June 3, 2020

REQUEST FOR PROPOSALS - RFP No. RP430-2020-01

FOR Synoptic Evaluation

CLARIFICATION – QUESTIONS & ANSWERS

Please see the answers below regarding any questions raised in relation to this RFP.

1. **Question:** We notice that Schedule A indicates there will be in-person focus groups at pre-scheduled in-person events, whereas Schedule C indicates there will be up to 7 virtual focus groups. Recognizing that plans have likely been evolving in light of COVID-19, can you please clarify which number/format of focus groups we should incorporate in our proposal?

   Answer: Pre-COVID, one pan-Canadian in-person meeting was planned for fall 2020. This meeting will now be replaced with a virtual meeting. For your Proposal, we request that you plan for 7 virtual focus groups.

2. **Question:** Are you able to indicate the available budget for this evaluation? We ask as This may help us to better understand the extent of work to be performed (e.g., it appears unknown how much project-specific evaluation material may be available for inclusion in data synthesis, triangulation, and reporting) and may also inform the nature of activities we propose (e.g., around the client engagement approach). This figure may also be impacted by whether/how much travel is necessary to conduct in-person focus groups, if applicable.?

   Answer:
   The budget allocated for this evaluation is in the range of $100,000 – $120,000.

   For this evaluation, the successful Proponent is not expected to travel across the country to conduct evaluation. Rather, virtual mechanisms are preferred. While it is preferred that the final evaluation results be presented in-person at the Partnership's office in Toronto, the Partnership will assess the feasibility of holding either an in-person or virtual meeting at a later point in time.

3. **Question:** Are you able to identify the six funded partners (and eight jurisdictions) at this time?

   Answer:

Agency
BC Provincial Health Services Authority (pathology reporting across entire province)
Health PEI (pathology reporting across entire province)

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CancerCare Manitoba (surgery reporting across specific communities and regions)
Eastern Health Region Agency (Newfoundland) (surgery reporting within Eastern Health region)
Canadian Association of Thoracic Surgeons (surgery reporting across multiple jurisdictions: QC, BC, ON, NS, and MB)
Alberta Health Services (survey reporting across specific regions and academic institutions)

4. **Question:** Is an indigenous community included within the catchment area/population for any of the jurisdictions?

   Answer: While several provinces participating in the projects provide services to indigenous communities, the project interventions are aimed at primary stakeholders such as physicians/clinicians, delivery care institutions, and health system planning agencies.

5. **Question:** Is there a requirement for the proponent to have French language capacity?

   Answer: No.

6. **Question:** Have you developed a Theory of Change and/or logic model for this initiative and if so, are you able to share these resources at this time?

   Answer: Yes, the logic model will be issued with this Final Questions and Answers document.

7. **Question:** Are you able to identify the approximate total number of clinicians in each jurisdiction that will be invited to complete the survey (QI experience)?

   Answer: Approximately 50 clinicians (6-8 per project).

8. **Question:** Is there a requirement (or interest) to attain statistical representativeness in the sample of clinicians that participate in the survey (e.g. at the jurisdiction level, at the project level)?

   Answer: There is an interest to attain the best representation of participating clinicians possible across projects. While participation in the survey is encouraged, its is optional. It is unlikely that statistical representativeness will be attained.

9. **Question:** We appreciate that the scheduling / timeline for the data collection / evaluation activities could change due to COVID related delays. We note that in Schedule A of the RFP - Item #7 Evaluation Management, the timeline for Phase 2 (pg. 20, Evaluation Implementation for qualitative data collection) is reported as **January 2021 to December 2021**. We also note that the scheduling timeline on pg. 21 shows the qualitative data collection period as **March 2021 to August 2021**. Could you confirm which time period we should be referencing for the purpose of preparing our proposal?

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Answer: The Partnership anticipates that data collection can begin January 2021. During that time, the Partnership will be responsible for collecting all quantitative performance measures and project specific QI measures. It is anticipated that qualitative data collection could begin beginning March 2021 and be wrapped up by August 2021. Based on newly revised partner project end dates, all data collection should be completed by December 2021 in order to allow time for final analysis. It should be noted that there is some flexibility here should additional qualitative collection be required after all quantitative data is received.

10. **Question:** We note that in Schedule C of the RFP (Pricing Sheet) that up to **seven focus groups** are to be conducted in a 'virtual' format as part of Phase 2. We also note that Phase 2 of the evaluation (pg. 20 of the RFP) calls for 'in person' focus groups to be conducted (pg. 20 appears to indicate that two focus groups are required). We are assuming that the focus groups will be virtual given the COVID situation. Can you confirm if the focus groups are to be conducted virtually or in person and the number of sessions (i.e. seven, two or other)?

    Answer: It was anticipated that the prescheduled in-person partner meetings (1 per year) could be leveraged to conduct focus groups among partner project stakeholders (clinician leads, project managers, etc.). Due to COVID, it is unclear whether it will be possible to bring together partners into one setting. Therefore, it is expected that seven (7) virtual focus groups be conducted (1 per funded project, and 1 for all experts and coaches).

11. **Question**: Are you able to provide an indication of what the budget range or cap is for completing the Synoptic Evaluation?

    Answer: Please see response to Question 2.

12. **Question:** What is CPAC's approximate level of investment in the synoptic quality improvement projects?

    Answer: $2.4 million across six projects.

13. **Question:** With respect to design and data collection, to what extent is there an expectation that the approach will be customized for each of the six (6) projects? Are results expected to be reported separately for the projects, as well as aggregated across the projects?

    Answer: While the evaluation design incorporates a common set of questions for data collection across six projects, we anticipate some quantitative data collection will be specific to the quality improvement initiative implemented locally by the project teams.

    The final report should provide a breakdown of results by project, but also demonstrate overall learnings. While the focus of each quality improvement project varies by partner, all partners are approaching the implementation in a similar way (e.g. Community of

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Practice meetings to bring together participating clinicians and stakeholders).

The Partnership will be responsible for creating project-specific knowledge products leveraged from the final report and summary data.

14. **Question:** P27-28 of the RFP outlines tasks and deliverables for the evaluation. Is there flexibility for the supplier to enhance or modify this approach?

    Answer: Multiple stakeholders have been consulted on the design of the evaluation. There is some flexibility in modifying aspects of the design should it align to the goals of the evaluation, and work for partners and stakeholders. We are open to hearing the Proponents' perspective on enhancing the approach.

15. **Question:** Does CPAC have a budget ceiling in mind for this evaluation?

    Answer:. Please see response to Question 2.

16. **Question:** The RFP says that CPAC will lead the engagement process. Are we correct in assuming that the consultants will be conducting the consultations in addition to providing materials that support the engagement?

    Answer: The Partnership will leverage the relationship it holds with partners to introduce them to the successful Proponent and work with the them to design and execute the engagement process. The successful Proponent will develop materials to support the engagement, conduct interviews, analyze data and more. Please see Schedule A of the RFP, specifically #7 Evaluation Management.

17. **Question:** Can you confirm the project teams and jurisdictions that are in scope?

    Answer: Please see response to Question 3.

18. **Question:** Should we assume that travel costs will be determined later depending on whether the pandemic conditions allow for in-person consultations at the time?

    Answer: Please see response to Question 2.

19. **Question:** Did all jurisdictions implement the same scope of pathology and surgical synoptic reporting for the same tumour types?

    Answer:
    While the six project teams have used common methods to lead and implement quality improvement (QI) initiatives, QI topics are unique and aim to address a specific problem. The QI indicators for each project involve process (e.g., # of patients received biomarker testing and referrals to medical oncologists), outcome (e.g., timely triage and treatment), and balancing/unintended consequence measures (e.g., increase in cost due

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to increased biomarker testing). The table below describes the aims of the QI projects of each funded partner.

Project Type	Project Partner	Number of QI Topics	QI Project Focus and Aim
Cancer surgery	NL	1	Breast: • Increase the use of neo-adjuvant chemotherapy in invasive breast cancers by 10%, making biomarker testing on core biopsies (invasive breast cancer only) routine
	MB	3	Colorectal: • 10% increase in laparoscopic surgery for colon cancer in Manitoba Breast: • 10% decrease in the proportion of axillary clearance for breast cancer in Manitoba • 10% increase in the proportion of immediate reconstruction for breast cancer in Manitoba
	CATS	9	Thoracic: • Reduce prolonged airleak after sublobar resection and lobectomy, at participating hospitals by 10% • Reduce afib after sublobar resection and lobectomy at participating hospitals by 10%. • Reduce LOS after lobectomy, segmentectomy, wedge resection, and esophagectomy at participating hospitals by 1 day. • Reduce anastomotic leak after esophagectomy by 10% at participating hospitals.
	AB	5	Breast: • 10% decrease in variance of surgeons performing SNB retrieving 1 sentinel node during SLN biopsy Ovary: • Define and potentially reduce perioperative morbidity/mortality rate in patients with advanced ovarian cancer by achieving 100% implementation of the frailty index in the surgical decision platform Colorectal: • Increase the number of patients receiving preop staging tests by 10% Thyroid: • Increase the number of patients receiving ultrasound LN assessment by 10% • Reduce the number of patients receiving DVT heparin prophylaxis by 10% • Reduce variability in the range by 10% for surgeon level data
	PEI	4	Endometrial:

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Cancer diagnosis (pathology)			• Reduce the turnaround time for send outs of endometrial biopsy specimens to Halifax to 2 days Breast: • Achieve 100% specimen orientation for breast • Increase the number of patients receiving appropriate neo-adjuvant treatment Colorectal: • Increase identification of lymphovascular invasion in CRC cases to 30% (increase of 19.5%)
	BC	5	Colorectal: • Decrease the variation in TME completeness across sites in BC and reach an incomplete resection rate of less than 10% • Increase cases where >12 lymph nodes have been harvested Prostate: • Decrease number of cases of positive margins in PT2 Breast: • Decrease number of cases of positive margins in invasive breast carcinoma • Increase consistency in documenting assessment of response to treatment as per the classification system by 33%. Have a province wide single standardized system for grossing, sampling and reporting

Additional information will be shared with the successful Proponent.

20. **Question:** Can you clarify the 8 predetermined performance indicators referenced in the RFP and any other data elements that CPAC plans to collect and the number of data elements per jurisdiction?

Answer: The following are the 8 performance measures that are collected across all 6 funded projects:

1. Number of procedures in concordance with best practice/ clinical evidence to treat cancer cases, by disease site
2. # of pathologists consistently following documentation standards to report on cancer cases, by targeted disease sites
3. # of QI initiatives being implemented in by jurisdiction where synoptic data are being used, by project
4. # of pathologists and surgeons participating in the implementation of QI initiatives in each jurisdiction where synoptic data are being used
5. # of QI initiatives identified for implementation, by project
6. Communities of Practice Participation Rate
7. % of pathologists receiving synoptic feedback reports, by jurisdiction
8. % of surgeons receiving synoptic feedback reports, by jurisdiction

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21. **Question:** Section 1.3 (p. 5) notes that the financial proposal should be submitted as a separate file from the technical proposal. However, in section 1.8, Proposal Content (p. 7), the list of items to be included in the proposal includes "proposed cost for the work and any assumptions used to derive the budget (i.e. estimated number of days of work, level of effort and team composition)". We would like to confirm that pricing is to be submitted separately and is not included within the 10-page limit for the proposal.

    Answer: Pricing (Schedule C) must be in a separate electronic file. Please do not included within the 10-page limit.

22. **Question:** Is there a project logic model or evaluation framework that has already been developed? If so, can this be shared?

    Answer: Please see response to Question 6.

23. **Question:** Is it possible to provide proponents with a brief description of the pilot projects that will be evaluated?

    Answer: All funded projects have common elements and activities outlined in Schedule A of the RFP. For more information on the specific QI focus of each funded project, please refer to response to Question 19.

24. **Question:** Can you provide a list of the specific indicators to be assessed through the quantitative data items #1 and #2 (Schedule A, Section 4.b, p. 18)? This will allow us to better understand the type of analysis that may be required and give an accurate estimate of the time required for analysis.

    Answer: Please see response to Question 20 for the list of performance indicators. Examples of QI measures by funded project can be found in Question 19 which are currently being refined by funded partners.

25. **Question:** Can you confirm that the community of practice survey, item #3 in this same list (Schedule A, Section 4.b, p. 18), is composed of mainly/all closed-ended questions? Approximately how many questions are included, how many respondents, and how many points in time is the survey conducted?

    Answer: The community of practice (CoP) survey is composed of 14 questions, including 6 multi-part questions using the Likert scale, 5 multiple choice questions and 3 open-ended questions. The CoP survey data are collected semiannually or annually by the project teams and then sent to the Partnership. We are in the process of confirming the number of respondents to date.

26. **Question:** In Section 7 of Schedule A (Evaluation Management, p. 20) it indicates that focus groups will be conducted at in-person events, but in the pricing schedule on p. 27, it notes that focus groups will be completed virtually. Is the consultant expected to include contingency for travel for in-person focus groups if public health measures allow, or is it acceptable to conduct all data collection remotely given the current context of COVID-19?

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Answer: Please see response to Question 1.

27. **Question:** To help us budget for appropriate analysis of the indicator data, could you provide more information about the quantitative tools and indicators? Specifically,

    a. What are the standardized performance indicators?
    b. How many points in time are captured for each standardized performance indicator?
    c. What format will the data be in?

    Answer: Please refer to response to Question 19. We anticipate performance indicators to be collected at 2 time points (not including baseline). Data will be collected by the Partnership levering a data collection template in excel format.

28. **Question:** Is there an existing logic model for this initiative, and if so, could you share it with prospective bidders?

    Answer: Please see response to Question 6.

29. **Question:** Can you share an overview/description of the 6 synoptic projects? E.g.,

    a. Purpose/goals
    b. Jurisdictions covered for each project
    c. QI project leads
    d. Areas of focus
    e. Stakeholders involved, including any champions
    f. Involvement of expert coaches - ongoing involvement? Or only at the start?

    Answer: General project purpose and goals are outlined in the RFP, please see Schedule A. For QI specific project aims or areas of focus, see question 19. QI project leads are comprised of clinician thought leaders and project managers. Stakeholders include physicians, inter-disciplinary groups of clinicians, administrators, project teams, decision-makers, and others. Please refer to the logic model for additional information. Additional QI project-specific details will be shared with the successful Proponent.

30. **Question:** Evaluation question 5 is asking what each QI intervention has contributed to elimination of low-benefit practices and adoption of high-benefit practices. Can you clarify whether "QI interventions" is referring to the 6 synoptic projects or to specific interventions that are being implemented through the 6 projects? If the latter, could you provide more information about the interventions being implemented?

    Answer: The QI interventions refer to a specific action taken to address a problem/gap in care. An example of a QI intervention is, in line with best practice, implement a process to triage so that appropriate cancer cases get biomarker testing done and get referred for chemotherapy and or surgery. Another example of a QI intervention is delivery education workshop to build knowledge and ability to consistently capture diagnostic elements as per the classification system.

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31. **Question:** Regarding the Community of Practice generally:

    a. Who is invited to participate?
    b. How often do events take place?
    c. How many events have taken place so far?
    d. What are the topics of discussion?
    e. So far, approximately how many people attend events?

    Answer:
    a. Participants are clinicians (pathologists, surgeon, medical oncologists, radiation oncologists and project administrators, depending on the QI topic)
    b. Timing varies by QI topic; often though CoPs are held semiannually or annually.
    c. Since the inception of the project in 2017, multiple CoPs have been held. The number of CoPs varies by project, ranging from 5 to 25.
    d. Discussion topics are focused on approaches to address a problem (see Question 19, aims of the QI projects and Question 30 to see examples of interventions).
    e. CoP attendees varies by project and jurisdiction; minimum of 5 and maximum of 70.

32. **Question:** For the standardized community of practice surveys:

    a. How many times (approx.) will the surveys be distributed?
    b. Will the same survey be distributed each time?
    c. How many questions are on the survey? (# closed-ended, # open-ended)
    d. How many individuals will it be sent to?
    e. What is the anticipated response rate?
    f. In what format will the Partnership provide the survey data? (e.g., Excel file with raw data, aggregated report)
    g. Will the successful vendor be responsible for preparing team-level or jurisdiction-level summaries of the survey results?

    Answer: Please refer to responses to Questions 25 and 32 (a-e). Raw survey data will be provided for analysis to the successful Proponent in excel format (f). It is expected that the successful Proponent analyze and synthesize survey data by project, and as an aggregate.

33. **Question:** For the clinician QI experience survey:

    a. How many individuals will it be sent to?
    b. What is the anticipated response rate?
    c. In what format will the Partnership provide the survey data? (e.g., Excel files with raw data, aggregated reports)
    d. Will the successful vendor be responsible for preparing team-level or jurisdiction-level summaries of the survey results?

    Answer: The QI experience survey will be sent to approximately 50 clinicians (a). The Partnership will work with funded partners promote the survey to receive an acceptable response rate (b). Raw survey data will be provided for analysis to the successful proponent in excel format (c). It is expected that the successful Proponent analyze and

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synthesize survey data by project (if appropriate based on response rate), and as an aggregate (d).

34. **Question:** In total, how many of each of the following are involved:

    a. Clinician leads
    b. Project administrators
    c. Engaged experts

    (We noted that 12-13 clinician leads, and 5-7 expert coaches were to participate in interviews but were unsure if this was a sample or the full population.)

    Answer: Collecting perspectives via semi-structured Interviews with clinician leads (13) and expert coaches (7) are expected. These number represent the total number within the stakeholder group.

35. **Question:** How is it envisioned that project administrators participate in the qualitative data collection? (No interviews are noted with them on page 27. Perhaps they would be invited to participate in the team focus groups only?)

    Answer: Project administrators should be included in the project team focus groups.

36. **Question:** Would it be possible to share the allotted project budget (or the budget range)? Having a sense of the investment CPAC is looking to make in this evaluation will enable us to submit a proposal that is aligned with needs and limitations.

    Answer: Please see response to Question 2.

37. **Question:** Page 20 suggests that the Partnership is seeking two in-person focus groups, however page 27 appears to request up to seven virtual focus groups. Could you clarify the expected number of focus groups to conduct in Phase 2, and whether these should be in-person or virtual?

    Answer: Please see response to Question 1.

38. **Question:** If focus groups are expected to be in-person, are there certain sites in mind for where these would be held? Knowing site preference would help to estimate any required travel costs.

    Answer: Due to COVID-19, Focus groups are expected to be conducted virtually.

39. **Question:** Are any meetings or presentations expected to be in-person? If so, would they be held in Toronto?

    Answer: Please see response to Question 2.

40. **Question:** Is it possible to provide any information on the nature of quantitative data elements that have already been defined or are currently being collected? Knowing a bit

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more about that data will help to calculate time required for data cleaning, analysis and reporting.

Answer: Please see responses to Questions 19 and 24.

41. **Question:** Is it safe to assume that "low benefit" and "high value" practices are clearly defined already?

Answer: Such practices are based on clinical guidelines and/or best practice. The focus of each project is carefully defined, analyzed, selected, and discussed at Communities of Practice events by clinical leads and the clinicians participating in the QI project.

42. **Question:** Can the Partnership confirm that the Proponent is only expected to create one survey for clinicians to be administered at one point in time? Page 18 references a community of practice survey that is administered at various timepoints, but that survey appears to be out of scope for the Proponent. Will the Proponent be expected to play a role in the development or analysis of the community of practice survey?

Answer: Correct. The QI Experience Survey will only be issued at one point in time towards the end of the project. The successful Proponent needs only create 1 of the 2 surveys built into the evaluation design. The CoP Survey already exists, and as such, only requires analysis.

43. **Question:** Is there an estimate of the number of clinicians who would be participating in the clinician experience survey?

Answer: Please see response to Question 34.

44. **Question:** Are there any engagement-related challenges the Partnership thinks the Proponent should be aware of?

Answer: The Partnership has strong relationships with clinical and project leads and coaches who have all expressed enthusiasm in participating in the pan-Canadian evaluation and leveraging the results. It should be noted that the Partnership will rely on funded partners to identify and reach out participating clinicians to gain their perspective (via QI experience survey).

45. **Question:** Is there an anticipated budget range for the Proponent to work within?

Answer: Please see response to Question 2.

46. **Question:** Can the Partnership confirm that required forms and information (e.g., References forms, Submission Forms, etc.) do not count to the 10 page limit of the RFP as outlined on page 7?

Answer: No, the Schedules are not included in the 10-page limit.

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47. **Question:** Quantitative Data (outlined on pages 18 and 19 of the RFP):
    a. Four major items are listed in the RFP. Is it the Partnerships expectation that the Successful Proponent will be responsible for developing the tools and questions to collect quantitative data? Or will the Partnership's internal resources handle this portion of the engagement?
        i. Note: We understand that the Clinician QI survey will be developed by the Successful Proponent (as listed on page 20 of the RFP)
    b. Is it the Partnership's expectation that the Successful Proponent will develop a quantitative data collection plan/timetable for this engagement? (i.e., for those items that require inputs at multiple points in time)

    Answer: All quantitative data will be collected by the Partnership and shared with the successful Proponent for analysis and synthesis. The timepoint in which the QI Experience Survey will be issued will be determined at a later date.

48. **Question:** Will the Successful Proponent be required to travel to any of the focus groups or is the Partnership open to holding these focus groups virtually?

    Answer: Travel will be minimal. The successful Proponent should expect to complete all data collection they are responsible for (qualitative) virtually.

49. **Question:** Does the Partnership have a maximum budget allocated for this project? If so, would the Partnership be willing to provide the maximum budget?

    Answer: Please see response to Question 2.

50. **Question:** What is meant by "sealed electronic file". Is there a particular method being requested for sealing a file?

    Answer: Please ignore the word "sealed" and replace as a "separate" electronic file, stated throughout the document.

51. **Question:** Does CPAC have a ceiling for the budget for this project?

    Answer: Please see response to Question 2.

52. **Question:** Given current distancing protocols imposed due to COVID, can you indicate whether any in-person engagement is anticipated for this project? If so, would these be contingent on events as they unfold over the next year? Should we assume that all engagements will take place remotely via teleconference / videoconference only?

    Answer: Please see response to Question 1.

53. **Question:** The RFP indicates that six project teams have been, or are to be, set up to support eight jurisdictions to use synoptic data and evidence-based methodologies. Are those teams in place? Where are they located? Can you estimate the numbers of individuals associated with each of the teams, and would you expect that all involved will

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be interviewed in this process? What are the respective roles of the individuals on those teams? Who beyond the teams do you envision being interviewed for this evaluation?

Answer: Please see response to Question 3 to better understand the breakdown of funded partners and involved jurisdictions. Each project team is made up of a clinician lead, project managers/coordinators/analysts who are in place to support the implementation of the project. The exact size and composition of these teams varies across projects but is between 5-10 individuals. Most of these individuals will participate in a focus group for an interview. Please refer to Schedule C of the RFP which stipulates methods and expected number of stakeholders in qualitative data collection during phase 2.

54. **Question:** We understand that timelines are somewhat in flux due to the COVID pandemic. In the Table on Page 21 of the RFP, it is stated that the partner projects are anticipated to end in the first quarter of fiscal year 2021/2022, meaning April-June 2021. However, on page 16, under Outcomes, it states that the 6 funded projects are to be completed by March 31, 2022. The table on page 21 also indicates that qualitative data collection will be conducted between March 2021 and August 2021. Partner engagement meetings are said to be rescheduled due to COVID. Could you clarify the expected timeline for the project and indicate when you would anticipate project completion to be?

    Answer: Due to COVID-19, many funded partners' project timelines have been extended into 2021. It is possible that projects may be extended further but must be completed by the end of the Partnership's 5-year mandate of March 2022. Based on current planning, it is anticipated that qualitative data collection with project teams will happen close to the end of their projects (Q1 of 2021/2022), and other perspectives that are not reliant on a project timelines will occur after (e.g. coaches). The estimated timelines for phase 3 are in place to accommodate the time needed to collect final data and have the successful proponent analyze, synthesize and translate evaluation results into the final deliverable, due March 2022.

    Please see response to Question 1 related to partner engagement meetings.

55. **Question:** CPAC will be responsible for collecting all quantitative data and providing that to the successful proponent (page 19). What form do you anticipate the quantitative data to take that will be available to the proponent? Will that be raw data or aggregated?

    Answer: Quantitative data will be collected by the Partnership using a data collection template and will be shared with the successful proponent for analysis in excel format. Most, if not all quantitative data collected will be raw.

56. **Question:** On page 18 of the RFP it states that "pre-determined quantitative measures will be leveraged from provincial administrative data sets and collected at baseline, time 1 and time2." The RFP also talks about eight pre-determined performance indicators will be collected. Have these indicators been determined, or will they be determined at the beginning of the project?

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Answer: Please refer to response to Questions 19 and 20 for more information on the two types of quantitative measures listed in the RFP. The QI measures noted in question 20 are currently being refined with funded partners.

57. Question: Can you clarify whether the measures to assess the effectiveness of the program have been determined or will be determined in consultation with the proponent at the beginning of the project? Will the deliverables for the evaluation be established at that time as well?

Answer: While the Partnership is open to hearing your thoughts and considerations, much of the evaluation design has been determined and reviewed by funded partners. As it relates to quantitative QI measures, the Partnership relies on the funded partners to determine measures that meet their needs, and accurately measure the focus of their work. Please see response to Questions 19 and 20 to view the pre—determined performance indicators, and the proposed QI measures by project. Please refer to Schedule C (pg. 27) of the RFP as it relates to expected deliverables.

End of Questions and Answers

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Program Logic Model

CANADIAN PARTNERSHIP AGAINST CANCER | PARTENARIAT CANADIEN CONTRE LE CANCER

Division	**Cancer Control**
Department	Diagnosis and Clinical Care
Program	Embed and Use Synoptic Reporting : 2017-2020 (extended to 2021)
Program Objectives	Catalyze the use of synoptic data across jurisdictions to 1) identify diagnostic and treatment gaps to improve patient care 2) implement quality improvement initiatives to address those gaps 3) Engage clinicals to adopt evidence-based practice change 4) mobilize evidence-based practice data to inform improvements in health system planning
New Canadian Strategy for Cancer Control (alignment only)	Priority 3: Deliver high-quality care in a sustainable world class system Action 1: Set best practices and standards for care delivery and promote their adoption
CPAC Long-term Outcomes (by 2037)	Fewer Canadians die from cancer
CPAC Intermediate Outcomes (by 2027)	1. More patients receive better, faster, safer screening, diagnosis and treatment 2. Canada's cancer system is efficient and sustainable
CPAC Short-term Outcomes (by 2022)	Treatment: Patients with cancer get safe, fast quality care Diagnosis: Canadians who might have cancer are diagnosed sooner
Program Outcomes (by 2022)	1. Implementation of data driven QI initiatives informs improvements in health system planning and standardization of clinical practice 2. Pathologists and surgeons adopt evidence-based practice changes catalyzed by implementation of QI work 3. Pathologists and Surgeons form consensus on gaps which inform implementation of QI initiatives. 4. Synoptic data are effectively leveraged through audit and feedback reports to identify and address gaps in delivering standardized high-quality diagnosis and treatment to patients
Outputs	• Number of comparative physician-level synoptic feedback reports generated by jurisdiction, by disease site • Number of clinical forums convened (local communities of practice) led by partners • Number of multidisciplinary clinicians participating in clinical forum discussions • Number of national forums convened to catalyze knowledge and enhance clinical accountability (led by CPAC) • Number of quality improvement initiatives implemented to address gaps and improve patient care by jurisdiction • Number of synoptic clinical diagnostic and treatment care pathways developed by jurisdiction, by disease site • Number of clinical practice guidelines, and/or program planning documents created by jurisdiction, by disease site • Number of products released (e.g., environmental Scan) • # of trainings offered to partners

Program Logic Model

CANADIAN PARTNERSHIP AGAINST CANCER | PARTENARIAT CANADIEN CONTRE LE CANCER

Stakeholders

- **Canadian pathologists and surgeons (primary end users)**
- Canadian Association of Pathologists
- Multi-disciplinary clinicians
- Provincial cancer programs
- Ministries of health
- Hospital administrators
- Health system influencers and advocates
- Medical societies, colleges/ associations (provincial/national)
- Ministries of health
- Provincial cancer programs/ regional agencies
- Hospital administrators
- Health system influencers and advocates

Key Activities

CPAC:

- Fund and support 6 partners to implement quality improvement initiatives based on synoptic data
- Implement coaching model to assist clinicians with mobilizing data and knowledge
- Convene funded partners and stakeholders at bi-annual meetings to build new knowledge and advance collective action
- Development and implementation of national forums convened to catalyze knowledge and enhance clinical accountability
- Provide training
- Publish peer reviewed journals

Partners:

- Generate physician level synoptic feedback reports
- Implement and convene local clinical forums (communities of practice)
- Leverage data to identify and implement quality improvement projects to address gaps and improve patient care
  a) At the individual physician level (and across physicians collectively) to standardize clinical practice
  b) At the jurisdictional level in order to inform health system planning

Inputs

1) CPAC resource (staff time, other costs)
2) Partner funding and other resources
3) Coaches (expert advisors)

Performance Indicators (Revised January 2020)

- Number of procedures in concordance with best practice/ clinical evidence to treat cancer cases, by disease site
- # of pathologists consistently following documentation standards to report on cancer cases, by targeted disease sites
- # of QI initiatives being implemented in by jurisdiction where synoptic data are being used, by project
- # of pathologists and surgeons participating in the implementation of QI initiatives in each jurisdiction where synoptic data are being used
- # of QI initiatives identified for implementation, by project
- Communities of Practice Participation Rate
- % of pathologists receiving synoptic feedback reports, by jurisdiction
- % of surgeons receiving synoptic feedback reports, by jurisdiction

Assumptions:

- Leveraging the principles of change management provides funded partners with an ability to lead change, implement QI projects, and establish the culture of quality improvement in a sustainable manner.
- CPAC levers such as: funding, convening partners and building capacity through workshops, providing coaching and training through experts and project management support to influence and guide, will help to catalyze a culture of quality improvement across jurisdictions so that synoptic data is routinely used to review, discuss and address clinical gaps in care.
- Ownership will be established to transition the project into operations; this will include dedicated resources, infrastructure to build on products and processes generated as a result of the QI projects among funded partners will be sustained post funding; and governance for guiding continuous quality improvement.

External Factors:

- Political will among jurisdictions, and the ability of partners and their respective stakeholders to influence and engage decision makers to continue work post funding.
- Ability of funded partners to build a culture of quality improvement within their jurisdictions – among clinicians, administrators and health system leaders.

Approach:

- Provide training, project management support and coaching to funded partners to strategize physician engagement approaches, design physician feedback reports, promote participation in organized forums and in quality improvement initiatives with the goal to drive performance across jurisdictions or adopt a practice.
- Use local communities of practice as a forum to discuss synoptic data and advance quality improvement across jurisdictions

List of Funded Partners

Agency	Project Name
Provincial Health Services Authority	BC – ESPRI (entire province of BC)
Health PEI	Health PEI – ESPRI (entire province of PEI)
CancerCare Manitoba	ESSQUI MB (2- jurisdictions—MB and NL—academic institutions across regions)
Canadian Association of Thoracic Surgeons	CATS- ESSQU (Multiple jurisdictions: QC, BC, ON, NS, and MB)
Alberta Health Services	AHS – ESSQUI (academic institutions and regional)

Post-CoP Event Survey

Section 1. Your Feedback report

	Very Valuable	Valuable	Uncertain	Not so valuable	Not at all valuable	Not applicable
1. How valuable were the data presented in your individual comparative feedback report?	O	O	O	O	O	O

2. The data in the individual comparative feedback report:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
a. Made me aware of targets	O	O	O	O	O	O
b. Made me aware of action items	O	O	O	O	O	O
c. Were easy to interpret	O	O	O	O	O	O
d. Were delivered in a timely fashion	O	O	O	O	O	O
e. Signaled the need for change	O	O	O	O	O	O
f. Highlighted specific quality improvement opportunities	O	O	O	O	O	O

3. How likely are you to use the data from individual comparative feedback reports for:	Highly likely	Likely	Uncertain	Unlikely	Very unlikely	Not applicable
a. Self-reflection and self-assessment	O	O	O	O	O	O
b. Adopting existing best practices to	O	O	O	O	O	O
c. Discussing cases with my peers to direct patient care	O	O	O	O	O	O
d. For improving patient care	O	O	O	O	O	O

4. How often do you look at your individual comparative feedback data?
O Daily
O Weekly
O Monthly
O Annually
O I don't use it

5. If applicable, select 3 primary factors that enable you to more often use feedback reports for the purposes of improving care	
[ ] Time	[ ] Motivation to learn
[ ] Clinical relevance	[ ] Better Communication
[ ] Relevance for patient care	[ ] Other (please specify) _____

6. What information regarding the indicators would you like to see and/or not like to see on your next comparative feedback report?
a. Examples of indicators or description of text (including targets) I would like to see in my next feedback report and why:
b. Examples of indicators or description of text I would **not** like to see in my next feedback report and why:

Section 2. Communities of practice – Please tell us to what extent you agree with the following

7. Overall, this CoP discussion	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
a. Motivated me to modify my clinical practice	O	O	O	O	O	O
b. Was a good use of my time	O	O	O	O	O	O

8. The community of practice gave me the opportunity to:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
a. Network with colleagues	O	O	O	O	O	O
b. Self-reflect about my own data	O	O	O	O	O	O
c. Learn information relevant to my daily work	O	O	O	O	O	O
d. Learn evidence-based guidelines/best practices	O	O	O	O	O	O
e. Gain insights on approaches to improve quality	O	O	O	O	O	O
f. Take on a leadership role to lead innovations in care	O	O	O	O	O	O
g. Learn how to drive system change	O	O	O	O	O	O
h. Influence colleagues who I directly work with	O	O	O	O	O	O
i. Influence colleagues who I indirectly work with	O	O	O	O	O	O
j. Lead discussions with decision-makers in my organization	O	O	O	O	O	O
k. Understand organizational constraints & opportunities to improve care	O	O	O	O	O	O

9. I intend to use the information provided in the current session to:	Strongly Agree	Agree	Uncertain	Disagree	Strongly Disagree	Not Applicable
a. Inform patient care activities	O	O	O	O	O	O
b. Adjust my practice, as needed	O	O	O	O	O	O
c. Design projects, programs, or training	O	O	O	O	O	O
d. Mentor my colleagues	O	O	O	O	O	O
e. Develop and lead communities of practice in my institution or region	O	O	O	O	O	O
f. Present information at clinician forums (e.g., Grand Rounds)	O	O	O	O	O	O
g. Influence decision-makers	O	O	O	O	O	O
h. Other (please specify):						

10. What factors most motivated you to participate in this CoP? (please choose one option that best applies)	
O To support patient care activities and meet clinical goals	O To lead innovations as a community
O To stay current in my area of discipline	O To network with my peers
O To meet CME requirements	O To support organizational priorities
O Other (please specify) _____	

11. The CoP helped me identify approaches to achieve the following: (check all that apply)	
O Build relationships and establish trust with interdisciplinary team	O Align with priorities shared by local, regional or provincial organizations
O Implement projects with peers and team members to improve quality of care	O Break down silos in practice between peers, organizations and disciplines
O Gain organizational support to implement quality improvement initiative	O Increase technical expertise to delivery care
O Other (please specify):	

12. Identify who else should be invited to this CoP (check all that apply)	
O Clinical specialities not present at this CoP meeting (please specify) _____	O Organizational leads (hospital, medical society/association, etc.)
O Decision makers (agencies, regional, provincial, etc.)	O Patient or patient groups
O Other (please specify):	

13. Are there any specific topics that you would like to discuss at a future CoP?

14. Do you have any other comments, questions, or concerns related to CoPs?