CQCO Cancer Quality Council of Ontario

Signature Event Report: Recommendations and Proceedings

WALK the TALK

REMOVING BARRIERS TO CANCER CARE FOR ALL

Cancer Quality Council of Ontario
2013 Signature Event
November 20, 2013
Toronto, Metropolitan Hotel

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1.0 Executive Summary

The Cancer Quality Council of Ontario (CQCO) is an arm's-length advisory group that was established in 2002 to guide Cancer Care Ontario (CCO) and the Ministry of Health and Long-Term Care in their efforts to improve the quality of cancer care in Ontario. Our mandate is to monitor and report publicly on the quality of cancer services in Ontario, and to improve cancer system quality by identifying quality gaps and—through the use of international expertise and advice—commissioning special studies to address them.

The CQCO Signature Event series is one of our key tools in achieving our mission. Held annually, the Signature Event brings together stakeholders and decision-makers to address a quality gap and help us to better understand issues surrounding cancer services. Each Event is action-oriented, bringing together international leaders and experts on the topic, clinical leaders, managers, providers, patient representatives and decision-makers to collaborate on developing solutions to pressing quality challenges for Ontario's cancer system.

Walk the Talk: Removing Barriers to Cancer Care for All was CQCO's tenth Signature Event. Held in Toronto on November 20, 2013, *Walk the Talk* focused on equity in cancer care, and had several important objectives.

- Discuss promising and practical solutions from jurisdictions and organizations at the system level that reduce inequities and are adaptable for cancer care. In particular, highlight strategies to overcome potential barriers to care including income, distance, education, age, sex, culture, disability and other disparities.
- Discuss models for community partnerships in order to seamlessly connect the cancer system to the community where patients are located.
- Discuss the role of the system and provider in providing equitable care to patients, including measures and/or tools for ensuring safe, effective treatment for all patients in a person-centred environment.

Walk the Talk featured an analysis of the inequities in Ontario's cancer system and solutions to address barriers to care, including discussion of different approaches across several different jurisdictions, both in Ontario and internationally. The day also included a number of interactive components including a rapid rounds session with local and provincial presentations, a cross-discipline panel and a breakout session. Finally, CCO and CQCO stated their commitment to creating an equitable cancer system.

Based on the presentations and discussions throughout the day, the audience helped create the CQCO recommendations outlined below. They cover the areas of prioritizing equity, understanding patient populations and the public, creating partnerships to affect change, engaging patients and identifying their needs, and supporting patients and providers.

1.1 Prioritizing Equity

- Include equity as a priority in the Ontario Cancer Plan IV.
- Evaluate programs according to how they incorporate equity into planning and funding mechanisms.

1.2 Understanding Patient Populations and the Public

- Analyze current population data to see where the greatest disparities exist in order to plan for resource needs.
- Collect equity data of patients.
- Ensure physicians, regardless of practice model, have access to the cancer screening reports of their patients.
- Encourage the research agenda to apply an equity lens in order to learn more about treatment outcomes of different populations.

1.3 Aligning and Creating Partnerships to Affect Change

- CCO should advocate government to create government-wide support on issues related to patient care.

1.4 Engaging Patients and Identifying Patients' Needs

- Screen for social determinants of health at point-of-care.
- Identify tools for subpopulations/populations at-risk to reduce inequities in care.

1.5 Supporting Patients and Providers

- Support health-care professionals to address equity issues.
- Encourage more peer/patient navigators to support patients.
- Examine policies and funding mechanisms that consider the equity gap.

2.0 Background

The Cancer Quality Council of Ontario (CQCO) is an arm's-length advisory group that was established in 2002 to guide Cancer Care Ontario (CCO) and the Ministry of Health and Long-Term Care in their efforts to improve the quality of cancer care in Ontario. Our mandate is to monitor and report publicly on the quality of cancer services in Ontario, and to improve cancer system quality by identifying quality gaps and—through the use of international expertise and advice—commissioning special studies to address them. More information about our mandate and activities can be found on our website (www.cqco.on.ca).

The CQCO Signature Event is one of four key tools that we use to achieve our mission. The other three tools are:

- The **Cancer System Quality Index**, an interactive web-based public reporting tool released annually since 2005, tracks Ontario's progress towards better outcomes in cancer care and highlights where cancer service providers can advance the quality and performance of care (more information can be found at www.csqi.on.ca).

- The **Quality and Innovation Awards,** an annual competition first held in 2006, encourage and recognize significant contributions to quality or innovation that enhances and improves the delivery of cancer care across the province. The Awards are sponsored by the CQCO, CCO and the Canadian Cancer Society—Ontario Division (more information can be found at www.cqco.ca/awards).

- An annual **Programmatic Review** brings international experts to Ontario to share their best practices and review progress, and to analyze the effectiveness of existing cancer system programs (or the formation of emerging program).

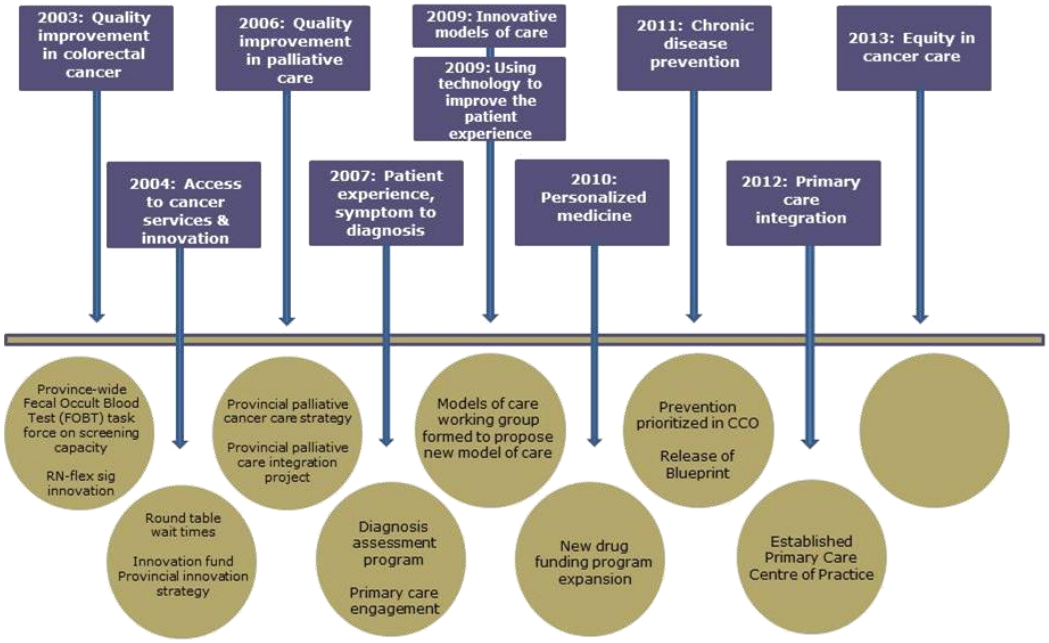
The CQCO incorporates national and international benchmarking tools in all of its products to help monitor, report and enhance the performance of the Ontario cancer system.

2.1 CQCO Signature Event Series

The annual Signature Event series, hosted by the CQCO since 2003, brings together practice leaders, policy makers, providers, patients and family representatives with international and national experts to address a quality gap and help us to better understand issues surrounding cancer services. The events are action-oriented and identify both areas of opportunity *and* tangible actions that can be taken to improve the quality of health services delivery within Ontario.

Areas of focus and outcomes from previous Signature events are shown in *Figure 1*.

Figure 1: Areas of focus and key outcomes from Signature Events, 2003–2013



Source: *Cancer Quality Council of Ontario*

2.2 CQCO's 10th Annual Signature Event: Focus on Equity in Cancer Care

Walk the Talk: Removing Barriers to Cancer Care for All, CQCO's tenth annual Signature Event, was held in Toronto on November 20th, 2013. This report summarizes the event's proceedings, as well as the recommendations that were drafted by the CQCO after input from presentations by international and local experts, panel discussions and participants discussions in breakout groups.

Through its work on system performance measurement via the Cancer System Quality Index (found at www.csqi.on.ca), the CQCO identified the need to strengthen equitable care for cancer patients throughout the cancer journey.

The event had several key objectives.

- Discuss promising and practical solutions from jurisdictions and organizations at the system level that reduce inequities and are adaptable for cancer care. In particular, highlight strategies to overcome potential barriers to care including income, distance, education, age, sex, culture, disability and other disparities.
- Discuss models for community partnerships in order to seamlessly connect the cancer system to the community where patients are located.
- Discuss the role of the system and provider in providing equitable care to patients including measures and/or tools for ensuring safe, effective treatment for all patients in a person-centred environment.

As a result of the event, the CQCO identified key actions that will enhance equitable care in its recommendations for Cancer Care Ontario.

3.0 CQCO Recommendations

3.1 Prioritizing Equity

- Include equity as a priority in the Ontario Cancer Plan IV:
    - within the equity priority, encourage CCO and regions to consider equity in policy planning and quality improvement (e.g. using tools such as the Health Equity Impact Assessment tool and having equity plans across the entire patient journey); and
    - develop an engagement strategy for community partners, with a focus on high-needs populations.
- Evaluate programs according to how they incorporate equity into planning and funding mechanisms (e.g. include equity as a factor in CCO's corporate strategy annual business planning process).

3.2 Understanding Patient Populations and the Public

- Analyze current population data to see where the greatest disparities exist in order to plan for resource needs.
- Collect equity data of patients and do the following:
    - consider adopting the Toronto Central Local Health Integration Network (LHIN) equity data collection project to cancer care;
    - encourage the Ministry of Health and Long-Term Care to incentivize the collection of equity data; and
    - assess leveraging Health Links to identify high-needs communities.
- Ensure physicians, regardless of practice model, have access to the cancer screening reports of their patients (e.g. reports for Aboriginal populations in remote communities).
- Encourage the research agenda to apply an equity lens in order to learn more about treatment outcomes of different populations.

3.3 Aligning and Creating Partnerships to Affect Change

- CCO should advocate government to create government-wide support on issues related to patient care, such as:
    - aligning equity strategies across the health and government system;
    - taking a health-in-all-policies approach; and
    - working with partners like Public Health Ontario to help organizations address barriers to care and assist with required resources for local projects addressed at underserved populations.

3.4 Engaging Patients and Identifying Patients' Needs

- Screen for social determinants of health at point-of-care (e.g. examining the use of poverty screening tools to collect social determinants of health information).
- Identify tools for subpopulations/populations at-risk to reduce inequities in care, and do the following:
    - examine the use of the Diagnostic Assessment Program for high-needs populations;
    - consider using a model of specialists visiting patients in the community; and
    - encourage wider use of telemedicine to overcome issues related to distance.

3.5 Supporting Patients and Providers

- Support health-care professionals to address equity issues by:
    - providing resource tool kits;
    - enabling cultural competence strategies;
    - considering equity and patient preferences when developing disease pathways; and
    - encouraging the inclusion of support staff (such as social workers) when responding to patient needs.
- Encourage more peer/patient navigators to support patients.
- Examine policies and funding mechanisms that consider the equity gap.

4.0 Introduction to the Event

Ms. Virginia McLaughlin, Chair of the Cancer Quality Council of Ontario, welcomed everyone to the CQCO's 10th Annual Signature Event, *Walk the Talk: Removing Barriers to Cancer Care for All*. She highlighted past event topics and results (seen in *Figure 2*), such as last year's event on primary care integration with specialist care, which provided input into a Primary Care Centre of Practice at Cancer Care Ontario.

Ms. McLaughlin then described how the topic of equity was identified as poor in the Cancer System Quality Index, highlighting how the system lacks measures of equity. Indeed, available measures show inequities, such as screening participation rates and emergency department visits at a patient's end of life. She also highlighted evidence that access to Canadian cancer services is most inequitable at the beginning (i.e., screening) and the end (i.e., end-of-life care) of the continuum of care. Inequities are still present during diagnosis and treatment of cancer, however, and inequities at multiple points of the cancer journey need to be understood, because access to each point-of-care is dependent on the proceeding points.[1]

For the purpose of *Walk the Talk*, Ms. McLaughlin stated health equity is the distribution of resources and other processes that drive a particular kind of health inequity, and that addressing equity means everyone has access to the resources they require for optimal care. Barriers could include (but are not limited to) income, language, education, age, sex, and geography. She provided examples of what reducing inequities would mean to Ontarians: if every LHIN in 2005 had five-year survival rates as high as those in the LHIN with the best rates, 213 more women with breast cancer, 200 more Ontarians with colorectal cancer and 49 more Ontarians with lung cancer would still have been alive five years later.

Ms. McLaughlin outlined the scope of the topics for the event, which included:

- accessing safe, effective person-centred care (including palliative, survivorship and end-of-life care);
- organizing a system-level approach to identifying inequities early and connecting patients with required resources to ensure equitable treatment;
- learning from other parts of the cancer journey—including primary care, screening, diagnosis, and chronic diseases—with a focus on strategic directions, mechanisms and levers that can drive change; and
- discussing possible actions and next steps.

Although social determinants of health, government-wide approaches, changes at the practice level, and detailed discussions of measures, information technologies and funding are considered beyond the scope for *Walk the Talk*, Ms. McLaughlin acknowledged their importance in reducing inequities.

5.0 Health Inequities in Ontario

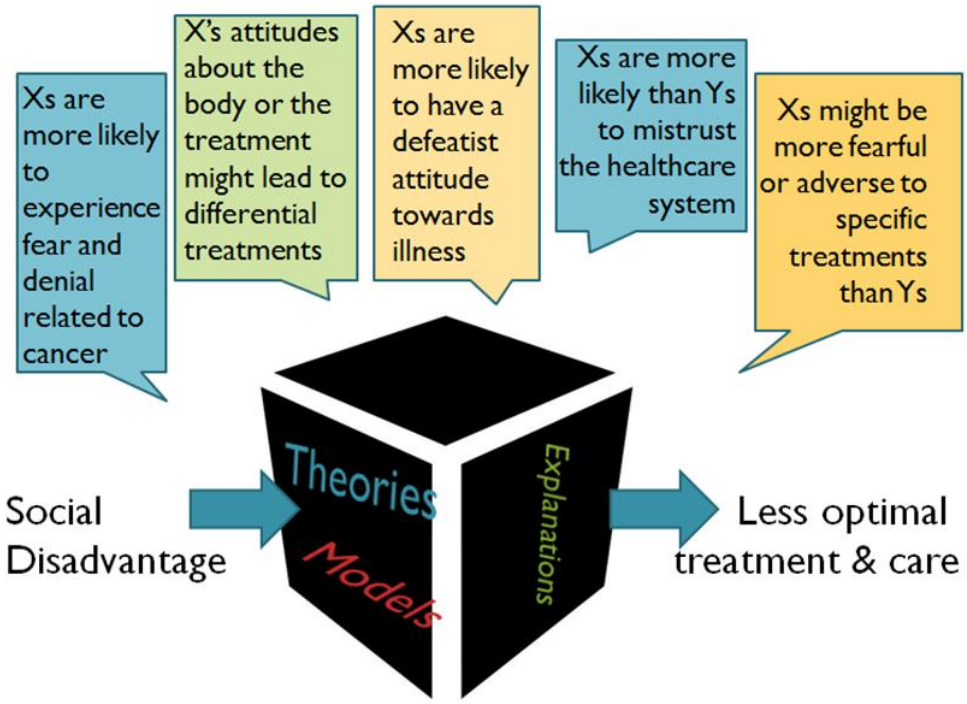
5.1 Inequities in Cancer Care: Barriers and Lessons

Dr. Christina Sinding (PhD), Associate Professor at McMaster University, began by referencing the "Code Red" series by Steve Buist of the *Hamilton Spectator* in order to highlight health disparities between populations that are geographically close. She explained that numerous studies link social advantage with living longer after a cancer diagnosis, but what is studied less frequently is *the basis* of that that link. Research shows that it is not only the stage of cancer at diagnosis that relates to survival; survival rates also are compromised by inadequate access to optimal treatment.

Dr. Sinding explained that numerous models attempt to explain how inequities occur, with reasons such as out-of-pocket costs for cancer care (e.g. transportation and medication costs). She stated that the connection between people's personal decisions and broader public policy decisions is something that requires attention. For example, some people may choose to forego treatment because of an inability to access adequate support services at home (which are determined by public policy).

Disparities often are located in patients' attitudes, beliefs and distrust of the care system. Yet these models or assumptions are extremely over-simplified and inadequate (as indicated in *Figure 2*). For example, individuals with a diagnosis of mental illness in one study were fearful about cancer treatment, but their physical symptoms (which later turned out to be signals of cancer) were overlooked or dismissed, and they were incorrectly referred to mental health services. Dr. Sinding pointed out that in these cases, system issues—and not patient fears—resulted in delays in diagnosis and treatment, and issues with the system are less often examined. She also presented positive outcomes to these challenges, where providers developed processes to ensure that both mental and physical health systems were speaking to one another to provide integrated care.

Figure 2: Examples of overly simplistic and individualized explanations for the links between the social disadvantage, and compromised access to treatments and services



Source: *Sinding (2013), "Inequities in Cancer Care: Barriers and Lesson" (Presentation at CQCO 2013 Signature Event), Slide 12. Toronto, November 20, 2013.*

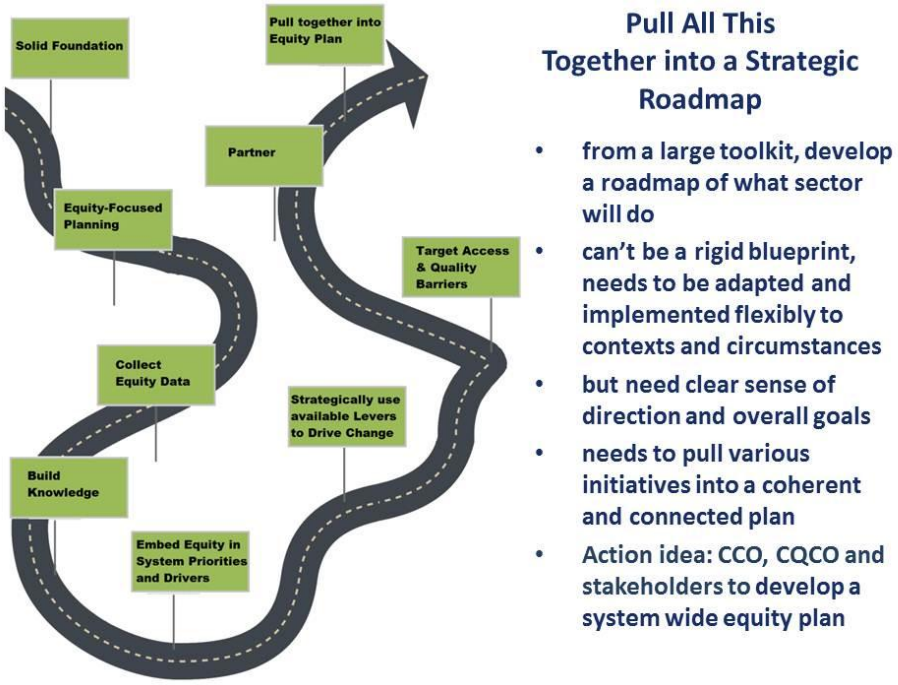
Another explanation is that some patients are more passive in their treatment (meaning they are less likely to seek information and advocate for health resources). Dr. Sinding suggested that this explanation is also problematic. There is enthusiasm for "active" and "involved" patients, but this must be tempered by equity considerations. A study on decision-making practices highlighted how different patient pathways can occur because of different patient expectations of physicians, providing an example of patients from different socioeconomic circumstances interpreting care options differently. A related study concluded that treatments related to the best outcomes were least likely to be chosen by ethnically diverse and socially disadvantaged women because those treatments interfered in more profound ways with their lives. Dr. Sinding explained that socially advantaged patients can use the system more effectively to get what they need (or more than what they need). This would be unimportant if health-care providers were able to provide robust care coordination and monitoring and tracking for all patients, but when there is no overall coordination or case manager—and when professionals are stretched—inequities can emerge for the most marginalized patients.

5.2 Inequities in the Health and Cancer System: Identifying Barriers and Moving to Solutions

Dr. Bob Gardner (PhD), Director of Policy at the Wellesley Institute, began by stressing the importance of having a clear sense of success—of how equitable care would look. He proposed a collection of proven approaches, directions or tools (outlined in *Figure 3*) that are action-oriented,

manageable and measurable. He also highlighted that many of these approaches have been implemented and tested elsewhere, and they would simply need to be adapted to the cancer care system. The first foundational direction is having a solid strategic commitment to equity that cascades through the entire system: from the province—the *Excellent Care for All Act* includes equity as a fundamental principle—to the LHINs, organizations such as Cancer Care Ontario, and all providers. Operationalizing this commitment requires building equity into all care planning and delivery.

Figure 3: Examples of proven approaches, directions and tools for an equity roadmap



Source: *Gardner (2013), "Quality Cancer Care for All: An Equity Toolkit" (Presentation at CQCO 2013 Signature Event), Slide 17. Toronto, November 20, 2013.*

The next foundational directions are:

- using the Health Equity Impact Assessment tool and other equity-focused planning tools and processes;
- systematically collecting social determinants and other equity relevant patient data;
- building diverse research and practice evidence into understanding about existing inequitable variations in outcomes across the province; and
- identifying specific disadvantaged populations and access barriers, ultimately incorporating this knowledge into program planning.

At the system level, that means having informative quantitative data and community-based research; at the practice level, that means working with patients so their views and needs are built into service delivery.

Another key direction is to embed equity into system priorities and drivers. For example, this could mean ensuring equity indicators and targets are built into performance management systems, and aligning them with incentives, funding and the overall performance management system. This may mean setting targets to improve screening rates and wait times from diagnosis to treatment; an emphasis on equity will reduce differences by socio-economic status, geography and specific populations.

From there, Dr. Gardner suggests strategic use of available levers to drive change and target barriers to access and quality. For example, equity should be built into the quality improvement plans developed by hospitals and many other institutions. At a delivery level, the priority of patient-centred care means customizing care to each individual; the emphasis on equity means paying particular attention to the poor living conditions, social inequality and exclusion faced by many. A useful practice tool is taking the social history of patients as well as their medical history. Targeting particularly disadvantaged populations or access/quality barriers also is important; cultural competence and accessible interpretation are vital. Access barriers can be mitigated through already existing navigation tools and drawing on trained professional and peer navigators.

One of the most important approaches is to build community partnerships. Partnering with community agencies is particularly critical, not only for identifying the complex barriers to screening and successful treatment faced by marginalized populations, but also for reducing them. Finally, Dr. Gardner stressed these various directions and initiatives need to be pulled together into an overarching equity plan (or "road map") in order to move forward.

6.0 System-Level Strategy Planning

6.1 Developing, Implementing and Measuring an Equity Strategy: The Welsh Experience

Mr. Chris Tudor-Smith, Head of the Health Improvement Division of the Department of Public Health and Health Provisions in Wales, began by describing the context of the Welsh government, which has a devolved administration with powers to deal the health sector, education, environment and internal affairs. He stated that Wales has a legacy of poor health that is visible in geographic variations in health across the country, and in addition to these differences in service provision, it was evident that the areas of greatest need tend to have the poorest services. With that knowledge, the Welsh government changed funding formulas for health authorities over the last decade, basing them on direct needs and making investments into projects to address inequalities. Many of those projects were successful, but their scope was small and they were not sustainable—as a result, inequalities continued to grow. The Welsh government estimated the cost to the economy of the growing inequality gap at about $5 billion, and it concluded that significant changes need to be made.

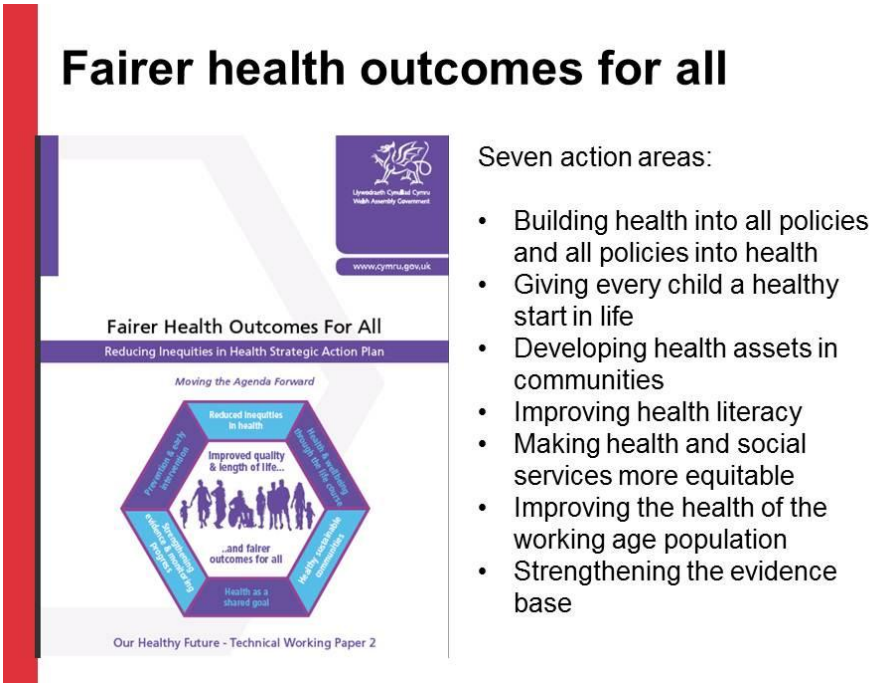
Mr. Tudor-Smith explained how the government had independent experts undertake a review of the Welsh public health system, resulting in the key recommendation of a unifying public health strategy. Widespread engagement in the process of developing this strategic approach was crucial to changing what health services, local governments and the voluntary sector were doing, but also for increasing the likelihood that all levels would assist in delivering the approach.

To this end, the Welsh government developed seven task groups—each led by one of their partners—to look at the main public health issues, map the current state for their area, suggest evidence-based solutions to the issues, and develop an overarching vision for 2020. This exercise provided the government with a network of informed individuals with whom they continue to work, and resulting contributions were collated into a document for broader stakeholder engagement.

Valuable principles from work by Professor Michael Marmot of the WHO Commission on the Social Determinants of Health also influenced the work. These areas included finding a moral rationale behind reducing inequalities that was aligned with the Welsh political approach, giving government sectors beyond health a role in the process, considering across people's life course to address inequities between different social gradients, and having provisions proportional to the level of disadvantage.

The final report, entitled *Our Healthy Future*, is a high-level strategic framework that aims to improve the quality and length of life for all, and to provide fairer health outcomes for everyone through 10 priorities (one of which specifically address reducing health inequities). Each priority has a strategic plan; for equity, the plan is called *Fairer Health Outcomes for All*. It targets improving healthy life expectancy for everyone, and closing the gap between each quintile of deprivation by an average of 2.5% by 2020. The plan outlines seven action areas (listed in *Figure 4*), with the first being a government-wide approach and building health equity into all policies. Each area will have tasks and indicators owned by different parts of government, which Mr. Tudor-Smith explained has been a challenge, but it has resulted in a consensus on a small number of indicators over which all of government would take ownership.

Figure 4: Fairer Health Outcomes For All seven action areas



Source: *Tudor-Smith (2013), "Developing, Implementing and Measuring a Government-Wide Equity Strategy: The Welsh Experience" (Presentation at CQCO 2013 Signature Event), Slide 16. Toronto, November 20, 2013*.

In consultation with their task groups and others, the Welsh government created guiding principles for the indicators, one of which stated that they should be reportable at the local level, cover issues related to life expectancy, and be outcome-based and comparable to neighbouring countries. The government also accepted, however, that many indicators did not cover all the criteria. Recognizing the limitations, they proposed a number of indicators for the action areas including literacy and numeracy tests, access to GP surgery, amenable mortality and independent living.

The next step was having government parties commit to delivering the indicators because strong political commitment is a critical factor. The government also consulted with the public and found that the majority of people favoured legislating equity, so they are proceeding with the *Future Generations* bill, which will mandate reporting on initiatives designed to reduce inequities. In addition, they have been producing delivery plans for a number of major conditions—including cancer—that share the common theme of reducing inequities in incidence mortality rates through performance management. This is being done to improve quality of care for individuals in the poorest communities. Mr. Tudor-Smith concluded by stating systems can make changes at a large scale, and that success is possible through education, legislation and changes to the health care environment.

Q and A Highlights with Mr. Chris Tudor-Smith

Overcoming barriers

- It is important to change people's opinions and show them that success is possible.
- The current economic environment reinforces the need to redirect resources and avoid waste and variation.

Indicators

- Amenable mortality refers to those deaths that could be avoided through high-quality health care (in the light of medical knowledge and technology at the time of death).
- Health literacy is a costly indicator, so overall literacy is instead measured. When resources are available, however, the Welsh government plans to collect data on health literacy.

7.0 System-Level Community Engagement

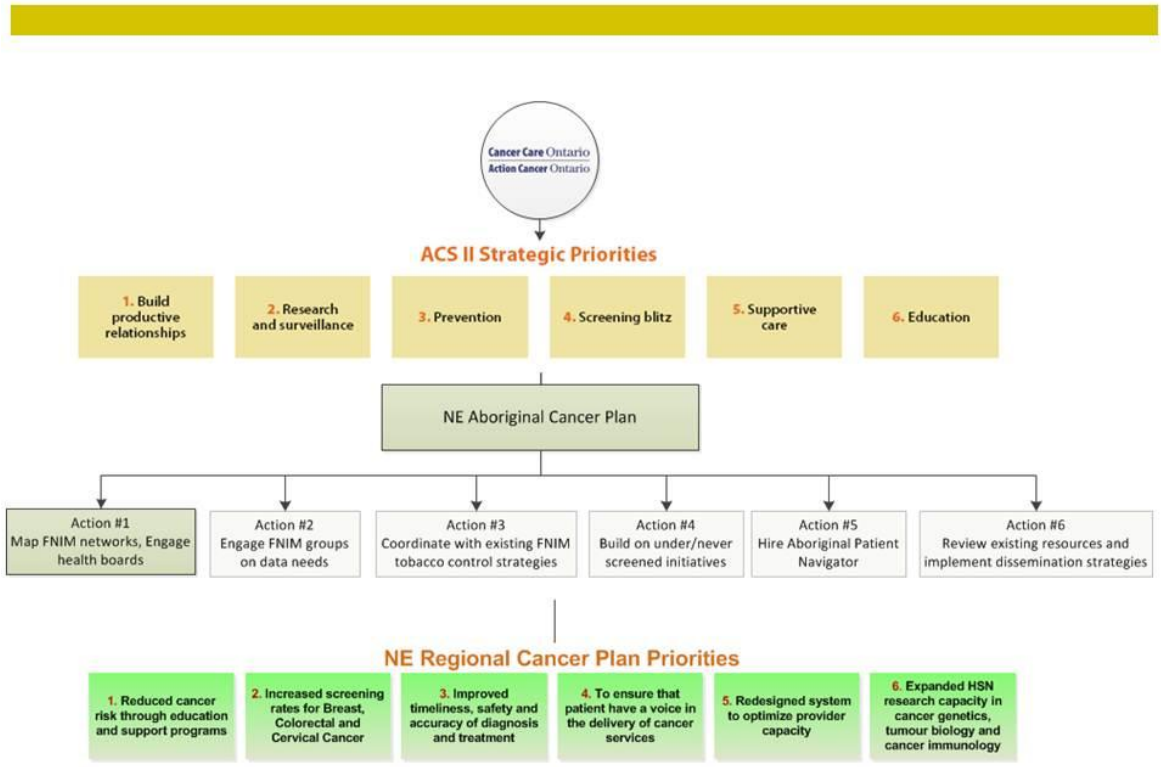
7.1 Relationship Building and Engagement with First Nations, Inuit and Métis Peoples: CCO's Aboriginal Cancer Strategy

Ms. Alethea Kewayosh, Director of Aboriginal Cancer Control at Cancer Care Ontario, provided a history of Aboriginal people and described her team's work developing and implementing the Aboriginal Cancer Strategy II. She first explained that First Nations are a distinct, constitutionally recognized people with treaty rights, before continuing by discussing the *Indian Act* (1876), which gave the federal government exclusive authority to legislate in relation to Aboriginal people and land, but which only acknowledged Aboriginals as people if they renounced their Indian status. Amendments in 1920 made residential schools compulsory from Aboriginal children ages 7 to 15, devastating First Nations' culture, way of life, language and community. Currently, there are approximately 300,000 Aboriginal people from five main cultural groups in Ontario, many of whom live in remote communities with considerable health inequities.

Not only is cancer incidence rising more quickly in First Nations communities, but First Nations, Inuit and Métis people are diagnosed at a later stage and their survival is significantly worse. Specific to the cancer and health system, issues such as a lack of family physicians and transportation to services are of concern, as is the poor coordination of care and lack of data on Aboriginal people. Beyond the health system, issues related to the social determinants of health (such as poverty), and modifiable risk factors (such as smoking and poor nutrition) contribute to poorer health outcomes, and intergenerational trauma associated with colonialism and disputes between the provincial and federal government over responsibilities contribute to distrust of the health system.

CCO's Aboriginal Cancer Control Unit was developed to provide an Aboriginal perspective to the organization's work, to implement the Aboriginal Cancer Strategy, to engage directly with the First Nations, Inuit and Métis people, and to help support regional cancer programs. Ms. Kewayosh explained that the Aboriginal Cancer Strategy II, launched in June 2012, is CCO's road map to addressing First Nations, Inuit and Métis cancer control issues and needs in Ontario. The Aboriginal Cancer Strategy II outlines the commitment to improve the First Nations, Inuit and Métis cancer journey, and it presents six strategic priorities (highlighted in *Figure* 5), the foundational priority being Building Productive Relationships. To accomplish this, the Aboriginal Cancer Control Unit began work with 10 regions that have significant Aboriginal populations, establishing primary contacts and supporting each region to create customized Aboriginal cancer plans, six of which are currently drafted.

Figure 5: Aboriginal Cancer Strategy II strategic priorities and actions



Source: *Kewayosh (2013), "Aboriginal Cancer Strategy II"(Presentation at CQCO 2013 Signature Event), Slide 31. Toronto, November 20, 2013.*

Ms. Kewayosh explained that CCO's Aboriginal Cancer Control is looking at ways to build capacity in the regional cancer programs to better address the issues specific to the cancer system, dedicate resources and ensure the engagement process is sustainable. The Aboriginal Cancer Strategy II involves identifying and mapping the core First Nations, Inuit and Métis health tables in the 10 regions. Aboriginal Cancer Control also has developed relationship protocols to formalize the relationships with the provincial level Aboriginal organizations, to create accountability for the strategy and to represent a unique relationship based on trust and mutual respect between CCO, First Nations, Inuit and Métis. In conclusion, Ms. Kewayosh indicated that Aboriginal Cancer Control is hiring Aboriginal Patient Navigators to support patients and families, and to ensure each patient's outcome is as positive as possible.

Q and A Highlights with Ms. Alethea Kewayosh

- Ms. Kewayosh explained she is working with counterparts at other cancer agencies across the country to create a business case for First Nations leadership that will identify the policy needs for resolving issues regarding jurisdictional responsibilities.
- The engagement tables were agreed upon for the Aboriginal Cancer Strategy II and that is their focus. There are, however, opportunities to introduce other organizations and health issues to the tables once the foundation has been established.

7.2 Raising Cancer Awareness in Minority Groups: Measuring Knowledge of Cancer Prevention and the Uptake of Screening Programs

Ms. Paula Lloyd-Knight, Head of Patients and Public Voice for NHS England, described their project to raise awareness of the signs and symptoms of cancer in the Black and Ethnic Minority (BME) communities. A 2009 report by the National Cancer Intelligence Network identified major incidence levels in cancer among ethnic groups, including higher rates of prostate cancer and breast cancer for African Caribbean men and women (respectively), higher mortality rates and higher rates of cervical cancer for Asian women, and higher rates of mouth cancers for both Asian men and women. Ms. Lloyd-Knight explained that the pilot project, "Cancer does not Discriminate", was developed to increase awareness of early signs and symptoms of cancer amongst BME communities, to challenge myths and misconceptions about cancer held by some BME groups, and to improve participation of cancer screening programmes within the pilot areas by focusing on the most affected communities (including African, African Caribbean, and Asian populations).

Ms. Lloyd-Knight explained that the NHS used a co-production community engagement approach with four main methods: community development, a faith programme, a media programme and a targeted clinical intervention. The community development—which was led by the community itself—targeted community leaders and established community organizations, as well as partnerships with local voluntary sectors and health services.

The project focused on five specific geographic areas with large ethnic populations for a predetermined amount of time. For written communication, the NHS used the language of the targeted community, focusing on newspapers and applying different approaches, including specific

real life stories and "myth busting" sections. They also worked with different ethnic radio stations and piloted training for radio presenters to become advocates, and they arranged for numerous health-care professionals to give interviews on aspects of cancer and for community figures to make statements in support of cancer awareness and screening. Ms. Lloyd-Knight also highlighted how their faith program had "cancer champions" within the community who delivered information sessions and provided funds to organizations that wanted to run awareness sessions. Finally, a clinical intervention took place in three regions, with 30 general practitioners (GPs) participating in an effort to increase uptake of cervical screening among ethnic communities.

The project was measured by a number of quantitative indicators, including:

- the amount of information given out;
- increases in charity helpline calls;
- increases in screening uptake in target areas;
- increase in cervical screening uptake during the GP intervention pilot;
- the amount of people attending workshops; and
- the number of local champions trained.

They also made use of qualitative measures, such as changes in awareness levels.

Results compared from the pre- and post- campaign surveys showed that awareness of cancer services increased in the targeted regions, and most respondents indicated they would participate in screening. Ms. Lloyd-Knight stated that the partnerships established still exist today, despite the completion of the campaign, and she indicated that the grants created distinct legacies, with organizations continuing the work and collaborations with the local health services.

7.3 Addressing the Under-/Never-Screened in Ontario

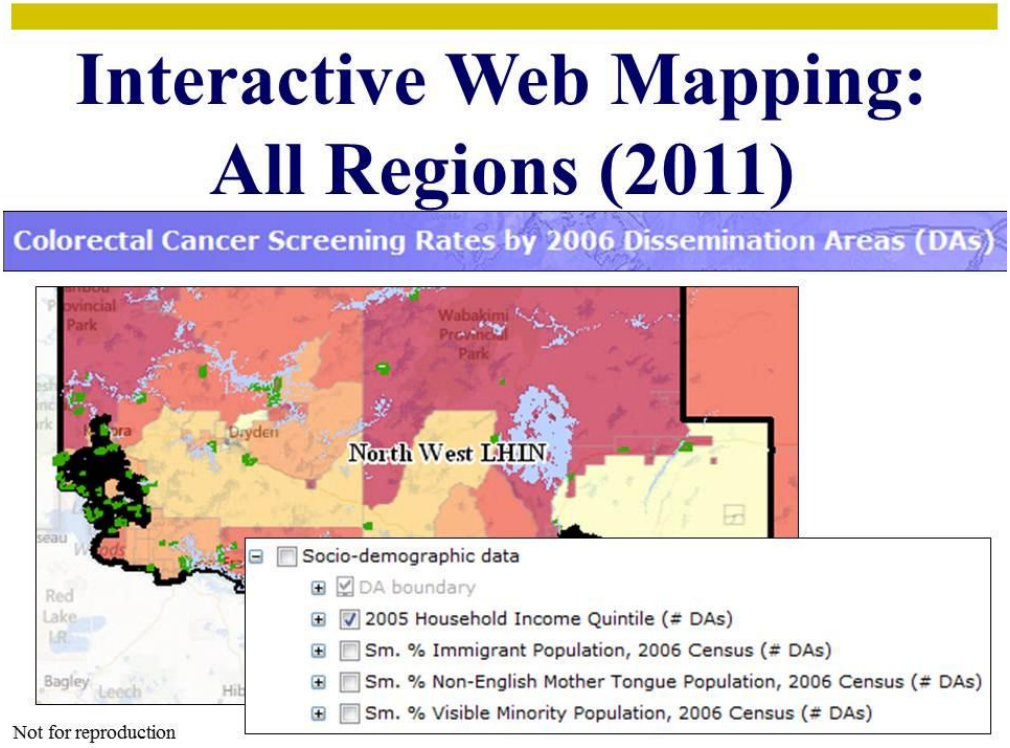
Dr. Linda Rabeneck, Vice President of Prevention and Cancer Control at Cancer Care Ontario, discussed addressing the equity gap for cancer screening in Ontario. She began by highlighting that nearly half the province is invited to screening programs for cervical, breast and colorectal cancers presenting challenges in geography and remote populations accessing these programs. For example, there are significant differences in screening rates for First Nations, Inuit and Métis populations compared to the overall population, identifying a clear equity gap that needs to be addressed. Dr. Rabeneck also stated that the Ontario Cancer Plan III contains a commitment to establish local and regional initiatives to address the under-/never-screened (target populations who either have no history of screening or who are not up-to-date with screening).

Dr. Rabeneck explained that there is no universal approach to tackling this equity gap, and that interventions need to be customized for each population, as they face very different barriers. She described a project, which CCO began funding three years ago, that was comprised of five regional initiatives. Four of the initiatives focused on Aboriginal never-screened populations, and the fifth focused on immigrant and low-income populations. Overall, the project aimed to build regional capacity to address equity gaps and increase screening rates. The initiatives include culturally-sensitive workshops, peer leads from the target populations and screening outreach coordinators. In addition, CCO created data tables to help depict the population in the five regions at the

dissemination-area level, and they provided information on socio-demographics, Aboriginal identity, health status, number of family physicians and screening participation rates. They also provided interactive web based maps (seen in *Figure 6*) with information that allows the regions to identify areas of focus.

Results from the initiatives indicate the need for clear accountability for CCO and the regions and a full-time dedicated Coordinator. Dr. Rabeneck explained that the next steps involve completing the evaluation, having the results inform the sustainability of the current work, and ultimately expanding it even further.

Figure 6: Sample of interactive web mapping for colorectal cancer screening rates



Source: *Rabeneck (2013), "Addressing the Under- or Never-Screened (UNS)" (Presentation at CQCO 2013 Signature Event), Slide 16. Toronto, November 20, 2013.*

Q and A Highlights with Dr. Linda Rabeneck

- Sustainability of the current work was highlighted as an important factor and the rationale that local organizations should be including equity into their strategic plans.

8.0 Rapid Round Debates

8.1 Systematic Consideration of Equity in Policy Planning: Using the Health Equity Impact Assessment Tool

Sheree Davis

Ms. Sheree Davis, Director of the Community and Population Health Branch, Health Systems Strategy and Policy, at the Ministry of Health and Long-Term Care (Ministry), shared the Health Equity Impact Assessment (HEIA) tool developed by the Ministry to provide a systematic method of embedding equity in planning and decision-making. The tool allows users to make policy and planning recommendations that might mitigate negative impacts and maximize positive impacts on specific population groups. She explained how the tool – which is based on evidence and existing health equity assessment methods and tools – involves five steps. These steps are as follows:

1.) scoping the objective of the intervention or program:
2.) identifying the potential positive and negative impacts to individual populations;
3.) developing mitigation strategies;
4.) monitoring the mitigation strategies; and
5.) disseminating the results.

Ms. Davis mentioned that uptake of the tool is slow since it has not been mandated by the Ministry. Early evaluation results are promising, however, and organizations that embed equity considerations into their culture begin to have an impact reducing health inequalities for targeted populations. She stated that applying this tool is a sustainable practice, promotes innovation through partnerships and cross-sectorial working relationships, supports quality improvement within organizations and anticipates issues.

Dr. Ingrid Tyler

Dr. Ingrid Tyler, a Public Health Physician at Public Health Ontario (PHO), highlighted her organization's collaboration with the Ministry on the HEIA tool and its supplements for public health units, as well as how they worked directly with public health units to integrate the tool into their respective operations.

Dr. Tyler then explained in greater detail how PHO applied the HEIA tool to policy recommendations in its 2012 report, *Taking Action to Prevent Chronic Disease* (developed jointly with CCO), in order to ensure that they would not exacerbate health inequities in Ontario. This included a rapid review of the literature (including peer reviewed, grey and informant interviews), and exporting the resulting data into the HEIA template. This process was performed for each of the 22 recommendations, and the data was included in the technical appendix of the document, along with a summary for those implementing them. According to Dr. Tyler, the process was a systematic way of identifying potential negative impacts to vulnerable populations.

Q and A Highlights from the Rapid Round Debate with Ms. Sheree Davis and Dr. Ingrid Tyler

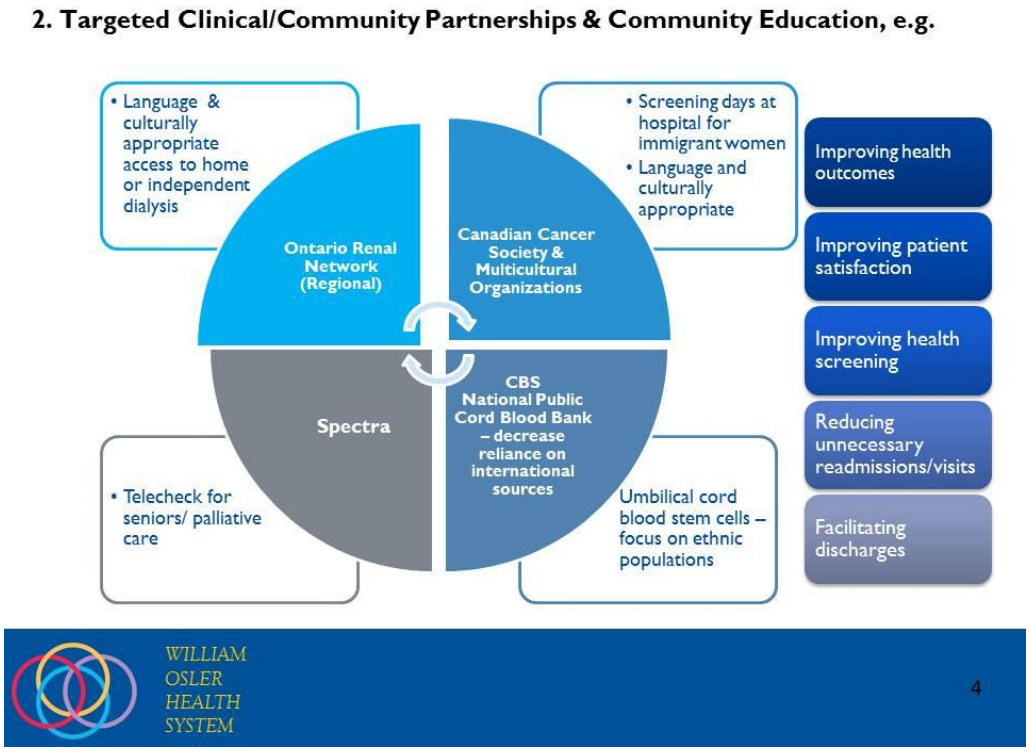
- Organizations and institutions delivering health services should use the HEIA tool to identify issues for marginalized populations.
- Conversation stimulated by using the HEIA tool was an outcome in itself, because applying the tool involves changing the organizational culture as much as it does altering the policies.

8.2 Addressing Barriers within an Institution: A Model for Embedding Equitable Service Delivery

Gurwinder Gill

Ms. Gurwinder Gill, Director of Patient Relations and Diversity Services at the William Osler Health System, began by stressing the importance of data collection and commitments from leadership to attempts to identify and reduce potential inequities. She described the data that has been collected by the institution, including socio-demographic information for residents of Brampton and Etobicoke and screening rates contrasted with the percentage of immigrants in neighbourhoods. The institution has created numerous clinical and community partnerships (summarized in *Figure 7*), including the Canadian Cancer Society, multicultural organizations, faith groups and ethic media. This has been accomplished through initiatives that are language and culturally appropriate, such as screening days for immigrant women. Ms. Gill indicated that they hope to achieve access to accurate interpretation services to reduce risks and increase safety in patient care, and to create an inclusive, welcoming and accessible environment.

Figure 7: Examples of targeted clinical and community partnerships and community education initiatives



Source: *Gill and Chidwick (2013), "Walk the Talk: Removing Barriers to Cancer Care for All" (Presentation at CQCO 2013 Signature Event), Slide 4. Toronto, November 20, 2013.*

Dr. Paula Chidwick

Dr. Paula Chidwick (PhD), Director of Clinical and Corporate Ethics at the William Osler Health System, stressed one of the basic obligations to patients is to provide person-centred care, which has the double effect of promoting equity. For example, sensitivity to language barriers should be incorporated within support tools for staff and community members. She stated that the William

Osler Health System also has made an effort to build capacity in their staff through self-awareness, communication and learning how best to serve diverse populations.
Dr. Chidwick then highlighted an initiative for community education, where her team has gone directly into the community and educated individuals on the decision-making process that occurs in the hospital, including the use of interpreters and the rules surrounding substitute decision-making. Dr. Chidwick also highlighted an app called "ChELO", which is a checklist for Ethical and Legal Obligations for health-care providers. ChELO collects information—such as patients' wishes, values, beliefs, advanced care planning, and power of attorney—with the goal of reducing errors and helping providers ask the appropriate questions.

Q and A Highlights from the Rapid Round Debate with Ms. Gurwinder Gill and Dr. Paula Chidwick

- William Osler Health System has training modules for staff capacity building, which are tailored to the needs of the audience. They have focused on providers such as nurses who are most in direct contact with the patients and families.
- The greatest impacts of the hospital's work have resulted from data collection and community partnerships.

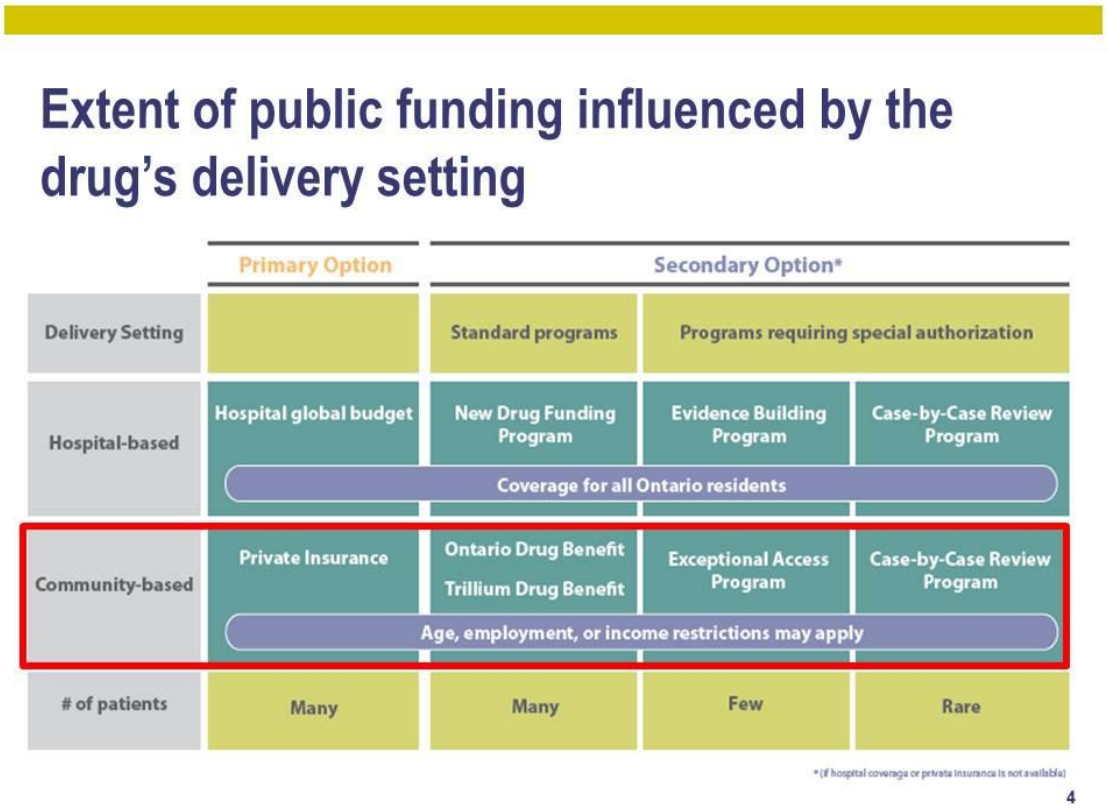
8.3 Drug Funding in Ontario: Ensuring Equitable Access for all Patients

Scott Gavura

Mr. Scott Gavura, Director of Provincial Drug Reimbursement Programs at Cancer Care Ontario, stated that cancer drug costs have increased over the last decade, making equity and access to cancer drugs a challenging aspect of care. The funding of drugs also is inconsistent between provinces, mainly due to the *Canada Health Act*, which excludes funding for outpatient drug treatments (such as cancer chemotherapy administration clinics). This forces provinces to develop benefit programs for their residents. CCO has been working with a number of initiatives, specifically the Pan-Canadian Oncology Drug Review and, more recently, the Ministry's involvement with the Pan-Canadian Purchasing Alliance, which are collaborations that encourage greater consistency in drug coverage across the country.

Mr. Gavura explained that cancer drugs in Ontario are funded by a mix of public and private sources, with about $216 million coming from the Ministry and its public reimbursement program, $215 million from CCO and the New Drug Funding Program, $66 million from hospital base budgets and $78 million from private sources. The extent of public funding is influenced by the setting in which the drug is administered (as shown in *Figure 8*), meaning that injectable drugs administered in hospitals are covered. Drugs administered in an outpatient setting (such as a community pharmacy), however, are not, making patients responsible for costs through their private insurance. If that is not available to them, there are a number of public programs that exist, but they are largely for populations on social assistance, seniors and residents who have drug costs that represent a significant portion of their income. A survey completed recently on drugs under development indicated that about half would be administered in the community setting. This offers tremendous benefits to patients (who can take them at home), but funding these expensive treatments does represent a challenge.

Figure 8: Cancer drug funding in Ontario by delivery setting



Source: *Gavura (2013), "Drug Funding in Ontario: Ensuring Equitable Access for All Patients" (Presentation at CQCO 2013 Signature Event), Slide 4.Toronto, November 20, 2013.*

Dr. Scott Berry

Dr. Scott Berry, a medical oncologist at Sunnybrook Odette Cancer Centre, presented a number of clinical scenarios highlighting the inequities that exist across disease and tumour sites. He explained how there are inequities in accessing oral chemotherapy drugs for a number of reasons, including age, type of cancer, the province in which you live, whether or not you have private insurance, and whether you personally have the ability to pay for the drug.

One of the solutions proposed by Dr. Berry is for clinicians to become patient advocates. He explained that clinicians already spend a significant amount of time advocating for patients, including finding compassionate access programs, putting them on clinical trials, and making sure that they get private insurance coverage when possible. Another solution, he suggests, is to ensure that one of the core competencies for medical oncologists is the ability to talk to patients about these tough choices, as well as an understanding of how to have those discussions.

Q and A Highlights from the Rapid Round Debate with Mr. Scott Gavura and Dr. Scott Berry

- There will always be a lag between the announcement of trials and the decision by public agencies about whether or not to fund the drug. This is because decisions need to include clinical data and value for money consideration, as well as collaboration with other provinces when negotiating prices.
- Dr. Berry stressed the importance of consistency in policies across institutions when it comes to private payment for injectable drugs administered in hospitals.

9.0 Reducing Inequities in Cancer Treatment

9.1 Creating the Case for Patient-Centred Care for All: Identifying and Supporting Cancer Patients from Diagnosis

Dr. Francesca Gany, Chief of the Immigrant Health and Cancer Disparities Service at Memorial Sloan Kettering Cancer Center (MSKCC) in New York, related how helping one particular immigrant community in New York made her and her colleagues question the experiences of other immigrant groups accessing care. This resulted in MSKCC bringing together health care sector community organizations and health-care institutions to try to systematically break down barriers to care, from the time that someone is diagnosed with cancer through to survivorship and sometimes end-of-life care.

Dr. Gany explained how this was done through the creation of a network of community members, community-based organizations, faith-based organizations, policy makers and researchers, all of whom shared a mission to facilitate the delivery of linguistically, culturally, and epidemiologically sensitive health services to newcomer populations. At the same time, these groups worked to decrease health disparities through changes at multiple levels, including public policy, the community, the organization and the individual.

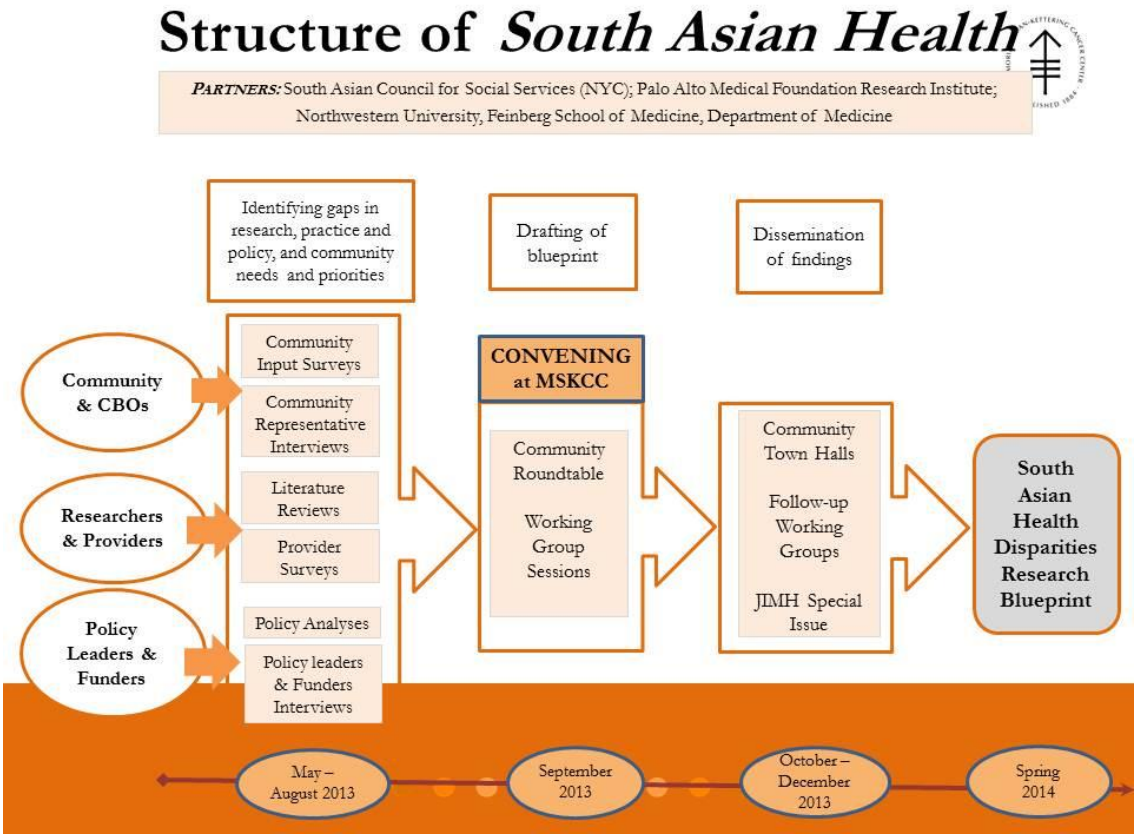
At the community level, this was accomplished through research, education and information dissemination; at the clinical level, it was done through service delivery and program and policy development with cultural and linguistic responsiveness being a key priority. Dr. Gany also described how the process used a transdisciplinary, community-engaged mixed methods approach that often evolved into a community-based participatory effort with partners such as food banks, consulates, the American Cancer Society and the Legal Aid Society.

Dr. Gany highlighted the three spheres of focus within the initiative:

1. barriers to care and treatment completion, and consideration of how the socioeconomic determinants of health impact treatment;
2. communities at risk, with a focus on prevention, screening and entry to care; and
3. focus on specific disease types and the need for epidemiological sensitive services.

One example of a project targeting the two latter spheres is the South Asian Health Initiative (seen in *Figure 9*). This initiative, guided by a multilingual Community Advisory Board, focused on screening, risk factor reduction, entry into care and follow-up care for oral cancer in the South Asian population.

Figure 9: Structure of MSKCC's South Asian Health Initiative



Source: *Gany (2013), "Creating the Case for Patient-Centred Care for All: Identifying and Supporting Cancer Patients from Diagnosis" (Presentation at CQCO 2013 Signature Event), Slide18. Toronto, November 20, 2013.*

For the first sphere, Dr. Gany highlighted data driving the work, which identified that only 75% of their immigrant cancer patients were completing treatment, and that members of that population were experiencing lengthy delays to access of care.

Based on this knowledge, the Integrated Cancer Care Access Network (ICCAN) was formed, which had four areas of focus:

1. treatment completion rates, including developing achievable goals and providing socioeconomic and other supports;
2. quality of life and patient-reported outcomes, such as providing food if needed and coaching patients on working with health providers;
3. supporting health, such as providing psychosocial support; and
4. assessing for co-morbidities, survivorship and follow-up visits.

ICAAN provides supports at the policy and systems level, addressing issues such as Medicaid coverage, clinic hours and availability of multilingual staff. It also operates at the patient level, providing individual needs assessments and access to facilitators who supply case management.

Dr. Gany explained that the institution continues the needs assessments throughout treatment in order to monitor socioeconomic and psychosocial needs across the care continuum. Through this assessment, they discovered 61% of patients have food insecurities, prompting the creation of a

series of medically tailored food pantries. They also began a language initiatives program, after finding that patients with limited English proficiency had poor cancer diagnosis knowledge. Dr. Gany described how ICAAN has served 4,500 patients since 2008, and how the combined initiatives to serve these patients cost approximately $1000 per patient. She also indicated that future activities will include expanding the program to additional facilities and building capacity so that staff at the institutions also can perform the work.

Q and A Highlights with Dr. Francesca Gany

- MSKCC currently has 354 partners and began with key informants in each of the communities, basically going from door-to-door to speak with people.
- Their work started with immigrant populations, but since then, they have expanded to serve anyone with health disparities.

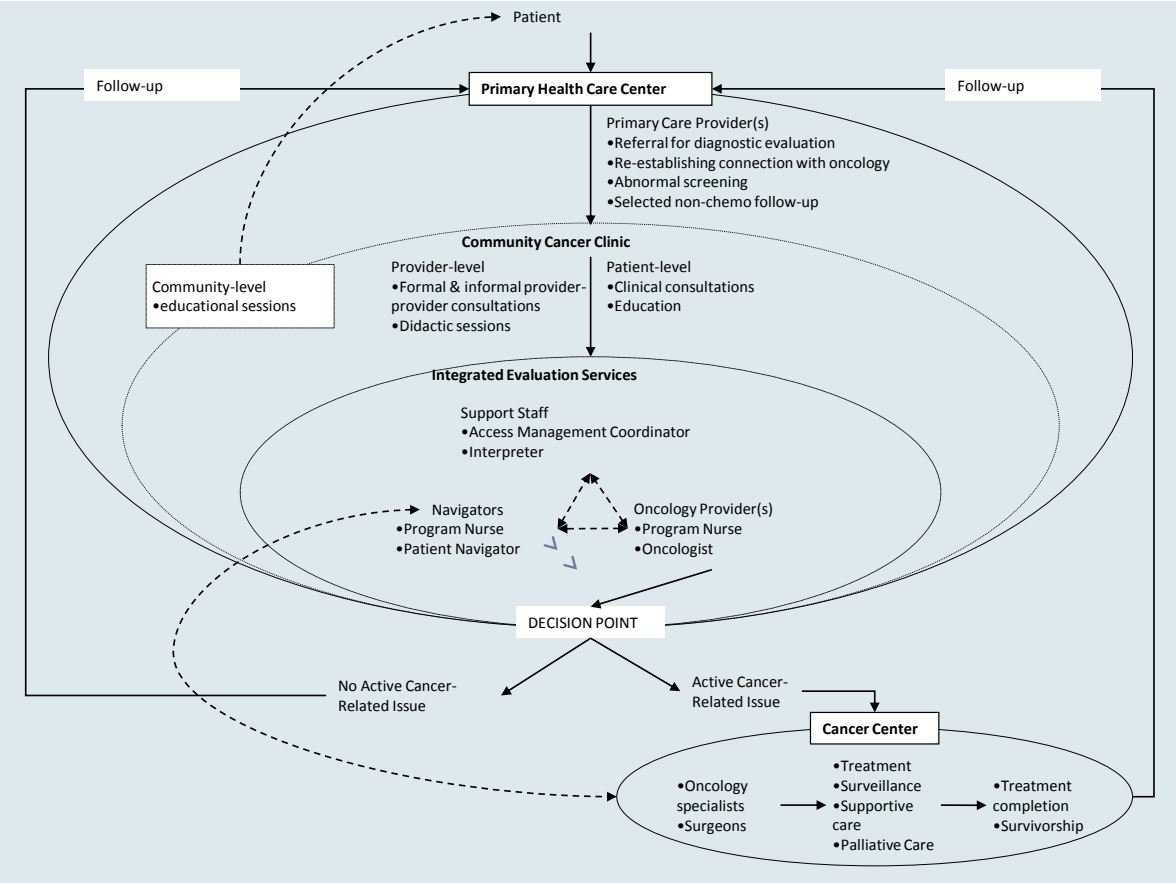
9.2 Bringing Specialist Care to Patients: Oncologists Seeing Patients at a Community Health Centre

Dr. Christopher Lathan, Faculty Director for Cancer Care Equity at the Dana-Farber Cancer Institute in Boston, shared his integrative outreach model at a community health centre. He explained the rationale for the program came from inequities across the whole spectrum of care, the decreased use of cancer centres and reduced enrolment in clinical trials for vulnerable populations, as well as poor relationships between health care institutions and these communities. The goal of the program is to improve local outcomes for the underserved across the spectrum of cancer-related disease by facilitating clinical access to preventive medicine, treatment and clinical trials.

Dr. Lathan explained that the process began with the creation of a disparities framework to look at the factors blocking patients from treatment. Disparities were divided into three areas, including clinical appropriateness, operation of the health-care system including access and insurance issues and discrimination bias. From looking at different patient scenarios entering the cancer system, they were able to determine that patients, particularly those from vulnerable populations, often can be lost to follow-up with specialists.

The outreach model—which was built on a "fast track" problem-solving methodology, as well as the presence of a nurse navigator with the expertise to triage patients—proposed oncologists visit the community and work with primary care physicians to assist with follow-up at a local health centre that serves a population with high levels of poverty. Before the model was implemented, an algorithm flow chart was created to determine the mechanics of the program (see *Figure 10*). Patients are referred based on a broad cancer-related symptom or follow-up from cancer treatment, and they are seen by clinicians visiting the health centre once a week. The clinicians determine if patients require follow-up pertaining to a cancer diagnosis or if they should return to their primary care physician.

Figure 10: Algorithm flow chart for the integrative outreach model at a community health centre



Source: *Lathan (2013), "Bringing Specialist Care to Patients: Oncologists Seeing Patients at a Community Health Centre" (Presentation at CQCO 2013 Signature Event), Slide 18. Toronto, November 20, 2013.*

The program has been running for 1.5 years and in that time, it has served 227 patients. Dr. Lathan explained how they initially spent 18 months building trust with the community and gaining support from leadership. Early evaluations have indicated that approximately 50% of the patients referred have cancer, showing how a significant number of cancer patients are in the primary care setting. For the patients referred to the cancer centre, 9.3% enrolled in a clinical trial, which is higher than the national rates. Dr. Lathan explained that the next steps are to look at sustainability of the program, to increase patient volumes, to expand to another site and to incorporate additional metrics (such as patient satisfaction, diagnosis times and a clinical operation efficiency review).

Q and A Highlights with Dr. Christopher Lathan

- The program, which is funded by a philanthropic gift, currently is focused on clinical efficiency. Sustainability is a concern, however, and the program is collecting data to demonstrate the value of the program. This will help to create a case for the program to be at least partially funded within the operating cost of the hospital.
- The program has an integrative function, where it provides education programs in survivorship and screening within the community.
- The program is built on the nurse navigator model because the process requires oncology experience and clinical expertise.

10.0 Panel Discussion

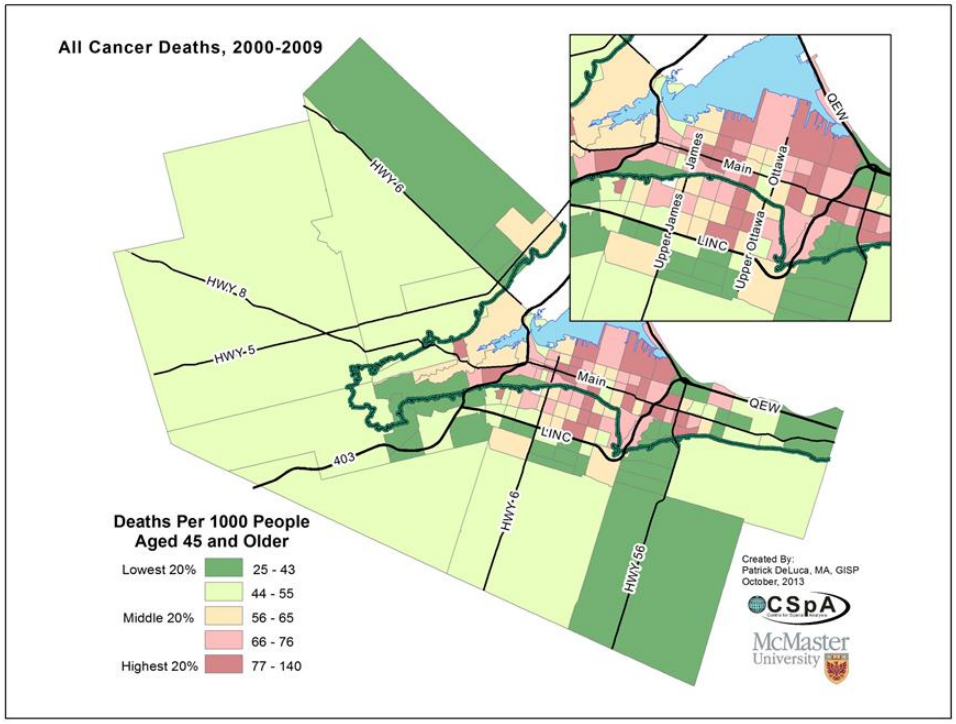
10.1 Models, Tools and Measures Supporting Patient Care: How Do We Coordinate and Embed Supports to Create a Better Cancer System for All?

Steve Buist

Mr. Steve Buist, investigative reporter at the *Hamilton Spectator*, provided an overview of his "Code Red" series of articles that was published in 2010. The series examined the health of Hamilton down to the neighbourhood level or census tract, creating maps that specifically displayed the connections between health and wealth. The maps illustrated significant disparities in health outcomes, such as a 21-year difference in life expectancy between the best and worst neighbourhoods.

When the same approach was applied to cancer, Mr. Buist found that incidence and mortality rates were higher in the less affluent parts of Hamilton than the wealthier parts (as seen in *Figure 11*). These significant differences followed a similar pattern, where the inner-city regions of Hamilton had higher cancer incidence rates and mortality than the wealthier outer suburban regions. In fact, if the morality rate in Ancaster, Hamilton's wealthiest suburb, was applied to the former City of Hamilton, there would have been 3,438 fewer deaths over 10 years. Mr. Buist indicated that data obtained from a telephone survey showed higher smoking rates in the inner city core, as well as worse breast cancer screening participation rates, and that fewer residents in that area were attached to a family physician.

Figure 11: Cancer mortality rates for Hamilton and surrounding area by census tract



Source: *Buist (2013), "Cancer, Hamilton and the Connections to the Social Determinants of Health (SDOH)' (Presentation at CQCO 2013 Signature Event), Slide 2.Toronto, November 20, 2013.*

Marylin Kanee

Ms. Marylin Kanee, Director of Diversity and Human Rights at Mount Sinai Hospital, described the patient demographic data collection project in the Toronto Central LHIN. She explained how the project—which has taken four years—originated from work to prepare health equity plans using data from postal codes, which was only able to infer the socioeconomic status of the population. Led by Mount Sinai Hospital, the Toronto Central LHIN initiated the Tri-Hospital and Toronto Public Health (TPH) Health Equity Data Collection Project to develop a method for hospitals to collect patient demographic data with the ability to link questions to health outcomes and self-reported health status. Goals of the project include improving the quality of care, understanding the population served by the hospital, identifying health inequities and developing strategies to address the gaps.

The report from the study, *We Ask Because We Care*, found that patients were willing to provide this data, with 82.5% of them participating. Other lessons included training the data collectors so they felt comfortable with surveying patients, overcoming initial time constraints as they gained experience and learning how to establish a rapport between patients with acute mental health issues and the provider who was asking the questions. Ms. Kanee emphasized that having the Toronto Central LHIN mandate the data collection was critical. The past two years have seen the program working with 18 hospitals, and it also will be implemented in 17 Community Health Centres in the LHIN.

Dr. Gary Bloch

Dr. Gary Bloch, a family physician at St. Michael's Hospital, began by telling the story of a patient who recently passed away from cancer—in particular, his battle with life circumstances. Stories like this, Dr. Bloch said, led him to focus on incorporating patients' social issues into health encounters. Dr. Bloch offered five interventions that front-line providers in the cancer system can use to address the social determinants of health (SDH). They include:

1. screen everyone for SDH often, and take time to listen to patient stories;
2. integrate interventions for SDH into every care plan so that both providers and case managers view it as their responsibility;
3. build capacity within teams to address SDH (Dr. Bloch provided an example of his team hiring an income security-focused health promoter);
4. include equitable outcomes for the most vulnerable populations in research and evaluations, and prioritize these populations in the cancer research agenda; and
5. encourage providers to advocate the reduction of SDH as a key cancer care intervention, both within the health system and broader society.

Dr. Bloch concluded by stating that the discussed interventions may require extra resources, reconsideration of daily activities and organizational support, but they can be implemented within months, and as his team has discovered, the transition has been a positive experience for patients and providers alike.

Dr. Shannon Wesley

Dr. Shannon Wesley, a First Nations physician, described her role as Aboriginal Cancer Lead for the North West region as it works to establish partnerships between CCO, primary care providers, and First Nations, Inuit and Métis health tables. Within the region, there are many isolated communities across a large geographic region, leading to transportation challenges. The region also has populations that are faced with complex medical and social issues, including poverty, addiction and generational trauma. Physicians might visit the area, but there are time constraints and screening information about the patients is often missing.

With these barriers in mind, Dr. Wesley explained that an initiative was undertaken—with the assistance of the First Nations organizations—the Wequedong Lodge Pilot Screening Program, which attempts to provide a safe environment to discuss cancer screening using culturally sensitive toolkits and visual aids. The program also provides education on cancer awareness and screening tests, and sends letters to physicians and other providers to inform them of the tests that need to be scheduled. Dr. Wesley stressed the importance of having a translator to assist clients and an aboriginal navigator to build relationships with patients and advocate for the patient.

Fay Strohschein

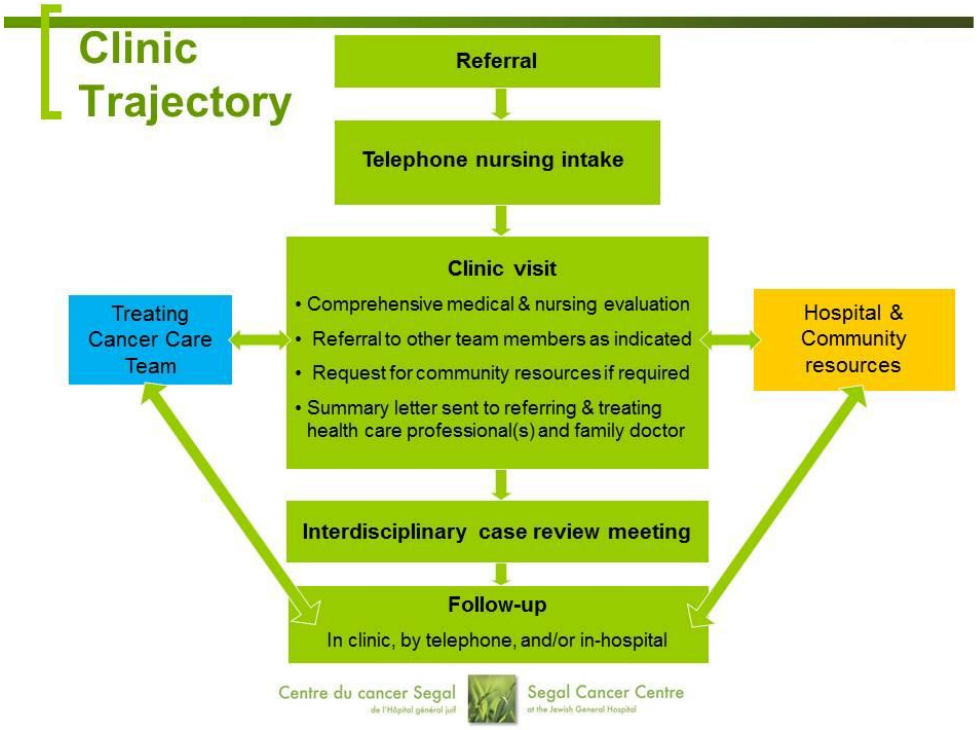
Ms. Fay Strohschein, a Nursing Clinical Consultant in the Oncology & Aging Program at the Segal Cancer Centre, Jewish General Hospital in Montreal, explained how the hospital introduced a model of care to address the needs and concerns of older adults with cancer. She explained how 43% of new cancer cases and 61% of cancer deaths occur in individuals over the age of 70. These patients show vast variation in terms of health and functional status, social supports, resources, and life

experiences, which influence their expectations for care. There are also physiological aspects of aging that affect treatment efficacy and side effects.

Research indicates patterns of under-treatment in older adults, even when comorbidities are controlled for. It is unclear, however, if this under-treatment is due to attitudes among health-care professionals or the preferences of patients. Where it is related to patient preferences, it also has not been determined if those preferences reflect patient values or misinformation about prognosis and treatment. Finally, in instances of over-treatment, increased tension between quality and quantity of life—as well as lack of inclusion in clinical trials—heightens challenges related to determining the appropriate treatment for older adults with cancer.

To begin to address these issues, the Segal Cancer Centre established a consultation service in 2006 with the aim of promoting a comprehensive approach to the care of older adults with cancer. This is done by combining expertise in oncology and geriatrics. The goal of the program is to work with the treating team to develop an individualized, integrated plan of care that is based on an interdisciplinary, multidimensional assessment that considers psychosocial, physical, cognitive, and functional measures. This plan ultimately will promote optimal treatment outcomes, reflect patient values, and support quality of life. The clinical trajectory is described in *Figure 12*.

Figure 12: Clinical trajectory for consultation service for older adults with cancer



Source: *Strohschein (2013), "Optimizing Care of Older Adults with Cancer: Consultation Service for Senior Oncology Patients" (Presentation at CQCO 2013 Signature Event), Slide 5. Toronto, November 20, 2013.*

Discussion Highlights from Panel Members

- Front-line SDH interventions need to be prioritized within the visit, but they can be as simple as asking "Do you ever have difficulty making ends meet at the end of the month?"
- Although there is the risk that projects such as the "Code Red" series can stigmatize populations, "shining a light" on health disparities have resulted in initiatives that are aimed at improving the health of those residents.
- Data collection needs to reach providers so that information can be incorporated into patient care.
- Presenters highlighted education strategies to encourage knowledge translation, including specialized fellowships (e.g. in Geriatric Oncology) and embedding this work into curriculum and staff training.

11.0 Breakout Group Discussions

Attendees were assigned to a breakout group with a diverse range of expertise. Having groups with a broad knowledge-base allowed for discussion of priorities for action that would address equity in cancer care from the perspective of the cancer system, providers at institutions, community groups and at the individual level. Groups had a half an hour to consider the priorities for action; one individual from each of the 10 groups then reported their "big idea".

'Bid Ideas' from Breakout Group Discussions

- Cancer Care Ontario should be another voice in the fight against poverty (with accountabilities across the organization), as opposed to an individual leading the work.
- Cancer Care Ontario needs to make a formal commitment to developing an equity strategy and framework.
- Collecting and having an understanding of equity data is a crucial part of enabling work to address inequities.
- Build equity into all indictors, instead of having separate equity indicators.
- Conduct equity impact assessments or apply an equity lens for all kinds of inequities, including those at point-of-care and those within institutions, regions and systems with support from the system level.
- Create meaningful partnerships and trust in the community, and systematize partnerships that are working well in order to spread them to other partnerships.
- Train providers to maximize time with patients during screening activities.
- Have a unified system for cancer screening (e.g. non-patient enrollment models have access to screening activity reports).
- Build screening for SDH into all patient encounters, while also ensuring clear direction for providers and creating partnerships at a system level to mitigate what providers are hearing from patients.

- Create pathways to work with partners that encompass information regarding SDH.
- Strengthen education and awareness about SDH among providers through peer engagement and communities of practice, taking into account local needs and issues.
- Add questions to the Interactive System Assessment and Collection (ISAAC) around SDH in order to build a common database and make referrals to community partners.
- Increase patient navigators and give them clear, distinct roles.

12.0 CCO Commitment

Dr. Michael Sherar (PhD), President and CEO of Cancer Care Ontario, reiterated CCO's vision of creating the best health-care system in the world. To achieve this vision, Dr. Sherar suggests, the organization needs to do better in a few areas, including improving equity. He highlighted how access to treatment services and outcomes are influenced by social determinants of patients and the public, and how this quality gap needs to be narrowed. He then emphasized how addressing equity goes beyond quality—it is critical to achieving a sustainable health-care system for future generations. CCO has a large financial resource within the system, and the organization needs to look at how resources are spent to ensure they're allocated appropriately.

One of the themes Dr. Sherar articulated is the complexity of the equity problems, highlighting previous work by CCO with First Nations, Inuit and Métis people. He stated that the solutions are not a one-size-fits-all approach, drawing a parallel to personalized medicine. With the Ontario Cancer Plan III, CCO focuses on personalized medicine, which tailors services to an individual's biological footprint, but to be truly effective, CCO needs to better understand the social footprint, combining it with biological needs in order to tailor care to the *whole person*.

Dr. Sherar then emphasized the opportunity for CCO to make a commitment in the Ontario Cancer Plan IV, but he also recognized that it takes a government-wide approach. Addressing equity needs to be examined beyond a health perspective, because those needs relate to other determinants and therefore require broader partnerships with organizations that have an understanding of the population and the ability to affect changes. Dr. Sherar also stated that CCO already has many significant capacities and abilities thanks to its work with partners across the province, and he highlighted some activities that it has undertaken, including collecting data, changing the culture of how the system provides services to meet patient and public needs, and providing policy advice to assist in this effort.

Dr. Sherar thanked Ms. McLaughlin and the Cancer Quality Council of Ontario for the work on this year's Signature Event, stating that this work leads to an exciting chapter for CCO and partners. Progress from this event and recommendations will be monitored, he said, ensuring CCO achieves its vision by tailoring the system to everyone in the province.

13.0 CQCO Commitment

Ms. Virginia McLaughlin, Chair of the Cancer Quality Council of Ontario, expressed her thanks to the speakers, facilitators, panelists, and the Steering Committee for guiding the content of the event.

She also thanked CCO for supporting the work of the Council. She stated that the CQCO is committed to presenting more equity data in the Cancer System Quality Index and to holding CCO accountable to reducing barriers to care as a priority for the cancer system. Ms. McLaughlin thanked attendees for participating in this valuable work, and she emphasized how this is an on-going dialogue—one that CQCO hopes will continue in the coming months and years in order to improve the quality of life for all Ontarians.

[1] Maddison AR, Asada Y, Urquhart R (2011). Inequity in Access to Cancer Care: A Review of the Canadian Literature.

The Cancer Quality Council of Ontario is pleased to present our Tenth Annual Signature Event.

CQCO Cancer Quality Council of Ontario

Metropolitan Hotel
108 Chestnut St.
Toronto, Ontario
7:30 am - 4:30 pm

WALK the TALK

REMOVING BARRIERS TO CANCER CARE FOR ALL

The Cancer Quality Council of Ontario (CQCO) advises Cancer Care Ontario and the Ministry of Health and Long-Term Care in their efforts to improve the quality of cancer care in the province.
For more information, go to www.cqco.ca

Ontario

7:30 am - **Registration/ Networking (continental breakfast)**

8:30 am - **Introductions**
Virginia McLaughlin, Chair, Cancer Quality Council of Ontario, Toronto
The imperative for addressing barriers to cancer care for Ontarians

8:45 am - **Health Inequities In Ontario**
Christina Sinding, Associate Professor, Department of Health, Aging & Society, School of Social Work, McMaster University, Hamilton
Bob Gardner, Director of Policy, Wellesley Institute, Toronto
Inequities in the Health and Cancer System: Identifying barriers and moving to solutions

9:15 am - **Keynote: System Level Strategy Planning**
Chris Tudor-Smith, Head of Health Improvement Division, Directorate for Public Health, Welsh Government, Wales
Developing, Implementing and Measuring an Equity Strategy: The Welsh experience
Q&A to follow keynote

9:55 am - **System Level Community Engagement**
Alethea Kewayosh, Director, Aboriginal Cancer Strategy, Cancer Care Ontario, Toronto
Relationship Building and Engagement with First Nations, Inuit and Métis peoples : CCO's Aboriginal Cancer Strategy
Q&A to follow presentation

10:45 am - **Morning Break**

11:00 am - **Paula Lloyd-Knight**, Head of Patient and Public Voice, NHS England (London Region), England
Raising Cancer Awareness in Minority Groups: Measuring knowledge of cancer prevention and uptake of screening programs

11:25 am - **Dr. Linda Rabeneck**, Vice President, Prevention and Cancer Control, Cancer Care Ontario, Toronto
Addressing the Under-/Never-Screened in Ontario
Q&A to follow presentations

11:45 AM – RAPID ROUND DEBATES
SYSTEM LEVEL TOOLS AND MODELS TO REDUCE INEQUITIES
HOW DO WE BUILD EQUITY INTO POLICY PLANNING, TRANSFORMATIONAL CHANGE AT INSTITUTIONS AND THE FIELD OF DRUG FUNDING?

(Rapid Round Debates topic presentations to be followed by a Q & A)

Panel Facilitator: **Dr. Robert Bell**, President and CEO, University Health Network, Toronto

Panel Speakers:

Systematic consideration of equity in policy planning: Using the Health Equity Impact Assessment Tool
Sheree Davis, Director, Community and Population Health Branch, Health Systems Strategy and Policy, Ontario Ministry of Health and Long Term Care, Toronto
Dr. Ingrid Tyler, Public Health Physician, Public Health Ontario, Toronto

Addressing barriers within an institution: A model embedding equitable service delivery
Gurwinder Gill, Director of Patient Relations & Diversity Services, William Osler Health System, Toronto
Paula Chidwick, Director, Clinical & Corporate Ethics, William Osler Health System, Toronto

Drug funding in Ontario: Ensuring equitable access for all patients
Scott Gavura, Director, Provincial Drug Reimbursement Programs, Cancer Care Ontario, Toronto
Dr. Scott Berry, Medical Oncologist, Sunnybrook Odette Cancer Centre, Toronto

12:30 pm - Lunch and Networking

1:15 pm - Keynote: Reducing Inequities In Cancer Treatment
Dr. Francesca Gany - Chief of the Immigrant Health and Cancer Disparities Service, Memorial Sloan-Kettering Cancer Center
Creating the Case for Patient-centred Care for All: Identifying and supporting cancer patients from diagnosis
Q&A to follow keynote

1:55 pm - Dr. Christopher Lathan - Faculty Director for Cancer Care Equity, Dana-Farber Cancer Institute
Bringing Specialist Care to Patients: Oncologists seeing patients at a community health centre
Q&A to follow presentation

2:30 pm - Afternoon Break

2:45 PM – PANEL DISCUSSION
MODELS, TOOLS AND MEASURES SUPPORTING PATIENT CARE
HOW DO WE COORDINATE AND EMBED SUPPORTS TO CREATE A BETTER CANCER SYSTEM FOR ALL?

Panel Facilitator:
Virginia Flintoft, Project Manager, Safer Healthcare Now!
Central Measurement Team, Institute for Health Policy, Management and Evaluation, University of Toronto

Panel Speakers:
Steve Buist, Investigative reporter, Hamilton Spectator, Hamilton
Marylin Kanee, Director of Human Rights and Health Equity, Mount Sinai Hospital, Toronto
Dr. Gary Bloch, Family Physician, St. Michael's Hospital, Toronto
Dr. Shannon Wesley, Regional Aboriginal Cancer Lead, North West Regional Cancer Centre, Thunder Bay
Fay Strohschein, Nursing Clinical Consultant, Oncology & Aging Program, Jewish General Hospital, Montreal

3:30 pm - Breakout Group Discussions/ Report Back
Virginia McLaughlin - Chair, Cancer Quality Council of Ontario, Toronto

4:15 pm - Cancer Care Ontario Commitment
Michael Sherar - President and CEO, Cancer Care Ontario, Toronto

4:25 pm - CQCO Commitment
Virginia McLaughlin - Chair of Cancer Quality Council of Ontario, Toronto

Cancer Quality Council of Ontario – Members

CQCO Council Members are a multidisciplinary group of healthcare providers, cancer survivors, and experts in the areas of oncology, health system policy and administration, and performance measurement and health services research.

Virginia McLaughlin (Chair)
President, Helmhorst Investments Ltd.

Julia Abelson
Professor, Department of Clinical Epidemiology and Biostatistics, Centre for Health Economics and Policy Analysis (CHEPA), McMaster University

Dr. Robert Bell (Past-Chair)
President and CEO, University Health Network

Arlene Bierman
Chair, Women's Health, Ontario Women's Health Council, Li Ka Shing Knowledge Institute, St. Michael's Hospital

Adalsteinn Brown
Director, Institute of Health Policy, Management and Evaluation, Division Head of Public Health Policy, Faculty of Medicine, University of Toronto
Scientist, Keenan Research Centre Li Ka Shing Knowledge Institute, St. Michael's Hospital

Jenny Cockram
Principal, J Cockram Associates

Ruthe-Anne Conyngham
Chair, Board of Directors of the London Health Sciences Centre

Winnie Doyle
Vice President, Clinical Services, Chief Nursing Executive, St. Joseph's Healthcare Hamilton

William (Bill) Evans (Vice-Chair)
Former President, Juravinski Hospital and Cancer Centre

Darren Larsen
Lead Physician, Thornhill Village FHO
Physician Lead, Quality Partnerships and Integration, OntarioMD

Michael Marcaccio
Professor, Department of Surgery, McMaster University
Director, General Surgery Residency Program, McMaster University
General Site Lead, Juravinski Hospital & Cancer Centre

Kevin Mercer
Principal, K. Mercer Consulting

Dawn Powell
President, Dawn M Powell Appraisals Inc.
Chair of the Patient and Family Oncology Partnership Council at Thunder Bay Regional Health Sciences Centre

Padraig Warde - ex-officio member
Interim Provincial VP, Clinical Programs and Quality Initiatives, Cancer Care Ontario
Professor, Department of Medicine, Public Health Sciences, Health Policy, Management and Evaluation

Michael Sherar - ex-officio member
President & CEO, Cancer Care Ontario

Craig McFadyen - ex-officio member
Regional Vice-President, Central West & Mississauga Halton, Cancer Care Ontario

2013 CQCO Signature Event Steering Committee

With acknowledgement and gratitude to the members of our CQCO Signature Event Steering Committee for their guidance and support in planning this event:

Virginia McLaughlin (Chair), Miin Alikhan, Arlene Bierman, Adalsteinn Brown, Dan Burns, Stacey Daub, Bob Gardner, Gurwinder Gill, Axelle Janczur, Monika Krzyzanowska, Nizar Ladak, Rowena Pinto, Dawn Powell, Michael Rachlis, Padraig Warde, Donna Czukar.

Cancer Quality Council of Ontario Secretariat

Rebecca Anas, Director, Cancer Quality Council of Ontario

Rebecca Comrie, Interim Director

Staff: Jennifer Stiff, Nicoda Foster, Katrina Santiago, Thivya Shanthakumar.

For more information

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Walk the Talk: Removing Barriers to Cancer Care for All

CQCO 2013 Signature Event

Biographies of Speakers

[In order of presentation]

Virginia McLaughlin

CQCO CHAIR: Virginia McLaughlin: (Member from 2011 - present)

Virginia McLaughlin currently serves as the Chair of CQCO. In addition she sits on the Boards of the University of Guelph and the Canadian Museum of Science and Technology Corporation and serves as Honorary Lieutenant-Colonel of the 25 (Toronto) Field Ambulance. She is a past Chair of the Board of Directors, Sunnybrook Health Sciences Centre and the Governance Leadership Council of the Ontario Hospital Association.

Prior to becoming a member of the Sunnybrook & Women's Board of Directors, Ms. McLaughlin was a member of the Board of Trustees, York Central Hospital
(1985-1997) and Chair of the Board from 1995-97. She chaired the GTA/905 Healthcare Alliance from 1995-1998 and the York Region Tri-Hospital group from 1995-97.

Ms. McLaughlin has also participated in governance for the Ontario Hospital Association as a member of the Regional Council Executive Committee for Region 3 (Toronto, York, Peel and Durham) 1998-2008, as chair of the RCEC 2000-2002, member of the OHA board of Directors 2000-2002 and chair of the OHA Advocacy Committee (2001-2002) and from 2004 until November 2007 was the Chair of the Ontario Hospital Association Governance Leadership Council.

Other recent volunteer commitments include Chair of the Board of Trustees of the University of Trinity College (2003-2005; member since 1999), Chair of Finance Committee (2000-2003) and member of Nominating Committee for the Provost (2001). She continues to sit on the Strength to Strength Campaign Cabinet for Trinity.

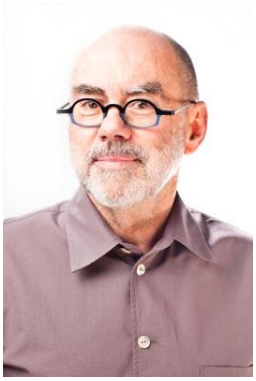
During the 1980's and early 1990's Ms. McLaughlin served as a volunteer member of the Toronto Symphony Board, Toronto Symphony Volunteer Committee and Junior Women's Committee and as a member of the Country Day School Board and Chair of the Junior School Curriculum Committee.

In private life, Ms. McLaughlin is President of Helmhorst Investments Limited, a family owned company comprising agricultural operations, real estate and a portfolio of market investments. She is married and has two adult children and two grandchildren.

Christina Sinding, PhD

Christina Sinding is an Associate Professor at McMaster University in Hamilton, Ontario, jointly appointed to the School of Social Work and the Department of Health, Aging and Society. Her research focuses on health and social justice. She has led several studies examining how people experience cancer and navigate cancer care systems, including a participatory project about lesbians' experiences of cancer, a study with women diagnosed with cancer over the age of 70, and an examination of barriers to cancer care for people with mental health disabilities.

With an interdisciplinary research team and supported by a New Investigator award, Christina is currently completing a CIHR-funded study that addresses cancer disparities both quantitatively (examining associations between socioeconomic status and the allocation of treatment and supportive care resources) and qualitatively (exploring the often-subtle ways that disparities in access to resources actually come about).



Bob Gardner, PhD

Bob Gardner is Director of Policy at the Wellesley Institute, an independent non-profit research and policy think tank on urban population health. He researches, writes and speaks widely on health equity; works with governments, LHINs, service provider networks and community partners to develop effective strategies and action plans to operationalize health equity; and has served on many health policy advisory forums, working groups and boards. Bob has a PhD in sociology; has been an academic, public sector executive and consultant; and has been a community activist on HIV/AIDS, reproductive health and other issues.

Chris Tudor-Smith

Chris Tudor-Smith is Head of Health Improvement Division at the Welsh Government. The Division focuses on evidenced based policy and action in relation to lifestyle related health behaviours and risk factors, the determinants of health and inequities in health. He was formally Director of Research and Development at Health Promotion Wales. For five years he was International Coordinator of WHO's Health Behaviour in School-Aged Children Study.

Alethea Kewayosh

Alethea Kewayosh has worked at Cancer Care Ontario since February 22, 2010, originally as the Provincial Lead Aboriginal Cancer Control and more recently as the Director Aboriginal Cancer Control. She has extensive experience working with First Nations and other Aboriginal groups at both the national and regional levels. An important focus of her work over the years has been to address First Nation health issues and she spent some 13 years working to address diabetes. From a one year contract position with the Canadian Diabetes Association in the mid-80's Alethea was able to develop a First Nation diabetes program for the province of Ontario that in turn led to the development of a trilateral agreement with Health Canada, the Canadian Diabetes Association and the Assembly of First Nations for a national diabetes program administered through the Assembly of First Nations. Her work to address diabetes also helped lead to the development of the National Aboriginal Diabetes Association.

Alethea has long been an advocate for the improved health and well-being of Aboriginal peoples in Ontario, she believes the best approach to working with Aboriginal people is to be respectful of the diversity of the First Nation, Inuit and Métis peoples and their communities, knowledgeable of their governance and political protocols and considerate of the need to develop regular engagement and dialogue with each of the groups that lead to relationships based on trust and mutual respect. She recently launched the Aboriginal Cancer Strategy which epitomizes her approach to working with First Nations, Inuit and Métis people through direct engagement with each nation, now being formally established through the development of Relationship Protocols.

Alethea maintains a close affiliation with her home community of the Walpole Island First Nation to visit family, relatives and to participate in community events.

Paula Lloyd Knight

After graduating from the University of Leicester in 1993 with a BA in Politics, Paula began her career at Leicestershire County Council Social Services Department as an adult social worker. Paula has worked in a health and social care for over 20 years and held posts at various levels at the local authority, housing and the health sectors.

In her role as Associate Director Patient Experience for the National Cancer Action Team, Paula was responsible for developing the National BME Cancer Patient Experience Programme, and established; the National BME Cancer Voice, the National BME Cancer Alliance, the Cancer and Ethnicity Resource portal and the ' Cancer does Not Discriminate Pilot Programme'.

Paula has spoken at a number of international conferences on inequalities in cancer including the World Cancer conference (China 2013), the Cancer and Equalities Conference (Paris 2012) and the International Migrant Conference (Milan 2012).

Paula commenced her current position as Head of Patient and Public Voice for NHS England (London Region) in April 2013 and has established the London Healthwatch Network and London Engagement leads Network.

Paula is married with two children.

Dr. Linda Rabeneck

Dr. Linda Rabeneck is Vice President, Prevention and Cancer Control, Cancer Care Ontario (CCO). She is Professor of Medicine at the University of Toronto and Senior Scientist at the Institute for Clinical Evaluative Sciences (ICES) in Toronto. Previous leadership roles include Director, Division of Gastroenterology, University of Toronto, and Regional Vice President, CCO and Chief of Sunnybrook's Odette Cancer Centre.

Dr. Rabeneck received her medical degree from the University of British Columbia. She completed post-graduate training in internal medicine and gastroenterology at the University of British Columbia and the University of Toronto, respectively. She received her Master's degree in Public Health from Yale University, where she trained as a Robert Wood Johnson Clinical Scholar.

Dr. Rabeneck played a leadership role in launching ColonCancerCheck in Ontario, Canada's first organized, province-wide colorectal cancer screening program. Dr. Rabeneck leads an active research program focusing on the quality and effectiveness of cancer screening. She serves as Chair of the World Endoscopy Organization (WEO) Colorectal Cancer Screening Committee, which facilitates the generation and sharing of new information on the science and practice of colorectal cancer screening internationally. In 2012, Dr. Rabeneck was elected to Fellowship in the Canadian Academy of Health Sciences.

Dr. Robert S. Bell

Dr. Robert Bell was appointed as President and CEO of University Health Network (UHN) in June 2005. An internationally recognized Orthopaedic surgeon, health care executive, clinician-scientist, and educator, Dr. Bell brings more than 20 years of experience in academic health care to leadership of Canada's largest research hospital. From 2000 to 2005, he served as Chief Operating Officer of UHN's Princess Margaret Hospital where he was responsible for leading Canada's largest comprehensive cancer centre. From 2003 to 2005, he served as Regional Vice President and Chair of the Clinical Council of Cancer Care Ontario.

Dr. Bell earned a Doctor of Medicine from McGill University in 1975 and a Masters of Science from the University of Toronto in 1981. He completed a Fellowship in Orthopaedic Oncology at Massachusetts General Hospital and Harvard University in 1985. During his career as a clinician-scientist at the University of Toronto, he received more than five million dollars in peer reviewed funding and published more than 170 peer-reviewed papers. He participated in the Advanced Management Program at Harvard Business School in 2005. Dr. Bell is a Fellow of the Royal College of Physicians and Surgeons of Canada, the American College of Surgeons and the Royal College of Surgeons of Edinburgh.

Sheree Davis

Sheree is the Director of the Community and Population Health Branch in the Ontario Ministry of Health and Long Term Care. Sheree began her public service career working for the Ministry of Correctional Services and the Ministry of the Attorney General. An energetic and creative problem solver, she went to serve in Cabinet Office managing files in Justice, Native Affairs, and Race Relations. After several years at Management Board, Sheree then moved to Health and Long Term Care.

Through her distinguished career as a public servant, Sheree has initiated and led policy development for key government initiatives, including Sunday Shopping, giving public servants the right to strike, the Commitment to the Future of Medicare Act, and the negotiation of the Social Contract and the first Health Accord.

With the Health System Strategy Division, Sheree is currently leading policy work with improving maternal child health with the development of Birth Centres and the Ontario Donor Human Milk Bank, Fertility Awareness, and is leading the implementation of the Comprehensive Mental Health and Addictions Strategy.

Dr. Ingrid Tyler

Ingrid Tyler is a physician at Public Health Ontario (PHO), in the Health Promotion, Chronic Disease and Injury Prevention Directorate, Assistant Professor at the Dalla Lana School of Public Health, University of Toronto.

Ingrid has been working on PHOs equity mandate, including activities across the spectrum of knowledge generation, knowledge synthesis, knowledge exchange and capacity building, since 2009. Her activities include developing tools, training, research and reviews to support integration of equity considerations with local, provincial and national partners. Her research in this area is focused on evaluating the application and outcomes of equity planning tools. Ingrid is also has a keen interest in child and maternal health, and is currently working on projects related social pediatrics and advancing primary care/public health collaboration in this area. Ingrid is also involved in health systems research, including the development of measures for the impact of knowledge organizations in health.

Ingrid's teaching commitments include her role as the Associate Course Director for the Determinants of Community Health Course, a community, population and public health course for first year medical students at the Faculty of Medicine, University of Toronto, and the Health Promotion and Education Course in the Physician Assistants Program delivered through the Department of Family and Community Medicine, Faculty of Medicine, University of Toronto. Ingrid obtained her MD from the Faculty of Medicine of the University of British Columbia. She completed her residency training at the University of Toronto and is a fellow of the Royal College of Physicians and Surgeons of Canada in Public Health and Preventive Medicine and a certificant of the College of Family Physicians of Canada in Family Medicine. She also has a Master of Health Sciences from the University of British Columbia and a Masters of Education from the Ontario Institute for Studies in Education (OISE).

Gurwinder K Gill

Gurwinder has been leading and managing innovative programs in diversity, equity and cultural competency within healthcare, social and community services for over 25 years. Her current role is with William Osler Health System (Osler) for over five years - Director of Equity and Volunteer Services. Ms. Gill has been recognized for the following awards:
Women Worth Watching – profiled in the Diversity Journal, Sept/Oct 2013 issue, National profiled in the Globe and Mail June 2013, Osler - Diversity in Governance Award 2013, Osler - Canada's Best Diversity Employers Award 2013 , Osler - Leading Practice from Accreditation Canada – Embracing Diversity in Palliative Care 2012.

Gurwinder has presented nationally and internationally, participates in the World Health Organization's International Task Force for Culturally Competent Hospitals, co-chairs the Central West LHIN's Diversity & Equity Core Action Group, and is a board member for Bethell Hospice and the Regional Diversity Roundtable of Peel. She pioneered the first language-specific/culturally appropriate LTC Centre in Peel for those with Alzheimer's/chronic disabilities funded by the Ministry of Health.

Paula Chidwick, PhD

Dr. Paula Chidwick is the Director Clinical & Corporate Ethics and Ethicist at William Osler Health System. She was the first full-time Ethicist to be hired at a community hospital. She has a PhD in Philosophy specializing in Bioethics from the University of Guelph and a Fellowship in Clinical Ethics from the University of Toronto Joint Centre for Bioethics. Paula provides ethics services to health care organizations throughout Ontario. She publishes and lectures widely on a variety of topics including ethics in transitions, ethics quality improvement, ethics and error, end-of-life, and advance care planning. She has served on the Canadian Bioethics Society Executive, Health Canada's Scientific and Expert Advisory Panels, MOHLTC Critical Care Coaching Teams and Critical Care Services Ontario. She is currently a member of the Education and Training Committee of Technology Evaluation in the Elderly Network and a founding member of the Clinical Ethics Summer Institute (CESI).

Scott Gavura

Scott Gavura is Director, Provincial Drug Reimbursement Programs at Cancer Care Ontario. In this position Scott is responsible for the strategic management of CCO's cancer reimbursement programs. Scott is a registered pharmacist and has a Bachelor of Science in Pharmacy degree as well as an MBA from the University of Toronto.

Dr. Scott Berry

Dr. Scott Berry is a medical oncologist at Sunnybrook Odette Cancer Centre and an associate professor in the Faculty of Medicine at the University of Toronto. He completed his general medical training and medical oncology training at the University of Toronto.

Dr. Berry is an active participant in clinical research at the National Cancer Institute of Canada (NCIC) Clinical Trials Group and the North American Intergroup. He has been involved in important international trials in colorectal cancer that have been published in journals including the New England Journal of Medicine and the Annals of Oncology. Dr. Berry has also authored several prostate and colorectal cancer guidelines for the Cancer Care Ontario Program in Evidence Based Care and chaired national consensus guideline meetings for the Colorectal Cancer Association of Canada.

Dr. Berry also loves teaching and holds several leadership positions in education. He has won several teaching awards and the University of Toronto Division of Medical Oncology Education Award. He chairs the Royal College of Physicians and Surgeons of Canada Specialty Committee for Medical Oncology. He is the Program Director for the Medical Oncology Training Program at the University of Toronto and co-medical director of www.oncologyeducation.com.

His other academic interest is the bioethical issues surrounding the care of people with cancer, in particular the ethical issues surrounding funding new and expensive cancer medications. Dr. Berry has a Masters degree in bioethics from the University of Toronto. He has also served on the ASCO Ethics Committee and is the ethics advisor to the pan-Canadian Oncology Drug Review and the NCIC Data Safety Monitoring Committee.

Dr. Francesca Gany

Francesca Gany, MD, MS, is the Chief of the Immigrant Health and Cancer Disparities Service at Memorial Sloan-Kettering Cancer Center, the Director of the Center for Immigrant Health and Cancer Disparities, and a Director of the community based participatory South Asian Health Initiative. She works to bridge immigrants, minority community members, and the medically underserved with the healthcare system, and to eliminate health disparities. Her groundbreaking work has led to an improvement in health outcomes and to the development of long-term clinical, health policy, and programmatic changes.

Prior to joining Memorial Sloan-Kettering, Dr. Gany was the founder and Director of the Center for Immigrant Health at the New York University (NYU) School of Medicine; of the NYU Cancer Institute CORE Center (Cancer Outreach, Outcomes and Research for Equity); and of the Health Promotion, Disease Prevention, and Human Migration concentration in the NYU Global Masters of Public Health program. She has served as the Principal Investigator on a number of pioneering immigrant health studies in the areas of cancer, language access and cultural competence, technology and immigrant health, healthcare access, and cardiovascular disease.

Dr. Christopher Lathan

Christopher S. Lathan, MD, MS, MPH is the Faculty Director of the Cancer Care Equity Program at the Dana-Farber Cancer Institute, as well as the Director of the Dana Farber Community Cancer Clinic at Whittier Street Health Center in Roxbury. He is a Medical Oncologist in the Lowe Center for Thoracic Oncology at Dana Farber Cancer Institute. Dr. Lathan is also an Assistant Professor of Medicine at Harvard Medical School. His primary research interests are centered on racial/ethnic disparities in cancer care.

Virginia Flintoft

Ms. Flintoft obtained her Bachelor of Nursing from the University of Calgary; and her MSc in Design, Measurement and Evaluation (Clinical Epidemiology) from McMaster University.

In 2002 she joined the Institute of Health Policy, Management and Evaluation at the University of Toronto. She is a co-author and National Project Manager for the Canadian Adverse Events Study (CMAJ, May 2004), and the Canadian Paediatric Adverse Event Study (CMAJ, July 2012). She was also a member of the Patient Safety Collaborative of the Canadian Association of Paediatric Health Centres (CAPHC) which developed the Canadian Paediatric Trigger Tool.

Virginia is the Project Manager for the "Safer Healthcare Now! – Central Measurement Team" at the University of Toronto, and also works on other patient safety projects with Professor G. Ross Baker including leading the Pan-Canadian survey for the Implementation of the Surgical Safety Checklist and Safety at Home – Root Cause Analysis of Adverse Events related to Medication and Falls.

She worked for 12 years as a senior research coordinator at the Institute for Clinical Evaluative Sciences (ICES) managing health services research projects and providing research support to leading scientists including Drs. C. David Naylor and Jack V. Tu. Her clinical experience has been primarily in cardiac and cardiovascular intensive care nursing and as a research coordinator in clinical medical research in a number of healthcare facilities across Canada.

Virginia was a member of the Cancer Quality Council of Ontario; and is currently on the boards of the Toronto-York Victoria Order of Nurses; and Screen Colons Canada.

Steve Buist

Steve Buist is an investigative reporter and feature writer at The Hamilton Spectator. He has won three National Newspaper Awards and been a finalist five times. He's been named the Canadian Association of Journalists' Investigative Journalist of the Year three times and Ontario's Journalist of the Year three times. Buist has a B.Sc. in human biology and a Master's degree in journalism, exploring the issue of how Canadian newspapers report the financial relationships that exist between university researchers and pharmaceutical companies.

Marylin Kanee

Marylin Kanee has been the Director of Human Rights and Health Equity at Mount Sinai Hospital since 2000. The Human Rights and Health Equity Office aims to create organizational change by addressing harassment and discrimination complaints and developing educational campaigns and policies to ensure equity in the hospital for patients, visitors and workers. She currently leads a TC LHIN wide initiative to collect patient level demographic data to improve the quality of health care and achieve health equity.

Dr. Gary Bloch

Gary Bloch is a family physician with St. Michael's Hospital, and the Chair of the Ontario College of Family Physicians' Committee on Poverty and Health. He is a founding member of Health Providers Against Poverty. He is actively engaged in education, research, clinical program development and advocacy on health-based interventions into poverty.

Dr. Shannon Wesley

Dr. Shannon Wesley contributes to healthcare in Northwestern Ontario in two important roles. As a family physician, Shannon currently practices family medicine with the Superior Family Health Team in Thunder Bay, Ontario. Originally from Dryden, Ontario, she obtained her Medical Degree at the University of Minnesota and completed her family medicine residency at the Northern Ontario School of Medicine.

In addition to her medical practice, one of Shannon's greatest passions is improving the health of First Nations people in Northwestern Ontario.

As the Northwest Regional Aboriginal Cancer Lead with Cancer Care Ontario and Prevention and Screening Services at Thunder Bay Regional Health Sciences Centre, Shannon is both a leader in the medical community for promoting cancer screening among her peers and the greater community, and advocating for and linking First Nation communities and community members with improved access to and education about cancer screening services.

Fay Strohschein

Fay Strohschein is a Nursing Clinical Consultant with the Consultation Service for Senior Oncology Patients at the Jewish General Hospital in Montreal, Canada. She is currently working towards her PhD in nursing at McGill University, focusing on processes of treatment decision making among older adults with colorectal cancer. She has worked with Service since shortly after its inception in 2006.

Michael Sherar, PhD

Dr. Michael Sherar is President and CEO of Cancer Care Ontario. From 2006 to 2011, he was the provincial agency's Vice-President, Planning and Regional Programs, leading the development of Regional Cancer Programs, including capital planning for cancer services across the province. In this role, he led the development of the *Ontario Cancer Plan 2011-2015*.

Dr. Sherar is Professor of Medical Biophysics at the University of Toronto and Senior Scientist at the Ontario Cancer Institute/Princess Margaret Hospital where he carries out research and development of minimally invasive thermal therapy technologies for cancer including radiofrequency ablation.

In 2001, he was selected as one of *Canada's Top 40 under 40* for achievements in leadership. He was previously Regional Vice President, Cancer Services, London for Cancer Care Ontario and Vice President, London Regional Cancer Program (LRCP), London Health Sciences Centre (LHSC). Dr. Sherar received a BA in Physics from Oxford University in 1985 and his PhD in Medical Biophysics from University of Toronto in 1989.

2013 Cancer Quality Council of Ontario Signature Event
Walk the Talk: Removing barriers to cancer care for all, November 20, 2013
ATTENDEE LIST

Organization	Attendee name	Title
Access Alliance	Axelle Janczur	Executive Director, Access Alliance
Canada Health Infoway	Jennifer Zelmer	Senior Vice President, Clinical Adoption and Innovation, Canada Health Infoway
Canadian Association of Provincial Cancer Agencies	Heather Logan	Executive Director, CAPCA
Canadian Cancer Society	Donna Czukar	Senior Director, Support Programs
Canadian Cancer Society	Martin Kabat	Chief Executive Officer, CCS
Canadian Cancer Society	Rowena Pinto	Vice -President, Public Affairs and Strategic Initiatives, CCS
Canadian Cancer Society	Anna Sangha	Screening Saving Lives Coordinator
Canadian Institute for Health Information	Greg Webster	Director, Primary Health Care Information and Clinical Registries
Canadian Partnership Against Cancer	Rami Rahal	Director, System Performance and Surveillance
Cancer Care Ontario	Usman Aslam	Senior Manager
Cancer Care Ontario	Hasmik Beglaryan	Program Manager, Models of Care
Cancer Care Ontario	Karen Bramhill	Program Manager
Cancer Care Ontario	Sandy Buchman	Clinical Lead QI & Primary Care Engagement, Palliative Care
Cancer Care Ontario	Scott Campbell	Board Member, Cancer Care Ontario
Cancer Care Ontario	Darren Cargill	Physician
Cancer Care Ontario	Dafna Carr	Director, Policy, Planning and KTE, Cancer Care Ontario
Cancer Care Ontario	Steve Carroll	Director, Provinical Operations, Screening, Cancer Care Ontario
Cancer Care Ontario	Kathi Carroll	Project Manager, Prevention and Cancer Control
Cancer Care Ontario	Cathy Cattaruzza	Director, ATC and ORN IP, Cancer Care Ontario
Cancer Care Ontario	Jennifer D'Amore	Corporate Event and Internal Communications Advisor, Cancer Care Ontario
Cancer Care Ontario	Jason Garay	Director, Evaluation and Reporting, Cancer Care Ontario
Cancer Care Ontario	Scott Gavura	Director, Provincial Drug Reimbursement Program, Cancer Care Ontario
Cancer Care Ontario	Angelika Gollnow	Program Manager, DPM
Cancer Care Ontario	Maria Grant	Program Manager, Survivorship
Cancer Care Ontario	Esther Green	Program Head, Nursing & PSO, Cancer Care Ontario
Cancer Care Ontario	Lynn Guerriero	Managing Director, Cancer Screening, Cancer Care Ontario
Cancer Care Ontario	Eric Gutierrez	Program Manager, Radiation
Cancer Care Ontario	Rebecca Harvey	VP, ORN
Cancer Care Ontario	Doug Hawe	Director, Strategy & Digital, Communications, Cancer Care Ontario
Cancer Care Ontario	Malcolm Heins	Board Member, Cancer Care Ontario
Cancer Care Ontario	Sherrie Hertz	Program Manager, Specialized Services
Cancer Care Ontario	Amber Hunter	Program Manager, Surgical Oncology
Cancer Care Ontario	Keely Hyatt	Manager, Regional Projects
Cancer Care Ontario	Zahra Ismail	Program Manager, PSO & Nursing
Cancer Care Ontario	Leonard Kaizer	Provincial Head, Clinical Programs
Cancer Care Ontario	Alethea Kewayosh	Director, Prevention and Cancer Control - Aboriginal Cancer Control, Cancer Care Ontario
Cancer Care Ontario	Paula Knight	Vice President, Communications, Cancer Care Ontario
Cancer Care Ontario	Nancy Kraetschmer	Program Manager, Patient Experience
Cancer Care Ontario	Hakim Lakhani	Director, Reporting & Analytics - CIO, Cancer Care Ontario
Cancer Care Ontario	Patricia Lang	Board Member, Cancer Care Ontario
Cancer Care Ontario	Aimee Langan	Director, Regional Operations, Prevention and Cancer Control
Cancer Care Ontario	Lester Ly	Senior Project Manager
Cancer Care Ontario	Laura Macdougall	Director, Clinical Programs - Patient Experience, Cancer care Ontario
Cancer Care Ontario	Marnie MacKinnon	Director, Integrated Care, Cancer Care Ontario
Cancer Care Ontario	Oonagh Maley	Director, Office of Strategy Management
Cancer Care Ontario	Loraine Marrett	Senior Scientist, Aboriginal Cancer Control Unit

2013 Cancer Quality Council of Ontario Signature Event
Walk the Talk: Removing barriers to cancer care for all, November 20, 2013
ATTENDEE LIST

Organization	Attendee name	Title
Cancer Care Ontario	Garth Matheson	Vice President Planning & Regional Programs, Cancer Care Ontario
Cancer Care Ontario	Robin McLeod	Surgical Lead, Quality Improvement and Knowledge Transfer
Cancer Care Ontario	Elaine Meertens	Director, Cancer Planning and Regional Planning
Cancer Care Ontario	Saul Melamed	Director, Clinical Programs-Diagnosis & Treatment
Cancer Care Ontario	Lisa Milgram	Program Manager, Provincial Drug Reimbursment Program
Cancer Care Ontario	Sean Molloy	Program Manager, OCSMC
Cancer Care Ontario	Todd Norwood	Staff Scientist, Research, Prevention and Cancer Control
Cancer Care Ontario	Kathryn Perry	Senior Communications Strategist, Cancer Care Ontario
Cancer Care Ontario	Alice Peter	Director, Prevention and Surveillance
Cancer Care Ontario	Aaron Pollett	Provincial Head, Pathology & Laboratory Medicine Program, Cancer Care Ontario
Cancer Care Ontario	Linda Rabeneck	Vice President, Prevention and Cancer Control, Cancer Care Ontario
Cancer Care Ontario	Erin Rae	Program Manger, Systemic Treatment
Cancer Care Ontario	Jillian Ross	Director, Clinical Programs, Cancer Care Ontario
Cancer Care Ontario	Lisa Sarsfield	Director, Cancer Information Program, CIO, Cancer Care Ontario
Cancer Care Ontario	Joel Simard	Director, Communications, Cancer Care Ontario
Cancer Care Ontario	Pamela Spencer	Vice President, Corporate Services, General Counsel & Chief Privacy
Cancer Care Ontario	Ken Sutcliffe	Interim CIO, Director of Technology Services & Chief Technology Officer, Cancer Care Ontario
Cancer Care Ontario	Harvey Thomson	Board Member, Cancer Care Ontario
Cancer Care Ontario	Sara Urowitz	Program Manager, Palliative Care
Cancer Care Ontario	Maggie Wang Maric	Senior Communications Strategist, Cancer Care Ontario
Cancer Care Ontario	Vickie Welch	Director, Informatics - Centres of Excellence
Cancer Care Ontario	Lyndee Yeung	Clinical Program Manager, New Emerging Drugs Program
Cancer Care Ontario	Jeff Hoch	Director, Pharmacoeconomics Research Unit
Cancer Care Ontario; Cancer Quality Council of Ontario	Michael Sherar	President & CEO
Cancer Care Ontario; Cancer Quality Council of Ontario;	Padraig Warde	Interim VP Clinical Programs & Quality Initiatives; Provincial Head, Radiation Treatment Program
Cancer Centre of Southeastern Ontario	Brenda Carter	Regional Vice President,
Cancer Quality Council of Ontario Secretariat	Rebecca Anas	Director, CQCO Secretariat
Cancer Quality Council of Ontario Secretariat	Rebecca Comrie	Interim Director, CQCO Secretariat
Cancer Quality Council of Ontario Secretariat	Nicoda Foster	Policy Research Analyst, CQCO Secretariat
Cancer Quality Council of Ontario Secretariat	Katrina Santiago	Senior Administration Assistant, CQCO Secretariat
Cancer Quality Council of Ontario Secretariat	Thivya Shanthakumar	Research Assistant, CQCO Secretariat
Cancer Quality Council of Ontario Secretariat	Jennifer Stiff	Manager, CQCO Secretariat
Cancer Quality Council of Ontario, Helmhorst Investments Ltd.	Virginia McLaughlin (CQCO Chair)	President
Cancer Quality Council of Ontario; Carlo Fidani Peel Regional Cancer Centre	Craig McFadyen	Regional Vice President
Cancer Quality Council of Ontario; Dawn M Powell Appraisals Inc.; Patient and Family Oncology Partnership Council, Thunder Bay	Dawn Powell	President; Chair
Cancer Quality Council of Ontario; J. Cockram Associates Ltd.	Jenny Cockram	Principal
Cancer Quality Council of Ontario; K Mercer Consulting	Kevin Mercer	Principal
Cancer Quality Council of Ontario; London Health Sciences Centre	Ruthe Anne Conyngham	Chair, Board of Directors
Cancer Quality Council of Ontario; Ontario MD	Darren Larsen	Lead Physician, Thornhill Village FHO and Senior Physician Peer Lead
Cancer Quality Council of Ontario; University Health Network	Robert Bell	President & CEO

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ATTENDEE LIST

Organization	Attendee name	Title
Cardiac Care Network	Sudha Kutty	Director, Knowledge Management
Cardiac Care Network	Mike Setterfield	Program Director, Vascular Services
Central East - RS McLaughlin Durham Regional	Tamara Dus	Regional Director
Dana-Farber/Harvard Cancer Centre	Christopher Lathan	Faculty Director for Cancer Care Equity
Grand River Hospital	Carol Gunsch	GI DAP Nurse Navigator
Grand River Regional Cancer Centre	Judy Burns	Regional Vice President,
Hamilton Health Sciences	Vina Alexopoulou	Pathology Lead
Hamilton Niagara Haldimand Brant	Carol Rand	Regional Director
Hamilton Niagara Haldimand Brant LHIN	Donna Cripps	Chief Executive Officer
Hamilton Spectator	Steve Buist	Investigative reporter
Health Quality Ontario	Michelle Rey	Director, Research (A); Manager, Public Reporting, HQO
Institute for Clinical Evaluative Sciences	Craig Earle	Director, Prov-Research-Director
Jewish General Hospital	Fay Strohschein	Nursing Clinical Consultant, Oncology & Aging Program
Juravinski Hospital and Cancer Center	Ralph Meyer	Regional Vice President,
Juravinski Hospital and Cancer Center	Cathy Bennett	Patient Education Lead
London Regional Cancer Program	Neil Johnson	Regional Vice President,
McMaster University	Christina Sinding	Associate Professor, Department of Health, Aging & Society, School of Social Work
McMaster University	Eric Stanton	Associate Professor, Division of Cardiology, Department of Medicine
Memorial Sloan-Kettering Cancer Center	Francesca Gany	Chief, Immigrant Health and Cancer Disparities Service
Ministry of Health and Long Term Care	Miin Alikhan	Director - Health Quality Branch
Ministry of Health and Long Term Care	Sheree Davis	Director, Community and Population Health Branch
Ministry of Health and Long Term Care	Susan Fitzpatrick	Assistant Deputy Minister, Negotiations and Accountability Management Division
Ministry of Health and Long Term Care	Jillian Paul	Manager, Policy Development and Implementation, Health Quality Branch, Negotiations and Accountability Management Division
Ministry of Health and Long Term Care	Anna Greenberg	Director, Transformation Secretariat
Mississauga Halton LHIN	Judy Bowyer	Chief Executive Officer
Mount Sinai Hospital	Marylin Kanee	Director of Human Rights and Health Equity
NHS England (London Region)	Paula Lloyd-Knight	Head of Patient and Public Voice
North East LHIN	Susan Hegge	Surgical Lead
North Simcoe Muskoka Regional Cancer Centre	Carole Beals	Manager of the systemic treatment unit
North Simcoe Muskoka Regional Cancer Centre	Lindsey Crawford	Regional Vice President,
North Simcoe Muskoka Regional Cancer Centre	Tracey Keighley-Clarke	Regional Director
North West - Thunder Bay Regional Health Sciences Centre Regional Cancer Care	Andrea Docherty	Manager, Outpatient Nursing and Clinic Operations
North West - Thunder Bay Regional Health Sciences Centre Regional Cancer Care	Joanne Lacourciere	Regional Director
North West Regional Cancer Centre	Shannon Wesley	Regional Aboriginal Cancer Lead
Northeast Cancer Centre/Health Sciences North	Mark Hartman	Regional Vice President,
Northeast Cancer Centre/Health Sciences North	Carole Mayer	Director of Research and Regional Clinical Lead
Nurse Practitioners Association	Theresa Agnew Cell	Executive Director, Nurse Practitioners Association
Nurse Practitioners Association	Kathryn Roka	Director of Education and Membership
Odette Cancer Centre	Calvin Law	Regional Vice President
Ontario Hospital Association	Anthony Dale	Interim President and CEO, OHA
Ontario Hospital Association	Drupati Maharaj	OHA Board
Ontario Institute for Cancer Research	Mary Ann O'Brien	Knowledge Translation Research Network
Ontario Medical Association	Maggie Keresteci	Director, Regional Engagement and Constituency Services, OMA
Ontario Medical Association	Adam Steacie	Board Of Directors Member
Ontario Pharmacists Association	Allen Malek	Senior Vice President, Professional Affairs
Ontario Women's Health Network	Julie Maher	Evaluatioin Specialist, ICES
Ottawa Hospital Regional Cancer Centre	Paula Doering	Regional Vice President,
Patient Family Advisory Council	Joanne MacPhail	PFAC Member
Princess Margaret Hospital	Nazek Abdelmutti	Regional Representative, Patient Education Committee
Princess Margaret Hospital	Marnie Escaf	Senior Vice President
Public Health Ontario	Ingrid Tyler	Public Health Physician

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Registered Nurses Association of Ontario	Doris Grinspun	Chief Executive Officer, RNAO
Registered Nurses Association of Ontario	Lynn Anne Mulrooney	Senior Policy Analyst
RS McLaughlin Durham Regional Cancer Centre	Tom McHugh	Regional Vice President,
Sherbourne Health Centre	Ed Kucharski	Staff Physician
South West	Brenda Fleming	Regional Director
Southlake Regional Health Centre	Catherine Mahut	Surgical Oncology Lead
St. Michael's Hospital	Gary Bloch	Family Physician
St. Michael's Hospital	Susan Blacker	Director, Cancer Services, Planning and Performance
St. Michael's Hospital	Alexandra Pinto	Department of Family and Community Medicine
Stronach Regional Cancer Centre at Southlake Regional Health Centre	Paul Clarry	Interim Regional Vice President
Sunnybrook Health Sciences Centre	Scott Berry	Medical Oncologist
Sunnybrook Health Sciences Centre	Tamara Harth	Program Manager and Regional Lead
Sunnybrook Health Sciences Centre	Elaine Martinovic	Radiologist
Sunnybrook Health Sciences Centre	Simron Singh	Medical Oncologist
Toronto Central - Princess Margaret Hospital	Martha Wyatt	Regional Director
Toronto Central CCAC	Stacey Daub	CEO, Toronto Central CCAC
Toronto Central LHIN	Rachel Solomon	Senior Director, Performance Measurement and Information Management
University Health Network	Monika Krzyzanowska	Clinical Lead, Quality Care and Access, Systemic Treatment Program
University of Toronto	Virginia Flintoft	Senior Research Associate, Institute for Health Policy, Management and Evaluation
Waterloo Wellington	Mark Berry	Regional Director
Wellesley Institute	Bob Gardner	Director, Policy, Wellesley Institute
Wellspring	Margaret Valois	Director, Communications
Welsh Assembly Government	Chris Tudor-Smith	Head of Health Improvement Division, Department of Public Health and Health Professions
William Osler Health System	Paula Chidwick	Director, Clinical & Corporate Ethics
William Osler Health System	Gurwinder Gill	Director, Equity & Volunteer Services
William Osler Health System	Sairah Ratanshi	Diversity Director
Windsor Regional Cancer Program	Jeff Booth	Regional Director
Windsor Regional Cancer Program	Claudia Den Boer Grima	Regional Vice President,
Womens College Hospital/Patient Experience Steering Committee	Craig Thompson	PESC Member