2nd CRC Summit Highlights

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Victorian Tumour Summits

2nd Victorian Colorectal Cancer Summit Highlights

On 16 March Victorian Integrated Cancer Services and the Department of

Health and Human Services hosted the 2nd Colorectal Cancer Summit (CRC Summit) in Melbourne. We were thrilled to have great multi-disciplinary attendance working to prioritise unwarranted variations in care and patient outcomes in Victoria.

Summit participants prioritised six variations using a matrix assessing the impact on patient outcomes and the effort it would take to reduce presented variations. Two variations were considered to be high impact/low effort by the majority of participants:

1. Increasing the proportion of CRC patients having a multidisciplinary meeting (MDM) (range of 56% - 96% by ICS of treatement)

2. Increasing the utilisation of adjuvant chemotherapy for stage III colon cancer patients (range of 82% - 95% by ICS of surgery).

Four variations were considered of high impact but with high effort required to change them:

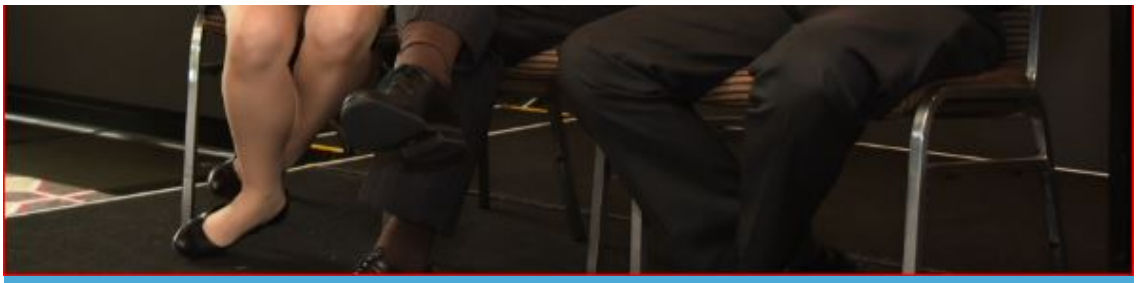
3. Increasing the percentage of MDM discussions for rectal cancer patients before commencing treatment (30% of discussions occur after treatment begins, varying by ICS of treatment).

4. Increasing the utilisation of neoadjuvant radiotherapy in rectal cancer patients (range 14% - 36% by ICS of surgery).

5. Increasing the number of resected lymph nodes for colon cancer patients to twelve and above (range 72% - 92% by ICS and campus of surgery).

6. Increasing the timeliness of adjuvant chemotherapy for stage III colon cancer patients to within eight weeks of surgery [range 53% - 80% by ICS of surgery (public hospitals only)].

Click here for the 2011-2015 CRC Data Presentation on our website



Some excellent suggestions for tackling these six variations came out of the group work session. The clinician panel was inspirational. Three clinicians, Dr Zee Wan Wong, Dr Geoff Chong and Mr Brian Hodgkins shared how they investigated and reduced unwarranted variations in care.

Dr Wong, Head of Oncology Unit at Peninsula Health, and colleagues looked at timeliness of patient presentation at their combined GI multidisciplinary meetings (MDMs).
An audit showed ~60% of presentations were colorectal and ~40% were Upper GI (UGI) cancers.

"This was not without effort - it was a lot of hard work and commitment and determination to make it work. I represent the people who gave their time and effort to make this possible and I'm grateful for that."

Discussed and polled across all disciplines, the consensus was to split multidisciplinary meetings into separate colorectal and UGI streams, improving timeliness of patient presentation.

Dr Wang and colleagues organised with the Heads of Radiology, Pathology and Surgery alternative MDM times that colorectal surgeons could attend the colorectal MDMs.

"We had to have Executive engagement and buy-in to justify the increase in workload on pathologists and radiologists because this was a contracted service."

Within three months from the beginning of this clinician-led improvement the first colorectal-only MDM was held in January 2018.

Next time: More on clinician-led improvement and planning local action.

All Summit presentations were filmed and will be available with our next April newsletter.

Many Summit attendees have joined us at Linkedin. Please sign in to your Linkedin account, then click below to ask to join us:

LinkedIn

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