Key observations

PROCARE
PROJECT ON CANCER OF THE RECTUM
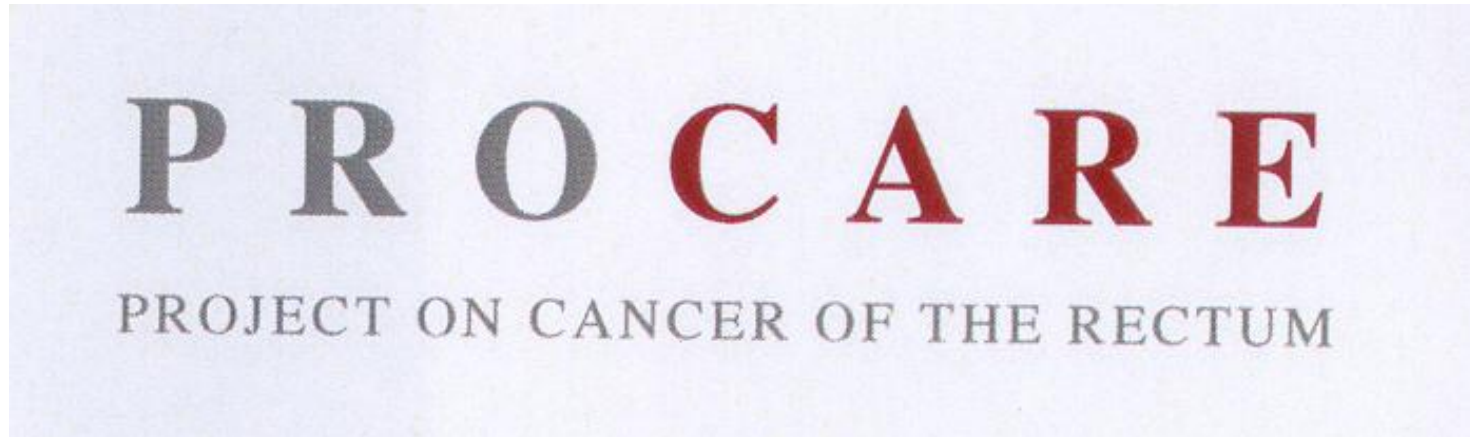
Penninckx F
on behalf of all participating teams
and the PROCARE Steering Group

The PROCARE project
AIMS

improve outcome & reduce variability

for <u>all</u> aspects and stages of RC

- Multidisciplinary (teams)
- Profession-driven, all centers/teams
- Voluntary participation
- Educational (confidentiality)

The PROCARE project
METHODS

- multidisc. **guidelines and QCI** (2005, 07, 08)

- quality assurance (**implementation** of GL)

  - training (TME, pathology, RX, RT)

  - registration of 151 items/patient (>1/2006)

  - feedback / benchmarking (2008 - ...)

financial support from the KCE
Foundation against Cancer (2006-2007)
Health Authorities RIZIV / INAMI (2007-2012)

The PROCARE project
Key observations

- Most physician-specialists want to know
- Participation on a voluntary basis = incomplete data
- Health authorities are willing to support
- Confidentiality is essential
- Variabilities in management of rectal cancer
- Adjusted benchmarking is required for many QCI's
- Enthusiasm vs variable use of training facilities
- From project to structure
- Audit is unavoidable BUT Improvement is the goal

A major effort on a voluntary basis
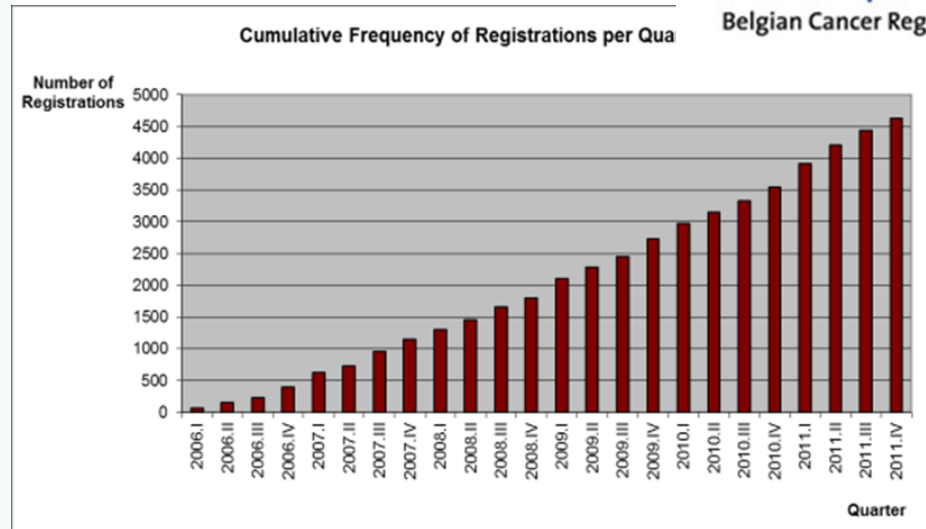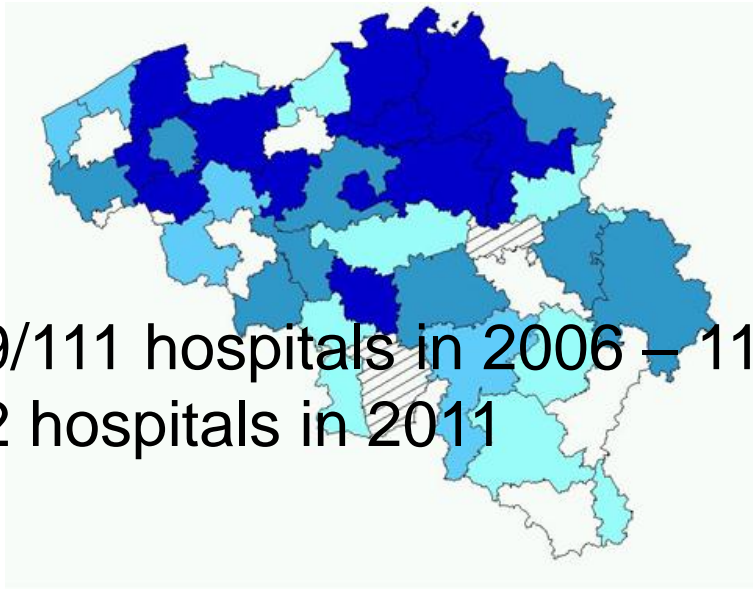## registered patients per hospital per district

1/12/2011

> 5700 patients

Belgian Cancer Registry

89/111 hospitals in 2006 – 11
62 hospitals in 2011

1. Many professionals want to contribute and to know
2. Incomplete and variable participation (50% surgery)
3. Benchmarking requires complete participation of all

PROCARE
PROJECT ON CANCER OF THE RECTUM

Burden of registration should be limited

Acta Chir Belg 2011

Time in hours:minutes:seconds	MINIMUM	MAXIMUM
Early RC	0:34:13	1:01:52
cStage II-III short RT	1:03:05	1:42:40
cStage II-III long RCT	1:19:57	2:04:08
Metastatic RC palliative	0:24:40	0:58:29
Follow-up	*0:07:39*	*0:19:36*

70% physician time – 30% datanurse time

1. Burden of registration too high
2. **Limited dataset** (64 items) needed for obligatory registration
3. **Synoptic templates** should be developed
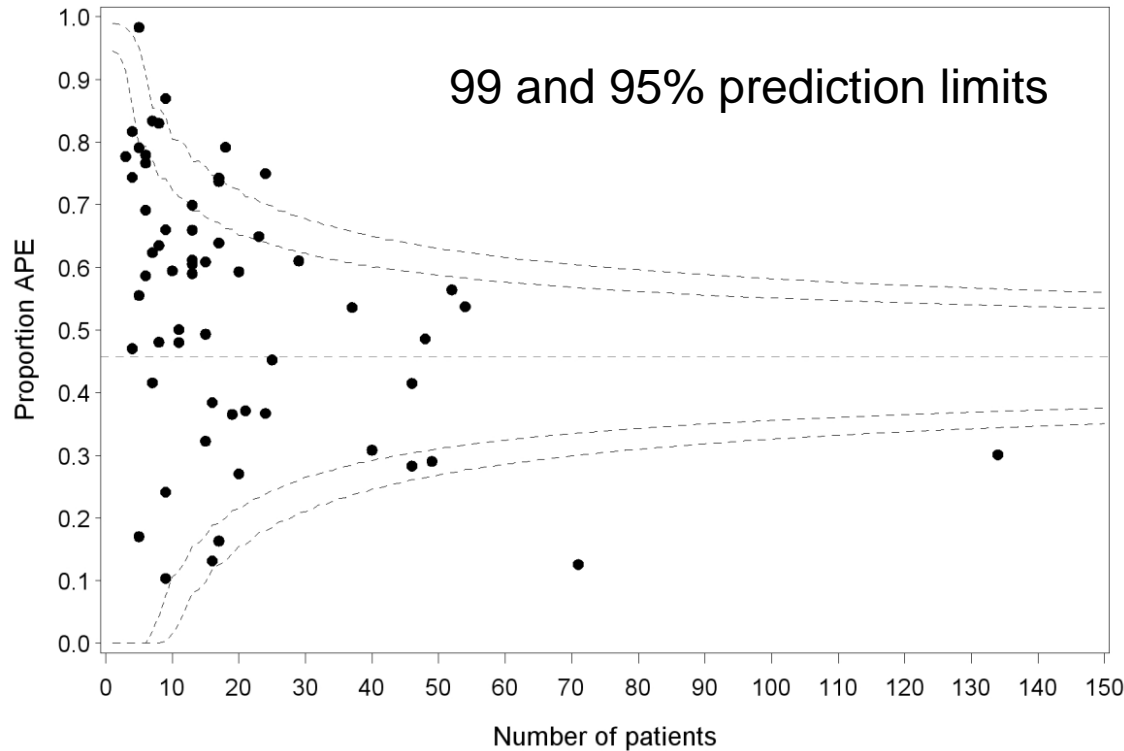4. Minimum dataset should allow adjusted benchmarking

PROCARE
PROJECT ON CANCER OF THE RECTUM

Variability in management (staging)

Reported cCRM in cStage II–III
Feedback 2011
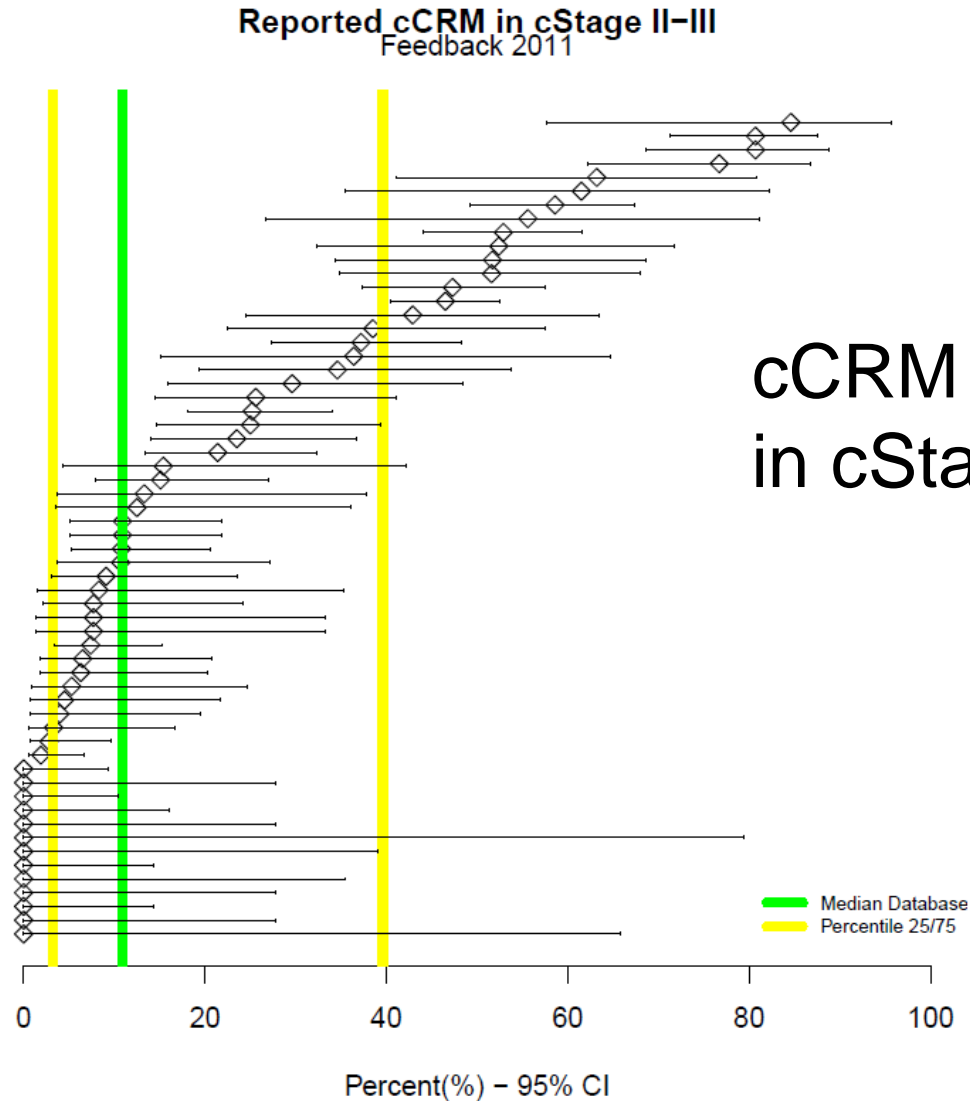
cCRM reported in cStage II - III

Median Database
Percentile 25/75

Percent(%) − 95% CI

Abdominoperineal excision rate for low RC

Gut, published online April 23, 2012

99 and 95% prediction limits

adjustment for level, age, sex, ASA, cT4, preop incontinence

Before   14
After   8 + 2

Proportion APE

Number of patients

1. Adjustment for confounders is essential for outlying perform.
2. Experts have to pre-determine relevant confounders
3. Outliers should improve, monitored by peers

PROCARE
PROJECT ON CANCER OF THE RECTUM

'Cancer registration' is not enough

	BCR 2006-mid 2008 N = 5504	PROCARE 2006-2011 N = 4583
cStage known	**56%**	**83%**
(y)pStage known	**70%**	**90%**

1. Obligatory registration at BCR does not result in complete data
2. Registration must be controlled for completeness
3. BCR does not provide all items for benchmarking (+ age, sex)
4. A cancer-specific (sub)database is required

PROCARE
PROJECT ON CANCER OF THE RECTUM

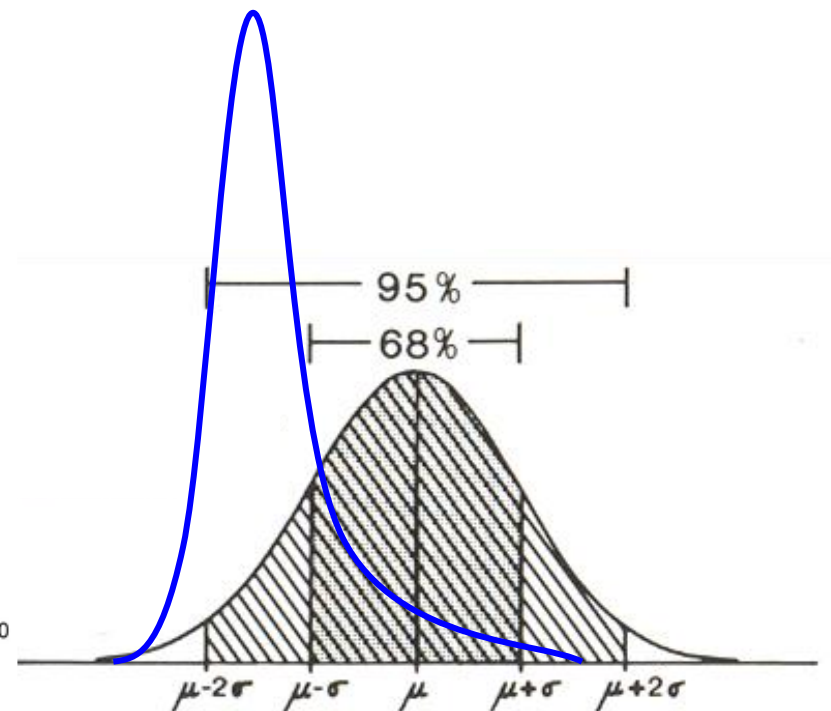# From project to structure
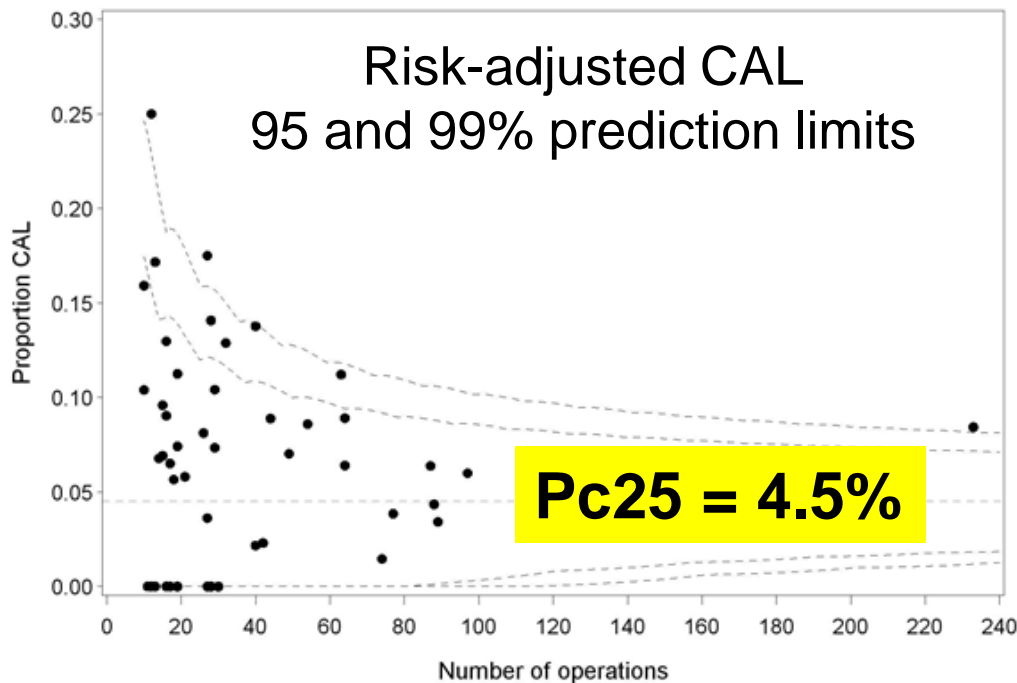# Proposed 'audit loop'
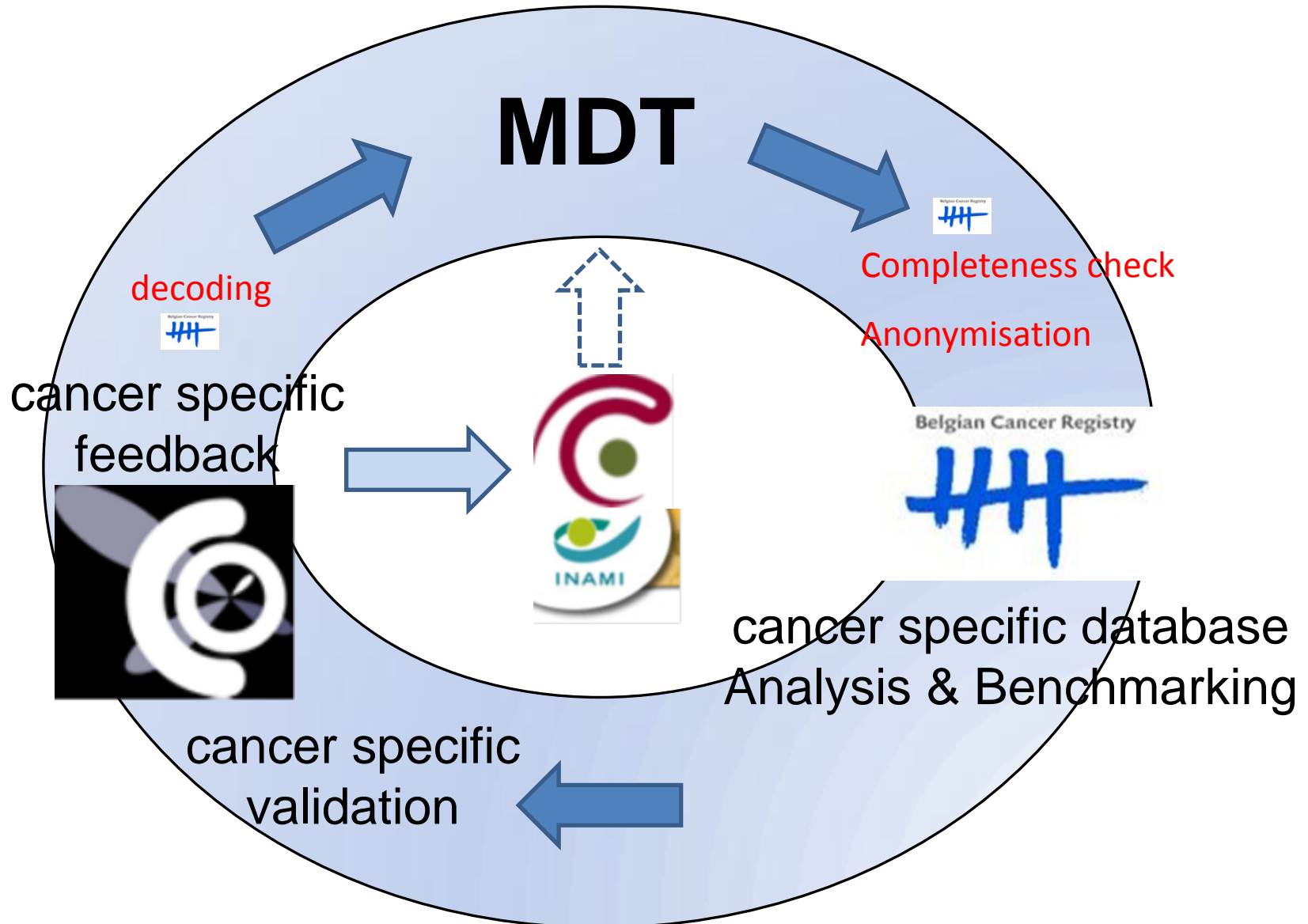
Audit is unavoidable, but Improvement is the goal
What benchmark or 'target value'?

Median with CI 95 % = mediocre progress
The 'top teams' with CI 95% (CI 90%?)
For every QCI or for a set of QCIs ? .../...

Risk-adjusted CAL
95 and 99% prediction limits

Pc25 = 4.5%

The PROCARE project
Key observations

- Most physician-specialists want to know
- Participation on a voluntary basis = incomplete data
- Health authorities are willing to support
- Confidentiality is essential
- Variabilities in management of rectal cancer
- Adjusted benchmarking is required for many QCI's
- Enthusiasm vs variable use of training facilities
- From project to structure
- Audit is unavoidable BUT Improvement is the goal