A systematic approach to closing evidence gaps in cancer care: The Sydney Catalyst experience

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Evidence into Practice (T2/T3) Working Group

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Collaborating sites
Western NSW LHD: Ruth Jones & team
St Vincent’s Hospital/Kinghorn: Emily Stone, Alan Spigelman & team
Royal Prince Alfred/Lifehouse: David Barnes, Philip Beale & team
Why Implementation Science?

Evidence Based Medicine 1990’s - present

- Discovery
- Clinical trials
- Guidelines

30-40% of care not evidence-based

Modest impact on safety metrics

Translate evidence into Practice – implementation science

- Gap analysis
- Apply/evaluate interventions
- Data analytics
- Engage system and clinicians

Research

30-40% of care not evidence-based

Modest impact on safety metrics
Why lung cancer?

Burden of Illness
High incidence & mortality in NSW population
Poor outcomes; poor survival: 14% after 5 years (2008)
Paucity of research

National and State Priorities
Cancer Australia, Cancer Institute NSW

Sydney Catalyst: Local Context
Significant issue for Catalyst catchment
Clinical leaders and expertise within Catalyst membership
Flagship program

IDENTIFY GAP

- Literature review (patterns of care studies previous data linkages studies etc)
- New local data analyses eg MBS VA and ClinCR

PRIORITISE GAPS AND ENGAGE TEAMS

- Listing of potential target areas
- Prioritisation at clinical sites
- Engage with clinical sites - understand environment

APPLY INTERVENTIONS

- Evaluate impact
- Intervention(s)
- Gather baseline data

CLOSE GAP

Support Implementation studies Link with local initiatives
Identifying evidence-practice gaps

- Patterns of Care Studies
- Data linkage studies – registry and administrative datasets
- Clinical practice guidelines
- Systematic reviews and meta-analyses
- Peer reviewed publications
- Grey literature, including government publications
- Local sources of data: Clinical Cancer Registry data for one Sydney Catalyst member hospital
Evidence-practice gaps

1. Not all people with lung cancer receive **timely diagnosis and referral for treatment**; unnecessary delays at the patient, provider and service levels have the potential to negatively impact on patient outcomes.

2. People with **potentially curable lung cancer** who will benefit from **active treatment** do not always receive it; active treatments including surgery, radiation therapy and chemotherapy are under-utilised.

3. People with **advanced lung cancer** who will benefit from **palliative treatment** do not always receive it; palliative treatments including palliative radiation therapy and chemotherapy are under-utilised.
Evidence-practice gaps

4. People with lung cancer who are of an older age or with co-morbidities who may benefit from active treatment do not always receive treatment; active treatments including surgery, radiation therapy and chemotherapy are under-utilised.

5. People with lung cancer who would benefit from review at a multidisciplinary team meeting are not always being reviewed.

6. People with lung cancer have high levels of psychosocial needs which are not always being met, resulting in poorer outcomes and poorer quality of life.

7. Not all people with lung cancer who would benefit from early referral to palliative care services are offered this option, which may result in poorer symptom control and poorer quality of life.
Priority setting process

1. Gain consensus on gaps - add new ones if agreed
2. Prioritise gaps individually against 4 criteria
3. Nominate gold and silver gaps across criteria in group
4. Discuss reasons for distribution of priorities and look for consensus
5. Invest $100 Catalyst across priorities
### Setting Priorities for Cancer Care – Lung Cancer
### Evidence-Practice Gaps Priority Setting Matrix

**Professions in group:**

<table>
<thead>
<tr>
<th>Relevance to local setting</th>
<th>Magnitude of the gap (size)</th>
<th>Burden of suffering (severity)</th>
<th>Amenable to change</th>
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**Other:**

- [ ] Vulnerability factors

*Other:*
Priority gaps

- Timely diagnosis and referral for treatment
- Early referral to palliative care services
Flagship Phase II

• Mapping lung cancer care pathways
  – Process mapping
  – Qualitative interviews (Consumers, GPs and targeted physicians)
  – Quantitative data audit (ClinCR and medical records)

• Pilot implementation project to reduce at least one evidence-practice gap in lung cancer

• Generating program of work including CA Demo Project

Draft process map from Orange Cancer Services meeting