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Cancer
Network

RCN update

FALL | 2015



In this issue



Speeding up chemotherapy appointments

Thanks to new equipment and workflow changes, patients are in and out of their cancer centre faster ...p2



The RCN's first annual retreat: a great success!

The director of the Princess Margaret Cancer Centre delivered the keynote address to 100 health professionals ...p8



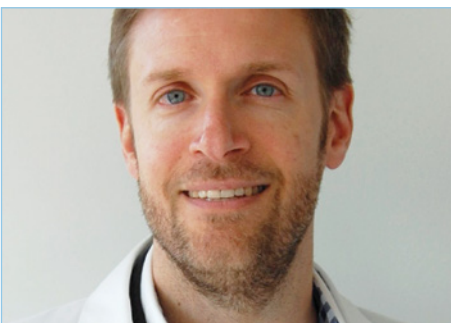
Research on the front lines of cancer care

Innovative RCN grants are looking at ways to streamline the delivery of care and improve outcomes ...p6



Collaboration: Sharing best practices internationally

Cancer experts from Poitiers, France came to learn how the RCN is improving care ...p9



Training staff to reduce costs without impacting care

A masters in Health Economics will help a radiation oncologist optimize resources in the network ...p3



Addressing the emotional toll of the cancer journey

The RCN is part of a groundbreaking Canadian initiative to improve screening for distress ...p4

People are talking about the RCN!

The RCN graced the cover of the summer issue of *Oncology Exchange*, a national peer-reviewed magazine that discusses emerging trends in cancer treatment and supportive care.

The journal focussed on how the RCN's Cancer Quality & Innovation (CQI) program is enabling the McGill-affiliated hospitals to improve cancer care. CQI's multi-pronged approach impacts skill building with the Investing in the Future – Education Grants, and puts research on the front lines of care with the annual CQI Research Grants. To find out more about CQI projects underway in your hospital, turn to page 3 and 6. ♦

Check out all the media coverage at mcgill.ca/rcr-rcn

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Streamlining chemotherapy wait times

FROM NEW EQUIPMENT, TO NEW SOFTWARE AND WORKFLOW CHANGES, AN RCN PROJECT IS TAKING THE WAIT OUT OF CHEMOTHERAPY

For cancer patients, the repeat visits required for blood tests, treatments and appointments with their oncologist mean that time spent in hospital waiting rooms can really add up. In fact, when the RCN commissioned a patient satisfaction survey in order to target improvements, one of the areas that patients felt needed to be worked on the most was the wait time involved for out-patient chemotherapy.

As part of its commitment to improve the experience for patients in the network, an RCN team took on the challenge of finding ways to improve patient flow and reduce backlogs. By using focus groups with patients and clinicians to discuss the current care pathways, along with time mapping and benchmarking at the McGill University Health Centre (MUHC), the Jewish General Hospital (JGH), and St. Mary's Hospital Center, the team was able to identify changes that could save patients time.

The JGH harmonized its practices with the other centres by moving from single-day chemotherapy — where blood work and treatment take place on a single and often long day — to alternate day scheduling for chemotherapy. Patients now have their blood drawn and see the doctor on the first day they visit, and when they return on the second day, their chemotherapy prescription is already prepared and waiting for them.

Workflow changes across the hospitals, such as booking less complex cases earlier in the day, separating check-in and check-out tasks and streamlining the review of patient files before they reach the pharmacy were also found to have an important impact on shortening the waiting period.

At St. Mary's, a number of additional changes were put in place to streamline the workflow around blood tests (phlebotomy), which was a part of the chemotherapy process that could get backlogged on very busy days. A new phlebotomy chair was added to the centre to increase the capacity of patients



Thanks to the addition of new phlebotomy chair, blood tests now move more quickly at St. Mary's Cancer Care Day Clinic.

that could be seen by nursing staff in a short period of time. Patients were already being given vibrating pagers which allow them to walk around if they choose and to know when it's their turn to have their blood drawn. Now, an indicator light in the reception area lets the secretaries at reception know immediately when a phlebotomy station is free, so they can call patients more quickly.

Just as importantly, a new software connection between the automated kiosk at registration and the computer in the chemotherapy area allows staff there to know when patients have arrived for their treatment and call them in at the time of their appointment.

"We really see the difference this project has made. We don't have the same kind of bottlenecks in the waiting area that we used to. Patients no longer have to wait as long to register," explained Manon Allard, the oncology program manager at St. Mary's. "It makes the process much easier on our patients and frees up the staff to see other patients more quickly." ♦

Reducing costs without impacting care

AN RCN EDUCATION GRANT IS GIVING AN MD THE TRAINING TO STREAMLINE CARE WHERE IT COUNTS

Health care budget cuts are now the norm and care providers are expected to do more with less, all without impacting patient care. While this might seem like *Mission: Impossible*, Dr. Tarek Hijal, Radiation Oncologist at the McGill University Health Centre (MUHC) is convinced a "surgical approach" to health care cuts, which eliminates unnecessary investigations or treatments, can translate into significant savings without compromising quality.

Thanks to an Investing in the Future grant from the RCN, Dr. Hijal is wrapping up a two-year London School of Economics executive master's degree in Health Economics, Policy and Management. The degree covers topics such as health care financing strategies, quality outcomes in health and cost effectiveness analyses of health care projects. The RCN's Education Fund sponsors two renewable Investing in the Future grants, aimed at giving existing teams targeted skills to improve cancer care quality.

"Over the last two years, I've learned the basics of economic policy and management. The program allowed me to see that socialized medicine, which is often painted in a negative light, works really well when implemented correctly and with the right resources," explains Dr. Hijal. His classmates in London came from over 20 countries, from the US, Latin America, Scandinavia, Africa and the Middle East, and provided valuable insight into the ways different institutions have implemented quality improvement initiatives.

Dr. Hijal is currently finishing his thesis, which examines the cost of unnecessary radiologic testing in breast cancer staging. "The medical commu-

nity is trying to direct resources to tests that impact care and eliminate those tests that don't," says Dr. Hijal. "I am looking at how many unnecessary tests Quebec patients with breast cancer undergo each year and calculating the cost to the system."

A recent Ontario study found that 80 percent of patients in that province are undergoing tests they don't need. Dr. Hijal expects the situation is similar in Quebec. He speculates that some doctors are requesting them out of habit, or due to a lack of knowledge of clinical practice guidelines or because some patients insist on them.

"I am looking at how many unnecessary tests Quebec patients with breast cancer undergo each year and calculating the cost to the system"



Dr. Hijal (left) during a friendly soccer game with classmates in London.

Several North American agencies have developed clinical practice guidelines for breast cancer care, based on the findings of evidence-based medicine. The guidelines outline which radiologic tests are required. "For example,



Dr. Tarek Hijal

patients with stage 3 breast cancer, a more advanced form of the disease, require bone scans and abdominal ultrasounds to determine if the disease has spread. However, patients with stage 1 or 2 breast cancer don't need these tests, yet doctors frequently order them. This not only subjects patients to undue stress and unnecessary exposure to radiation, it also costs the system money," he explains.

Dr. Hijal sees other ways of putting the knowledge he garnered at the London School of Economics to good use. He has been an active participant as a team member in several RCN initiatives to improve the patient experience (see *RCN Spring Update*, page 2 and 4, available online at mcgill.ca/rcr-rcn).

"A lot can be done to improve the quality of care we provide. For example, by incentivizing key stakeholders or redesigning a clinic, we might be able to lower wait times for patients, reduce errors and improve satisfaction. Sometimes it's just a matter of analyzing the situation and making very small high-impact changes." ♦

Calling all oncology nurses!

This year's Investing in the Future Grants are designed specifically to enhance your skills and support your ability to give our patients the best care.

Launching soon: check back at mcgill.ca/rcr-rcn

Dealing with distress

WORKING WITH PARTNERS ACROSS CANADA, THE RCN IS DEVELOPING NEW WAYS TO SUPPORT PATIENTS' PSYCHOLOGICAL WELL-BEING

How would Julie Szasz characterize the distress screening process when she first started cancer treatments five years ago? "Pretty random," says this patient advocate. "I had stage 2B breast cancer, so the treatments I was going through were protocol. They said 'She's young; she'll be fine.' So I thought, 'I'll be fine.' I overlooked a lot of things that would have helped me because I didn't believe — and nobody insisted — that this would be necessary for me, that I should get any psychosocial help."

Although it's well-known that distress seriously impacts cancer patients' outcomes, including adherence to treatment and quality of life, psychosocial care has lagged behind other treatment advances. Changing that is the aim of a new three-year joint project between the RCN and Cancer Care Ontario (CCO) called Improving Patient Experience and Health Outcomes Collaborative, or iPEHOC (pronounced EYE-pea-hoc). Szasz, who was rediagnosed with metastatic breast cancer two years ago, is one of four patient advisors for the project which will look at four specific symptoms — depression, anxiety, pain and fatigue — from diagnosis to treatment to survivorship or end-of-life care.

"In all the surveys across Canada, emotional distress is the one area where patients consistently and significantly reported being the least satisfied," explains Dr. Zeev Rosberger, iPEHOC's principal investigator and the Director of the Louise Granofsky-Psychosocial Oncology Program at the Jewish General Hospital (JGH). "The idea is that once we understand the patient's experience through the screening and outcome measures, we will be able to target the symptom and get the patient to the right intervention in a timely manner. And we know that is not happening as well as it should at this point."

The right support at the right time

All cancer patients experience distress of some kind — from sadness to pain to trouble sleeping. "The literature reports that 35 to 45% of cancer patients experience sufficient emotional distress to warrant professional intervention," explains Dr. Marc Hamel, project co-lead and Clinical Director of Psychosocial Oncology at the Montreal University Health Centre (MUHC) where field implementation testing will be done at the lung clinic. A lot of the distress can be managed by front-line staff, but about 15% of patients need referral to a mental health care professional.

"In all the surveys across Canada, emotional distress is the one area where patients consistently and significantly reported being the least satisfied"



Patients taking part in the pilot will complete an electronic questionnaire which will screen for distress at multiple points in their treatment journey.

Adds Dr. Rosberger, "If you start doing the math, that's a lot of people." In fact, the Canadian Partnership Against Cancer (CPAC) calls distress the "sixth vital sign."

This is where iPEHOC comes in. "The screening is going to help us identify this 35 to 45% that can be assessed and responded to by the people already taking care of them, but also to identify the other 15% that needs more specialized care," explains Rosana Faria, project co-lead and Clinical Psychologist at St. Mary's Hospital Center, where a pilot involving all patients supported by the pivot nurse is being implemented. A pilot will also take place at the JGH with gynecological oncology patients.

CCO has been doing routine distress screening for 15 years. The Montreal teams have done screening on a smaller scale, and are keen to learn from their Ontario colleagues' experience and build on it. iPEHOC is the first program of its kind in Quebec. "We want to standardize screening across Montreal, across the province, across the country so that every patient — whether they are seen in Montreal or elsewhere — can expect the same kind of assessment and screening," says Dr. Hamel.

Northern needs

This includes specialized distress screening with adapted questionnaires for First Nations, Inuit and Métis cancer patients. "We know the tools that we have are not always appropriate for this population with their specific needs," explains Dr. Hamel. "It's a language issue, it's a culture issue. If I ask them 'Are you anxious?,' that might not have the same meaning to them, so anxiety might not be the right word."

In Quebec, iPEHOC is being rolled out at the JGH, the MUHC and St. Mary's as well as within Inuit, First Nations and Métis communities treated within the McGill RUIS (Réseau universitaire intégré de santé) with the long-term goal of contributing to the national implementation of standardized distress screening for cancer patients. The project is funded by a \$1 million grant from CPAC, with the RCN providing \$400,000 for staffing resources and the implementation of an electronic platform.

Screen Time

Patients will be offered distress screening at set intervals in their treatment journey using a tablet computer.

The Distress Assessment and Response Tool (DART) software — developed through a joint effort between Princess Margaret Cancer Centre in Toronto, CCO and CPAC — will evaluate their responses and generate a summary which assesses needs and interventions on an ongoing basis. DART, already integrated across all Princess Margaret clinics, builds on the ESAS (Edmonton Symptom Assessment System) used by clinicians in cancer care, and adds a pain inventory, a fatigue scale and anxiety and depression measures. The summary will in turn be provided to both the health team and the patient.

"What was really interesting to me is that this was about the patient experience and it really fit with the RCN mission and vision," says Dr. Rosberger. Importantly, patients are very involved with designing the program, including making sure the questions and education materials are clear, as are members of the health care team, including nurses, oncologists, psychologists.

"One of the primary goals is to make it easy for patients to participate," explains Linda Tracey, a recovering breast and uterine cancer patient and iPEHOC patient advisor. "Cancer patients are already overwhelmed and a lot of them are elderly, and filling out these questionnaires just becomes something else they

have to do. We have to help patients understand that it's in their best interest to be actively engaged in this way."

Patients on board

To make this happen, patient education materials, including a video and booklet, are being put together to explain how the screening works and what its benefits are. Patients will be



The project is led by Dr. Zeev Rosberger (left) at the JGH with his co-leads Rosana Faria at St. Mary's and Dr. Marc Hamel at the MUHC.

given copies of their assessments and the entire health care team, including professionals in other hospitals, will be able to access them electronically.

For Faria, it's a win-win. "We are empowering patients, physicians and nurses with more knowledge. The patient is aware of what's happening, aware of the resources and is sharing in the decision-making."

And this is why it's so important to get buy-in from the patients, says Szasz. "From the get-go, patients have to feel that if something doesn't feel right, then someone is addressing that. This is not just for research, it's not just about statistics; it's about helping patients right now." ♦



Julie Szasz (left) and Linda Tracey are advisors ensuring the project takes into account the patient's perspective.

Research on the front lines of cancer care

A SERIES OF RCN GRANTS IS LOOKING AT WAYS TO IMPROVE THE DELIVERY OF CARE ACROSS THE NETWORK

Last fall, the RCN awarded six Cancer Quality and Innovation Research Grants, totalling \$550,000. By creating partnerships across RCN hospitals to investigate pressing issues, the project teams aim to impact cancer care by using a network approach to problem solving. Three projects were profiled in the Spring 2015 issue of *RCN Update* (available online at mcgill.ca/rcr-rcn); the last three projects, profiled here, target barriers to optimal care and support for patients.

Faster treatment for oesophago-gastric cancer patients

Surgeon Lorenzo Ferri has a hunch that ramping up co-ordination is the best way to improve care for patients with oesophago-gastric cancer — and he's hopeful this will ultimately improve survival, too.

"Unfortunately stomach and oesophageal cancers are among the most aggressive we treat," explains Dr. Ferri. "They're also some of the more symptomatic. The difficulty eating associated with these cancers can interfere with our ability to effectively treat these patients. One of our primary goals is to shorten the time between diagnosis and the initiation of treatment."

To achieve this, Dr. Ferri, the principal investigator of the STOP-Cancer Initiative (STOP stands for Streamlining the Trajectory for Oesophago-gastric Patients), wants to first put in place a navigator, "someone with a vested interest in helping patients navigate the healthcare system;" and second, "to have physicians and allied health professionals speak to each other and work on the same level."

The changes in patient flow will make a huge difference to all patients, but especially those from out of town. "They're here for a day or two and we coordinate their gastroscopies, endoscopic ultrasound, CT scan and all the visits of the surgeons, oncologists and radiation oncologists within a 24-hour period," says Dr. Ferri. "That way, by the end of 24 hours, they know exactly what their treatment plan is going to be." Treatment will then be carried out at a hospital closer to home, if possible.

The STOP-Cancer team, based at the McGill University Health Centre (MUHC), is measuring quality of life, anxiety and how long it takes patients to work their way through the system with the goal of improving in all three areas. "We see an average of 250 people a year with stomach and oesophageal cancer; it's the largest program in Canada," says Dr. Ferri. "We've been active for six months and over 120 people have been involved in the study."



Dr. Lorenzo Ferri: speeding up treatment for oesophago-gastric cancer patients.

MUHC-JGH-SMHC Team:

Dr. Lorenzo Ferri will lead a team which includes Dr. Thierry Alcindor, Dr. Gad Friedman, Dr. Gaetano Morelli, and Dr. Kevin Waschke.

Mapping the "new normal" for survivors

"Survivorship is very challenging," explains Rosana Faria, a psychologist at St. Mary's Hospital Center. "Patients feel they are left to themselves without a lot of resources to learn skills to deal with their 'new normal.'" Cancer patients need roughly the same amount of time to recover from treatments as they spent being treated, yet they are offered little guidance in the post-treatment phase. Faria and her team are looking at ways to improve this in an innovative participatory research project, entitled Looking Forward.

The Looking Forward research team is made up of five patients who are in the survivorship phase of their cancer experience and seven health professionals from St. Mary's (SMHC) and the MUHC. "Patients will have the same potential power in terms of their opinions, evaluations and propositions," explains Faria. Together they will design and produce an experience-based intervention program for patients completing treatment. The program will then be piloted at oncology clinics at St. Mary's and the MUHC.

The method chosen for data collection is participatory as well. The focus groups and co-design session with patients and health care professionals have helped form an idea of what information patients need and prefer. Important priorities include physical recovery, emotional changes, and returning to work. Delivery methods such as face-to-face meetings with a health professional, websites, and videos have been discussed.

Connecting survivors with community services is another big part of the project. "We will come out with a list of available resources which have been evaluated by our patient collaborators," says Faria. In addition, seasoned survivors will share their experiences in post-treatment areas such as exercise — a difficult lifestyle change — to help more recent survivors find ways to stick with it.

SMHC-MUHC Team: Ms. Rosana Faria will lead a team which includes Dr. Tarek Hijal, Dr. Susan Law, Ms. Manon Allard, Dr. Joan Zidulka, Dr. Sergio Faria, Ms. Lisa Kathryn Goldenberg, Dr. Marc David, Dr. George Michaels, Dr. Laurie Hendren, Danielle Potas, Monique Ferland, and Givette Volet.

Prostate cancer guidelines and the disease management puzzle

Could the increasingly complex management of castration-resistant prostate cancer (CRPC) be making it tough for oncologists to follow national clinical guidelines? That's what McGill health economics & health outcomes researcher Dr. Alice Dragomir is attempting to investigate. Her two-year study aims to figure out to what extent this is the case and what effect it has on outcomes.

"The problem with this late phase of prostate cancer is that, because of the high number of medicines that are now used in its management, it is very complex and in continuous evolution," explains Dr. Dragomir. "In 2013, new Canadian clinical guidelines were issued for CRPC, so we wanted to assess the quality of care received by our patients by measuring adherence to these guidelines."

The team is looking at the charts of around 500 CRPC patients from the MUHC and the Jewish General Hospital (JGH). So far, the preliminary analysis of the MUHC data

"Stomach and oesophageal cancers are among the most aggressive we treat. Our goal is to shorten the time between diagnosis and treatment"

Dr. Alice Dragomir: untangling the puzzle of prostate cancer management.



Ms. Rosana Faria: supporting cancer survivors in finding a "new normal"

indicates that, indeed, patients did not always receive treatment in the sequence recommended by the national guidelines. Further work will be done to explain the observed differences.

"For example, the clinical guidelines state that symptomatic patients should receive abiraterone [CRPC drug] only post-docetaxel [chemotherapy], however there are some patients that received it prior to docetaxel."

Adding even more complexity are physicians' own preferences for certain medications and patients' private health insurance plans that allow for different sequences of treatments, in addition to newer

drugs that haven't yet made it onto the provincial formulary. Dr. Dragomir and her team are also looking at these factors to see if they lead to inequities in access.

MUHC-JGH Team: Dr. Alice Dragomir will lead a team which includes Dr. Franck Bladou, Dr. Fabio Cury, Ms. Olga Guerra, Dr. Wassim Kassouf, and Dr. Marie Vanhuyse. ♦

Cancer Quality and Innovation Research Grants

We're announcing this year's recipients!

Turn to page 10 to see the 6 selected projects.

We were there

The RCN's First Annual Retreat

The RCN held its first annual retreat at the Mont-Royal Centre on June 6 and the day was a great success!

The RCN was extremely privileged to have Dr. Mary Gospodarowicz, medical director of the Princess Margaret Cancer Centre in Toronto — one of the top 5 cancer centres in North America — and past president of the Union for International Cancer Control, deliver an inspiring keynote address. Dr. Gospodarowicz spoke about what makes great can-



Dr. Geneviève Chaput of the MUHC's Cancer Survivorship Program and Project Workstream Lead for the RCN's survivorship initiative answers questions after her presentation.



Dr. Samuel Benaroya, chair of the RCN Executive Committee catches up with Manon Allard, the Cancer Care program manager for St. Mary's Hospital Centre, and a member of the RCN Program Steering Committee.

cer centres, highlighting the importance of collaboration, initiative and accountability.

Close to 100 clinicians, researchers and allied health professionals involved in cancer care at the JGH, the MUHC and St. Mary's came together to learn about the work being done across the RCN and to give their feedback on key initiatives.

Dr. Wilson H. Miller Jr., clinical lead of the RCN and deputy director the Segal Cancer Centre, led the day's activities. RCN project leads outlined the gains made by the RCN workstreams over the past two years along with upcoming goals.

Attendees had terrific feedback and questions during the Q+A and breakout discussions, and there was a great deal of interest in participating in new initiatives.

To download the Retreat presentations and program, or to see more photos, visit mcgill.ca/rcr-rcn/retreat-2015.

CAPO annual conference

The Canadian Association of Psychosocial Oncologists celebrated its 30th anniversary at its annual conference in Montreal in April and the RCN was on hand as one of 25 exhibitors.

Many RCN collaborators were front and centre for the presentations. Among the keynote speakers was Dr. Eduardo Franco, chair of McGill's Department of Oncology and member of the RCN Executive Committee. He gave an impassioned talk about the pitfalls of over-relying on randomized control trials.

Renata Benc, clinical nurse specialist in oncology at the JGH and a member of the RCN project team that created booklets and a video to demystify the radiotherapy journey spoke about the impact these tools have had on the Patient Edu-

cation Sessions the JGH clinic holds weekly.

Dr. Zeev Rosberger project lead for iPEHOC, the RCN's distress screening initiative, and director of Psychology for the JGH, presented this new initiative being undertaken along with partners at Cancer Care Ontario (see page 4 for more details).

His two co-leads on the iPEHOC project also presented papers: Rosana Faria, a psychologist at St. Mary's presented psychosocial oncology referral guidelines and Marc Hamel, director of Psychosocial Oncology for the MUHC, discussed empirical data about interventions to lessen distress in cancer patients. ♦



Dr. Eduardo Franco, chair of McGill's Department of Oncology and member of the RCN Executive Committee giving his keynote speech at the CAPO annual meeting.



Two members of the RCN Executive Committee, Dr. Armen Aprikian (far left), and Dr. Eduardo Franco (far right) join keynote speaker Dr. Mary Gospodarowicz (left) and Dr. Morag Park, Director of the Goodman Cancer Research Centre.



The RCN shares best practices with French cancer experts

As cancer centres become more focused on improving the patient experience in the health care system, sharing best practices among leading centres is essential to find new ways to support patients and streamline the delivery of care in the complex and often emotional cancer journey.

In early September, the RCN welcomed a delegation from the Pôle de cancérologie du Centre Hospitalier Universitaire (CHU) de Poitiers in France as part of an initiative to share best practices internationally.

"This is a tremendous opportunity to share knowledge with other teaching hospitals that aim to deliver exceptional care to their cancer patients," said Dr. Eduardo Franco, Chair of McGill's Department of Oncology and a member of the RCN's Executive Committee. "The RCN already receives input from world-leading cancer centres through its International Advisory Committee. This exchange is an opportunity to share our expertise and develop new partnerships."

The team from Poitiers came to learn how the McGill University-affiliated hospitals are organizing care pathways,

structuring treatments and developing new ways to accompany patients. The CHU delegation was welcomed at each hospital by one of the members of the RCN's Executive Committee: Dr. Armen Aprikian, chief of oncology at the MUHC; Dr. Gerald Batist, director of the Segal Cancer Centre at the JGH; and Dr. Adrian Langleben, chief of oncology at St. Mary's.

After a tour of each facility, the group attended presentations by key stakeholders, including nursing staff, pathologists, social workers and palliative care and learned about initiatives put in place by the RCN to smooth the treatment journey and improve the quality of care. RCN Executive Committee member Dr. Ari Meguerditchian provided an overview of how funding through the RCN's Cancer Quality & Innovation Program, which he heads, is impacting care in the hospitals.

The director general of the CHU de Poitiers, Jean Pierre Dewitte and Professor Jean Marc Tourani, chief of the CHU's regional cancer centre were joined by key members of their team, including an oncology nurse, a medical oncologist, a chief administrator and IT project director.

"We were very impressed with the system of pivot nurses used to follow oncology patients. In our centre, there isn't that connecting thread throughout the patient's cancer journey," explained Prof. Tourani. "That is something that we feel

Above: A team of cancer experts from Poitiers, France toured the radiation oncology facility at the MUHC.



Dr. Gerald Batist, director of the Segal Cancer Center gave an overview of RCN workstreams.

is very important for the patient, and it would also free up clinicians and physicians to focus on other areas of care. We are definitely returning home with grounds for reflection."

The CHU de Poitiers is the first CHU in France to bring together all of cancer care — from diagnosis, to treatment and complementary wellness therapies — in a single location, with the inauguration five years ago of a state-of-the-art building. The institution treats over 5,500 cases a year.

Dr. Wilson H. Miller, Jr., the RCN's Clinical Lead, was also on hand to discuss the work being done by the RCN to track performance across the hospitals. "Putting in place a system to benchmark results is key to implementing quality improvement initiatives that really make a difference. This also allows us to benchmark ourselves against the best in the world," explained Dr. Miller. "We hope to inspire other centres to follow our lead." ♦

Dr. Adrian Langleben (left) and two members of his team at St. Mary's shared how the RCN supports patients through their cancer journey.





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Cancer Quality and Innovation Research Grants

Announcing the 2015 recipients!!

The RCN is excited to unveil the 6 new research projects which will be funded this year as part of its Cancer Quality and Innovation program.

The grants support health care teams in continually improving cancer care delivery, while developing research and training platforms for the rapid generation of scientific knowledge related to cancer care quality.

Funding is open to all health professionals who provide care to cancer patients in the network's partner hospitals — anyone from physicians and nurses to rehabilitation experts, nutritionists and psychosocial experts.

Projects must include a collaborative component with equal representation from at least two hospitals in the network.

This 6 projects selected this year are:

Dr. Sarit Assoulane — Adherence to guidelines in the management of chronic myeloid leukemia in Quebec.

Dr. Franco Carli — Using multimodal prehabilitation to improve outcomes for frail patients undergoing resection of colorectal cancer.

Dr. Jeffrey Chankowsky — Marching Ahead: Imaging Biomarkers, a new revolution in patient management and care for Human Papilloma Virus Positive Oropharyngeal Cancer.

Dr. Reza Forghani — Spectral dual energy CT and textural radiogenomic analysis for optimal tumor delineation, patient staging, and biomarker for head and neck squamous cell carcinoma.

Dr. Jordi Perez — Ultra-low-dose methadone as coadjuvant opioid therapy for cancer pain.

Dr. Jana Taylor — Texture Imaging: A novel technique to guide treatment and improve quality of life in patients with Non-Small Cell lung Carcinoma

For more about the projects, look for the next issue of *RCN Update* in January, or visit: mcgill.ca/rcr-rcn/rcn-grants.

RCN update

Editor: **Sophie Lorenzo**
Contributors: **Lisa Dutton**
Gillian Woodford
Translator: **Geneviève Gravelle**
Design: **RVH Medical Multimedia Services**

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About the RCN

The Rossy Cancer Network is a partnership of McGill University's Faculty of Medicine, the McGill University Health Centre (MUHC), the Jewish General Hospital (JGH) and St. Mary's Hospital Center (SMHC), dedicated to providing world-class patient care, research and teaching. Its mission is to improve quality, effectiveness and efficiency across the continuum of cancer care for

patients in the McGill-affiliated hospitals. Launched in 2012, thanks to a transformative gift from the Rossy Family Foundation, the RCN is proudly supported through the fundraising efforts of McGill along with the Cedars Cancer Foundation of the MUHC, the Jewish General Hospital Foundation and St. Mary's Hospital Foundation.