Key observations

Penninckx F
on behalf of all participating teams
and the PROCARE Steering Group
The PROCARE project AIMS

improve outcome & reduce variability for all 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

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
Burden of registration should be limited
Acta Chir Belg 2011

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

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
Variability in management (staging)

Reported cCRM in cStage II - III

cCRM reported in cStage II - III
1. Adjustment for confounders is essential for outlying perform.
2. Experts have to pre-determine relevant confounders
3. Outliers should improve, monitored by peers
‘Cancer registration’ is not enough

<table>
<thead>
<tr>
<th></th>
<th>BCR 2006-mid 2008 N = 5504</th>
<th>PROCARE 2006-2011 N = 4583</th>
</tr>
</thead>
<tbody>
<tr>
<td>cStage known</td>
<td>56%</td>
<td>83%</td>
</tr>
<tr>
<td>(y)pStage known</td>
<td>70%</td>
<td>90%</td>
</tr>
</tbody>
</table>

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
From project to structure
Proposed ‘audit loop’

- Complete check
- Anonymisation

- Decoding

Cancer specific feedback
- Cancer specific validation

Cancer specific database Analysis & Benchmarking
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
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