INTRODUCTION

• The Disease Site (DS) groups form the clinical focus of the RCN. They are the multidisciplinary teams involved in meeting the needs of a population of patients with cancer.

• The DS groups have been operational now for over one year.

• The aim of the DS group is to harmonize and improve the quality of care for patients and their families, across the McGill-affiliated hospitals.

• Each DS group is co-led and supported by a DS Steering Committee.

• The DS co-leads must work collaboratively to develop a network culture within their DS group and provide the guidance and direction to allow the DS group to achieve its objective, which is to improve the quality of cancer care received by all patients across the RCN partner hospitals.

MANDATE

q Establish a Steering Committee, which should consist of a multidisciplinary team and is inclusive of members from the 3 network hospitals.

q The DSG Steering Committee will:
  o Select and prioritize clinical quality indicators to measure quality of care across different disciplines.
  o Set targets & identify benchmarks for indicators.
  o Review and validate indicator results.

q Select targeted improvement initiatives that will directly impact patient care across the network. It is expected that the improvement initiative will be largely driven by the indicator results.

q Increase awareness of clinical trials and encourage participation. The DS group is expected to discuss priorities for clinical trials, evaluate accrual and support mechanisms for inter-institutional patient referral to best specialized therapy, including, but not limited to, clinical trials.

Additional opportunities:

• Develop, adopt or adapt internal care pathways (i.e. Disease Site Guidelines or Practice policies) for the disease site and/or sub-diseases.

• Expand the Steering Committee membership to include researchers, clinicians, pharmacists and other allied health professionals.

• Develop academic partnerships with McGill basic and translational researchers.

• Develop workshops and programs for continuing medical education credits

• Collaborate on network-wide research projects

DISEASE SITE CO-LEADS

BREAST  GI  GU  GYNE  HEME  H&S  LUNG

Jamil Asselah  Thierry Alcindor  Simon Tanguay  Ziggy Zeng  John Storring  Anthony Zeitouni  Ziggy Zeng  Wilson Miller

RCN DS Facilitators
Aid in indicator data collection, support QI projects and provide admin support

RCN Project Manager
Manager Quality improvement initiatives

QUALITY IMPROVEMENT INITIATIVES

<table>
<thead>
<tr>
<th>DS</th>
<th>QI Initiative</th>
<th>Patient Voice</th>
<th>RCN strategic priority</th>
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<tbody>
<tr>
<td>BREAST</td>
<td>Develop RCN learning guidelines for breast cancer care</td>
<td>Provide the best care for patients with breast cancer</td>
<td>Evidence-based care</td>
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<tr>
<td>GI</td>
<td>Develop guidelines for gastrointestinal cancer care</td>
<td>Provide the best care and decreasing hospital days by improving the quality of care provided</td>
<td>Evidence-based care</td>
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<tr>
<td>GU</td>
<td>Develop guidelines for urological cancer care</td>
<td>Ensuring that my surgeon is fully involved in the decision-making process</td>
<td>Evidence-based care</td>
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<tr>
<td>HEME</td>
<td>Implement a joint CDTC at MUHC</td>
<td>Enhancing the effectiveness of care</td>
<td>Evidence-based care</td>
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OUTCOMES OF MEASURING INDICATORS

(1) Additional analyses: After an indicator has been measured, additional analyses are always needed to understand rate limiting steps or to have a better understanding of the causality of the results. Below are two such examples.

| GI | % Positive surgical margins (PSM) for radical prostatectomy |
|---|---|---|
| p<0.05 | Data to be publically released March 2017 |

Additional analyses:

• Are there significant variations by surgeon?
• What are the biochemical recurrence rate overall and by surgeon?
• Do the biochemical recurrence correlate with PSM?
• Do PSM differ because some surgeons use more nerve sparing techniques?

HEME | Turnaround time for molecular testing of FLT3, NPM1, CEBPb |
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<td>Data to be publically released March 2017</td>
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Additional analyses:

• What is the range for the turnaround time?
• Does TAT differ depending on clinician ordering test?
• What is the turnaround time by pathologist reporting the test?
• What % of patients are tested more than once?
• What % of patients require repeat testing?
• Why are there some really extreme outliers (>30 days)?

(2) Improvement without formalized QI projects

• We have noted the beginning of a culture change with several DS groups
• There is an intrinsic professional motivation/williness by clinicians and other colleagues to improve
• Behavior is being altered simply due to the effect of measuring (Observer effect)

(3) Increased interest and involvement of residents

• 3 residents now actively involved in projects – main role has been in chart reviews and evaluation of current clinical practice. Soon to be involved in the implementation of improvement projects.
• Training future clinical leaders in quality

(4) Improved Communication

This past year, communication has improved within the Steering Committees.

→ Data analysis & review
→ Discussion of clinical practice
→ Research / QI collaborative grant ideas

We now aim to improve communication within the expanded teams to include other clinicians, allied health care professionals & administrators.

→ 1st newsletter sent out to >400 recipients in August 2016. 5% responded to the survey rating the newsletter as very useful
→ 18 individual emails with positive feedback

For questions, contact alia.ali@mcgill.ca