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Surgical Oncology news

QUICK NEWS UPDATES...

Staff Departures & Arrivals

Please join us in welcoming **Dr. Robin McLeod** as Surgical Lead, Quality Improvement and **Sarah Stevens** as our new Program Manager in the Surgical Oncology Program. These two individuals bring a wealth of experience, skill and tremendous enthusiasm in working with the rest of the team to improve the quality of cancer surgery in Ontario.

Dr. Bernard Langer is retiring as Lead of Quality Improvement, and we wish him well with many relaxing travel-filled days ahead.

Rose Cook has departed the Surgical Oncology Program to pursue a consultant position with the Toronto Central LHIN and we wish her well in her future endeavours.

Elena Goubanova has been recruited as Resource Analyst at the Ottawa Hospital Regional Cancer Centre and we wish her much success in her new role.

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Laparoscopic Mentoring Project

An Overview

The Laparoscopic (LAP) Mentoring Project was created from the need to ensure the quality and accessibility of lap colon resection surgery. One of the recommendations from the Laparoscopic Surgery for Cancer of the Colon Guideline, created by Cancer Care Ontario in September 2005, is that surgeons interested in performing Laparoscopic surgery should complete 20 cases with a mentor beforehand.

Benefits

In partnership with the Ontario Association of General Surgeons, the LAP Mentoring Project was established to;
1) foster quality and accessibility by supporting surgeons in meeting the provincial guideline;
2) assist Ontario hospitals in the drive to increase cancer surgeries; and
3) build a sustainable network of surgeons across the province for future communities of practice, educational and project-based initiatives, and for the advancement of LAP surgery.

Current Focus

In order to support a longitudinal mentorship project and a communities of practice, we have brought together surgeons, administrators, and researchers, who are working together to make the Mentoring Project a reality.

There are various programs and regions that can potentially support the LAP Mentoring Project. These include, but are not limited to;

- The Minimally Invasive Surgery Program at the Ottawa Hospital;
- Canadian Surgical Technologies & Advanced Robotics (CSTAR) at the London Health Sciences Centre;
- The Centre for Minimal Access Surgery at the Hamilton Health Sciences Centre; and
- The Toronto Minimally Invasive Surgery Group at the Humber River Regional Hospital
- Royal Victoria Hospital, Barrie
- The Toronto General Hospital

Participation

To participate in the Mentorship Project, as a mentor or

mentoree, please:

- Contact Dr. Andy Smith, Claire Crossley, or one of the programs in your region.
- Visit the Ontario Association of General Surgeons' website at http://www.oags.org

Project Lead:
Dr. Andy Smith
416-480-6100 ext 3885
andy.smith@sunnybrook.ca

Project Coordinator:
Claire Crossley, on behalf of Cancer Care Ontario
416-971-9800 ext 3379
claire.crossley@cancercare.on.ca

Please visit the Mentoring Project website at http://www.oags.org/mentorship.htm for answers regarding mentoring criteria, guidelines, contact information, and more.

The Evidence-Based Series Report: www.cancercare.on.ca/pdf/pebc2-20-2f.pdf

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Cancer System Quality Index (CSQI) 2007

The Cancer System Quality Index (CSQI) is an online report that tells us how the cancer system is performing. The Index is a publicly accessible website providing 30 evidence-based measures of cancer system quality across the full spectrum of cancer services, from prevention to end-of-life care.

The Index was created to evaluate progress, point out where improvements can be made and make the cancer system more accountable so that we can prevent cancer, diagnose it sooner and treat people faster and better.

Highlights related to cancer surgery include:

- Evidence: 77% of colorectal cancer surgeries had 12 or more lymph nodes reported (per the provincial standard) between September and October 2006. This is a statistically significant improvement from 70% in 2005.
- Access: Wait times are continually improving for radiation therapy and cancer surgery.
    - As well, wait times from an abnormal mammogram to first surgery for breast cancer patients have remained high since 2000. However, the wait times for a woman to find out that she did not have cancer have dropped by one week.
    - During the period from August 2005 to January 2007, median cancer surgery wait times have been relatively stable, but 90th percentile waits have decreased 16%. This means the provincial target of 90% of patients being seen within 84 days has been exceeded and patients waiting the longest have seen the greatest improvements.

To view the results of all of the 30 evidence-based measures go to: http://www.cancercare.on.ca/qualityindex2007/

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Ontario Colorectal Cancer Screening Program

The Ontario Ministry of Health and Long-Term Care and Cancer Care Ontario are introducing a provincial colorectal cancer screening program starting this spring. This will be Canada's first provincial colorectal cancer screening program. Family physicians, along with gastroenterologists and general surgeons, will have a central role in delivering this program to Ontarians.

What are the components of Ontario's colorectal cancer screening program?

The screening program will be rolled out over five years.

Beginning in 2007, there will be increased funding for additional colonoscopies across the province for individuals at increased risk because of a family history of colorectal cancer, and those who have a positive FOBT.

Family history means having one or more first degree relatives – parent, sibling or child – with a history of colorectal cancer. It is recommended that patients with a first degree relative who was diagnosed with colorectal cancer should receive an initial colonoscopy beginning at age 50 or 10 years earlier than the age at which the relative was diagnosed, whichever occurs first.

Clinical and patient counseling tools – including guidelines, decision aids and information for patients about screening, preparing for a screening test and completing the FOBT – will be made available to all family physicians and other health professionals.

The Ontario College of Family Physicians will work with Cancer Care Ontario and the Ministry of Health and Long-Term Care to educate family physicians about the guidelines and evidence about colorectal cancer screening and to support them to participate in Ontario's program.

In the second year of the program, FOBT kits will be made more widely available as part of an organized program through physicians' offices, primary care clinics, Family Health Teams and other group practices. People without family physicians will be able to pick up FOBT kits from pharmacies or order them through Telehealth. Patients will send completed FOBT kits free-of-charge in a pre-addressed envelope to a designated laboratory that will be

used for all FOBT testing. There will be a single laboratory to handle all FOBT tests to ensure consistent quality standards. There will also be one standard FOBT test for all patients to improve consistency and ease of use.

There will be a major public education effort launched to coincide with the broad distribution of FOBT kits.

The plan is to offer all family physicians incentives to provide FOBT to patients similar to the incentives currently being offered to physicians who practice in Family Health Teams and other group practices, starting in the second year of the program. The Ministry will work with the Ontario Medical Association to implement these incentives.

There will also be one information system to send reminders to individuals about screening, assist in result and follow-up notification for individuals without access to primary care providers, and evaluate the program's performance.

The information system or registry will notify family physicians by mail when their patients receive a positive FOBT test and will notify family physicians about colonoscopy results.

Negative FOBT results will be mailed to individuals as well as their family physicians from the registry.

The program will follow up and track screening results for people without access to a primary care provider.

How physicians will be involved

Family physicians will play a central role in the colorectal screening program. They are the first point of access for identifying patients at increased risk and for offering screening to average risk individuals aged 50 and over.

Gastroenterologists and general surgeons will be responsible for delivering additional colonoscopies to those with a positive FOBT and to those at increased risk because of a family history of one or more first degree relatives with the disease. They will also play a leadership role in their hospitals and LHINs to ensure clinical guidelines and quality standards for colonoscopies are consistently met.

For additional information please refer to: http://www.cancercare.on.ca/index_colorectalScreening.htm

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Regional Updates

Central

Dr. Mahut, Surgical Oncology lead, is working with regional administrators and practioners within this region and to implement the CCO Thoracic Cancer Surgery Standards. Southlake Regional Health Centre in the Central LHIN is recognized by CCO as a **Level I Thoracic Program** in terms of meeting the Thoracic Surgical Standards. Southlake presently has two full time thoracic surgeons on staff and planning to add a third.

In order to meet and potentially exceed the CCO standards in HPB surgery, preliminary discussions with regional hospitals are taking place to agree on centralizing HPB surgery at a high volume site, which could possibly be outside the LHIN. This will require a change in patient referral patterns and acceptance by physicians and hospital administrators. In order to facilitate this process, Dr. Mahut is targeting physicians for consultation and discussions.

Southlake is working on the development of **Diagnostic Assessment Units**, one for breast and one for lung, using some of the learnings from the Champlain LHIN model. Visits to The Ottawa Hospital and other centres have been very helpful through the information gained. Use of their templates and other documentation will speed up the establishment of organized assessment centres initially for breast and lung, and eventually also for prostate and colorectal. This important undertaking will streamline the diagnostic process and eliminate or sharply reduce bottlenecks that contribute to unacceptable delays and wait times for our patients.

Finally, the region is involved with CCO's provincial **Stage Capture Project** aimed at increasing cancer staging to 90% of all cases included in the 2007/08 cancer surgery agreement. Southlake is also a pilot site for some of the proposed new CCO documents, such as the Endometrial surgical pathology referral form.

North West

Dr. Kenneth Gehman has recently joined us as the new regional surgical lead for the North West. Dr. Gehman is a thoracic specialist working out of Thunder Bay Regional Health Sciences Centre. Thunder Bay has recently initiated MCCs for both the gynecological and thyroid disease sites. These clinics met in January and February respectively. As

well, an outpatient thoracic pathway is currently under development. In response to the laparoscopic surgery guidelines two surgeons at Thunder Bay Regional are currently trained in lap colon surgery and two integrated operating rooms are in the process of being constructed to support this program.

North East

The new thoracic multidisciplinary clinic is well underway. In this clinic patients are able to see the surgeon, medical oncologist, radiation oncologist as well as allied professionals all at the same time. The **Thoracic Multidisciplinary Cancer Conference** occurs at lunchtime on the day of these clinics. A set of indicators is currently being developed to evaluate this clinic. Indicators will include wait times and patient/provider satisfaction. Another wait times project underway is the project: **Access to Care for Prostate Cancer Patients in Northeastern Ontario**. This project is evaluating the time intervals from diagnosis to initiation of treatment for our prostate cancer patients. Focus groups have also been arranged to gain a front line perspective on the journey of these patients through our healthcare system. **Videoconferenced Multidisciplinary Cancer Conferences** have been expanded to include Sudbury, North Bay and Timmins. Sault Ste Marie will begin MCCs in the near future.

Champlain

On Wednesday, February 21, 2007, the Champlain Regional Cancer Program Surgical Oncology Program held a **Colorectal Cancer Community of Practice Journal Club**. This meeting brought together representatives from 6 regional hospitals to discuss **Preoperative Work-up and Preparation for Surgery: Rectal Cancer**. The objective of the meeting was to address immediate needs related to establishment of the regional guidelines and evidence based practice parameters. Participants discussed an optimal treatment model for rectal cancer surgical care and reached agreement on the following guideline: **"Champlain Regional Clinical Practice Guideline: Rectal Cancer-Peri-operative Care"**. A link to the CCO CSQI indicators and guidelines on MCCs and Radiation therapy was made. The group endorsed the multidisciplinary approach to the care of the rectal cancer patient and discussed means to streamline the diagnostic process. According to the post-event feedback form (response rate 70%), 67% of respondents plan to change their practice based on information received at the meeting. Positive changes in the **Colorectal Cancer Community of Practice** are reflected in the increased rates of surgical attendance at the regional multidisciplinary cancer conferences from 11% to 27% in the last 6 months.

Waterloo-Wellington
Terry Sullivan, CEO of Cancer Care Ontario, officially opened the **Breast Diagnostic Assessment Unit (DAU)** on April 23. The centre is part of the Waterloo-Wellington Breast Centre at the Freeport Health Centre site of Grand River Hospital, which opened on February 14, 2007. The aim of the centre is to increase screening of women in the Waterloo- Wellington region and to provide a timely pathway to breast assessment for all patients if needed.

On April 21, the Waterloo-Wellington Regional Cancer Program hosted a **Community Fair for Cancer Care.** The event was a great success and featured keynote speaker Dr. Robert Buckman. Additional presentations explored Breast Screening, Cervical Cancer Prevention, Colorectal Screening, and stories of survivorship.

The **Thoracic DAU** will open on June 27th. Improving access to better and more rapid cancer diagnosis has been identified as a priority for Cancer Care Ontario. In response, the Thoracic DAU has been designed with the following core principles, i) to ensure that an environment of patient centered care is established; ii) to ensure that coordinated referral and follow-ups are established; and iii) to ensure that indicators of quality are established and monitored.

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Pathology Checklist Reporting Project

The overall goal of the Pathology Checklist reporting project is to improve patient health outcomes through the implementation of standardized pathology report content and format – synoptic reporting.

Over the last decade, the College of American Pathologists (CAP) through its Cancer Committee has established a checklist-based system of standardized cancer pathology reporting. The protocols and checklists are evidence-based and have been developed by disease site-specific expert pathologists with input from surgeons and medical and radiation oncologists. In 2004 Cancer Care Ontario, in consultation with the Ontario Association of Pathologists, endorsed the use the CAP checklist program as the provincial standard for 16 common disease sites.

Where we've been and where we're going

This project builds on the Pathology Information Management System (PIMS) Project that was rolled out in phases from 1999 to March 2005. PIMS automated the transmission of data from hospital laboratories to CCO. Currently, 50 labs are live with PIMS, representing 90% of the total volume of the province's cancer pathology.

Initially, PIMS focused on how the data was acquired for the purpose of cancer case ascertainment. Now the focus has shifted to concentrate on the data format and content via synoptic reporting. It will allow the data to be stored in discrete data fields where it can be used in support of cancer planning, disease surveillance, research and quality monitoring.

Pathology Project Work Streams

Overall, the Pathology Project consists of a number of sub-projects, which together will achieve the project's goal of enhancing patient care and health outcomes. The sub-projects include:

Audit – Pathology reports are manually abstracted and audited for completeness (target of 90%) against their respective CAP Checklist. Audited disease sites this year include, Lung, Breast, CRC, Prostate and Endometrium.

Audit findings are published in CSQI and were sent to CSA hospitals in the spring of 2007. http://www.cancercare.on.ca/qualityindex2007/

Synoptic Rollout –Implementation of electronic synoptic reporting tools in all Cancer Surgery Agreement (CSA) hospitals.

Path Reporting – Reporting back to the hospitals concerning the data that they submit.

Surgical Pathology Requisition Forms – Development of forms for surgeon use in order to aid the pathologist in achieving 100% report completeness.

Support of Collaborative Stage (CS) –CCO's vision is to ultimately receive all the data elements for calculating TNM and prognostic factors electronically through electronic submissions of synoptic pathology, diagnostic imaging, lab and surgical reports. CCO has commenced "Collaborative Staging Pilots" to assess the feasibility of obtaining staging data from synoptic pathology reports as efficiently as possible. For more information about the Stage Capture Project see the related article.

For further CAP information and checklists visit http://www.cap.org/

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Cancer Stage Capture Project

The Cancer Care Ontario led Stage Capture Project, is a multi-year initiative that is aimed at improving the capture rate, validity, and use of stage data in Ontario. As a critical prognostic factor, cancer stage information adds considerable value understanding factors driving incidence and prevalence, assessing the impact of screening programs and evaluation of cancer service treatment patterns and outcomes. In spite of that, there are relatively few published cancer system indicators in Ontario that utilize stage. This is mainly because currently, CCO collects valid stage data for approximately 33% of total new incident cases in the province. This stage data currently comes from 12 of the 14 Integrated Cancer Programs (ICPs) in the province for radiation and systemic therapy cases; none of the other hospitals treating cancer are currently reporting stage, and there are some ICP cases, generally those treated by surgery only, that are also not currently reported.

The overall valid stage capture rate can be improved from 33% to 41% by increasing the proportion of cases with valid stage reported by all ICPs from the current 72% to 90%.

Improving the stage capture rate will use a multifaceted approach which includes supporting the Clinician Mentor role. This physician leadership role is intended to provide active support to the TNM Expansion project through the development of systems and processes for enhancing the ICP's current stage capture rate as well as the capture of staging for all surgical cancer cases that are not seen in the Regional Cancer Centre. The Clinician Mentors will also have a role in providing education and ongoing feedback to their clinical peers regarding stage capture for the ICP.

The knowledge transfer literature clearly identifies the role of local experts as a key component in the successful implementation and sustainability of clinical practice initiatives. The Clinician Mentor role will provide a key resource to physician colleagues throughout the TNM Expansion project.

For further information please contact either of the Co-Clinical Leads:
Dr. Tom McGowan (TMcGowan@cvh.on.ca) or
Dr. Kevin Imrie (kevin.imrie@utoronto.ca).

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Quality Improvements

The Surgical Oncology Program (SOP) held a Retreat Friday, November 17, 2006, to assess cancer surgery quality issues and priorities in Ontario. The lively discussion was a vehicle to highlight the issues facing cancer surgeons and patients. Participants were asked to i) discuss the guideline and standard priorities for Ontario cancer surgery in the next two to three years and ii) brainstorm ideas to foster practice change.

The Retreat is guiding the quality work plan of the SOP and the Program in Evidence-based Care (PEBC) for the upcoming fiscal years including the development of cancer surgery guidelines for the breast, gastric, and head & neck disease sites. All of the projects identified are important and we will work to move them forward over the next several years.

Many important items concerning the implementation of guidelines and/or standards were examined. The importance of data capture (e.g., synoptic operative reporting) was highlighted as critical to helping understand quality issues and enabling the ongoing measurement of quality improvement. Some key activities identified as being integral to quality implementation include wide distribution of quality documents, facilitating implementation incentives and support of clinical and administrative engagement and collaboration. This feedback will be instrumental to not only the SOP but Cancer Care Ontario in future implementation strategies.

The Retreat Proceedings can be accessed at: http://www.cancercare.on.ca/documents/SOPQualityRetreatProceedingsNov-17-2006.doc

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Program in Evidence-Based Care Scientific Symposium

On February 28, 2007 the Program in Evidence-Based Care (PEBC) hosted a **Scientific Symposium in Toronto on "The Nature of Evidence"**. We brought together guideline developers from the UK and the USA, methodological experts outside of the PEBC and clinicians and research methodologists who have participated in PEBC guideline development to consider how we define, use, implement and apply evidence in the development of guidelines and standards documents. The objectives of the meeting were:
1. To debate and discuss the role of evidence as it applies to the work of the PEBC.
2. To identify common principles, where possible, in the use, application, and interpretation of evidence in advice documents developed by the PEBC.

Program

Following a welcome by Terry Sullivan, Melissa Brouwers presented a historical context for the meeting and set the stage for the sessions to follow. During the morning plenary sessions, broad perspectives on guideline development were provided by Gordon Guyatt (McMaster University) who spoke on the GRADE methodology for evaluating evidence, Peter Littlejohns (National Institute for Health and Clinical Excellence, NICE) who presented a perspective from the UK and Lisa Newman (American Society of Clinical Oncology, ASCO) who talked about the ASCO guideline program. Questions from the audience were taken by each speaker individually following their talk and as a panel at the end of the plenary. There was lively discussion and debate of issues and ideas raised by the speakers, particularly with regard to evaluating evidence and how this affects guideline development, clinical practice and policy decisions.

Three break-out discussion sessions took place in the afternoon, each focussed on a different aspect of how evidence has been used in PEBC guidelines. Session 1 was on the use of studies other than Phase III RCTs and evidence from abstracts, Session 2 on outcome measures and Session 3 on magnitude of benefit. Many useful ideas and suggestions were brought forward from these discussions regarding the use and misuse of evidence in guiding practice and policy, evidence gaps, methodologic

issues and application of evidence to clinical practice. The following general principles were identified to guide PEBC document development.
1. State explicitly when a recommendation is based on a consensus of clinical opinion.
2. Adopt new strategies for more efficiently obtaining, interpreting and applying non-Phase III evidence.
3. Make the linkages between evidence and recommendation more explicit in the documents.

The proceedings of the symposium will be made available at: http://www.cancercare.on.ca/index_practiceGuidelines.htm

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Conferences and Events

Celebrating Innovations in Health Care Expo 2007
May 23 & 24, Toronto
http://www.qualityhealthcarenetwork.ca/pdfs/Celebratinginnovations07.pdf

33rd Annual Toronto Thoracic Surgery Refresher Course 2007
June 1 & 2, Toronto
http://www.cme.utoronto.ca

The 27th Annual Assembly of General Surgeons and Residents
June 7, Toronto
http://www.surg.med.utoronto.ca/gen/events.html

National Healthcare Leadership Conference
June 11 & 12, Toronto
http://www.healthcareleadershipconference.ca/default1.asp

Patient Safety Culture Symposium
July 4 & 5, Toronto
http://www.qualityhealthcarenetwork.ca/pdfs/Yorkptsafetysymp2007.pdf

Guidelines International Network (GIN) 2007 Conference
August 22-25, Toronto
http://www.gin2007.org/

2007 Canadian Surgery Forum
September 6-9, Toronto
surgeryforum@rcpsc.edu

Update in Surgical Oncology 2007
October 26, Toronto
http://www.cme.utoronto.ca

Update in Urology 2007
October 26 & 27, Toronto
http://www.cme.utoronto.ca

O.A.G.S. 13th Annual Meeting

November 3, Toronto
info@oags.org

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