Colon cancer project

...we work with....

...regional challenges with the patient’s process in focus

“Each piece of art is about material, instrument and management and it is practice that gives knowledge to it. Practice reveals weaknesses and shows phenomenon and it is theory to explain the phenomenon and to eliminate weaknesses. This leads to the conclusion that there is no artist who doesn’t discuss and speak well about his or her piece of art.”

Dennis Diderot, 1751
BMJ 6 Oct 2012

• The balance of power in health systems needs to be shifted so that people are enabled to live the life that they want rather than having to fit in with professional and commercial views says Nigel Crisp

• Our right and responsibilities to health as citizens could be rewritten…..

A sense of urgency?

Before and Now

• Dominant element
  Disease
  Care
  Doctor and Nurse
  Specialization
  Hospitals
  Episodic treatment
  Standardization
  Patients comes to CG
  The patient must have patience
  Produce

Drivers
The development of knowledge
Demographics
Epidemiology
Technology
Robotization
Costs
Patients awareness
Social Networks
Complex systems

• The new Health Support prevention Team
  Integrated treatment Network
  Follow-up care
  Individual Interaction at a distance
  Proactive patients
  Quality and Safety
"I can not see what a patient diary would bring. I know what my patients feel and think - that's what I do all day, talking to them about their care and treatment."

If we would do the colon cancer project again, we would, already from the very beginning, include even more patients and start from their questions. We could have done focus groups with patients already at the beginning..."

/physician

"I am listening a bit more now, ask more questions to find out how things are going when the patient comes to me."

/physician
Project cooperation concerning colon cancer

Niklas a surgent
Success factors and structural opportunities

- Family members participating
- Quick exame
- Patient`s process map
- Preoperative work
- Early detection
- Schedule the whole individual process at once

A patient and his relative
Questions that we seeked answers to!

A. How can a region, as a system, achieve "best possible" results for the population, from the patients and relatives perspective in the whole cancer process?

B. How can a care process: prevention, early detection, diagnosis, care and treatment and palliation, be "best possible" every time in order to remove unwanted variation?

C. What general and specific lessons can be learned from the improvement work in colon cancer care process about how we achieve "best possible" health care from a patient, relatives and population perspective, during a trial period for the region's cancer care?

1) Minimize worthless waiting
2) Patient and relatives' contribution
3) Prevention
4) Early detection
5) Investigation, treatment, palliative care according to "best practice"
6) Multidisciplinary collaboration.
Execution Capacity

- Partnership with the patients and families in improvement work
- Process-oriented approach; mapping of the patient’s way
- Measure to learn and lead
- Learning concept
- System Map and systematic approach

Care Process colon cancer

Patient seeks care (primary care center) → Examination and assessment → Referral to surgical clinic → Visit to surgical clinic. Decision on treatment → Start of treatment Surgery → PAD-result → Revisit, information to patient → Referral to aftertreatment → Visit Oncology center → Healthy patient

1st contact with primary care till the operation= 66 days

Appointment at oncology= 45 days
The Patient's Process

- **Patient's context**
- **First symptom**
- **Patient's context**
- **First contact**

<table>
<thead>
<tr>
<th>Patient's context</th>
<th>First symptom</th>
<th>Patient's context</th>
<th>First contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient's preferences</td>
<td>Första symtomen</td>
<td>Patientens sammanhang</td>
<td>Första kontakt</td>
</tr>
</tbody>
</table>

Clinical Status

- **Complications**
- **Stadium after diagnosed**
- **Lead time**

Functional status / health status

- **Quality of life**
- **Agitation/Anxiety**
- **Appetite**
- **Main activities**

Patient/Customer's needs

- **Welcoming attitude**
- **Involvement**
- **Information**

Resources / Costs

- **Competence**
- **Hospitalization**
- **Investigation costs**

Value Compass for Colon Cancer

- **Survival Coverage ratio**

Home page
Coverage ratio 2011:4 – 2012:3 (the whole year)

Reported mortality per County/Region - coverage ratio, 2011-2012

System Map - South East Healthcare region - Idea
Primary prevention
Discussions and living habits
- e.g. health curve

Secondary prevention
Early detection
- Knowledge dissemination regarding screening, risk factors

Secondary prevention
Treatment
- e.g. patient partnership, improving healthcare, "best practice"

Chronically ill
Safe patient
Palliative Care
Cured

Healthy
Symptome
Sick
Dead

Partnership with patients and relatives in improvement work

- Patients, relatives, co-workers and researchers improve care together

- From ‘patient’ to ‘the person with patient experience’ ...

- Patients and relatives-
  Co-creators of the project ...

- Continuous evaluation of patient experience ...
Patient Perspective Protocol
PPP

Analysis of the process and the continuum of care of 245 patients who were diagnosed with colon cancer
110901-120430
Contacting healthcare because of abdominal discomfort 6 months after diagnosis

Time from the first visit till diagnosis

Three patients with extreme values in each group are not included in the figure: Jönköping (141 days) and Östergötland (140 and 171 days).
Time from diagnosis till information about diagnosis

Time from info about diagnosis till decision and treatment
"All patients will start adequate treatment within four weeks."

30 %

After diagnosis 54 %
Information to the patients and relatives at the same time?

Yes 40 %
No 30 %

No information in the medical record 30 %
Number of doctors met from the time of suspicion of tumor till information about diagnosis.

![Graph showing number of doctors met for different counties.](image1)

Number of doctors from the information about diagnosis till the latest information in the medical record.

![Graph showing number of doctors for different counties.](image2)
Quick examination
Landstinget i Kalmar län

Bakgrundsinformation:

I huvudsak påverkas de individer och de ortdifferenser i huvudet och i omgivningarna som de ursprungliga platsen av patienten. Dessutom innebär det sjukhusförhållanden och patientens tillstånd att följa patientens integrität och hälsa.

När patienten marbetalats en ekt- mard patienten kan en patient berätta sjukhuset tidigt, vilket är en del av snabb- och snabbvårdsbehandlingar. Dessutom patienten och patientens förkunnare till några patienter. Vissa patienter kan ha tidigt, vilket är svårigheter om de underrättarens roher olycksfall patientens sjukdom och patientens integrity.

S.N.A.P.S.-koncepten innebär att patienten behöver ta hänsyn till patientens besänkande och patientens besänkande och patientens besänkande med patientens besänkande för patientens besänkande.
Number of days from referral till diagnosis associated with SNAPS

1. High risk - prompt investigation

A. Identification via telephone or medical examinations

A total of 2 points or more acc. Steel Hamari score

Strong symptoms: 50 years (2 points)
- Rectal bleeding without anal symptoms, infection, etc. (RN, MD)
- Subileus symptoms (intermittent, escalating abdominal pain) (RN, MD)

Weak symptoms: 50 years (1 point)
- Changes in bowel habits (constipation, increased frequency, difficulty emptying, diarrhea, mucus, urgency)> 2 weeks without reasonable explanation (RN, MD)
- Iron deficiency anemia without reasonable explanation (MD)
- Pos F-Hb (MD)
- Rectal bleeding with anal symptoms (RN, MD)
- Emaciation, loss of appetite, fatigue> 1 month without reasonable explanation (RN, MD)
- Hereditary load regardless of age (2 or more 1st, 2nd-degree relatives) (RN, MD)
- Ulcerative colitis with 8-15 years duration depending on localization (RN, MD)

B. Execution

Patients with two or more points are dealt with urgently at the health center and referred forward as soon as possible

Examination at the health center
- Visit at the doctor’s within three working days, prepared for rectoscopy
- Sample F-Hb brought to the visit acc. instruction of RNs (non bleeding)
- Sampling (blood count, creatinine, height, weight, etc.)
- Rectoscopy are always
- Referral sent the same day to Surgery for extended study

C. Examination in the hospital

Surgical Clinic coordinate the investigation and convert to the appropriate diagnostic evaluation if colonoscopy is not considered appropriate

Tidig upptäckt av kolorektal cancer i primärvård, Fakta – allmänt kliniskt kunskapsstöd, Jönköping County Council
NICE-criteria

Anemy
Bleeding
Changed bowel habit with diarrhea
Palpable tumor

Family history
Polyp in the rectum

Prioritisation of referral for CT with suspected colon cancer

Bleeding >6 v Changed bowel movement>6 v
Anemia Family history(<60 år)
Distal rectal cancer has not been found

Anamnesis, clinical data ......
Question ......

Examination within 10 days when any of the above criteria are met
Low risk for colon cancer

1. Red blood on toilet paper:
   Palpation and rectoscopy if NICE criteria is missing. Possible treatment of anal disorders. New contact after 6 weeks.

2. No immediate indication of CT of colon:
   when the following symptoms occur alone (not NICE criteria):
   - constipation
   - thin stools
   - pos F-Hb without anemia
   - abdominal pain
   - weight Loss
   - fatigue

3. CT abdomen

4. Active watchful waiting.

If symptoms persist after 6 weeks of treatment, a new examination has to be done.

Three ways

CT colon (NICE)

CT abdomen without purgation

Active watchful waiting with appointments after 6 weeks

All patients were examined by rectal palpation and, in some cases, with anoskopi during the first visit.
Project

Collaboration with primary care
Four health centers in the pilot study
Research (resident physician)
Adherence
Outcome
Multidisciplinary conferences

 Colon Cancer Project created the idea of testing a new approach for investigations of patients with suspected cancer of the gastrointestinal tract.

Patients told us:

"We felt insecure and abandoned during the investigation period!"

"I did not really know whom and where should I turn to with my worsening symptoms!"
"Matchmaking"

What is the best cancer care for everyone?

The same needs?
The same conditions?
The same individual choice?

Working with lead time
Jönköping County Council

Collaboration between a surgeon, contact nurse, radiologist and oncologist, who has jointly developed action graphs for better understanding of the complexity of the process.

It is stated on the referral from radiology when the patient has time for a multidisciplinary discussion- set times that all of us are familiar with
Regional co-operation in radiology and CT- colon competence

Number of days between x-ray till the visit and decision about treatment in case of colon cancer
All hospitals in the region performing colorectal surgery are now jointly implementing a concept for safe major abdominal surgery

ERAS (Enhanced Recovery After Surgery)

"Our overall goal is that the clinic or unit will, in a structured way, get the resources to implement the perioperative care according to best proven methods. This is to ensure the best possible care for the patient and to ensure that the staff has the necessary conditions for providing it."

- Faster recovery
- Reduced proportion of complications
- Increased patient quality
- Reduced costs
- More secure employees

EIAS - Continuous performance feedback for ERAS
We now also have identified Process leaders in the region

Developing cancer from the patient’s perspective
Identify current processes
Create a model in the region that allows care on equal terms
Implement regional guidelines of PM
Responsibility for quality registries work in progress
Representing the region in the national health care programs and quality registries work
Submit proposals for “level structuring”

Study of the pilot program "more patient-focused and comprehensive cancer care"

Johan Thor, Jönköping Academy
Charlotte Lundgren, Linköpings Universitet
Anna-Lena Nilsson, Linnéuniversitetet
Felicia Gabrielson-Järhult, Hälsöhögskolan i Jönköping
Research Focus

1. What effects could a healthcare system achieve with a collaborative improvement work regarding colon cancer, and how?

2. What generally applicable lessons on improving cancer care from a population and patient perspective can be drawn from pilot program?

Approach

Campaign supported by improvement methodologies, including multidimensional performance measurement - gain "control of the situation"

- Patient and relatives involvement
- Process mapping
- Comparison of methods of diagnosis and treatment
- Practice variation through journal studies
- Consensus approach on "Best Practice"
- ERAS (Enhanced Recovery After Surgery)
We have learned from the colon cancer project:

- To work across traditional boundaries - "go outside the box" ... thinking one step further!
  - Palliative competence at the start of the care process
  - Multi-professional and multi-disciplinary collaboration, eg Cancer Investigation U.S. in Linköping
- Changed way of thinking - leads to other actions
- Individuals who change their behaviour make a difference

This is what we know

- Patients and relatives as partners to cross-disciplinary teams. It is essential for horizontal "Best Practice".
- Colon cancer can be detected earlier and lead times can be reduced; region's promises can be fulfilled.
- Modern quality registries that deliver data is a prerequisite for rapid improvement and renewal
- Regional collaboration could develop a common culture of learning.
- Interactive research stimulates, collects questions and challenges.
What have we learnt?

- An old world meets new. We have learned that we need to think again
- We thought we would design a treatment for colon patients, but it was more about designing a care for people with symptoms
- Patients who are well informed and involved in decisions in the care planning feel safer and can get a better quality of life.
- Then we received a better understanding of the patient's path through the care we have taken up questions that strengthen the potential for individualization of patient process.

All together