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
Sample Dashboard

Management Measures

Patient Experience

Clinical Indicators

Access/Pt flow | Treatment (quality, safety) | Outcome
---|---|---
Consultation | Pathology | Survival | Mortality
Sx | Chemo | RT | Psycho-social | Palliative
Breast | Gastrointestinal | Genitourinary | Gynecology | Hematology | Head & Neck | Lung

FOR PERSONAL USE ONLY
## 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

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

- 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

<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)
- Gyne (utr sarc, OV, VTE)
- Head & Neck
- GI (colorectal)
- Lung
- GU (prostate)
- Breast

Working groups
From indicator to improved care

1. Data Collection & Reporting
2. Review
3. Action
4. Monitor Progress

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

Patient care

RCN CQI & QI grants

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

Identify areas needing improvement

RCN FIRST ANNUAL RETREAT – JUNE 2015
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 be 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: __________
      Initiation 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.

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 suidein (PQDCS), http://www.inspq.qc.ca, Juillet 2005
Proposed model for clinical research

Disease Site Clinical Trials Committee
Monthly meetings

- Med-Onc
- Surgeons
- Radio-Onc

Inform committee of potential new trial

JGH Trial Manager
MUHC Trial Manager
SMH Trial Manager

- 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)

<table>
<thead>
<tr>
<th>Percent patients presented to a multi-disciplinary TB</th>
<th>Local TB</th>
<th>Network TB</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>JGH</td>
<td>MUHC</td>
</tr>
<tr>
<td>BRUST</td>
<td>34%</td>
<td>41%</td>
</tr>
<tr>
<td></td>
<td>(316)</td>
<td>(415)</td>
</tr>
<tr>
<td>COLORECTAL</td>
<td>12%</td>
<td>37%</td>
</tr>
<tr>
<td></td>
<td>(131)</td>
<td>(357)</td>
</tr>
<tr>
<td>LUNG</td>
<td>36%</td>
<td>14%</td>
</tr>
<tr>
<td></td>
<td>(140)</td>
<td>(487)</td>
</tr>
<tr>
<td>PROSTATE</td>
<td>8%</td>
<td>2%</td>
</tr>
<tr>
<td></td>
<td>(77)</td>
<td>(249)</td>
</tr>
</tbody>
</table>

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