

SCHEDULE “B”
PERFORMANCE REQUIREMENTS

A. Introduction

The Hospital shall perform the Performance Requirements as specified below, for the Program(s) for which the Funds have been allocated as specified in Schedule “A”.

All documents for submission to CCO as detailed in this Schedule “B” are to be submitted to RegionalPrograms@cancercare.on.ca unless otherwise specified.

B. Performance Requirements

1. Gastrointestinal Endoscopy Services

The purpose of the Gastrointestinal (GI) Endoscopy Quality-Based Procedure (QBP) initiative is to address practice variation and the changing nature of service delivery with the intention of improving upon the high-quality, patient-centred care across Ontario. As part of Ontario’s Health System Funding Reform (HSFR), QBP funding is a type of funding model that is patient-based. GI Endoscopy has been chosen as a QBP to be implemented as a five-year funding reform initiative. As part of this QBP, colonoscopy will be the first endoscopic procedure to be streamlined and funded on a performance basis through the patient-based funding framework. This framework identifies opportunities for process improvements, clinical re-design, improved patient outcomes, enhanced patient experience, and potential cost savings. Health care providers will be reimbursed for the determined cost of each procedure they perform, the type of patients they treat, and the quality of care delivered.

Hospital participation includes the following:

Performance Requirements

1. Ensure compliance with the GI Endoscopy QBP-endorsed provider and facility best practice standards.
 - 1.1 **Provider Standards:** The GI Endoscopy QBP has adopted interim standards that were recommended in CCO’s *Guideline for Colonoscopy Quality Assurance in Ontario*¹. The guideline summarizes the available evidence on colonoscopy quality assurance and makes evidence-based recommendations on standards. Sites are expected to ensure staff endoscopists are qualified and credentialed appropriately. (Please note: Provider Standards are updated on a biannual basis. Please refer to the Quality-Based Procedures Clinical Handbook for GI Endoscopy at: http://health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx.)
 - 1.2 **Facility Standards:** The GI Endoscopy QBP has developed interim best practice standards related to the environment in which GI endoscopy procedures are conducted, including equipment, staffing, and structural space. Sites are expected to meet all facility standards listed below. (Please note: Facility Standards are updated on a biannual basis, please refer to the Quality-Based Procedures Clinical Handbook for GI Endoscopy at: http://health.gov.on.ca/en/pro/programs/ecfa/funding/hs_funding_qbp.aspx.)

¹ Timmouth J, Kennedy E, Baron D, Burke M, Feinberg S, Gould M, et al. Guideline for Colonoscopy Quality Assurance in Ontario. Toronto (ON): Cancer Care Ontario; 2013 Sept 9. Program in Evidence-based Care Evidence-based Series No.: 15-5 Version 2.

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- 1.2.1 The hospital must be accredited and must meet comparable standards to independent health facilities (IHF) and out-of-hospital premises (OHPs) where applicable.
- 1.2.2 The hospital must ensure staff responsible for endoscope care and maintenance are up-to-date and attend regular in-servicing.
- 1.2.3 The hospital must adhere to professional and/or institutional standards for granting and renewing privileges.
- 1.2.4 The hospital must offer sedation for all procedures and have necessary infrastructure for safe sedation (i.e. recovery room and monitoring).
- 1.2.5 During endoscopy, under moderate sedation, the nurse may perform interruptible tasks, such as assisting with biopsy or polypectomy while continuing to actively monitor the patient, provided the patient is stable. For deep sedation, an individual trained to monitor patients must also be present in the room with no other responsibilities.
 - 1.2.5.1 Caveat for QBP as it relates to nursing care: all nurses must have Basic Cardiac Life Support (BCLS) training, and each facility must either 1) have a hospital code team or 2) be within a community based setting, with two or more Advanced Cardiac Life Support (ACLS) certified persons on location, when clinical care with sedation is provided.
- 1.2.6 The hospital must ensure continuous and appropriate monitoring of patients receiving conscious or deep sedation before, during, and after administration of sedation.
- 1.2.7 The hospital must ensure that only equipment of a high standard, that conforms to current safety and work practice standards/guidelines, and provides for optimal individual procedures is used. This is to be achieved by ensuring that:
 - 1.2.7.1 All equipment used performs at the optimal level;
 - 1.2.7.2 All equipment is subject to the manufacturers' recommended preventative maintenance programs and is tested according to technical specifications by qualified technicians;
 - 1.2.7.3 All equipment is subject to compliance testing and certification where required by jurisdictional statutory regulations;
 - 1.2.7.4 All equipment is selected or replaced as per industry norms, including keeping up with technological advancement and replacing equipment where necessary to maintain an up-to-date and high standard of service; and
 - 1.2.7.5 All equipment is subject to a regular quality control program; and the equipment required for the performance of a particular procedure is readily accessible.
- 1.2.8 The hospital must use automated endoscopic re-processors for all procedures.
- 1.2.9 The hospital must have appropriate re-processing capacity (i.e. appropriate ratio of basins to procedure volume).
- 1.2.10 The hospital must have appropriate supplies for providing safe endoscopy (e.g. intravenous fluid, setup, supplies and suction systems).
- 1.2.11 The hospital must determine readiness for discharge using an acceptable scoring system (e.g. Aldrete score, PADS, etc.).
- 1.2.12 The hospital must have resuscitation equipment immediately available, including but not limited to, a defibrillator, endotracheal tubes, airways,

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laryngoscope, oxygen sources with positive-pressure capabilities, emergency drugs, and oxygen tanks.

- 1.2.13 The hospital must have available the appropriate equipment to remove polyps and to manage related complications (e.g. post polypectomy bleeding), which must include, at a minimum, hemoclips, injectors, polypectomy snares, biopsy forceps, electrocautery equipment, and tattooing ink.
2. Collaborate with Regional Cancer Programs, endoscopists, and other health service providers in the region and across the province to establish a high quality GI endoscopy service program.
3. Collaborate with the Regional Colorectal Screening/GI Endoscopy Lead and Regional Director, who will establish and maintain a relationship with regional and provincial partners.
4. Maintain regular communication with the Regional Cancer Program and the Regional Colorectal Screening/GI Endoscopy Lead (RCSGIEL) as it pertains to business planning for volume projections and performance management.
5. Participate in operational activities as required through the QBP including performance management processes, quality improvement initiatives, business planning, etc.
6. The hospital must establish and implement a standard pre-procedural assessment process.
7. The hospital must establish and implement a clear discharge process, including but not limited to, when to discharge patients, follow up on results, and provide instructions in the event of complications.
8. The hospital must provide all patients with a post-procedure follow-up plan.
9. The hospital must establish and implement a general plan for resuscitation, including the identification of properly trained personnel.
10. The hospital must establish a quality assurance program in which complications and important quality metrics are monitored, reported to providers, and remediated when necessary (examples of quality metrics include cecal intubation rate, bowel preparation quality, and polyp detection rate).
11. The hospital must commit to monitoring performance results and engaging in improvement opportunities as per the defined QBP Quality Indicators. For a list of QBP Quality Indicators for the 2014/15 Fiscal Year, please refer to the table below:

2014/15 QBP Quality Indicators

Indicator Name	Indicator Description
Proportion of colonoscopies performed by endoscopists meeting volume standard	Proportion of colonoscopy procedures in the reporting year performed by endoscopists who have performed 200 or more colonoscopies, regardless of the location the procedure was performed.
Cecal Intubation Rate (CIR)	Percentage of outpatient colonoscopy procedures performed where the cecum or terminal ileum was reached.
Percentage of individuals who had a colonoscopy within 8 weeks of positive FOBT *	Percentage of Ontario screen-eligible individuals, 50-74 years old, who had an abnormal fecal occult blood test (FOBT) result and follow-up colonoscopy within 6 months, who underwent colonoscopy within 8 weeks.
Percent of colonoscopies within the 26 week wait time benchmark for family history **	Percentage of colonoscopies within the 26 week benchmark for individuals with family history of colorectal cancer defined by the family history colonoscopy indication in the Colonoscopy Interim Reporting Tool (CIRT).

*** Note:** This indicator is calculated differently from the related indicator used in the ColonCancerCheck (CCC) Program Performance Management Process. Specifically:

- The QBP indicator uses the abnormal FOBT test date (defined as the date that the FOBT kit is received by the laboratory) as the index date and calculates the percentage based on those with an abnormal result who received a colonoscopy within 6 months.
- The CCC indicator uses the colonoscopy referral date as the index date and calculates the percentage based on the total number of abnormal FOBT results.

**** Note:** This indicator is currently collected/measured as part of the ColonCancerCheck (CCC) Program Performance Management Process. Results are based on only those hospitals that are currently part of the CCC Program.

Additional ColonCancerCheck (CCC) Program Performance Requirements

In addition to the Performance Requirements set out above, Hospitals participating in the ColonCancerCheck (CCC) Program are expected to adhere to the following requirements:

1. Hospitals are expected to implement a centralized colonoscopy intake process, such as putting in place a dedicated fax line for family physicians to use to refer patients for colonoscopy that:
 - 1.1 Provides family physicians with a clear single point of referral for colonoscopy;
 - 1.2 Allows hospitals to schedule colonoscopies with endoscopists who have shorter wait times;
 - 1.3 Allows hospitals to easily capture the date of referral for colonoscopy (a required data element under this agreement); and

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- 1.4 Facilitates the implementation of Cancer Care Ontario's Organizational Standards for Diagnostic Assessment Programs
<http://www.cancercare.on.ca/common/pages/UserFile.aspx?fileId=36870>.
2. Hospitals are expected to report and ensure compliance to Cancer Care Ontario's Guideline for Colonoscopy Quality Assurance in Ontario, published September 2013.

Deliverables

1. The hospital will submit data as detailed in Schedule "C".
2. Within two weeks of receiving this Agreement, designate (or reconfirm) a Physician Lead/Administrative Lead for GI endoscopy services who will maintain a relationship with members of their local Regional Cancer Program.
3. A third quarter status report is to be submitted as part of the 2014/15 Q3 Quarterly Performance Review reporting templates, by no later than February 18, 2015.

Roles and Responsibilities

In addition to the Performance Requirements and Deliverables described above and the terms set out in Schedule "B-1", the following roles and responsibilities apply:

Regional Vice President (RVP): The RVP provides leadership and input on the ColonCancerCheck Program as well as the implementation of the Gastrointestinal (GI) Endoscopy QBP. RVPs will support the sites in the management of quality and performance across the region.

Regional Cancer Centre/Program Director (RD): The RD supports the RVP with operational elements including annual business planning, projecting volumes, and performance management.

Regional Colorectal Screening/GI Endoscopy Lead (RCSGIEL): The Regional Colorectal Screening/GI Endoscopy Lead (RCSGIEL) is the point person between the Regional Cancer Program and the colorectal cancer screening/GI endoscopy providers. The responsibility of the RCSGIEL is to understand the region's colorectal cancer screening and GI endoscopy landscape and provide clinical leadership at the regional and hospital level. The RCSGIEL will monitor clinical performance and provide guidance surrounding clinical issues and opportunities for quality improvement.

Head of Endoscopy: The Head of Endoscopy is responsible for providing guidance and clinical leadership at the hospital level and to assist in the management of effective execution of the contract elements related to quality, business planning, and performance management.

Physician/Administrative Lead: The Physician/Administrative Lead is designated to maintain a relationship with members of the local Regional Cancer Program including the Regional Colorectal Screening/GI Endoscopy Lead in order to discuss improvement opportunities and areas of concern.

GI Endoscopy Contract Management Lead: The Hospital's GI Endoscopy Contract Management Lead ensures elements of the contract are understood and warrants site compliance. The GI Endoscopy Contract Management Lead maintains an understanding of performance and any

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issues related to performance, and is the point person for any CCO communications regarding contracts.

GI Endoscopy Data Reporting Lead (DRL): The Hospital's GI Endoscopy Data Reporting Lead is responsible to ensure proper usage of CIHI DAD/NACRS and OHIP applications in his/her respective facilities. The DRL trains users and is the point person for any data entry issues. The DRL will also work to continually improve internal processes for data collection and data quality monitoring.