Update on 2014 Colorectal Cancer Summit: From recommendations to action

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Inaugural Colorectal Cancer Summit 2014

- Over 60 participants
- Discussed data on variations in care & outcomes for state-wide action
- Clinical working party formulated recommendations for action
Progress with 2014 CRC Summit Recommendations

### Colorectal Cancer Summit 2014

Clinician-led meeting to identify opportunities for improving outcomes and care for Victorian colorectal cancer patients

After the inaugural CRC Summit held in Melbourne on 12 September 2014, the clinical working party formulated recommendations for presentation to the Victorian Integrated Cancer Services Network. We are pleased to report at the Second CRC Summit in March 2018 that all recommendations were actioned.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Action Status</th>
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<tbody>
<tr>
<td><strong>Multidisciplinary meetings</strong></td>
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<tr>
<td>1. Measure the proportion of rectal cancer patients (actively treated) who have multidisciplinary treatment planning, with a target of more than 95%.</td>
<td>✔</td>
</tr>
<tr>
<td>2. Promote consistent standards and effectiveness of multidisciplinary teams and meetings.</td>
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<tr>
<td><strong>Variation in treatment received and quality of data</strong></td>
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<tr>
<td>3. Develop routine reporting (by region and health service) of the number of nodes examined during major CRC surgery.</td>
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<tr>
<td>4. Consider reporting on the proportion of stage III colon cancer receiving adjuvant chemotherapy.</td>
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<tr>
<td>5. Further work is undertaken to identify stage at diagnosis from Linked Victorian Cancer Registry-Victorian Admitted Episode Dataset.</td>
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<td>6. Provide information regarding methodology for identifying emergency presentations leading to major CRC surgery.</td>
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<tr>
<td><strong>Screening, colonoscopies and early diagnosis</strong></td>
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<tr>
<td>7. Call for collaboration to improve information about diagnostic colonoscopy wait times and participation in the National Bowel Cancer Screening Program (NBCSP).</td>
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<tr>
<td>8. Raise awareness of National Health and Medical Research Council (NHMRC) colonoscopy guidelines.</td>
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*Victorian Integrated Cancer Services, Cancer Council Victoria, Government of Victoria*
Progress with 2014 CRC Summit Recommendations cont.

The recommendations informed:

- Rectal Cancer MDM Audit & the development of Victorian Cancer MDM Quality Standards

- Developments in Cancer Data Analytics and Cancer Performance Indicator Reporting initiative

- The implementation of the Optimal Care Pathway for CRC in Victoria

- Highlighted the need for improving information flow about screening, colonoscopies and early diagnosis of CRC – DHHS update in information packs.
Developments in Cancer Data Analytics

<table>
<thead>
<tr>
<th>DHHS linked data set</th>
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<tbody>
<tr>
<td>Victorian Cancer Registry (VCR) 2011 – 2015</td>
</tr>
<tr>
<td>Hospital in-patient data (VAED) July 2006 – March 2017</td>
</tr>
<tr>
<td>Radiotherapy data (VRMDS) July 2010 – 2016</td>
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</tbody>
</table>

Data Linkage Performed By Victoria Data Linkage
Features of linked cancer dataset

State wide data - reliable linkage program

Population level outcomes - offers general indicative patterns

Limitations
• Does not identify in-community care
• Lacks specific disease features (e.g. staging, ECOG)
• Relies on hospital coding
• Some assumptions / use of proxy data (metastatic / non metastatic)
• Interstate treatment not included (mainly affects Hume RICS)

Currently developing on-line interactive platform
Cancer Performance Monitoring

• Development & testing of nine quality / performance indicators

• Aim: to develop systematic reporting, analysis and use of cancer data across the state

• Use = data is used to diagnose and address unwarranted variations at the point of care
CRC Optimal Care Pathway implementation

Aim: Coordinated improvement program of work (2016-17) designed to achieve impact at scale

Local aim: identify and address opportunities for optimising CRC care and outcomes

Multi-faceted approach through sector partnerships

Data informed
Vic. OCP Implementation Approach

Leading partnerships:

- 8 adult Integrated Cancer Service Network
- Primary Health Care Alliance *All 6 PHNs + state coordinator
- CCV & The University of Melbourne collaboration * Academic detailing in primary care (metro NW Melb and regional West Vic)

Method:

- Identification of gaps in care → targeted improvement activity
- Tumour Summits analyses and recommendations significantly informed local action plans

Results:

- Some impacts locally and many learnings re approach
OCP Implementation: MDM treatment planning

Following OCP implementation (2017)
GRICS %MDM increased to 74%

Following OCP implementation (2017)
GRICS %MDM increased to 84%

Percentage of documented MDM – Rectal cancer audit 2015

% MDM

MDM Target 95%
OCP Implementation: Timing of MDM
treatment planning for rectal cancer

Rectal cancer audit - timing of MDM
100% of patients that had surgery in second half of 2015 were included

By 2017 GICS increased % of patients discussed prospectively to 55%

Data source: DHHS clinical performance indicator audit 2015
### Other OCP Implementation Outcomes

<table>
<thead>
<tr>
<th>ICS</th>
<th>Health Service</th>
<th>Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>NEMICS</td>
<td>Eastern Health</td>
<td><strong>100% of first specialist appointment now occurring in 14 days</strong>, up from 19%<strong>83% of patients are commencing treatment within 42 days</strong>, up from 39%</td>
</tr>
<tr>
<td>LMICS</td>
<td>Mildura</td>
<td><strong>64% of patients have their ECOG status documented</strong>, up from 20%</td>
</tr>
<tr>
<td>BSWRICS</td>
<td>Portland DH</td>
<td><strong>99% of patients are being screened for their supportive care</strong></td>
</tr>
<tr>
<td></td>
<td>SW Health</td>
<td><strong>70% of patients are being screened for their supportive care</strong></td>
</tr>
<tr>
<td></td>
<td>Barwon Health</td>
<td><strong>60% of patients are being screened for their supportive care</strong>, up from 7%</td>
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</table>
Colonoscopy Referrals Project: intervention to improve GP referral quality

<table>
<thead>
<tr>
<th>Referral Item</th>
<th>Pre</th>
<th>Post</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full info on reason for referral</td>
<td>53%</td>
<td>68%</td>
<td>0.034</td>
</tr>
<tr>
<td>FOBT result attached for pos+ FOBT</td>
<td>31%</td>
<td>74%</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Family history of CRC</td>
<td>40%</td>
<td>41%</td>
<td>0.946</td>
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EG#1 OCP Service Redesign
EG#2 OCPs and Health Pathways

**Optimal care pathway for people with lung cancer**

**Quick reference guide**

**Step 1** Prevention and early detection

**Prevention:**
- All current smokers should be offered advice to quit smoking. Effective strategies include:
  - advice on quitting smoking and structured interventions by health professionals
  - individual or group counselling programs such as Quit (refer to www.quit.org.au)
  - nicotine replacement therapy and other pharmacological agents

**Risk factors:**
- Lifestyle factors:
  - tobacco use
  - environmental exposures such as asbestos, radon, and diesel exhaust
- Occupational exposures

**Step 2** Presentation, initial investigations and referral

**Signs and symptoms:**
The following is a list of signs and symptoms that may indicate lung cancer:
- Persistent haemoptysis
- Persistent cough
- Unexplained weight loss
- Unexplained fever

**General/primary practitioner investigations:**
- Chest X-ray: If cancer is suspected, refer immediately.
- Contrast spiral computed tomography (CT) of the chest and upper abdomen: If the chest X-ray is clear and symptoms persist, immediate referral if the CT is abnormal. Test results should be provided to the patient within one week. The first specialist appointment should take place within two weeks of referral.

**Red Flags**
- Massive haemoptysis
- Stridor
- Respiratory distress
- Severe signs of superior vena cava obstruction

**Assessment**
1. Consider:
   - lung cancer diagnosis for these symptoms and signs, if unexplained and > 3 weeks duration.
   - **Risk factors**
2. Arrange investigations:
   - Chest X-ray
   - If chest X-ray is suggestive or symptoms are still undiagnosed, arrange urgent CT scan of chest without IV contrast.

**Referral:**
Refer all patients with suspected or proven lung cancer to a specialist linked with a multidisciplinary team. Massive haemoptysis and/or signs of stridor require immediate referral to an emergency department.

**Communication – lead clinician to:**
- explain to the patient/carer why they are being referred to and why
- support the patient and carer while waiting for specialist appointments.
EG#3 I-PACED and GP education

Aim: to increase GPs awareness about critical primary care points and clinical care along the colorectal cancer and lung cancer OCP through:

- Prompt, accurate diagnosis
- Reduced over-investigation
- Defined referral pathways for cancer care

Mechanisms:

- Education sessions held in GP practices
- CCV nurses outreach visits
- Tools & resources tailored to primary care

Ref: Prof Jon Emery, Dr Anna Boltong et al. 2017
I-PACED Reach
- 194 practice visits on the CRC OCP
- 730 PHPs
  - 84% GPs
  - 14% Practice Nurses
  - 2% Practice Managers

Combined PHN & I-PACED Reach
1,288 GP practices visited - 68% of total Victorian GP practices

Ref: Prof Jon Emery, Dr Anna Boltong et al. 2017
Victoria’s Colonoscopy Categorisation Guidelines

Issues

• Demand for colonoscopy is growing
• Public patients have difficulty accessing services
• Some referrals and colonoscopy procedures are inappropriate
• Too many patients are having cancer detected too late

Guidelines

• In 2016, DHHS contracted RACS and ASERNIP-S to develop agreed categorisation policy guidelines for colonoscopy incl. specifying information required from referrer
Victoria’s Colonoscopy Categorisation Guidelines

Trial
• In 2016 the guidelines were trialled in 4 health services to confirm usability and examine hospital wait lists/efficiency
• Hospital executives and clinicians reported strong support

Validation
• In 2017 the Uni Melbourne Primary Cancer Research Group assessed the effectiveness & efficiency of the Guidelines
• Guidelines were confirmed as both effective in selecting patients for colonoscopy and the most efficient guidelines (cf. with two national guidelines currently in use)
Victoria’s Colonoscopy Categorisation Guidelines

Actions
In 2018 - 2019 DHHS will work with health services to:
• Ensure guidelines are implemented in all health services by 1 July 2018.
• Monitor the impact of the guidelines in health services.
• Improve the information provided in patient referrals to public hospitals.
• Establish the demand and monitor waiting times for endoscopy services in Victoria.
• Develop a strategy and actions for the collection of safety and quality measures for endoscopy

Gastroscopy
DHHS has again contracted RACS to develop categorisation guidelines for gastroscopy, due to be developed in 2018.

Guidelines and further information at
Acknowledgements

2014 CRC Summit Clinical Working Party
- chaired by Mr Brian Hodgkins

Victorian Integrated Cancer Services

Victorian Primary Health Network Alliance

Department of Health & Human Services:
- Cancer Screening & Prevention
- Admitted Care Policy & Planning
- Cancer Strategy & Development

Cancer Council Victoria
- Cancer Epidemiology and Intelligence Division
- Victorian Cancer Registry

The University of Melbourne, Centre for Cancer Research