Quality-Based Procedures Clinical Handbook for Colonoscopy

Ministry of Health and Long-Term Care

Ontario

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Quality-Based Procedures Clinical Handbook: Colonoscopy

1.0 Purpose

This handbook has been created to serve as a compendium of the evidence-based rationale and clinical consensus supporting the implementation of a strengthened policy framework concerning colonoscopies beginning 2013/2014. The Cancer Screening unit of Cancer Care Ontario (CCO) in collaboration with the Colonoscopy Clinical Expert Panel played an integral role in the planning process and provision of advice on best-practice care in the delivery of **colonoscopies** across Ontario.

This handbook is intended for a broad clinical and administrative audience. It is not, however, intended to be used as a clinical or detailed reference guide by clinicians and will not be replacing existing guidelines and funding applied to clinicians. Evidence-informed pathways and resources have been included in this handbook for your convenience.

2.0 Introduction

Ontario's health care system has not been immune to the climate of increasing global economic tension and uncertainty. Annual growth in health care spending has becoming more and more incompatible with the provincial deficit reduction plan.

In response to fiscal challenges and in an effort to strengthen the commitment to deliver high quality care, the Excellent Care for All Act (ECFAA) received royal assent in June 2010. ECFAA is a key component of a broad strategy to improve the quality and value of the patient experience by providing them with the right care at the right time in the right place through the application of evidence-informed health care policies. Ontario's Action Plan for Health Care advances the principles of ECFAA, reflecting quality as the primary objective in achieving system solutions, value and sustainability.

Health System Funding Reform (HSFR) has been identified as an important mechanism to strengthen the link between the delivery of high quality care and fiscal sustainability, advancing the provinces Action Plan for Health Care by and large. HSFR involves evidence-based health care reforms and developments which will provide Ontario the means to deliver high quality, efficient patient-centred care.

Quality-Based Procedures (QBPs) are groups of services for specific type of patients and an integral part of Ontario's Health System Funding Reform HSFR and a key component of the Patient-Based Funding (PBF).

2.1 What are we moving towards?

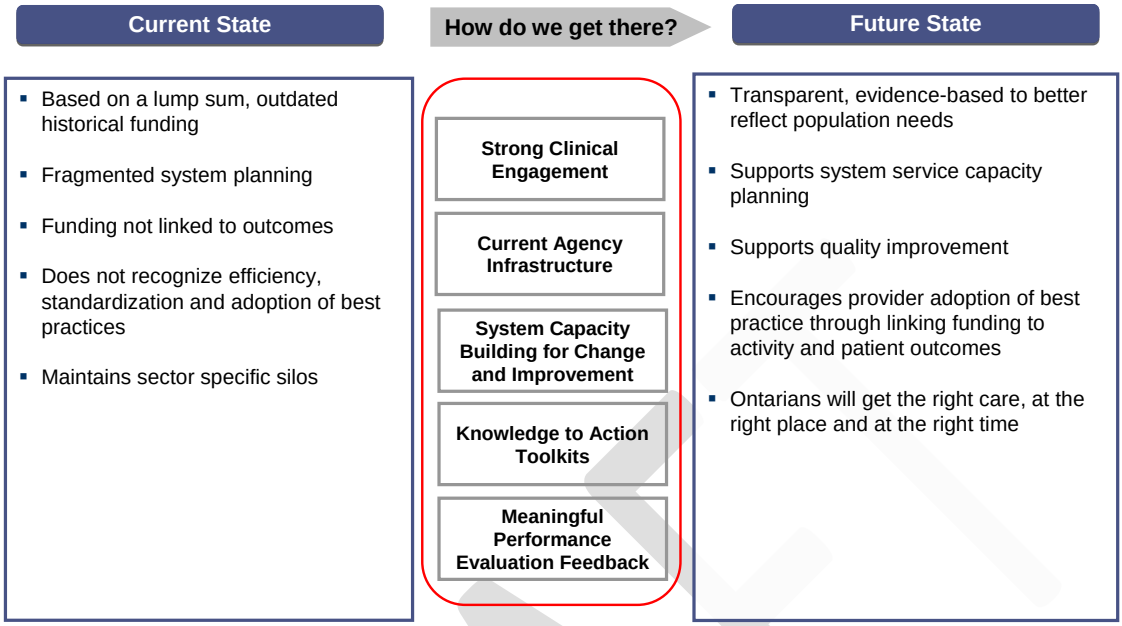
Prior to the introduction of HSFR, the majority of hospital funding has been allocated through what is known as a 'global-funding approach'. Global-funding models assign lump sum amounts to Health Service Providers (HSPs) which are generally not attached to specific targets or services performed with the exception of specific funding for some select provincial programs and wait times services. A number of studies have demonstrated that the fixed and unspecific nature of global-funding models reduce incentives for HSPs to adopt best practices that result in better patient outcomes in a cost-effective manner. Global-funding models can in fact incite the practice of unnecessary or expensive procedures without rewarding best-care practices.

To encourage quality improvements while discouraging unnecessary spending, the Ontario government has committed to moving towards a patient-centred funding (PBF) model for specific healthcare services. The idea behind PBF is that patients are funded instead of the institutions. PBF reflects local population and demographic trends as well as patient histories in order to deliver optimal patient outcomes (Figure 1) and potential cost savings.

PBF practices have been implemented to a greater or lesser degree, internationally and domestically, since 1983. As one of the recent jurisdictions to move down this path, Ontario is in an opportune position to learn from these examples and create a funding model that is best suited for our needs.

PBF supports system capacity planning (resulting in maximum resource efficiency) and quality improvement by directly linking funding to patient outcomes. PBF provides the incentive to health care providers to become more efficient and effective in their patient management and by adopting best practices that ensure Ontarians get the right care, at the right time in the right place.

Figure 1: The Ontario government is committed to moving towards patient-centred, evidence-informed funding that reflects local population needs and incents delivery of high quality care



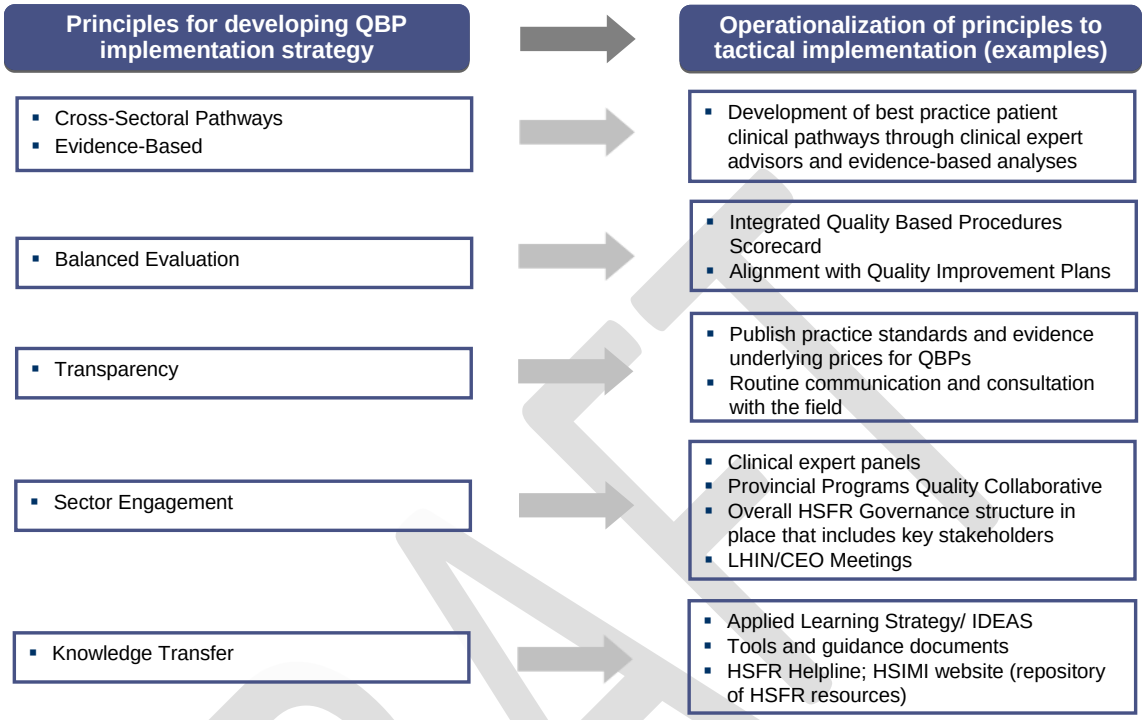
2.2 How will we get there?

The Ministry has adopted a three-year implementation strategy to phase in a patient-based funding model and will begin modest funding shifts starting in the 2013/14 fiscal year. A three-year outlook has been provided to the healthcare field to support planning for upcoming funding policy changes.

The Ministry has released a set of tools and guiding documents to further support the field in implementing the funding model changes. For example an interim list of Quality-Based Procedures (QBPs) to be standardized and funded specifically has been published for stakeholder consultation and to promote transparency and sector readiness for eventual changes. The list intends to encourage providers across the continuum to analyze their service provision and infrastructure to improve clinical processes and where necessary, build local capacity.

The successful transition from the current global funding model towards a 'patient-centred model' will be catalyzed by a number of key enablers and field supports. These enablers translate to actual principles that guide the development of the funding reform implementation strategy related to QBPs. These principles further translate into operational goals and tactical implementation, as presented in Figure 2.

Figure 2: Principles guiding the implementation of funding reform related to Quality-Based Procedures



2.3 What are Quality-Based Procedures?

A Quality-Based Procedure is a term for selected medical procedures and surgeries for which evidence-based best-practices have been established by clinical consensus alongside the evidence-based cost of the best-practice. QBP will help to standardize care and, along with that, minimize practice variation and allow patients, wherever they may be, to receive the best care possible.

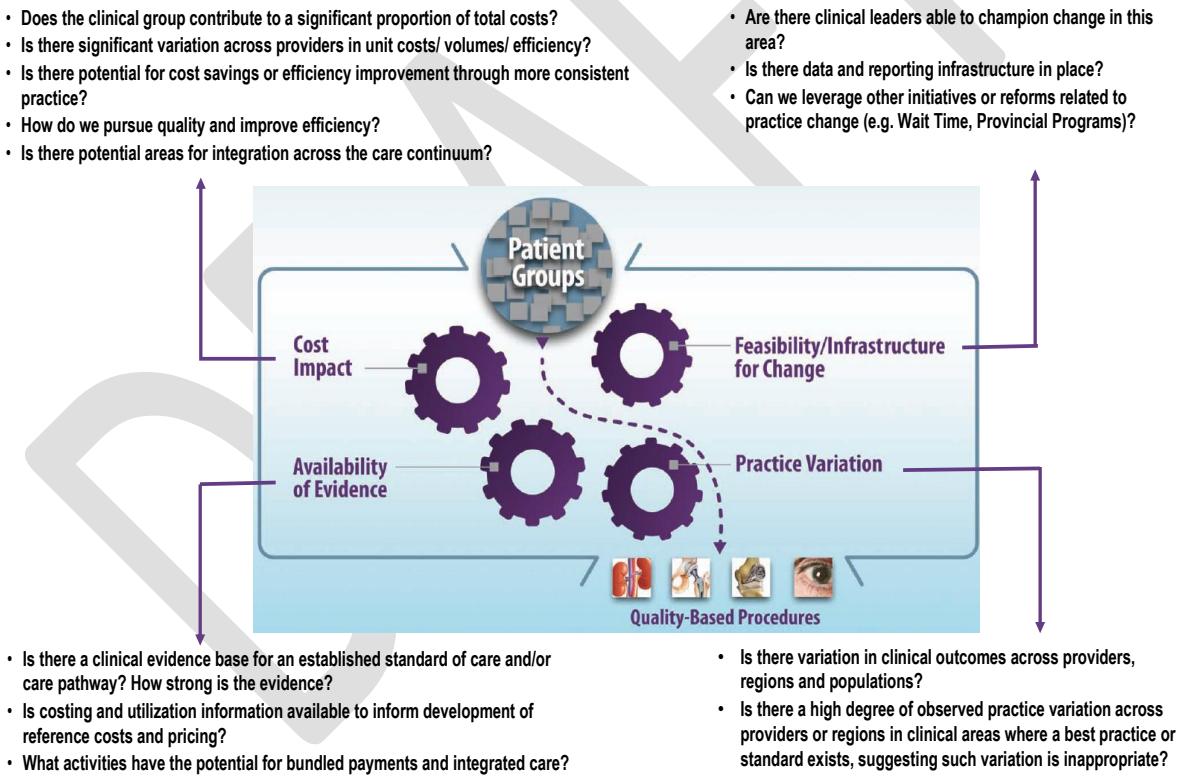
Gastrointestinal (GI) Endoscopy has been chosen as a QBP to be implemented over a five year funding reform initiative. As part of this QBP, colonoscopy will be the first endoscopic procedure to be streamlined and funded on a performance basis through the patient-based funding framework. Potential QBPs are identified using a selection framework, which identifies opportunities for process improvements, clinical re-design, improved patient outcomes, and enhanced patient experience and potential cost savings.

In a patient-based funding model, health care providers are reimbursed for the determined cost of each procedure they perform, the type of patients they treat and the quality of care delivered.

The evidence-based framework used data from the Discharge Abstract Database (DAD) adapted by the Ministry of Health and Long-Term Care for its Health Based Allocation Methodology (HBAM) repository. The HBAM Inpatient Grouper (HIG) groups inpatients based on the diagnosis or treatment responsible for the majority of their patient stay. Outpatient cases are grouped within the National Ambulatory Care Referral System (NACRS) according to the principal procedure they receive. Additional data was used from the Ontario Case Costing Initiative (OCCI). National and international publications and World Health Organization reports were also used to assist with the patient clusters and the assessment of potential opportunities.

The evidence-based framework assessed patients using four perspectives, as presented in Figure 3. This evidence-based framework has identified QBPs that have the potential to both improve quality outcomes and reduce costs.

Figure 3: Evidence-Based Framework



1. Practice Variation

The DAD has every Canadian patient discharge, coded and abstracted for the past 50 years. This information is used to identify patient transition through the acute care sector, including discharge locations, expected lengths of stay and readmissions for each patient, based on their diagnosis and treatment, age, gender, co-morbidities and complexities and other condition specific data. A demonstrated large practice or

outcome variance may represent a significant opportunity to improve patient outcomes by reducing this practice variation and focusing on evidence-informed practice. A large number of 'Beyond Expected Days' for length of stay and a large standard deviation for length of stay and costs, were flags to such variation. Ontario has detailed case costing data for all patients discharged from a case costing hospital from as far back as 1991, as well as daily utilization and cost data by department, by day and by admission.

2. Availability of Evidence

A significant amount of research has been completed both in Canada and across the world, to develop and guide clinical practice. Working with the clinical experts and best practice guidelines, clinical pathways and standards are being developed for the Endoscopy QBP and appropriate evidence-informed indicators will be established to measure performance.

3. Feasibility/ Infrastructure for Change

Clinical leaders play an integral role in this process. Their knowledge of the patients and the care provided or required represents an invaluable component of assessing where improvements can and should be made. Many groups of clinicians have already formed to provide the corroboration and rationale for care pathways and evidence-informed practice.

4. Cost Impact

The selected QBP should have no less than 1,000 cases per year in Ontario and represent at least 1 per cent of the provincial direct cost budget. While cases that fall below these thresholds may in fact represent opportunities for improvement, the resource requirements to implement a QBP may inhibit the effectiveness for such a small patient cluster, even if there are some cost efficiencies to be found. Clinicians may still work on implementing best practices for these patient sub-groups, especially if it aligns with the change in similar groups. However, at this time, there will be no funding implications. The introduction of evidence into agreed-upon practice for a set of patient clusters that demonstrate opportunity as identified by the framework can directly link quality with funding.

2.4 How will QBPs encourage innovation in health care delivery?

Implementing evidence-informed pricing for the targeted QBPs will encourage health care providers to adopt best practices in their care delivery models, and maximize their efficiency and effectiveness. Moreover, best practices that are defined by clinical consensus will be used to understand required resource utilization for the QBPs and further assist in the development of evidence-informed prices. Implementation of a 'price X volume' strategy for targeted clinical areas will incentivize providers to:

- Adopt best practice standards;
- Re-engineer their clinical processes to improve patient outcomes; and
- Develop innovative care delivery models to enhance the experience of patients.

Clinical process improvement may include the elimination of duplicate or unnecessary investigations, better discharge planning, and greater attention to the prevention of post-operative complications. The adoption of these evidence-informed practice changes, will improve the overall patient experience and clinical outcomes, and help create a sustainable model for health care delivery.

3.0 Description of colonoscopy as the first step in the GI Endoscopy QBP

Colorectal cancer, also referred to as cancer of the colon or rectum, is the second leading cause of death from cancer in Ontario and the third most common cancer diagnosed in Ontarians. Colorectal cancer incidence increases with age, especially after age 50, with 93 percent of cancers diagnosed in people 50 years of age or older.

Cancer in the colon or rectum can take up to 10 years or more to develop to an advanced stage. Screening is important in preventing, detecting, and curing colorectal cancer screening. If caught in its earliest stages, there is a 90 percent chance that one can be cured of colorectal cancer. Early detection also avoids more invasive forms of surgery, like the removal of portions of the colon. Colonoscopy procedures are used as a primary routine screening test for colorectal cancer.

A colonoscopy is not only used for cancer screening, it also serves as a primary endoscopic examination tool for all lower gastrointestinal investigation. Individuals with symptoms such as bleeding, abdominal pain, diarrhea, weight loss, altered bowel habits (among others), are candidates for colonoscopy procedures. Symptoms for colorectal cancer are non-specific; therefore colon cancer can be detected with a colonoscopy done for a wide variety of indications. CCO has decided to begin its funding reform initiative by establishing colonoscopies as the first GI endoscopic procedure for streamlining for a number of reasons. The frequency with which colonoscopies are currently recommended and performed suggests a priority in ensuring they are high-quality and cost effective. Further, as an indication for the need of a colonoscopy correlates poorly with the likelihood of colorectal cancer detection, it is important to establish standardized clinical guidelines. Finally, because positive changes in the delivery of colonoscopies intended to diagnose cancer will have a positive impact on the delivery of colonoscopies done in patients with other diseases, establishing colonoscopy as a QBP will have far reaching benefits.

CCO has prioritized all GI Endoscopy procedures to be established as a QBP under HSFR in the coming years but will begin the changes starting with colonoscopy. This QBP will affect the provision of colonoscopy service along the continuum of care, from screening/initial investigation through to definitive diagnosis for all indications according to the defined quality processes. Additional gastrointestinal services such as Gastroscopy, CT colonography, flexible sigmoidoscopy, and barium enema will be considered within this framework in the future.

The following draft standards have been proposed as best practice and cover both hospital and out-of-hospital requirements. Some professional guidelines have also been included for consideration:

DRAFT – Quality Standards. Expert Panel Group is still finalizing list

Criteria – Technical	Site Type	Criteria Component(s)
Must have full CPSO Pass status	OHP	Annual Fee ALCIS training for nurses Regular Inspections
Must have and use automated machine reprocessors	OHP & Hospital	Machine Depreciation Machine Chemicals Machine Maintenance
Must have and use oxygen, oxygen systems and supplies	OHP &Hospital	Oxygen (Tank Rental/Fill) Oxygen Supplies (Nasal, Tubing)
Must have and use suction systems and supplies	OHP & Hospital	Suction Pump Depreciation Suction Liners
Must have IV fluid, setup, and supplies and use where appropriate	OHP & Hospital	Sets Needles Bags
Must be equipped with picture-taking capabilities. Both analog and digital units are acceptable at this time though considerations for digital imaging requirements are being explored	OHP & Hospital	One-time Installation Annual Support
Must meet Nurse Staff Complement	OHP & Hospital	Nurse Hours Per Procedure RN Nurse Hourly Wage RPN Nurse Hourly Wage

Must have acceptable infection control processes in place (minimum standard)	OHP & Hospital	Solutions Disposables Linens Accessories
Must be able to meet all data submission deadlines	OHP & Hospital	Data Submission Correspondence
Must maintain the ability to offer sedation (recovery room, monitoring devices)	OHP & Hospital	Anaesthesia Drugs Syringes Needles
Endoscopes must be used for less than or equal to 300 procedures per year	OHP & Hospital	300 procedures/endoscope
Must have at least one AER/basin for every 1800 procedures per year	OHP & Hospital	1800 procedures/AER (basin)
Must use approved endoscopes	OHP & Hospital	Endoscope Generation Endoscope Manufacturer Endoscope Age
A Quality Assurance Program is implemented	OHP & Hospital	

Criteria - Professional	Criteria Component(s)
Must meet targets for quality indicators (currently being developed by Cancer Care Ontario) such as cecal intubation rates, polyp detection adequacy of bowel preparation, and physician training	Currently being determined by the Program in Evidence-Based Care (PEBC)

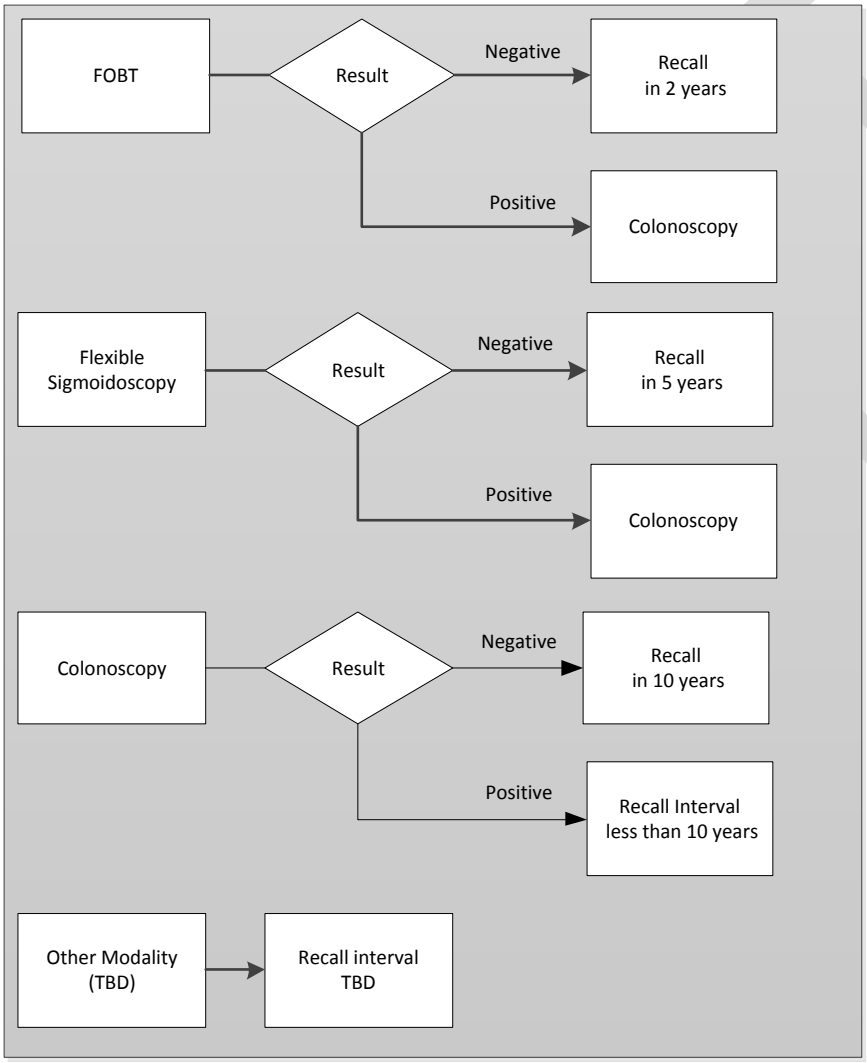
The key objectives of this QBP are to be accountable to the general public, improve health outcomes and manage the costs of endoscopy care. The new funding framework for GI endoscopy provides payment for procedures in a way that supports integration, quality and efficiency throughout the entire patient pathway. Equitable access to care for individuals across all of Ontario remains a strong priority. In addition, the implementation of this QBP does not support the over-provision of services. The funding framework works to provide funding aligned to best practice, appropriate provider reimbursement, and improved accountability for outcomes.

The GI Endoscopy colonoscopy QBP developed by CCO has significant potential for positive impact, particularly when aligned with related ICS initiatives to improve access to needed services, develop an expanded performance measurement and reporting framework, and promote more evidence-informed practice and quality improvement across the cancer system in Ontario.

4.0 Evidence-informed practice[1] guiding the implementation of funding for colonoscopies

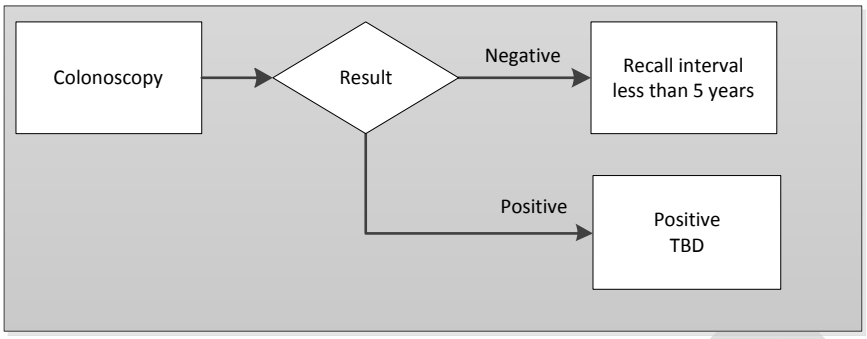
4.1 What is the clinical pathway for colorectal cancer screening?

Average Risk Asymptomatic Colorectal Cancer Screening

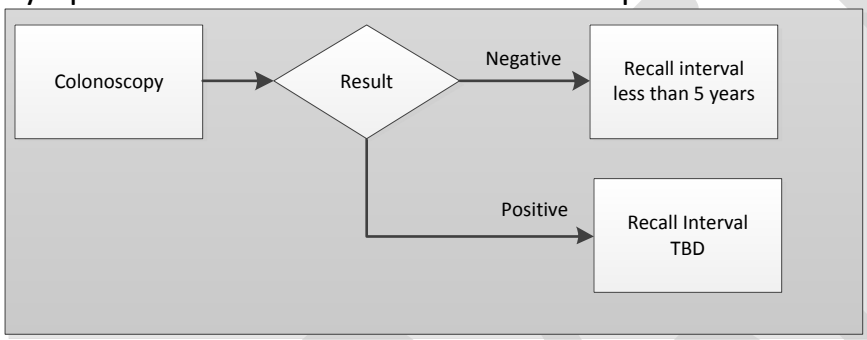


[1]Evidence-informed practice refers to a combination of best available evidence and clinical consensus

Increased Risk, Colorectal Cancer Screening



Symptomatic and Surveillance Colonoscopies



4.1 How was the pathway defined?

Collaboration between medical leads and clinicians has led to the establishment of the above colonoscopy pathway. This funding framework currently encompasses colonoscopy services performed as part of a lower gastrointestinal investigation. The aim is to review other services included in the gastrointestinal investigation such as barium enema and CT colonography and gastroscopy.

Colonoscopy funding will align with best practice guidelines and provide annual reimbursement using a model that follows the patient and discourages over-provision of services. Reimbursement will represent best practice throughout a patient's journey as shown in the colonoscopy pathway above. The draft quality standards in section 3.0 will be used to guide the reimbursement rate.

5.0 How do colonoscopies improve patient outcomes?

Enough can't be said about the importance of screening in preventing, detecting and curing colorectal cancer. Screening is the best way to stop colorectal cancer in its tracks.

If it is caught in its earliest stages there is a 90 % chance that you can be cured of colorectal cancer. Early detection also avoids more invasive forms of surgery, like the removal of portions of the colon.

6.0 What does it mean for clinicians?

6.1 How does a Colonoscopy QBP align with clinical practice?

The QBP for colonoscopy provides funding when best practice care is delivered and clinical pathways followed. The services as outlined in the clinical pathway and the best practices as outlined by the clinical guidelines. Payment for the appropriate level of care for an individual requiring the average quantity of services is developed based on these guidelines. In allocating funding for the average level of treatments defined by best practice, the funding framework allows for a range of patient complexity and thus, will support the treatment of individuals requiring a greater or lesser amount of care.

6.2 Will this have any implications for clinicians?

There may be an impact on the frequency of colonoscopy investigations, the requirements for concurrent investigations as well as the location in which procedures are delivered. Naturally, all of these changes will have implications for clinicians, though the objective to provide the highest quality care will ultimately benefit everyone.

During the implementation of funding changes, clinicians will be tasked with identifying and correcting deviations in their own practices from standard treatment protocols and ideally, best-practice protocols. Collaboration with their hospital administration will assist clinicians and staff in identifying opportunities for both improvements to service and potential challenges in maintaining best-practice protocols.

Clinicians will continue to play an essential role in delivering colonoscopies (both in hospital and non-hospital settings) in ways that fit the needs of their patient population and ensuring that the highest quality care is provided for all their patients.

6.3 Will this change current practice?

Providers who are currently delivering services excessive to evidence-informed standards will be stimulated to reduce their provision of services to only those deemed necessary. On the other hand, providers who deliver fewer services than the standard of care deemed essential to maintaining good practice, will be incentivized to increase their volume to the numbers outlined by evidence-informed clinical practice.

Another practical change may occur regarding the distribution of available services with the intention to ensure services are available and accessible to everyone. Of course the distribution of clinics will also reflect inpatient needs of the hospitals in which physicians also practice.
At this time, physician payment models and OHIP fee schedules as they relate to QBPs are out of scope for this initiative. Physicians who are currently working fee-for-service will continue to submit claims to OHIP for consultations, performing the procedure, and follow-up.

7.0 Service capacity planning

7.1 How will clinician volume management be affected by or affect hospital colonoscopy volumes?

At the moment there are a large number of colonoscopies performed at out-of-hospital premises (OHPs). These OHPs have emerged in response to the demand for endoscopy services and have become essential to managing patient wait times. The changes aim to recognize the value and importance of efficient, high quality OHPs while ensuring consistent delivery of quality services across the board.

Preliminary analyses suggest significant cost savings when certain colonoscopy services are delivered in out-of-hospital facilities. QBP implementation could result in the distribution of appropriate cases from hospitals to qualified OHPs. The objective is to support cost-efficiency in cases with no special requirements, while protecting the needs of those patients whose concurrent illnesses require hospital endoscopic services. MOHLTC and Cancer Care Ontario will consider the location of services when determining funding allocation. While no decision has been made regarding OHP funding for initial phases of GI Endoscopy QBP implementation, it is an option that is being considered for the future. Initially, the funding reform will focus on hospitals; facilitating uniform quality practices and determining the costs of best practices.

7.2 How will the new model of budget planning include clinicians?

Opportunities for clinicians to participate in the development and implementation of the GI endoscopy patient-focused funding model are available at different levels throughout the province. Clinical leaders can get involved in regional and provincial level working groups or within their respective organizations.

The new model for budget planning has included clinicians in the formulation of evidence-informed practice and standards of care. These standards are the basis of the funding model.

To inquire about participation in future CCO committees please send an e-mail to screening@cancercare.on.ca

8.0 Performance, monitoring and evaluation

Improving the quality, appropriateness and access to endoscopic services is central to the implementation of the new framework. Performance, monitoring and evaluation will be essential aspects of the new GI endoscopy funding framework, beginning with colonoscopy. The purpose of this is rooted in consistently providing the highest quality colonoscopy care across Ontario that meet expected outcomes, goals and objectives. The Ontario Colonoscopy Expert Panel and the colonoscopy working groups are working to define standards for quality assurance that will be used in program evaluation. The ColonCancerCheck program will also actively monitor and evaluate the effects of these policy changes.

Collaboration between the Ministry, clinicians and administrators will provide indicators to track and evaluate the performance of the colonoscopy patient-based funding model. An evaluation framework for assessing the impact of HSFR on the health care system will be developed through literature reviews and expert consultation. An integrated QBP scorecard will be developed to assess the impact of QBPs against indicators of quality. This scorecard will be aligned with existing quality indicators currently used in other reporting processes.

9.0 Support for Change

CCO will provide input on the overarching HSFR strategy for system change and specifically, manage the change related to GI Endoscopy service delivery.

The Ministry, in collaboration with its partners, will deploy a number of field supports to help in the adoption of the funding policy. These supports include:

- Strong clinical engagement with representation from cross-sectorial health care leaders and clinicians to develop standards of care and guide the development of evidence-informed patient clinical pathways for the QBPs

- Strengthened relationships with Ministry partners and supporting agencies to seek input on the development and implementation of QBP policy, disseminate quality improvement tools, support service capacity planning and collect input on QBP policy implementation.

- The requirement of hospitals to design and publish annual Quality Improvement Plans (QIPs) that establish their own platforms for quality improvement aligned with government priorities. As hospitals are required to report on a series of core indicators, QIP's can be used to harmonize quality improvement efforts across the system. QIPs facilitate communication between the hospital board, staff, providers and general public so that the hospital can implement quality improvements that best reflect organizational distinctions.

- The deployment of a provincial-scale learning strategy known as IDEAS (Improving the Delivery of Excellence Across Sectors). IDEAS is Ontario's investment in field-driven capacity building for improvement. IDEAS brings together health providers and administrators across sectors – from health care providers in primary care and hospitals to program planners in the long-term and community care sectors. In this way, learning will be peer to peer, interdisciplinary and team based. Its mission is to help build a high-performing health system by training a cadre of health system change agents that can support improvements of quality and value in Ontario. http://www.health.gov.on.ca/en/pro/programs/ecfa/quality/ideas

We hope that these supports, including this Clinical Handbook, will help facilitate a dialogue between hospital administration, clinicians, and staff on the underlying evidence guiding QBP implementation. The field supports are intended to complement the quality improvement processes currently underway in your organization.

10.0 Further Information

- Helpline
  - Email: HSF@ontario.ca
  - Phone: 416-327-8379
- The Ministry of Health's public website: www.health.gov.on.ca
- Access to the "Health Care Professionals" page
  - Excellent Care For All (www.health.gov.on.ca/en/ms/ecfa/pro/)
  - HSFR (http://www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx)
- Password protected website for provider: www.hsimi.on.ca
  - Repository of HSFR resources, including HBAM education materials

Or visit:

Excellent Care for All Act
http://www.health.gov.on.ca/en/ms/ecfa/pro/about/

Health System Funding Reform
http://www.health.gov.on.ca/en/ms/ecfa/pro/initiatives/funding.aspx

Cancer Care Ontario
https://www.cancercare.on.ca/

Integrated Screening
http://ocp.cancercare.on.ca/strategic_priorities/integrated_screening/

Ontario Medical Association
https://www.oma.org/Pages/default.aspx

Health Quality Ontario
www.hqontario.ca

Canadian Institute for Health Information
http://www.cihi.ca/CIHI-ext-portal/internet/EN/Home/home/cihi000001

Institute for Clinical Evaluative Sciences
http://www.ices.on.ca/

11.0 Ontario Colonoscopy Clinical Expert Panel Members

Name	LHIN / Region	Clinical Practice	Affiliations (Partial)
Dr. Michael Gould (Chair)	Central West	Gastroenterologist ➢ OHP Clinician ➢ William Osler Health Centre; Women's College Hospital	• Cancer Care Ontario Clinical Lead • Medical Director & President of Vaughan Endoscopy Clinic • VP, The Toronto Digestive Disease Associates Research Group • Board Member, Canadian Digestive Health Foundation
Dr. David Armstrong	Hamilton Niagara Haldimand Brant	Gastroenterologist ➢ Hamilton Health Sciences Centre	• Professor, Department of Medicine, McMaster University • Chair, CAG Endoscopy Committee (1996-2004) • Member, CCO Colonoscopy Expert Panel (2007) • Chief, Clinical Service for Gastroenterology (2000-2007)
Dr. Nancy Baxter	Toronto Central	General Surgeon ➢ St. Michael's Hospital	• Associate Professor, Department of Surgery-St. Michael's Hospital & the Department of Health Policy Management & Evaluation, University of Toronto • Scientist-Keenan Research Centre of the Li KaShing Knowledge Institute, St. Michael's Hospital • Adjunct Scientist, Cancer Theme Group, Institute for Clinical Evaluative Sciences
Dr. Jeffrey Kolbasnik	Mississauga Halton (Milton)	General Surgeon ➢ Halton Healthcare Services- Milton District Hospital ➢ Hamilton Health Sciences Centre	• President, Ontario Association of General Surgeons (OAG) • VP, Professional Staff Association, Halton Healthcare Services Board of Directors

Dr. David Morgan	Hamilton Niagara Haldimand Brant	Gastroenterologist ➢ Hamilton Health Sciences Centre ➢ St. Joseph's Hospital	• Professor, Division of Gastroenterology, Department of Medicine at McMaster University • Head, Service of Gastroenterology, St. Joseph's Hospital • President, Canadian Association of Gastroenterology (CAG)
Dr. Iain Murray	Central (Markham)	Gastroenterologist ➢ OHP Clinician ➢ Markham Stouffville Hospital	
Dr. Peter Rossos	Toronto Central	Gastroenterologist ➢ Mount Sinai Hospital ➢ Princess Margaret Hospital, ➢ Toronto General Hospital ➢ Toronto Western Hospital	• Director of Health Informatics, Centre for Innovation in Complex Care • Associate Professor of Medicine, University of Toronto • Chief Medical Information Officer, University Health Network (UHN) and SIMS Partnership
Dr. Jill Tinmouth	Toronto Central	Gastroenterologist ➢ Sunnybrook Health Sciences Centre	• Cancer Care Ontario Clinical Scientist • Scientist, Sunnybrook Research Institute, Inc. • Adjunct Scientist, Institute for Clinical Evaluative Sciences • Assistant Professor, Department of Medicine & Department of Health Policy Management & Evaluation, University of Toronto
Dr. David Weiner-Baron	Toronto Central	Gastroenterologist – OHP Clinician ➢ Baycrest Hospital ➢ Mount Sinai Hospital ➢ North York General Hospital	• President- Ontario Association of Gastroenterology (OAG)
Dr. Jamie Gregor	London	Chief of Gastroenterology ➢ Victoria Hospital	• Associate Professor of Medicine & Chief of Medicine, Victoria Hospital

Dr. Hugh Kendall	Central (Ajax)	General Surgeon ➢ Durham Endosurgery Centre	• President, Medical Director- Durham Endosurgery Centre • Member- CPSO Premises Inspection Committee • Peer Assessor, General Surgery- CPSO
Dr. Lawrence Hookey	Kingston	General Surgeon ➢ Hotel Dieu Hospital	• Assistant Professor, Queens University Division of Gastroenterology
Kay Rhodes	Toronto Central	Clinical Director ➢ Kensington Health Clinic	• Research associate – Administrative data specialist