Réseau de cancérologie Rossy

Rossy Cancer Network

Breast Disease Site

Jean-François Boileau, MD
Sarkis Meterissian, MD

Vision of the Co-Leads

- Address controversies in the diagnosis and treatment of breast cancer to harmonize care
- Support each other in clinical trial recruitment, improve knowledge of active trials and treat more breast cancer patients on trials
- Support each other's efforts in cancer quality & innovation

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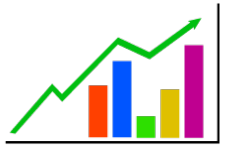
What are the Successes?

- **Creating a network culture**
  - Important collaboration among the RCN sites
  - Multidisciplinary steering committee meeting quarterly including pathology, medical oncology, radio-oncology, surgical oncology, and research

- **Harmonizing care across the RCN**
  - Delineating the trajectory of breast cancer patients at the RCN hospitals and finding mutual consensus.



- **Acting on quality indicators**
  - Shared support to improve quality of care based on indicator results:
    - Ex. BR2: focusing on improving accrual into clinical trials

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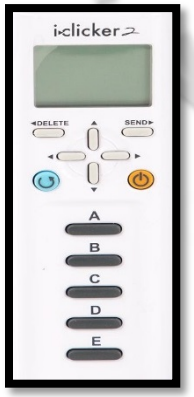
Harmonizing care: Consensus on Treatment and Diagnosis

- RCN Meeting initiative on November 1st, 2017 addressed the following:
  - Routine axillary ultrasound and biopsy of nodes
  - MRI necessity in stage I and II breast cancer
  - Sentinel node biopsy in women ≥70 years with hormone-positive breast cancer
- Multidisciplinary participation across RCN: Medical oncologists, radiation oncologists, surgical oncologists, and radiologists attended the meeting (21 attendees)
- Literature review related to the topics was sent to participants before the meeting
- To facilitate the discussion, i-clickers were provided for the participants to vote for their responses



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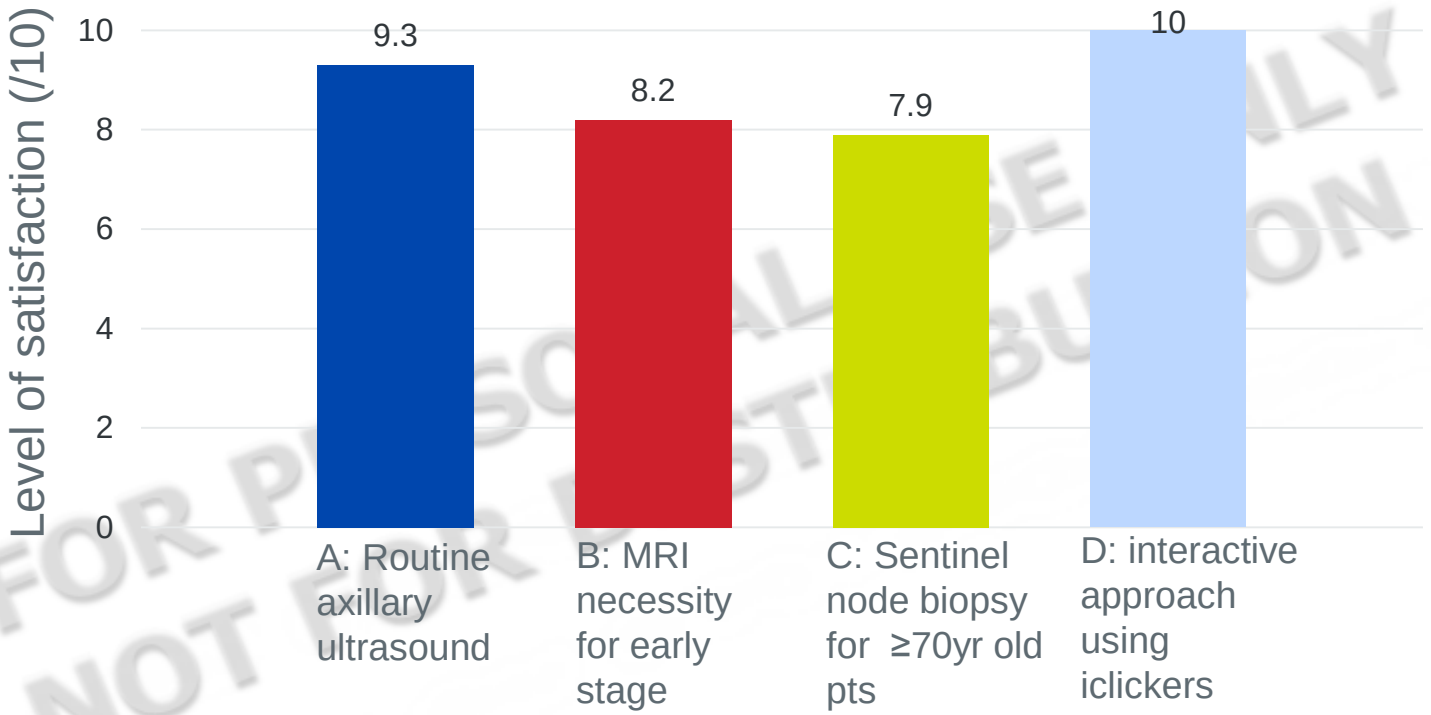
Harmonizing care: Consensus on Treatment and Diagnosis



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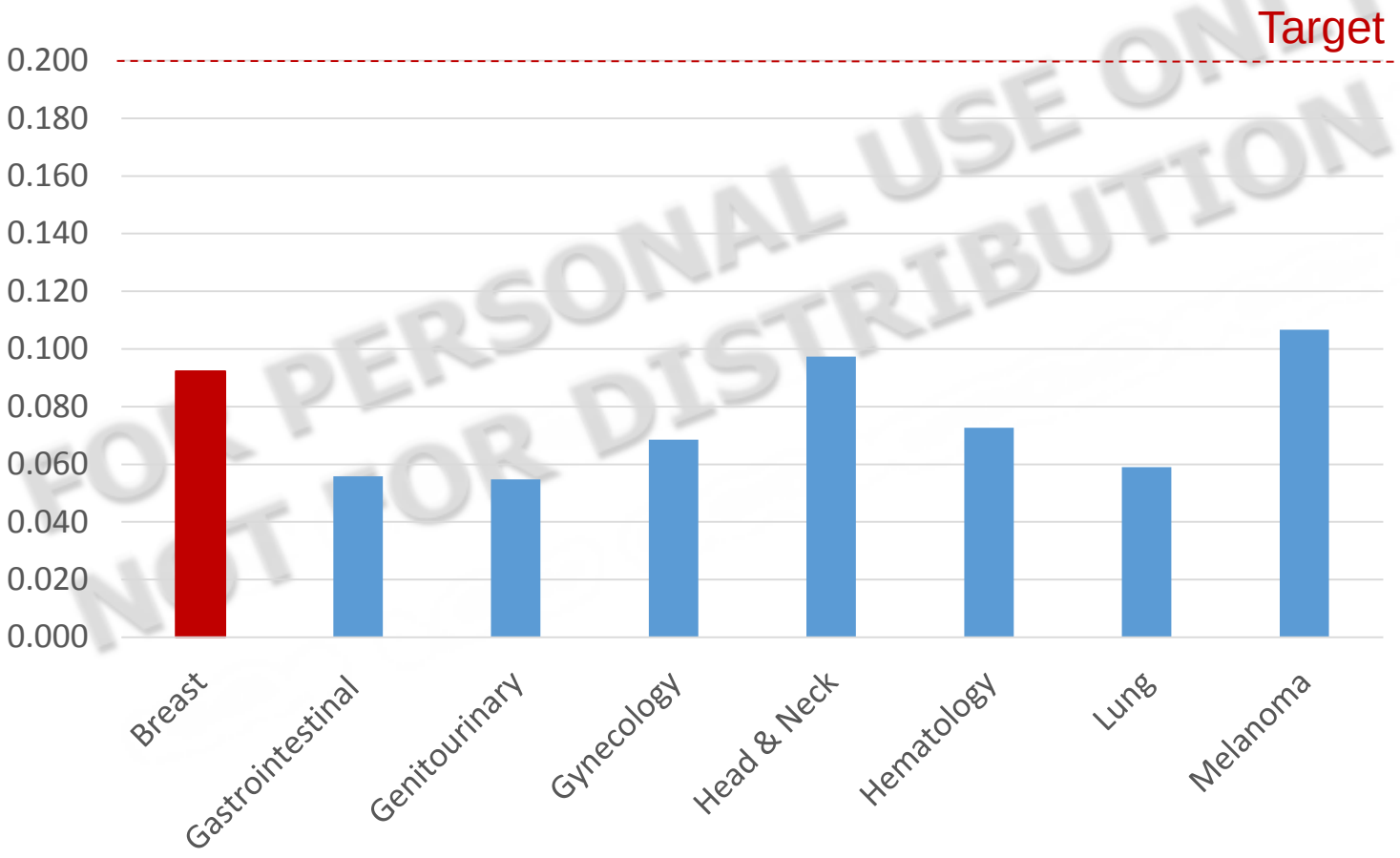
- Future topics to address:
  - Treatment focused genetic testing for BRCA1 and BRCA2
  - Neoadjuvant chemotherapy for TNBC and HER 2 positive

Acting on quality indicators: BR2- accrual ratio of breast cancer patients into interventional clinical trials



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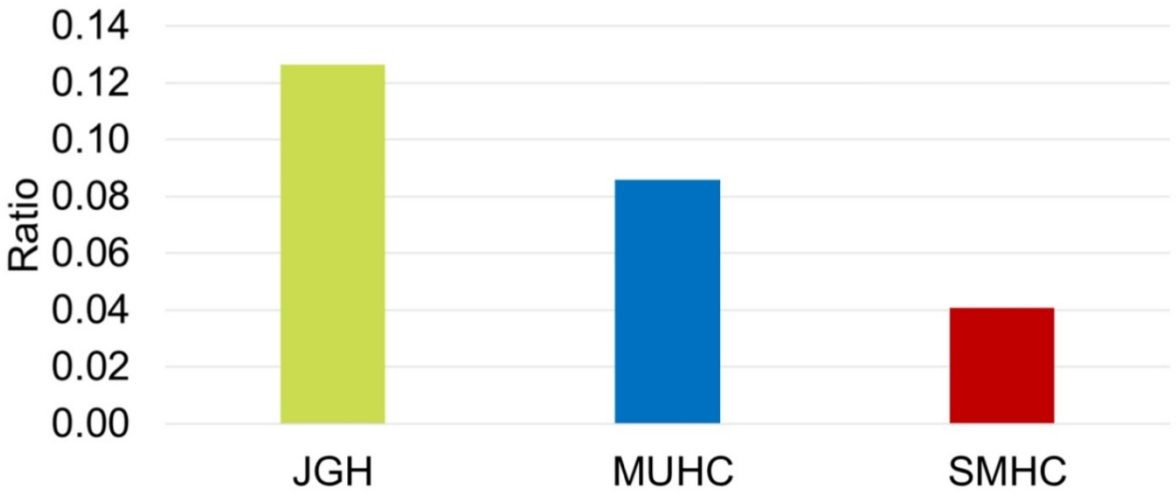
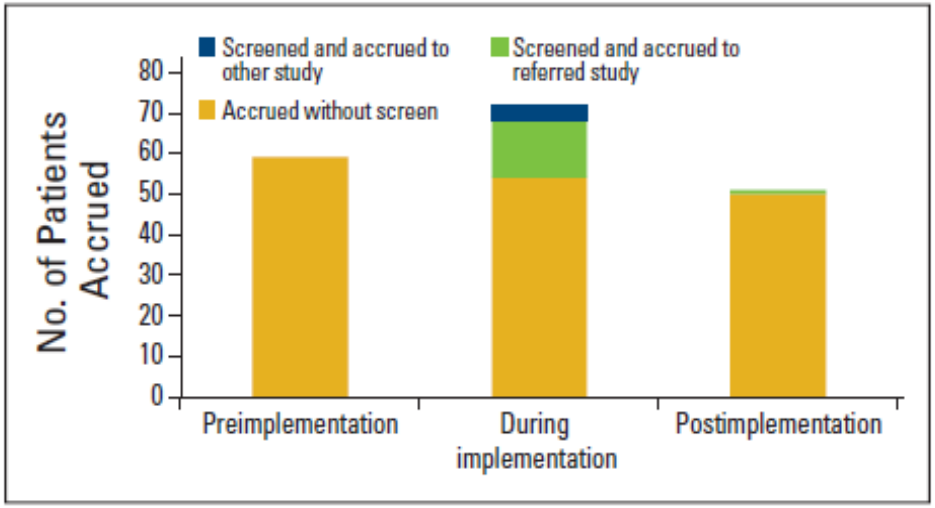
Acting on quality indicators: BR2- accrual ratio of breast cancer patients into interventional clinical trials

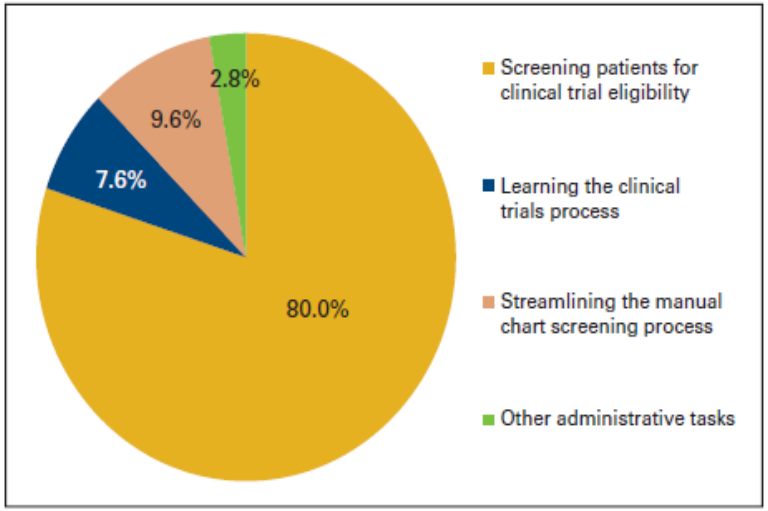
***Fig 2**: Ratio of breast cancer patients enrolled in treatment-based clinical trials to number of incident cases - 2016*



Evidence based-intervention to improve accrual activity

- 4-month intervention (**prescreening coordinator**) at BC cancer agency improved accrual into phase II-IV oncology trials.





- Similarly, at Meharry Medical College, 4-year intervention (**prescreening coordinator**) increased accrual rate by 12% in oncology trials.

- Ohio State University Comprehensive Cancer Center implemented an awareness driven intervention targeted for patients and caregivers for 3 years (**promotional tools**). This resulted in 40% increase in accrual activity.

PROJECT GOAL

To improve prescreening and accrual of breast cancer patients into interventional clinical trials

OBJECTIVES

To implement a method to prescreen new breast cancer patients

To create promotional materials for clinical trial awareness

STRATEGY / INTERVENTIONS

To develop tools (prescreening worksheets or electronic tools linking to Oacis or Endovault)

To hire and train DS breast facilitator

To capture accrual metrics **every 6 months**

To develop pamphlets, clinical trial participant testimonial posters, buttons (Ask you doctor about a clinical trial), and clinical trials video

SUCCESS CRITERIA

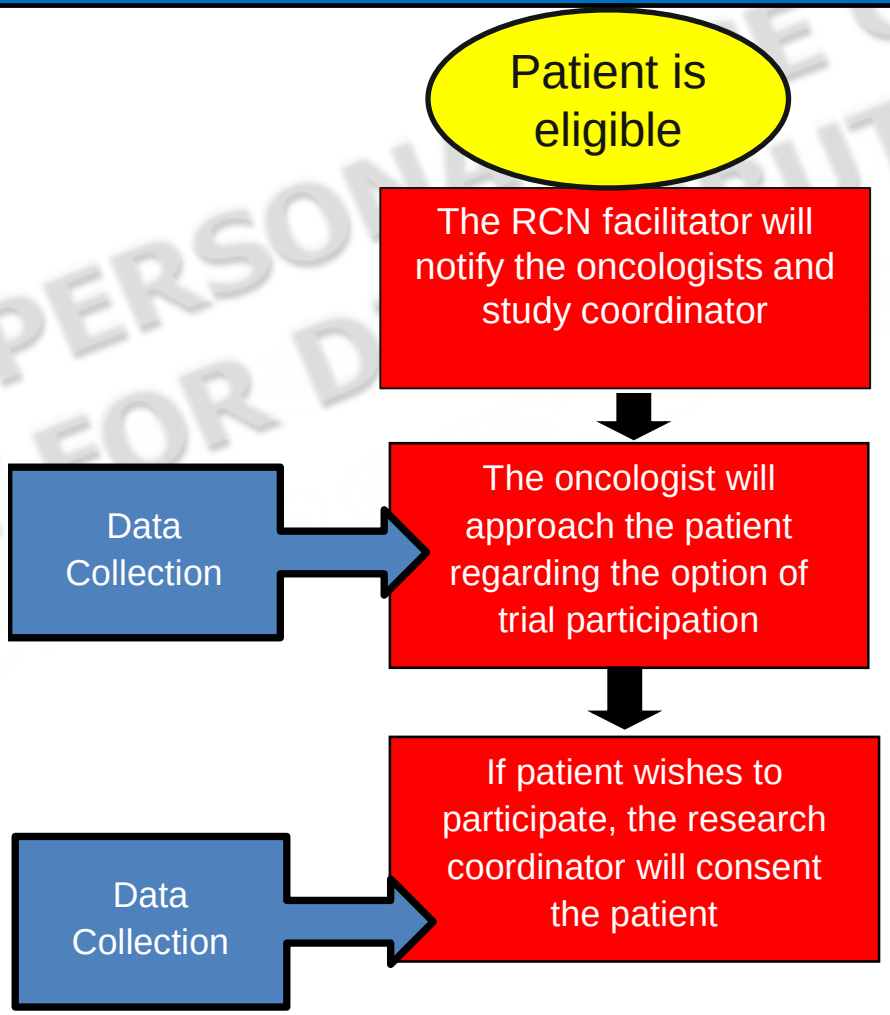
Improved accrual rate by 50%

Accuracy of prescreening by 80%

Increased N° of patients receptive to clinical trials

Objective 1: Prescreening breast cancer patients

The RCN facilitator will prescreen the breast cancer patients for clinical trial eligibility by reviewing the medical records (clinical history, imaging, laboratory results, pathology results).



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Objective 2: Clinical Trial awareness

- **Develop promotional materials:**
  - Clinical trials brochure
  - “Ask me about clinical trials” Buttons
  - Testimonial video in waiting area

- Elucidate in the promotional materials the **reasons to participate in trials**:
  - Medical treatments that work for patients that would otherwise not receive
  - Closely monitored by medical staff
  - Satisfaction in contributing to advance medical study

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Working through the challenges

- **Project approval at the 3 sites**
  - Quality improvement program versus IRB
- **Keeping list of clinical trials updated**
  - Especially umbrella trials with different cohorts
- **Clinical trial engagement**
  - Patient and physician perception of trials

- How best to **flag / inform physicians** of potential patient eligibility?
  - Different systems at the 3 hospitals (Endovault vs paper vs Oacis vs Email?)
  - How to record each step by step?
- **Changing physician practice**
  - Getting physicians on board with the project

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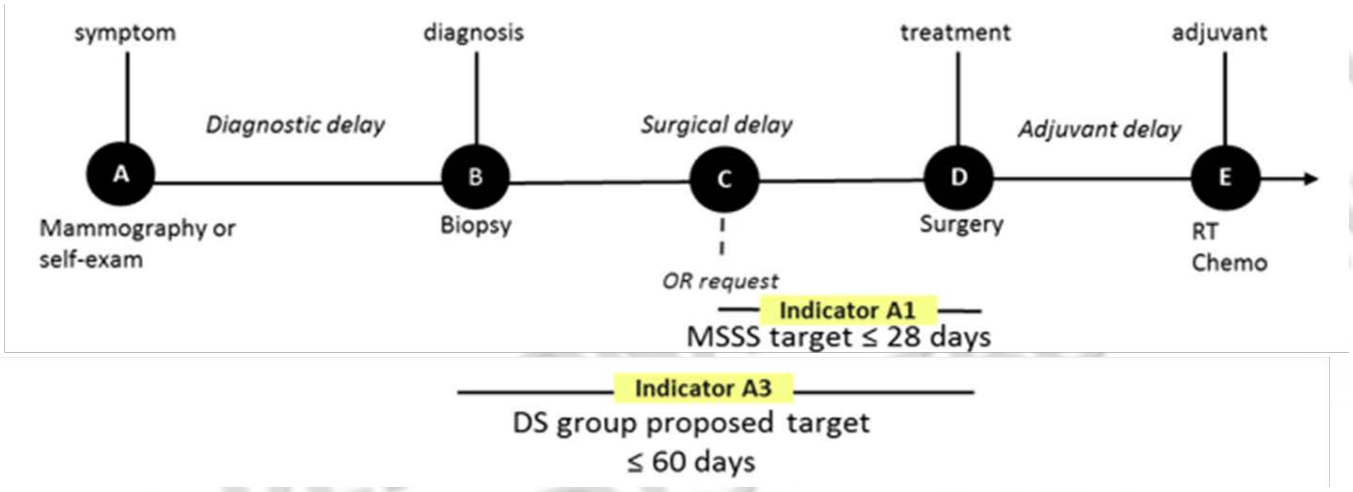
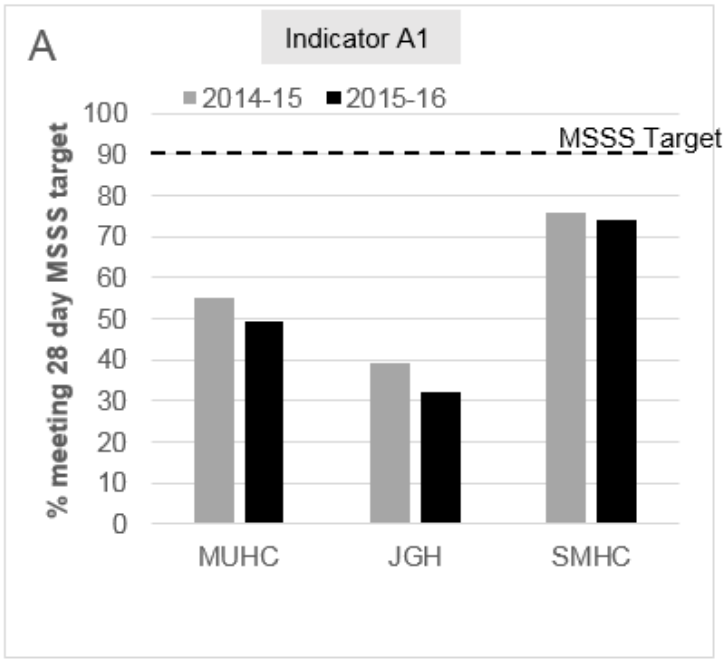
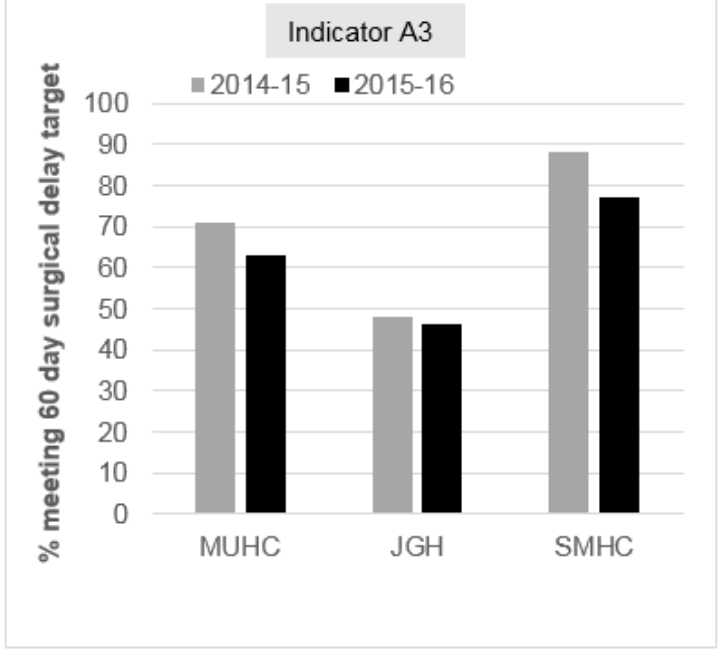
Acting on quality indicators: BR1-Surgical delays from biopsy to surgery







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Challenge: Reducing surgical delays

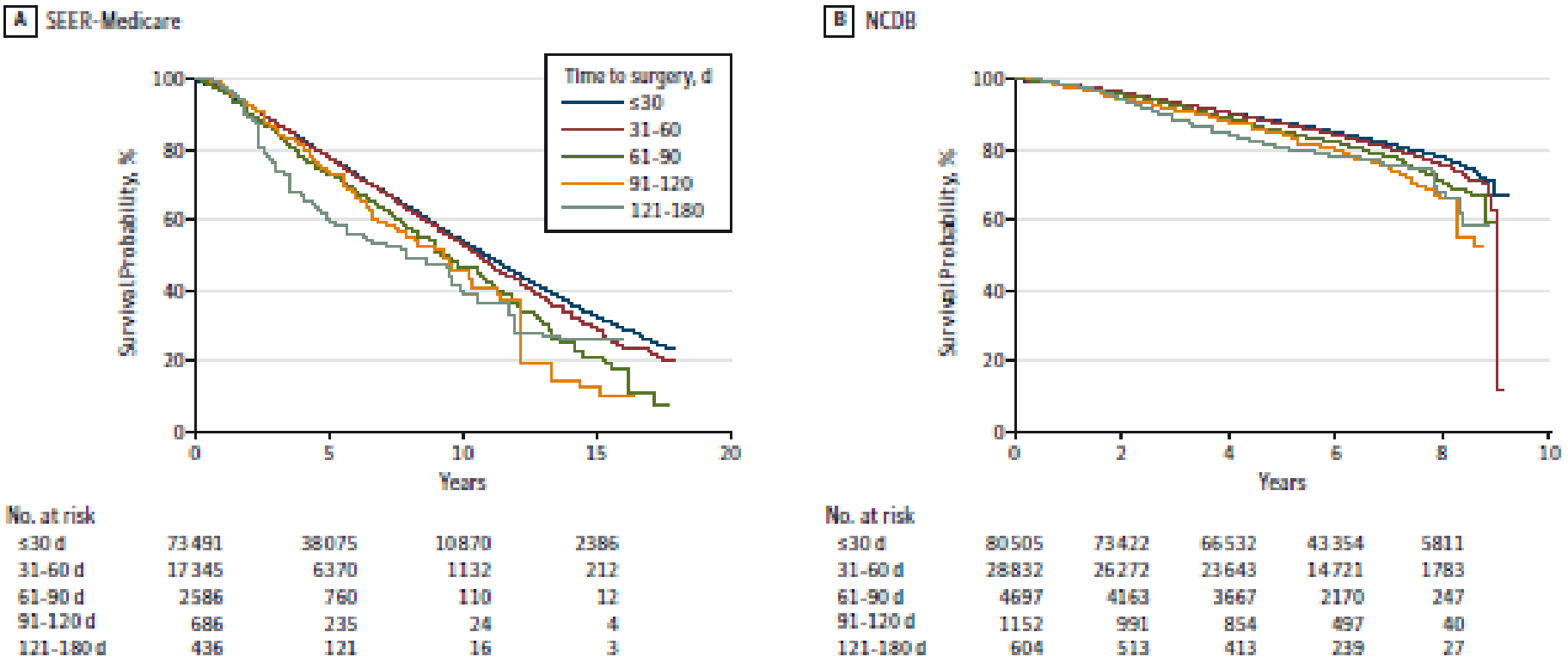
	MUHC	JGH	SMHC	RCN	Manitoba	Ontario
N	552	553	241	1436	*N/A*	*N/A*
Average	52.5	62.3	41.4	54.3		
Median	**50.0**	**63.0**	**37.0**	**53.0**	**39**	**35**
75th percentile	68.0	76.0	50.5	70.0	54	48
90th percentile	85.0	92.6	73.6	86.0	71	65

- MUHC and JGH have longer delays to surgery, with a median time to delay of **7 weeks and 8.6 weeks** respectively.

- Some causes for delays are patient-driven but most likely, these are system or physician driven, such as performing more extensive imaging studies (ex. MRI) or workups, and OR availability.

Challenge: Choosing the target

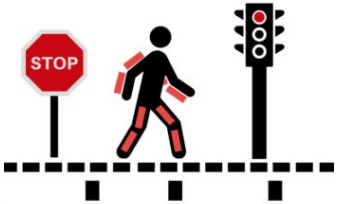
Figure 1. Adjusted Overall Survival



Adjusted overall survival for Surveillance, Epidemiology, and End Results (SEER)-Medicare Database patients (A) and National Cancer Database (NCDB) patients (B) for preoperative delay intervals of ≤30, 31-60, 61-90, 91-120, and 121-180 days. The hazard ratio for each increasing delay in SEER-Medicare interval was 1.09 (95% CI, 1.06-1.13; $P < .001$). The hazard ratio for each increasing delay interval in NCDB was 1.10 (95% CI, 1.07-1.13; $P < .001$).

JAMA Oncology, 2016;2:330-339

Working through the challenges



- Is 60-day a reasonable target for this indicator?
  - Should we have different targets based on priority level?
    - (ex. CCO has 14 days, 28 days, 84 days – DCIS vs invasive breast mass)

- Much of the challenge is in meeting MSSS 28-day delay from OR request to Surgery:
  - Hospital system admin issue
    - Could we envision a wait-list management system?

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Moving forward…

- Improving communication and participation
  - Encouraging colleagues to voice their opinion and be involved in collaborative problem solving

- Identify indicators together that will have the greatest impact on patient care and upon which our group can act!

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Rossy Cancer Network

Thank you!

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McGill University Health Centre

Hôpital général juif

Jewish General Hospital

Centre hospitalier de St. Mary

St. Mary's Hospital Center