Réseau de cancérologie Rossy

Rossy Cancer Network

The RCN Scorecard and Disease Site Program

Wilson Miller

McGill

Centre universitaire de santé McGill

McGill University Health Centre

Hôpital général juif

Jewish General Hospital

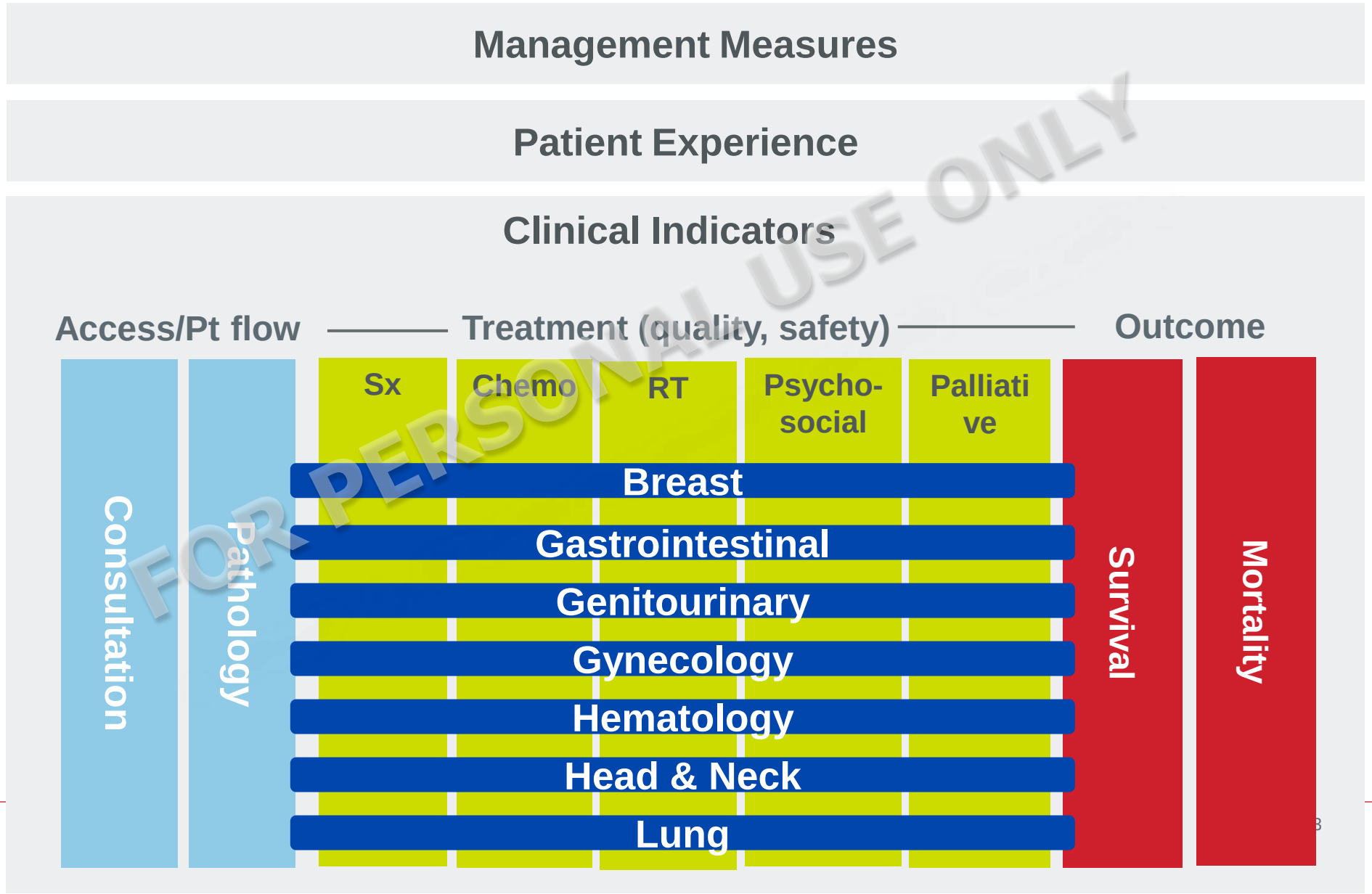
Centre hospitalier de St. Mary

St. Mary's Hospital Center

Scorecard objectives

- Track key performance metrics at all levels of cancer care
- Create a common dashboard to guide improvement programs
- Support transparency
- Focus on benchmarking against the best
- Implement a culture of continuous quality improvement

Sample Dashboard



Performance indicators

Performance indicators (common to all disease sites)	
1	Time between diagnosis and initial treatment
2	Percent of patients presented to a multi-disciplinary tumor board (MTB) at any time following diagnosis
3	Percent of patients with access to multi-disciplinary care (IPO)
4	Percent of patients treated on a clinical trial at any time following diagnosis

Access to multi-disciplinary care (IPO)

	JGH	MUHC	SMHC
Access to multi-disciplinary care, as measured by % patients having an appointment with an oncology pivot nurse	**37%**	**21%**	**30%**

- Numerator : Σ new (to IPO) cases (diagnosed anytime) who had an appointments with an oncology pivot nurse
- Denominator: Σ cases newly diagnosed with cancer (cases 0-22 ,diagnosed in FY 2013)

Next steps - Scorecard

- Define and collect indicators from all 7 disease site, building upon those already defined for breast, CRC, prostate, and lung.
- Automate data collection where possible
- Publication of scorecard – sharing with DGs and other hospital staff

Disease Site Program

The multi-disciplinary & multi-institutional disease site program forms the clinical focus of the RCN.

Disease site leads

TUMOUR SITE	DISEASE SITE LEAD(S)
Breast	Dr. Jamil Asselah
Gastro-intestinal	Dr. Thierry Alcindor
Genito-urinary	Dr. Franck Bladou and Dr. Simon Tanguay
Gynecological	Dr. Walter Gotlieb and Dr. Ziggy Zeng
Head & Neck	Dr. Khalil Sultanem
Hematological	Dr. John Storring
Lung	Dr. Victor Cohen and Dr. Scott Owen

Promoting a culture of clinical excellence

- Clinical indicators
- Treatment guidelines
- Leading-edge treatments - access to clinical trials
- Integrated tumor boards
- Synoptic reporting
- Academic partnerships

Indicators

- Important / pertinent
- Measurable
- Can have the ability to make improvements
- Can be benchmarked

Clinical indicators

Big dot indicators

Value-based (ex. ASCO Choosing Wisely® campaign)

- Discouraging inappropriate tests and treatments in oncology practice.
- Addressing the underlying issues contributing to the rising cost of cancer care.

Breast cancer clinical indicators

Big dot indicators

Breast Cancer

- Time from suspicious mammography to diagnostic biopsy
- Time from diagnostic biopsy to breast cancer surgery (if indicated)
- After breast conserving surgery, breast ca pts should receive RT.
- Pts with high risk BC should receive chemo within 8 wks post-op.
- Patients with systemic relapse post adjuvant therapy within 5 years of diagnosis.

Clinical indicators

working groups

Indicator lit. review

Select and prioritize

Preliminary list (20)

Feasibility (RCN)

Final Prioritized list (~6)

Reference document

Data collection

Report

GU *(bladder)*

Head & Neck

Heme
(lymphoma, AML)

Gyne
(utr sarc, OV, VTE)

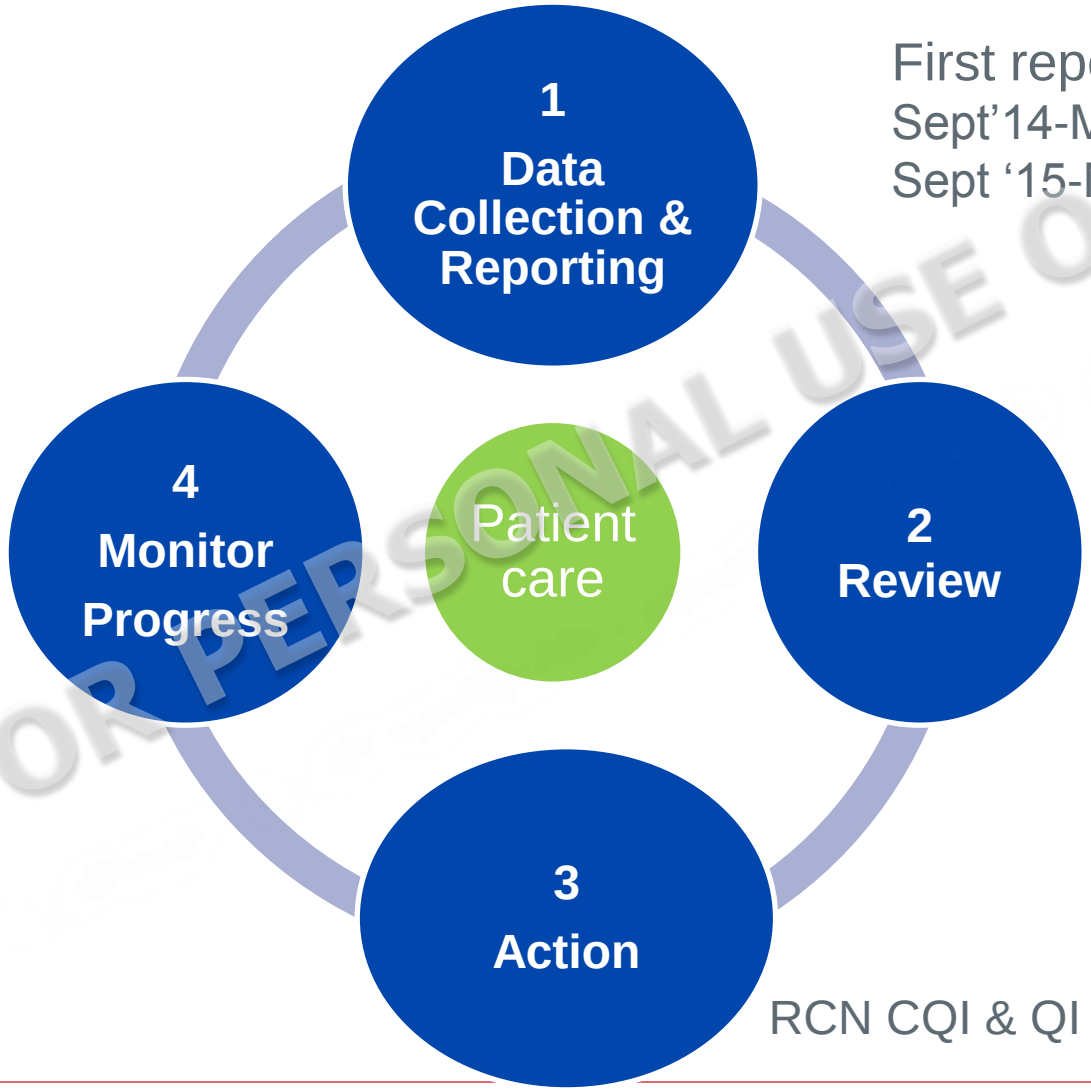
GI *(colorectal)*

Lung

GU *(prostate)*

Breast

From indicator to improved care



First report: April 2016
Sept'14-March'15 (retrospective)
Sept '15-March'16 (prospective)

DS Teams / DS steering committee / Program steering committee / Executive committee

Identify areas needing improvement

RCN CQI & QI grants

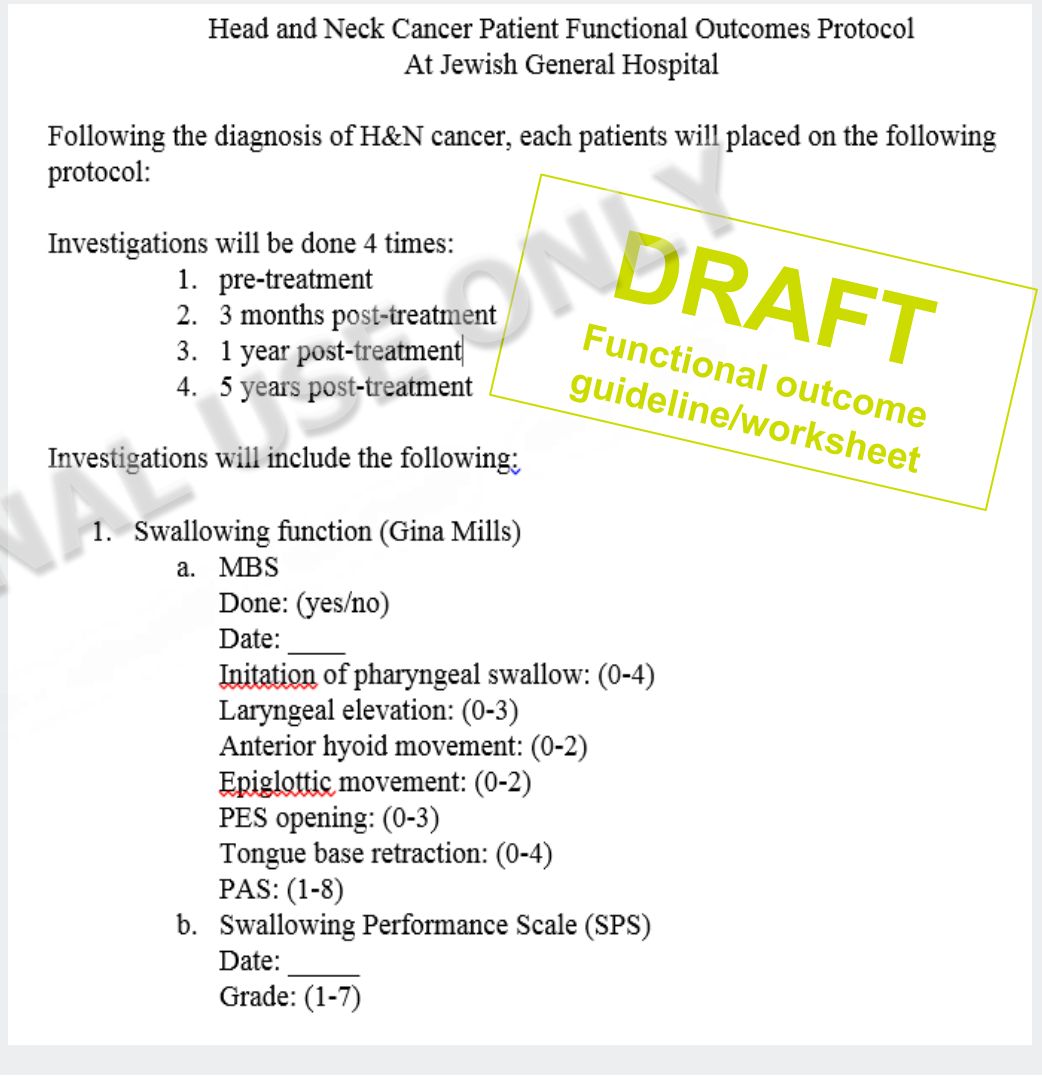
Treatment guidelines

- ASCO
- GEOQ
- NCCN
- COO
- Alberta
- DCQ
- Others …

Some disease sites will focus on treatment guidelines (ex. breast, lymphoma).

Other groups will focus on creating care pathway tools.

Support GEOQ/Quebec wide guidelines



Head and Neck Cancer Patient Functional Outcomes Protocol
At Jewish General Hospital

Following the diagnosis of H&N cancer, each patients will placed on the following protocol:

Investigations will be done 4 times:

1. pre-treatment
2. 3 months post-treatment
3. 1 year post-treatment
4. 5 years post-treatment

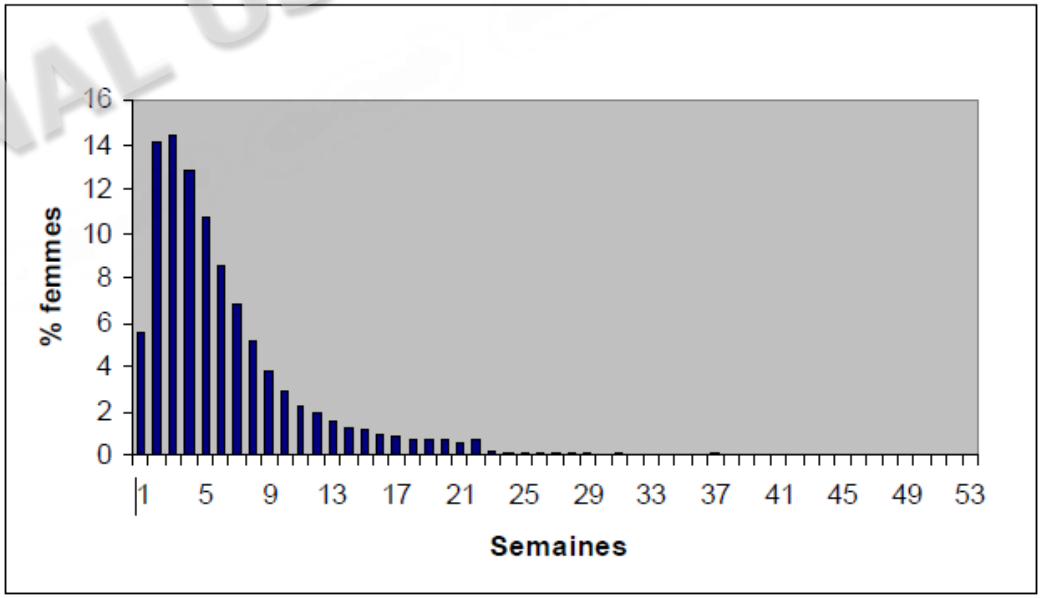
Investigations will include the following:

1. Swallowing function (Gina Mills)
   a. MBS
      Done: (yes/no)
      Date: ____
      Initation of pharyngeal swallow: (0-4)
      Laryngeal elevation: (0-3)
      Anterior hyoid movement: (0-2)
      Epiglottic movement: (0-2)
      PES opening: (0-3)
      Tongue base retraction: (0-4)
      PAS: (1-8)
   b. Swallowing Performance Scale (SPS)
      Date: _____
      Grade: (1-7)

Tools to monitor guideline adherence

Recommendations are that time from suspicious mammography to biopsy should be less than x weeks.

Figure 2 : Délai entre la mammographie de dépistage anormale et le diagnostic (1999-2000)



Source: Programme Québécois de dépistage du cancer su dein (PQDCS), http://www.inspq.qc.ca, Juillet 2005

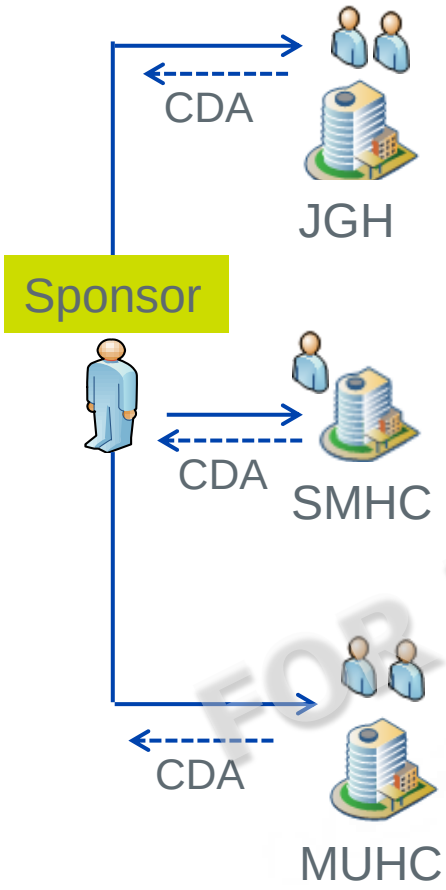
Barrier to indicator capture:

- Difficult to determine date of mammography when done outside RCN.

Proposed care pathway tool:

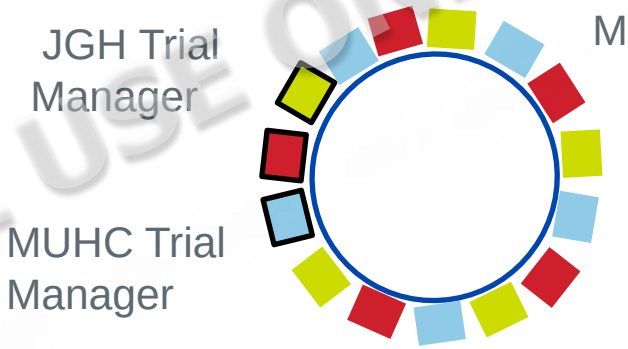
- At MD first evaluation, a worksheet could include field for date of mammography.

Proposed model for clinical research



Inform committee of potential new trial

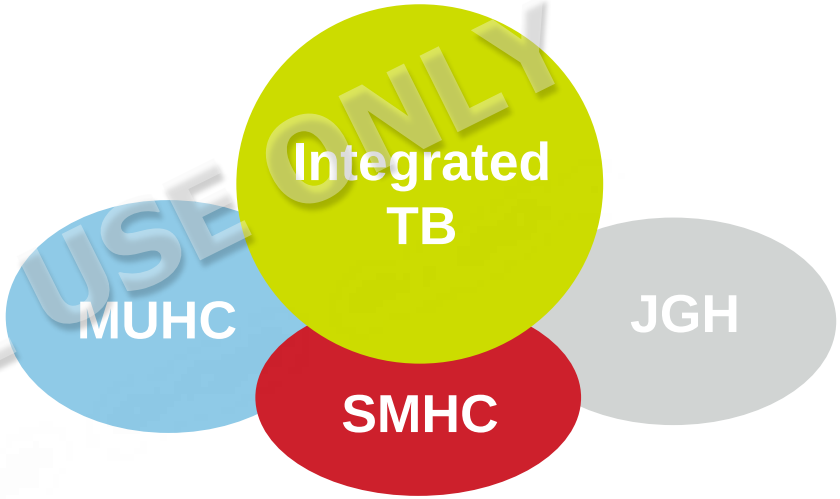
Disease Site Clinical Trials Committee Monthly meetings



- Determine PI-ship
- Site of record
- Multicenter or 1 institution
- Universal cost structure

Integrated tumor boards

- Multi-disciplinary, multi-institution
- Challenging cases
- Biweekly, monthly
- Complements local TBs



- Common tumor board reporting template
- Gather metrics from templates
- Possibility to share patient lists/recommendations

Patients presented to a multi-disciplinary tumor board (MTB)

Percent patients presented to a multi-disciplinary TB

	Local TB			Network TB
	JGH	**MUHC**	**HSMC**	
BREAST	34% (316)	41% (415)	26% (188)	0.8%
COLORECTAL	12% (131)	37% (357)	61% (95)	1.8%
LUNG	36% (140)	14% (487)	41% (54)	2.8%
PROSTATE	8% (77)	2% (249)	19% (16)	0.3%

Presentation within 1 year following diagnosis (FY 2012).
Numbers in brackets represents total new cases

Pathology synoptic reporting

Disease Site	Synoptic format			CAP adherence (audit)	Data Completeness
	MUHC	SMH	JGH	Are CAP checklists loaded in the systems?	How many pathologists do CAP synoptic reporting?
Breast	●	●	●		
GI (CRC)	●	●	●		
GU (prostate)	●	●	●		
Gyne	●	●	●		
Head & Neck	Not necessary. Not a priority.				
Hemato	N/A				
Lung	●	●	●		

● Synoptic reporting available ● No synoptic reporting but MDs would favor SR.

Moving forward & getting involved

- Communications to extended teams – approx every 3 months
- Opportunity to join your disease site steering committee
- Let your ideas be known:
  - ❑ Disease Site Leads
  - ❑ Clinical Lead
    Wilson Miller
    wilsonmiller@gmail.com
  - ❑ Senior Clinical Manager
    Caroline Rousseau
    caroline.rousseau@mail.mcgill.ca

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Thank you !

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