales. The ability of CCO to succeed in influencing broader public policy in chronic disease prevention particularly where the policy advice runs up against sensitive political issues, depends on the credibility of the advice and the quality of the supporting evidence..

The focus on integrated care is aimed at extending quality improvement across healthcare settings including primary care, hospital care, community care and home care, and making sure that care is seamless and effective for patients. To achieve this, CCO will work with organizations and providers of care to set standards for the delivery of cancer and renal care services in these settings. CCO will also develop indicators and measure the quality of care with a focus on how quality is experienced from the perspective of the patient as they cross settings. A challenge will be to develop clear accountability for performance with respect to patient care across healthcare settings, including the transitions of care. Accountability for transitions of care can be particularly complex in a jurisdiction such as Ontario, where many organizations with independent governance may be providing components of that care sequentially or even simultaneously. This is a significant shift for CCO, which has focussed the majority of its efforts to date on improving the quality of hospital care.

The fourth area of focus, value for money, is aimed at strengthening and broadening CCO's use of funding as a lever to drive quality improvement. This includes more tightly linking funding for services to quality at the patient level and stronger measurement and use of the data on how financial resources are used in Ontario's health system. The former goal is being achieved by CCO's central participation in a broader Health System Funding Reform (HSFR) initiative in Ontario, which is changing how hospitals and then other organizations are to be funded, from block funding with few ties to quality, to patient-specific activity tied to quality standards. As part of HSFR, CCO is changing the way dialysis, chemotherapy and endoscopy are funded and also, as a result of these changes, the full funding envelopes for these services will flow through CCO to provider organizations. In the past, CCO has used a partial financial lever based on incremental or growth funding flowing through CCO, with the base of funding flowed through the block funding the hospital received from the Ministry of Health. The consolidation of funding into single envelope, and the more specific tie of that funding to standardized care pathways, is expected to result in a more effective application of the funding lever to drive quality improvement in the cancer and renal care systems.

CCO's focus on knowledge sharing and support goes back to the premise that to realize the best cancer and renal care systems, CCO needs to support broader health-system improvement in areas that have relevance for cancer and renal care but where broader transformation is required. One specific example in this focus area, CCO's partnership with the College and Physicians and Surgeons of Ontario, is described in more detail later.

Implementing the Strategy

The five areas of strategic focus were a challenge to advance at CCO because they cut across programs (cancer, renal and access to care). They also required CCO to develop partnerships with other organizations such as Public Health Ontario, Health Quality Ontario, The College of Physicians and Surgeons of Ontario (CPSO) and the Ontario Medical Association, all of which oversee aspects of quality improvement in the areas identified, in order to achieve a coordinated approach. The strategy is taking CCO significantly beyond its' current activities both internally and with partners. To enable this change, an investment of up to 5% of CCO's annual central office budget was assigned to corporate strategy work each year for three years. And accountability for advancing each area of focus was assigned to a Vice President.

Internal challenges included a culture at CCO that was task-oriented. CCO was effective in carrying out the tasks associated with the current provincial cancer and renal plans but sometimes did not achieve the greatest leverage across programs. Achieving the goals of the corporate strategy relies on breaking down silos and achieving greater leverage of assets such as regional and clinical engagement, project management and informatics. The new corporate strategy's aim to build upon CCO's current model by broadening our activities and leveraging across programs was a challenging goal. It is sometimes easier to create and implement a new strategy when things are not going well. How do you, at the right pace, gradually change

an organization's focus? One tactic was to identify early-win initiatives and highlight initiatives that were already underway that we could point to as concrete examples of our work in each of the strategic focus areas. The work on health-system funding reform was an example of work underway that related directly to CCO's ability to measure and drive value for money in the health system. The partnership we developed with Public Health Ontario to produce the *Taking Action to Prevent Chronic Disease: Recommendations for a Healthier Ontario* report was an example of our work to provide policy recommendations to reduce the exposure of our population to risk factors for chronic disease. These were important signals to our staff at CCO and to our partners that we were committed to the change contemplated with the implementation of CCO's corporate strategy. Using these and other early-win projects, we began to build the teams that are enhancing our capacity in each of these areas and that will be key to sustaining the effort for the future.

One example of a new partnership that came from a broader view of CCO's role in health-system transformation in Ontario was the Quality Management Partnership (QMP), led in jointly by CCO and the CPSO. The initial trigger was the issue of the quality of pathology services in Ontario discussed earlier. The actual partnership opportunity was the result of a more comprehensive view of quality management across provincial, regional, local and down to individual physician performance. In 2013, the MOHLTC formally asked the two organizations to jointly develop provincial quality management programs for pathology, mammography and colonoscopy.

Why CCO and CPSO (CPSO is the regulator of physician services in Ontario)? The CPSO already had an established program for quality improvement of physician services. The CPSO also had a role for the quality of services provided in out-of-hospital premises. CCO was overseeing some aspects of quality in these services particularly as it pertained to cancer and mostly in hospitals. But no one could provide a comprehensive picture of quality for these services across all locations of service delivery and for all patients. It made sense to leverage the assets and programs from both organizations to develop integrated and comprehensive QMPs. But there were significant challenges.

As the regulator, the CPSO's main role is to ensure public safety and as such can suspend or ban a physician from practicing. The intent of the QMP is to develop non-punitive programs of quality improvement similar to the way mammography quality is overseen currently within the Ontario Breast Screening Program, which includes physician-level performance measurement and follow-up with respect to cancer detection. There was concern as to whether data on individual physician performance could now be used in an investigation by the CPSO that might lead to suspension of privileges. As it is, the CPSO has very a clear "firewall" between "quality improvement" and "investigations," but nevertheless, there was a perception among some physicians that the new QMP could lead to punitive results. Also, CCO had well-established programs in each of the QMP areas (e.g., the Ontario Breast Screening Program for screening mammography), and so, the way in which these cancer-specific programs would dovetail with a broader QMP work that was looking beyond cancer to all services provided in each area needed to be understood. Similarly, CPSO had existing programs for quality improvement that currently captured some of the activity envisioned by QMP. The duplication of activities was to be avoided, but we also did not want to lose or slow the more detailed and specific quality work that was ongoing with respect to cancer-related services in these areas at CCO. There was concern that the pace of work in cancer would be slowed while the QMP got up and running. The exact operational structure for the QMP programs and the relationship to existing programs at CCO and CPSO will be confirmed as the QMP programs are launched in an operational way.

CCO (and the CPSO) have a central principle of engaging providers in the planning and implementation of quality improvement initiatives and this was particularly important for the QMP. Clinical leads and expert panels were selected to take on this planning work with the two partner organizations. Importantly, although the panels had substantial physician representation, they were multi-disciplinary, including other key healthcare professionals and patient representatives. At the time of writing, the panels have made recommendations for early quality initiatives that will be implemented in 2014/2015 as the first year of implementation of QMP in Ontario. The panels are now in the process of finalizing a broader set of recommendations for full implementation of the QMP. The early concern and hesitancy of physicians to engage in the building of QMP has now subsided. The signs are good that this initiative will launch successfully over the next couple of years.

Conclusion

We started by outlining the major challenges for continued quality improvement in the health system and recognizing that although progress is being made overall acceleration is needed. Provincial approaches to cancer and renal care were implemented in part to reduce variation. It is clear that we needed more standardization based on evidence across these two areas in order for the system to be of most value to the public, as users of those services and as taxpayers. It is on this foundation of standard approaches that innovation can be encouraged, introduced and evaluated so that these standardized approaches can be rapidly improved upon. At the same time, approaches that are working to improve quality must be translated more broadly across the system and those that are not, discarded. This can

only be achieved if there is continuous and rigorous evaluation of quality improvement programs.

Also we need to turn more of our measurement of performance to indicators that patients, their families and the public feel are important in addition to clinical quality indicators. To do this effectively we must engage patients and the public much more in our work. And finally we must use stronger approaches to reduce the exposure of our population to risk factors for chronic disease if we are to sustain an excellent healthcare system for those who need it. HQ

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