MISSION
To improve the quality of cancer care received by the population served by the McGill Academic Health Network.

VISION
To establish within ten years The Rossy Cancer Network as a world-class comprehensive cancer network with outcomes in cancer survival, mortality, and patient satisfaction as good or better than those of the leading international comprehensive cancer centres, such as Memorial Sloan-Kettering, Dana Farber and MD Anderson.
Characteristics of world-class centers

National Cancer Institute designation of a Comprehensive Cancer Center (www.cancer.gov)

- Prevention, diagnosis and treatment of cancer
- Leading-edge treatments
- Trans-disciplinary research – basic, clinical, behavioral & population-based
- Outreach and education
- Commit to a patient-centered experience
- Adopt a culture of continuous quality improvement
- Focus on measurement and benchmarking against the best
Rossy Cancer Network

*multi-disciplinary & multi-institutional*
Improving cancer care: Equation for change

World-class center

Patients, clinical excellence, research

Members of the Rossy Cancer Network

Gift agreement, RCN staff

Scorecard
RCN Governance Structure

RCN Team

RCN Clinical Lead

Governance Group

Executive Committee

Program Steering Committee

• Chair, McGill Dept. of Oncology
• RCN Clinical Lead
• Cancer Quality & Innovation Lead
• Disease Site Leads
• Director of Operations
• Director of Operations
• Dean of Medicine, Chair
• Vice Dean of Medicine
• Hospital PDGs (3)
• RCN Executives
• Special Invitees
• Oncology Leads
• RCN Clinical Lead
• Chair, Dept. of Oncology
• CQI Lead
• RCN Executives
• Vice Dean Medicine, Chair
• Oncology Leads (3)
• RCN Clinical Lead (chair)
• Nursing Directors (3)
• CQI Lead
• IT Directors (3)
• Director of Operation
Patient Satisfaction Data
Manon Allard
Ambulatory Oncology Patient Satisfaction Survey (AOPSS)

• 1st RCN project as a network

• The AOPSS is a standardized instrument from NRC Picker (83-item survey) to assess the overall cancer patient experience

• It is used in multiple provinces in Canada and in the US

• The survey items are mapped among 6 dimensions covering different facets of care
  – Emotional support
  – Coordination and continuity of care
  – Respect for their preferences
  – Physical comfort
  – Information, communication and education
  – How well they were able to access their care
AOPSS - Methodology

• Surveys are mailed to a randomly selected group of patients who received a treatment in one of the RCN hospital

• Sampled over 2000 patients across the RCN institutions, with an average of 44.3 % response rate

• Institutions are receiving their results 4 times a year and a compilation of data on an annual basis. Results of the institutions can be compared to the network’s results and to the Canadian average
AOPSS General Results - 2014

- Access to Care: 67% (Canadian Average), 55% (RCN Average)
- Coord & Cont of Care: 68% (Canadian Average), 66% (RCN Average)
- Emotional Support: 53% (Canadian Average), 52% (RCN Average)
- Info, Comm and Education: 65% (Canadian Average), 62% (RCN Average)
- Physical Comfort: 78% (Canadian Average), 73% (RCN Average)
- Respect for Patient Pref's: 80% (Canadian Average), 76% (RCN Average)
AOPSS – Our best results as a network

- OP knew enough about therapy: 85.10% (RCN), 85% (Canadian)
- Treated with dignity and respect: 92.40% (RCN), 93.30% (Canadian)
- Family involved in care: 93.30% (RCN), 94.60% (Canadian)
- Would recommend providers at hospital: 91.80% (RCN), 90.70% (Canadian)
- Rate OP care: 98.10% (RCN), 97.90% (Canadian)

RCN FIRST ANNUAL RETREAT – JUNE 2015
AOPSS Specific Results – Areas for improvement

- Enough info on sexual activity changes
  - RCN Average: 32.80%
  - Canadian Average: 32.40%
- Wait for consultation appt. explained
  - RCN Average: 28.00%
  - Canadian Average: 32.40%
- Enough info on emotional changes
  - RCN Average: 40.90%
  - Canadian Average: 40.90%
- Enough info re: relationship changes
  - RCN Average: 21.20%
  - Canadian Average: 37.90%
- Wait longer than expected for OP chemo
  - RCN Average: 37.90%
  - Canadian Average: 44.20%
AOPSS-driven projects

**Emotional support**
- Improving Patient Experience and Health Outcomes Collaborative (IPEHOC)
- Finding Common Ground

**Access to care**
- Reducing chemotherapy wait times
- Implementing self-check-in system
- Improving the experience in the chemotherapy waiting room

**Information, education and communication**
- Continuum of information regarding radiotherapy treatment and its effects
Patient Experience

As per the Canadian Partnership Against Cancer, patient experience refers to:

“The sum of an individual’s perception, expectations and interactions related to their health and care throughout their cancer journey”
Engaging Primary Care Physicians
Geneviève Chaput & Michael Shulha
Problem Addressed: Need for Better Communication

- Canadian Partnership Against Cancer has identified a major deficit in the transition of survivorship care

- Clinical information about a survivor’s diagnosis, treatment, follow-up and surveillance needs are rarely communicated by any consistent or formal means between oncology specialists (OS) and family physicians (FP)

- The results of the Ambulatory Oncology Patient Satisfaction Survey (AOPSS) indicated that:
  - RCN is 20% behind Canadian average (i.e. 40% vs. 60%) on the issue of communication between OS and FP
Finding Common Ground Project

• Goal:
  Improve communication between OS and FP and enhance coordination of cancer care

• Objectives:
  1. Improve the communication of diagnosis, treatment plans and side effects to FP during active treatment
  2. Better understand the information needs of breast cancer survivors, FP and OS in the context of survivorship care plans
  3. Increase FP awareness and knowledge of common issues in cancer survivorship (Educational Workshop)

During Treatment
- Treatment Plan

Educational Workshops

Survivorship Care Plan

Post Treatment
Objective 1
Improve Communication During Treatment

• The objective of this workstream is to develop a template to communicate, in a routine manner, ongoing treatment info to family physicians

• A draft template based on the IOM framework and ASCO template was developed and then evaluated by 39 physicians

• 100% of respondents felt the information provided by the template was relevant and pertinent

• During the pilot phase (August), the tool will be sent to the family physicians of cancer patients starting treatment, for a period of 6 months. This pilot will assess feasibility of the implementation and relevance of the information provided.
SOMMAIRE ET PLAN DE TRAITEMENT INITIAL DU PATIENT EN ONCOLOGIE / ONCOLOGY PATIENT INITIAL SUMMARY AND TREATMENT PLAN

Diagnostic / Diagnosis : 
Date du diagnostic / Diagnosis date (AU - M - JD) : 
Pathologie / Pathology : 

Statut / Stage : 0 1 2 3 4 Non applicable / Not applicable 
Site des métastases / Site of metastasis : Oesophagus / Oesophagus Cervix / Cervix Brain / Brain Liver / Liver P neumon / Lung Autre(s) / Other(s) :

Chirurgie / Surgery : Oui / Yes Non / No Date (AU - M - JD) :

Problèmes cardiovasculaires / Cardiovascular problems :
Problèmes de santé mentale / Mental health problems :
Problèmes du système nerveux central / Central nervous system problems :
Problèmes endocrinologiques / Endocrine problems :
Problèmes nephrologiques / Renal issues :

Radiothérapie / Radiotherapy : Oui / Yes Non / No Date prévue du traitement / Expected treatment date :

Thérapie systémique / Systemic therapy :

Traitement hormonal / Hormonal treatment :

Effets secondaires et problèmes associés / Current side effects and issues :

Arché / Anxieté
Disposition / Depression
Trouble du sommeil / Sleep disorders
Déviation / Pain
Problèmes d'alimentation / Eating problems

Société cancérologie Rossy
Rossy Cancer Network

RCN FIRST ANNUAL RETREAT – JUNE 2015
Objective 2: Understand Information Needs for Survivorship Care Plans - Methods

• Question: In the context of transitioning breast cancer survivors to primary care at the completion of active oncology treatment, what are the unique information needs of:
  - Breast cancer survivors
  - Primary care physicians
  - Oncology specialists

• Approach
  - Delphi Study: A multiple round questionnaire to determine consensus on essential information items from each group's perspective
  - Focus Groups: Explore reactions to draft survivorship templates created from the consensus items of the Delphi study
Objective 2: Survivorship Care Plan Methods: Delphi Study

What information do you want included in an SCP? (92 item questionnaire*)

What follow up information (if any) would you like to receive back? (24 item questionnaire*)

Results
Survivors 87/92 items
Primary Care 66/92 Items
Oncologists 8/24 Items

15 Breast Cancer Survivors
15 Primary Care Physicians

15 Oncology Specialists
• 8 med onc
• 5 rad onc
• 2 surgery

*Questionnaire derived from Palmer et. al, (2014) Metrics to evaluate treatment summaries and survivorship care plans: A scorecard
## Achievements: Delphi Results

### Treatment Summary

<table>
<thead>
<tr>
<th>Diagnostic Tests Performed</th>
<th>Date</th>
<th>Diagnosis</th>
<th>Date of Biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Stage:</td>
<td>Grade: Left or Right Side</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Estrogen Receptor (+) (-)</td>
<td>Progesterone Receptor (+) (-)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>HER2 Receptor (+) (-)</td>
<td># of positive nodes:</td>
</tr>
<tr>
<td>Surgery</td>
<td>Date</td>
<td>Chemotherapy</td>
<td>Start</td>
</tr>
<tr>
<td>(type of surgery)</td>
<td></td>
<td>Drug name</td>
<td></td>
</tr>
<tr>
<td># of axillary nodes dissected</td>
<td>( )</td>
<td># of Cycles:</td>
<td>Route:</td>
</tr>
<tr>
<td># of sentinel nodes dissected</td>
<td>( )</td>
<td>Adjvant or Neoadjuvant</td>
<td>Dose Reduction (yes) or (no)</td>
</tr>
<tr>
<td>Reconstruction Date</td>
<td></td>
<td>Total Dose:</td>
<td></td>
</tr>
<tr>
<td>Radiotherapy</td>
<td>Start:</td>
<td>Stop:</td>
<td>Targeted Therapy</td>
</tr>
<tr>
<td>Type:</td>
<td></td>
<td>Subtype:</td>
<td>Drug name:</td>
</tr>
<tr>
<td>Chest Wall (y) or (n)</td>
<td></td>
<td>Breast (y) or (n)</td>
<td></td>
</tr>
<tr>
<td>Hormone Therapy</td>
<td>Start</td>
<td>Stop</td>
<td></td>
</tr>
<tr>
<td>Left or Right side</td>
<td>Total Dose:</td>
<td>Drug name:</td>
<td></td>
</tr>
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</table>

### Genetic Testing

<table>
<thead>
<tr>
<th>Date</th>
<th>Supportive Therapy</th>
<th>Start</th>
<th>Stop</th>
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</thead>
<tbody>
<tr>
<td>Result</td>
<td>type</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Care Plan

#### Toxicities

Expected course and recovery

#### Long term late effects

Symptoms

#### Surveillance Tests

<table>
<thead>
<tr>
<th>Reason</th>
<th>Frequency</th>
<th>Provider Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non Cancer</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Signs or Symptoms Second Cancers

Signs and Symptoms of Recurrence

### Potential Psychosocial Effects

<table>
<thead>
<tr>
<th>Key Points</th>
<th>More Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marriage/Partner Relationships</td>
<td></td>
</tr>
<tr>
<td>Sexual Functions</td>
<td></td>
</tr>
<tr>
<td>Work Employment</td>
<td></td>
</tr>
<tr>
<td>Parenting</td>
<td></td>
</tr>
<tr>
<td>Insurance</td>
<td></td>
</tr>
<tr>
<td>Finance</td>
<td></td>
</tr>
<tr>
<td>Psychosocial support</td>
<td></td>
</tr>
</tbody>
</table>

### Referral Information

<table>
<thead>
<tr>
<th>Name</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling Services</td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td></td>
</tr>
<tr>
<td>Support Groups</td>
<td></td>
</tr>
<tr>
<td>Fertility</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
</tbody>
</table>

### Healthy Behaviour Recommendations

Exercise

Nutrition

Immunizations

Chemoprevention strategies for secondary cancer prevention

### Breast Cancer Information Sources

#### Genetic Testing

Information on who should consider genetic counseling and testing

#### Familial cancer risk

Information for First Degree Relatives

Type of tests to be considered
Objective 2: Survivorship Care Plan Achievements - Initial Findings

- Survivorship Care Plan Ideal Characteristics
  - Accessible electronically by the different end users
  - Support different views into the care plan based on the information needs of the different users
  - A dynamic solution that can be updated by multiple end users over time
  - A feasible, sustainable solution that supports auto-completion of treatment summary based on existing patient data and guidelines
Objective 3: Educational Workshop

Caring for Cancer Survivors in Family Medicine

Gen Chaput, MD
Attending Physician, Assistant Professor, MUHC
MUHC Cancer Care Mission
Objective 3: Educational Workshop

Workshop developed based on 8 common issues of cancer survivors as per NCCN guidelines:

1) Psychosocial Late Effects: anxiety and depression
2) Cognitive deficits
3) Pain
4) Female and male sexual dysfunction
5) Fatigue and Sleep disorders
6) Cardiac issues
7) Immunizations and prevention of infections
8) Healthy lifestyle and exercise promotion

Workshop received MAINPRO accreditation
Objective 3: Educational Workshop Participants

- Target sample size of 70 FP
- Target exceeded: 90 FP
- Preliminary data reveals
  - 4 sites (out of 5)
  - Total PCP = 145
  - Total FP = 115
  - 90 FP participants
  - Response rate 78%

Workshop Participants (N = 90)

- St Mary's Hospital 39%
- Jewish General Hospital 32%
- CLSC 21%
- Queen Elizabeth Health Complex 8%
Objective 3: Educational Workshop

• Participants filled a pre and post workshop survey

• Specific outcome measures targeted:
  – Participant satisfaction
  – Knowledge of cancer survivorship
  – Confidence in providing cancer survivor care
  – Intent to change practice
Objective 3: Educational Workshop
Did FP learn anything?

Survey Q: Name 2 common late-effects of cancer treatment that you as a family physician would be expected to manage

– Pre-test: 51% identified 2 common effects
– Post-test: 100% identified 2 common effects
– Most common effects reported:
  • Mental health/psychosocial issues: 53.3%
  • Sexual dysfunction/loss of libido: 36.7%
  • Pain management: 27.8%

Results statistically significant
Objective 3: Educational Workshop
Did FP learn anything?

Survey Q: Did you learn anything today that you will put to use in your practice?

95% stated that the content was relevant to family medicine
Objective 3: Educational Workshop
Did FP learn anything?

Survey Q: List 2 Standards of Survivorship Care

Results statistically significant

Pre-test: 13.3%
Post-test: 66.7%
Next Steps

- Finding Common Ground objectives have been met
- Upcoming:
  - Piloting communication tool during active treatment
  - Detailed qualitative analysis of focus group data
  - Draft of prototype Survivorship Care Plans
  - Ongoing distribution of 3-month workshop survey
  - Design Pilot Studies for RCN Sites for Survivorship Care Plans
Empowering Patients in Radiation Oncology

John Kildea
Self Check-In System

- MGH radiation oncology department yearly volume:
  - ~ 10,000 consultation and follow-up visits and ~ 36,000 treatment visits

- Front desk check-in process involves a “paper number system” No electronic number distribution
  - No electronic signage - clerks call the numbers
  - Patient have to wait alertly for their number to be called
  - Technologists’ work constantly being disrupted as they have to check for patients’ arrival in the waiting room

- Results from an RCN pre-project survey indicate that 74% of patients found the front desk check-in inconvenient

- 65% of patients waited a long time to access the front desk
Self Check-In System

System components

- Self check-in kiosk
- Electronic display in physicians’ team room
- Electronic display in the waiting room
- Safety check-in (treatment room)
Self Check-In System

Patient use of self check-in kiosks
January - May 2015

- % Attempted: 106%
- % Eligible and successful: 94%
- % Eligible but unsuccessful: 6%
Self Check-In System

Patients' perception of the self-check-in system (6 months post-implementation)

- 80% of patients are satisfied with the self check-in process.
- 88% find self-check-in quicker than front desk check-in.
- 72% find self-check-in more convenient than front desk check-in.
- 84% have easier access to the front desk for non-check-in related requests.

May 2015
Continuum of information regarding radiotherapy treatment and its effects

- The results of the Ambulatory Oncology Patient Satisfaction Survey (AOPSS) indicated that patients undergoing radiotherapy treatment were less satisfied than those from the Canadian average, as per information received on how to manage side effects and make wait time more comfortable.

<table>
<thead>
<tr>
<th>Did someone tell you how to manage any side effects of radiation therapy?</th>
<th>YES, completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCN Average</td>
<td>Canada Average</td>
</tr>
<tr>
<td>72.4%</td>
<td>81.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>If you had to wait for your radiation therapy treatment, do you think the staff did everything they could to make you feel comfortable?</th>
<th>YES, completely</th>
</tr>
</thead>
<tbody>
<tr>
<td>RCN Average</td>
<td>Canada Average</td>
</tr>
<tr>
<td>58.8%</td>
<td>78.6%</td>
</tr>
</tbody>
</table>
Continuum of information regarding radiotherapy treatment and its effects

- A booklet and video were developed to harmonize patient information throughout the RCN in regards to radiotherapy treatments and associated side effects.

<table>
<thead>
<tr>
<th></th>
<th>JGH</th>
<th>SMH</th>
<th>MUHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Booklets given</td>
<td>DEC 2014</td>
<td>TO DATE</td>
<td>DEC 2014</td>
</tr>
<tr>
<td>TOTAL TO DATE</td>
<td>1220+</td>
<td></td>
<td>1200+</td>
</tr>
<tr>
<td>Booklets downloaded or viewed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Video views</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>TOTAL TO DATE</td>
<td>1220+</td>
<td></td>
<td>1200+</td>
</tr>
</tbody>
</table>
Distress has been recognized as the **Sixth Vital Sign** in Cancer Care
- Needs to be detected, measured and addressed

- Emotional support receives the lowest patient satisfaction score

- Grant awarded by Canadian Partnership Against Cancer for a three-year project (2014-2017)

- Partnership including cancer care centres in Quebec (RCN) and in Ontario (CCO) & FNIM
Objectives

The main objectives are:

- To facilitate the UPTAKE of a standardized core set of patient-reported outcome measures (PROMs) and patient-reported experience measures (PREMs) for ACTIONABLE and MEANINGFUL use in clinical practice
- To develop a standardized and sustainable patient-centered measurement system to improve patient experience of cancer and care applicable to all jurisdictions in Canada

«Completing a screening tool is not sufficient to achieve person-centered care. A coordinated, evidence based response to distress needs to be implemented in a planned and systematic way:…»

*Screening for Distress, the 6th Vital Sign: A Guide to Implementing Best Practices in Person-Centred Care. CPAC. (2012).*
Patient Reported Outcomes

ESAS-R + four patient-reported outcome (PROs) measures integrated into the clinical interaction:

- **Depression** – Personal Health Questionnaire (PHQ-9)
- **Anxiety** – Generalized Anxiety Disorder Scale (GAD-7)
- **Pain** – Brief Pain Inventory (BPI)
- **Fatigue** – Cancer Fatigue Scale (CFS)

![Screen with PROs](image1)

![Review Results](image2)

![Intervene](image3)

![Follow-Up](image4)
PATIENT REGISTRATION:

1. Please enter your MRN
   [TextBox]

2. Please enter your Date of birth
   Year: [2014]
   Month: [January]
   Day: [1]

3. Please enter your RAMQ ID
   [TextBox]

4. Please enter your First name
   [TextBox]

5. Please enter your Last name
   [TextBox]

6. Press NEXT to proceed
   [Button] Next
This questionnaire will ask you about any sense of fatigue you might be experiencing. For each question, please select only one number you think most aptly describes your current state. Try to answer on the basis of first impressions, without thinking deeply about each question.

**RIGHT NOW:**

<table>
<thead>
<tr>
<th>No</th>
<th>A little</th>
<th>Somewhat</th>
<th>Considerably</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you become tired easily?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have the urge to lie down?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you feel exhausted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

© 2000 Diugema et al., U.S. Cancer Pain Relief Committee
Patient Reported Outcomes

Assessed Clinical Concerns

Pain (BPI)

- Pain Interference
  - Graph showing pain interference levels over time with categories like 'Complete', 'Ongoing', etc.

Pain Severity Trend (Over Past 2 Months)

- Graph showing pain severity trend over the past 2 months.

Fatigue (CFS)

- Physical (Body)
- Affective (Emotion)
- Cognitive (Mind)

Graphs showing fatigue levels in different categories.

Emotional Distress (Frd-3 and GAD-7)

- Graph showing levels of emotional distress.

Trends in Quality of Life

- Graph showing trends in quality of life.

Changing the Conversation

Embrace the moment and let's continue the discussion.
Clinical Outcomes

Immediate Outcomes
- Reduce Symptom Severity and Distress
- Increase Person-Centered Communication and Collaborative Team Working
- Increase Patient Activation

Intermediate Outcomes
- Improve Patient Experience Outcomes

Long-Term Outcomes
- Standardize PROM use in cancer populations / Reduce population rates for urgent care and acute care hospitalizations related to symptoms
Next steps

- Clinician education
- Patient education
- Implementation
The RCN Scorecard and Disease Site Program
Wilson Miller
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
# Performance indicators

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

Access to multi-disciplinary care, as measured by % patients having an appointment with an oncology pivot nurse

- **Numerator**: $\Sigma$ new (to IPO) cases (diagnosed anytime) who had an appointments with an oncology pivot nurse

- **Denominator**: $\Sigma$ cases newly diagnosed with cancer (cases 0-22, diagnosed in FY 2013)

<table>
<thead>
<tr>
<th></th>
<th>JGH</th>
<th>MUHC</th>
<th>SMHC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access</td>
<td>37%</td>
<td>21%</td>
<td>30%</td>
</tr>
</tbody>
</table>

RCN FIRST ANNUAL RETREAT – JUNE 2015
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

<table>
<thead>
<tr>
<th>TUMOUR SITE</th>
<th>DISEASE SITE LEAD(S)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Breast</td>
<td>Dr. Jamil Asselah</td>
</tr>
<tr>
<td>Gastro-intestinal</td>
<td>Dr. Thierry Alcindor</td>
</tr>
<tr>
<td>Genito-urinary</td>
<td>Dr. Franck Bladou and Dr. Simon Tanguay</td>
</tr>
<tr>
<td>Gynecological</td>
<td>Dr. Walter Gotlieb and Dr. Ziggy Zeng</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Dr. Khalil Sultanem</td>
</tr>
<tr>
<td>Hematological</td>
<td>Dr. John Storring</td>
</tr>
<tr>
<td>Lung</td>
<td>Dr. Victor Cohen and Dr. Scott Owen</td>
</tr>
</tbody>
</table>
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

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

Access & patient flow

Treatment

Outcome

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

- Indicator lit. review
- Select and prioritize
- Preliminary list (20)
- Feasibility (RCN)
- Final Prioritized list (~6)
- Reference document
- Data collection
- Report

- Heme (lymphoma, AML)
- Head & Neck (bladder)
- Gyne (utr sarc, OV, VTE)
- GI (colorectal)
- Lung
- GU (prostate)
- Breast

working groups
From indicator to improved care

1. Data Collection & Reporting

2. Review
   - DS Teams / DS steering committee / Program steering committee / Executive committee
   - Identify areas needing improvement

3. Action

4. Monitor Progress

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

RCN CQI & QI grants

RCN FIRST ANNUAL RETREAT – JUNE 2015
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
Tools to monitor guideline adherence

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

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.

Source: Programme Québécois de dépistage du cancer du sein (PQDCS), [http://www.inspq.qc.ca](http://www.inspq.qc.ca), Juillet 2005
Proposed model for clinical research

Disease Site Clinical Trials Committee
Monthly meetings

- JGH Trial Manager
- MUHC Trial Manager
- SMH Trial Manager

Inform committee of potential new trial

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

JGH
SMHC
MUHC

Sponsor
CDA

RCN FIRST ANNUAL RETREAT – JUNE 2015
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)

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

<table>
<thead>
<tr>
<th></th>
<th>Local TB</th>
<th>Network TB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>JGH</td>
<td>MUHC</td>
</tr>
<tr>
<td>BREAST</td>
<td>34% (316)</td>
<td>41% (415)</td>
</tr>
<tr>
<td>COLORECTAL</td>
<td>12% (131)</td>
<td>37% (357)</td>
</tr>
<tr>
<td>LUNG</td>
<td>36% (140)</td>
<td>14% (487)</td>
</tr>
<tr>
<td>PROSTATE</td>
<td>8% (77)</td>
<td>2% (249)</td>
</tr>
</tbody>
</table>
# Pathology synoptic reporting

<table>
<thead>
<tr>
<th>Disease Site</th>
<th>Synoptic format</th>
<th>CAP adherence (audit)</th>
<th>Data Completeness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>MUHC</td>
<td>SMH</td>
<td>JGH</td>
</tr>
<tr>
<td>Breast</td>
<td>☀️</td>
<td>☀️</td>
<td>☀️</td>
</tr>
<tr>
<td>GI (CRC)</td>
<td>☀️</td>
<td>☀️</td>
<td>☀️</td>
</tr>
<tr>
<td>GU (prostate)</td>
<td>☀️</td>
<td>☀️</td>
<td>☀️</td>
</tr>
<tr>
<td>Gyne</td>
<td>☺️</td>
<td>☺️</td>
<td>☺️</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>Not necessary. Not a priority.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemato</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Lung</td>
<td>☀️</td>
<td>☀️</td>
<td>☀️</td>
</tr>
</tbody>
</table>

- Synoptic reporting available: ☀️
- No synoptic reporting but MDs would favor SR: ☺️

- Are CAP checklists loaded in the systems?
- How many pathologists do CAP synoptic reporting?
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
A Common IT Architecture for the RCN

Jeffrey Barkun
Why project Concord (IT infrastructure)?

• As of 2012, RCN focused on 4 work streams
  – Integrated View of Patients & Data (IVPD)
  – Synoptic Reporting
  – Indicators & Outcomes
  – Patient Experience

• The goal of IVPD was to integrate RCN patient data so that care providers treating those patients had quick access to the data

• To accomplish this, a common IT architecture was deemed essential and had to be defined
Why a common IT Architecture?

- Paperless data records are essential to share information for services received in more than one RCN hospital or on multiple sites at once

- No electronic prescribing to reduce medication errors

- No specialized decision support systems: e.g.: to link eligible patients to clinical trials
Chronology

2012
- RCN agrees on ASCO driven requirements for EHR

2013
- Feb
  - Work flow mapping, requirements gathering and test scenarios developed
- June
  - RCN Governance Group requests further reduction in project cost
- Sept
  - Large scale architecture plan proposed, blue sky approach, $28M

2014
- Concord Period
  - June
    - IT steering Committee created. Allows for more grounded clinician approach, simplified project scope and lower cost
  - May
  - Oct
  - Nov
  - RFI
  - Dec
    - RFI
- Sept
  - Major re-scoping of RAP, estimate project cost reduced from $28M
- Dec
  - RCN Governance Group approves $13 M project with permission to prepare for public tender
Main Concord Features

3 core components in Concord
  – Electronic Health Record
  – Oncology Data Analytics (“ODA”- data warehouse)
  – Oncology Patient Portal

• Turn-key approach
  – RCN covers funding capital and all recurring costs over a 5 year period.

• Gated Project Plan
  – Funding released upon measureable success criteria
    (EHR is first deployment to allow early use of meaningful data)

• Federated Model
  – EHR already deployed at JGH; will not change
    (Network data consolidation occurs at ODA Level)
Today

- RFP document is complete, ready to publish publically
- Awaiting Governance Group go-ahead to apply for MSSS permission to go to public tender.

Timeline:

- Current assumptions, and MSSS approvals, yields a vendor selection date +/- Fall 2015.
- First EHR deployment complete late 2016
  - First at MUHC (ready to start)
  - SMHC will follow when CIUSSS-appropriate
Funding Cancer Care Quality
Cancer Quality and Innovation Program
Ari Meguerditchian
RCN Research Fund - Goals

• Move from “catching up” on cancer care quality to leading.

• The best ideas on how to improve and lead will come from the frontline.

• Develop networks of collaborative care and science within the McGill oncology community.

• Accomplish the RCN’s mandate of research in the development of knowledge centered on cancer care quality.

• Assist McGill in ensuring regional leadership in establishing innovative cancer care quality standards.

• Develop research and training platforms for the rapid generation of scientific knowledge relevant to the domains of cancer care quality.
Research proposals must:

– Reflect a collaborative effort from at least 2 RCN-partner institutions

– Contain an educational component

– Propose innovative ways of improving the delivery of care

– Target unanswered questions in the implementation of cancer care quality

Research funds cannot supplement or replace operating budgets or support clinical trials of investigational drugs.
# RCN Research Fund - Assessment

<table>
<thead>
<tr>
<th>CRITERIA</th>
<th>SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quality and originality of proposal:</strong></td>
<td></td>
</tr>
<tr>
<td>- The project proposed is original and innovative</td>
<td></td>
</tr>
<tr>
<td>- The project targets cancer care quality improvement</td>
<td></td>
</tr>
<tr>
<td>- The project includes an objective assessment component</td>
<td>/4</td>
</tr>
<tr>
<td>- The objectives correspond to the hypothesis and are realistically attainable by the methods proposed</td>
<td></td>
</tr>
<tr>
<td><strong>Feasibility of the proposal within proposed teams and environments:</strong></td>
<td></td>
</tr>
<tr>
<td>- The methodological approach proposed is appropriate, realistic and feasible</td>
<td></td>
</tr>
<tr>
<td>- The team composition covers all relevant clinical / scientific skills required</td>
<td>/4</td>
</tr>
<tr>
<td>- The clinical / scientific activity of the proposed sites is able to support the proposed research activity</td>
<td></td>
</tr>
<tr>
<td><strong>Relevance of project to cancer care quality &amp; research:</strong></td>
<td></td>
</tr>
<tr>
<td>- The project targets an unanswered question in the science or the implementation of cancer care quality</td>
<td></td>
</tr>
<tr>
<td>- The project builds on currently existing knowledge</td>
<td></td>
</tr>
<tr>
<td>- The research question is relevant</td>
<td>/4</td>
</tr>
<tr>
<td>- Results from the proposed project will support larger research initiatives</td>
<td></td>
</tr>
<tr>
<td><strong>Budget relevance:</strong></td>
<td></td>
</tr>
<tr>
<td>- The proposed budget realistically reflects the requirements to successfully complete the project (sufficiency)</td>
<td></td>
</tr>
<tr>
<td>- The proposed budget covers all aspects to successfully complete the project (comprehensiveness)</td>
<td></td>
</tr>
<tr>
<td>- The proposed budget does not contain elements corresponding to institutional operating expenses</td>
<td></td>
</tr>
<tr>
<td>- The proposed budget is in compliance with the terms and conditions of the RRF</td>
<td></td>
</tr>
<tr>
<td>- The proposed project could realistically persist beyond research activities with reasonable, minimal support (sustainability)</td>
<td></td>
</tr>
<tr>
<td><strong>Relevance to the RCN goals and objectives:</strong></td>
<td></td>
</tr>
<tr>
<td>- The project is directly related to the science of cancer care delivery improvement</td>
<td></td>
</tr>
<tr>
<td>- The project involves more than one site as proportionally equal partners</td>
<td></td>
</tr>
<tr>
<td>- The project results in the development of cross site collaborative teams</td>
<td></td>
</tr>
<tr>
<td>- The project will generate knowledge / know-how or opportunities that can be exported to other RCN sites, priorities or initiatives</td>
<td>/4</td>
</tr>
</tbody>
</table>
## RCN Research Fund – 2014 Awards

<table>
<thead>
<tr>
<th>PROJECT</th>
<th>INVESTIGATOR</th>
<th>PARTNER SITES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improving the Quality of Care to Kidney Cancer Patients Undergoing Nephrectomy</td>
<td>Dr. Franck Bladou</td>
<td>JGH-MUHC</td>
</tr>
<tr>
<td>Castration-Resistant Prostate Cancer: Evaluation of the Quality of Care, Disease Management, and Associated Costs</td>
<td>Dr. Alice Dragomir</td>
<td>MUHC-JGH</td>
</tr>
<tr>
<td>A Supportive Re-entry Program Tailored by and for Patients Completing Cancer Treatment</td>
<td>Ms. Rosana Faria</td>
<td>SMHC-MUHC</td>
</tr>
<tr>
<td>Streamlining the Trajectory for Oesophago-gastric Patients with Cancer</td>
<td>Dr. Lorenzo Ferri</td>
<td>MUHC-JGH</td>
</tr>
<tr>
<td>Effect of Early Compression Therapy on Incidence of Lymphedema in Gynecological Cancer Patients</td>
<td>Ms. Shirin Shallwani and Dr. Anna Towers</td>
<td>MUHC-JGH</td>
</tr>
<tr>
<td>Women’s Experience with Breast Cancer</td>
<td>Dr. Donna Stern</td>
<td>SMHC-MUHC</td>
</tr>
</tbody>
</table>

**Total investment: $536,000**
RCN Education Fund - Goals

• Strategic investments in acquiring / increasing within the network’s oncology workforce the know-how and specific skills to achieve RCN clinical excellence objectives:
  – Health care project management
  – Cost assessment of initiatives
  – Evaluation process
  – Conflict resolution
  – Clinical skills

• Develop for the RCN an inventory of:
  – Skills gaps as felt by frontline teams
  – Educational opportunities relevant to RCN goals
RCN Education Fund – 2014 awards

- SMHC Nurses: Surgical oncology skills enhancement
- T. Hijal: Masters’ in health economics
- K. Lepage: Certificate in change management
Consolidating Nursing Excellence

• Certification = better care, less complications

• Frontline personnel delivering care: nursing

• Key areas of concern (expressed by them):
  – Cancer emergencies can be handled better
  – Chemo center nurses can better prepared
  – In-patient nurses feel the need to expand cancer specific skills for handling discharges

• Options explored:
  – ONCC
  – DeSouza Institute
Kuok Fellowship

• **GOAL**: Endowment to support graduate fellowships as part of the objectives of the Rossy Cancer Network

• **TARGET AUDIENCE**: Trainees enrolled in graduate training at McGill University and involved in cancer care quality-relevant research

• **AMOUNT**: $30,000 to $32,000 / year
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Quality Improvement Initiatives Fund
Antoinette Ehrler
Hospital specific quality improvement initiatives

• In the past, RCN hospitals independently undertook specific quality improvement initiatives in line with RCN mission and vision:
  – Improvement of management of patients with febrile neutropenia (MUHC)
  – Adherence to clinical guidelines for initial investigation
  – Caregiver Distress Screening
  – Information Guide On The Cancer Care Day Centre

• This resulted in:
  – Duplication of work
  – Suboptimal use of RCN and hospital resources
  – Missed opportunities for KT, and leveraging of existing knowledge/skills
  – Fragmentation, rather than integration of initiatives across the network
  – Missed opportunities for RCN funding
### Quality Improvement Initiatives Fund

The RCN QI Initiatives Fund was established to promote continuous improvement projects related to cancer care quality with a focus on the operational aspect of quality improvement and the potential to directly impact the quality of cancer care at two or more RCN hospitals.

<table>
<thead>
<tr>
<th>CQI Research Grant</th>
<th>QI Initiatives Fund</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cancer care optimization</td>
<td>✔</td>
</tr>
<tr>
<td>Collaborative effort from at least 2 RCN institutions</td>
<td>✔</td>
</tr>
<tr>
<td>Educational component</td>
<td>✔</td>
</tr>
<tr>
<td>Development of scientific knowledge based on sound research methodology</td>
<td>✔</td>
</tr>
<tr>
<td>Optimization of an important aspect of care delivery based on best practices</td>
<td>✔</td>
</tr>
<tr>
<td>Relies primarily on use of RCN resources</td>
<td>✔</td>
</tr>
</tbody>
</table>
Eligibility

- Available to all health professionals directly involved in the provision of cancer care as well as anyone who holds a position at one of the RCN hospitals and has an interest in the improvement of cancer care quality

- Projects must reflect a collaborative effort from at least 2 RCN-partner institutions

- RCN will facilitate the uptake of all the initiatives by providing a project manager to support the teams
Application process

- The reference document and application form will be available soon across the RCN institutions.
- The submission process will start during the fall.
- For this first cycle of funding 2 or 3 projects will be selected for funding.
- Projects will be reviewed by the RCN review committee consisting of the Oncology Chiefs and Nursing Directors from the RCN partner institutions and the RCN Project Management team.
Thank you!