



Wellness Beyond Cancer Program: Program Evaluation and Quality Assurance Review

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Introduction

The annual incidence of cancer in Canada is increasing with an estimated 202,400 new cases in 2016 (1). Of those diagnosed, 60% are expected to survive at least 5 years (1). Breast cancer (BC) as well as colorectal cancer (CRC) are both highly prevalent and curable diseases (1). As such, formal discharge or survivorship programs tailored to these disease sites are critical.

The Wellness Beyond Cancer Program (WBCP), a multidisciplinary team of health care providers within The Ottawa Hospital Cancer Program (TOHCP), was generated to ensure that all patient who have completed active treatment for BC or CRC have access to appropriate follow-up care and resources after formal discharge from their oncologist. This model represents a departure from traditional oncology follow-up model where patients would be seen by their oncologist during treatment and for a highly variable time after therapy had been completed. Suitable patients are transitioned to either their Primary Care Provider (PCP) with a care plan and their individual needs assessment or to the WBCP Nurse Practitioner (NP) stream (Figure 1). Early surveys demonstrated that both patients and PCPs support the WBCP; however, this program has yet to be formally assessed in terms of cancer specific outcomes (2).

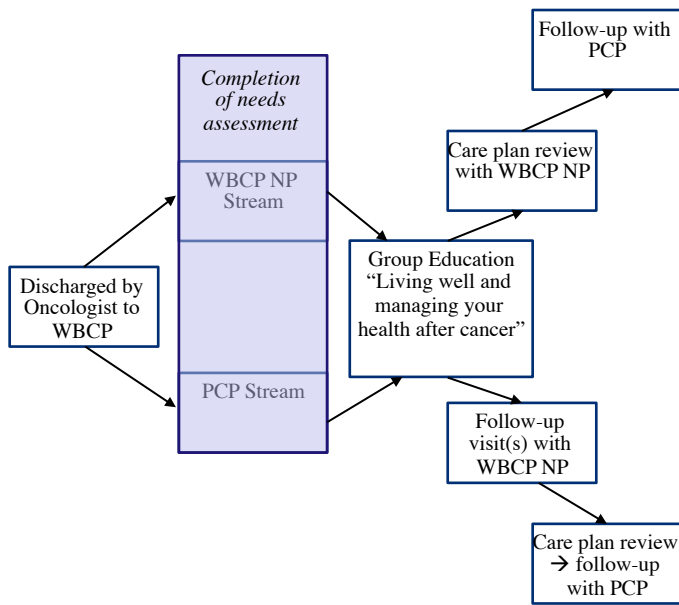


Figure 1. Flow of patients through the Wellness Beyond Cancer Program (WBCP).

Objectives: Conduct a quality assurance evaluation of the WBCP by exploring reasons and outcomes for patients who were referred back to TOHCP. Collect disease specific details, as well as the form and intent of treatment at the time of reassessment by an oncologist.

Methods

This quality assurance project was conducted by reviewing all paper and electronic records (OACIS and MOSAIQ) for every patient who re-entered the TOHCC from either the NP or PCP streams. The data collection began with the initial cohort discharged in March 2013 (CRC) and February 2013 for BC. Collection ended for both in August 2016. The reasons for re-entry (recurrence, new primary, benign disease) were coded along with demographic information, adverse events (presentations to emergency department, disease related complications), and treatment options and intent of treatment. All data was de-identified and stored in a password protected file. Descriptive statistics were conducted in Excel. This study was approved by the Chairman of The Ottawa Health Science Network Research Ethics Board (REB) who agreed as a QI project it did not require REB approval.

Results

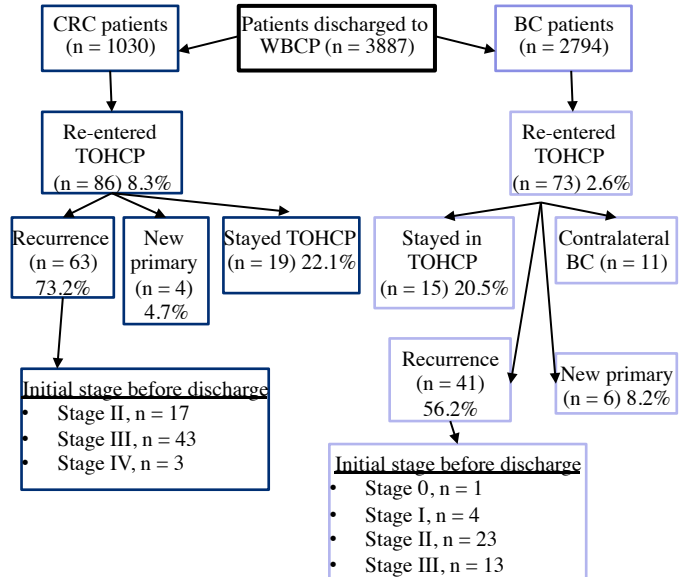


Figure 2. Reasons for patient re-entry and details of disease at the time of discharge via the WBCP.

Treatment prior to re-entry to TOHCP

Breast Cancer	
AC, Rx, HT	17
AC, HT	1
AC, Rx	6
NAC, Rx	2
NAC, HT	1
Rx, HT	6
Rx	2
HT	3
Surgery alone	3
Colorectal Cancer	
Rectal (n = 21)	
NAC, AC, Rx	15
NAC, Rx	1
Surgery alone	5
Colon (n = 42)	
AC	26
Surgery alone	16

Table 1. Form of treatment patients received before being discharged to WBCP. Adjuvant chemotherapy (AC), Radiation (Rx), Hormone therapy (HT), Neoadjuvant chemotherapy (NAC).

Discussion

Overall, the results support the notion that the WBCP allows for an efficient pathway for patients who relapse or require formal reassessment by an oncologist to be reconnected to TOHCP. All patients from both the CRC and BC cohorts who had confirmed recurrences were eligible for treatment when they re-entered the cancer program, with a minority declining further intervention for personal reasons. Impressively, eight of the twelve patients with CRC recurrences who were surgical candidates underwent metastatectomies with curative intent.

Within the BC group, no patients presented to the Emergency Department (ED) with critical complications such as cord compression. However, there were two patients who experienced new neurological symptoms and were found to have brain new brain lesions on assessment in ED. Additionally, two patients had pathological fractures.

This quality assessment evaluation is limited by the sample small size, short follow-up time given the program was initiated in 2013 and lacks a control group. Additionally, the true recurrence rates may be masked by patients not undergoing complete screening when discharged to the care of the PCP and therefore they were not referred back to the TOHCP. In order to address these limitations, a case-matching study is currently underway.

Conclusion: The initial data from this quality assurance project suggest that patients receive safe and appropriate care when discharged through a formalized program such as the WBCP.

References

1. Canadian Cancer Society's Advisory Committee on Cancer Statistics. Canadian Cancer Statistics 2016. Toronto, ON: Canadian Cancer Society; 2016
2. Rushton M, Morash R, Larocque G., Liska C., Stoica L., DeGrasse C., and Segal R., 2015. Wellness Beyond Cancer Program : building an effective survivorship program. Current Oncology, 11 (6), 419-434.