GHA | SURGICAL CENTRE

INDEPENDENT HEALTH FACILITY MEETS CANCER CARE ONTARIO AND CANADIAN ASSOCIATION OF GASTROENTEROLOGY GUIDELINES FOR ENDOSCOPIC PROCEDURE WAIT TIMES WHILE MEETING QUALITY INDICATORS SUMMARY

McMaster University

Joy EE[1], Sne N, Kegel F[1], Kahnamoui K[1], Shahsavar S[1], Collins C[1], Klotz L[1], Allard-Coutu A[1], Coates A[1], and Simunovic M [1 2]

Division of General Surgery [1], and Trauma [2]

McMaster University, Hamilton, Ontario, Canada

Colorectal cancer (CRC) is one of the most common cancers across North America affecting 1/15 men and 1/16 woman. With the initiation of screening for CRC the death related CRC has dropped by about 25% . Multiple societies including cancer care Ontario and Canadian association of gastroenterology have implemented endoscopic wait time guidelines for both symptomatic and asymptomatic patients who are at risk of having colorectal cancer. Multiple audits have been performed over the last decade to see if the time from consultation to consult and subsequently colonoscopy across Canada are meeting the recommended guidelines set forth for patients deemed to be at risk for colorectal cancer. Unfortunately the results of the published audits continuously report significant delays that far surpass the recommended guidelines

for times from referral to endoscopic evaluation. Given the above, our independent health facility (IHF) conducted a study that looks at wait time initiatives at our center with the primary goal being 1. Wait time from primary care referral to colonoscopy in both symptomatic and asymptomatic patients deemed to be at increased risk for colorectal cancer. A secondary end point was to 1. Review the quality of care performed by the endoscopist at the IHF by utilizing the predefined quality indicators set forth by CCO (for colonoscopy) while carefully reviewing 2. Complication rates (such as bleeding, perforation)

A review of the data from 2014 to 2015 was performed by a blinded group of research assistants. The results clearly outlined that our IHF was 1. Able to meet the recommended endoscopic wait time guidelines for both asymptomatic and symptomatic patients at risk for colorectal cancer. Furthermore, the quality indictors illustrate that our IHF has been able to meet and surpass the quality indicators set forth by CCO for colonoscopy. Lastly, the complication rates at our facility were much lower than the reported data in the current literature. This suggests that IHF's may play an important role in reducing wait time initiatives for endoscopic procedures in large urban centers without compromise in the quality of care.

The study reported above was accepted and presented at the recent peer reviewed CAGS meeting in Toronto.

Please See Reverse for full study

Independent Health Facility Meets Cancer Care Ontario and Canadian Association of Gastroenterology Guidelines for Endoscopic Procedure Wait Times While Meeting Quality Indicators

McMaster University

Joy EE[1], Sne N, Kegel F[1], Kahnamoui K[1], Shahsavar S[1], Collins C[1], Klotz L[1], Allard-Coutu A[1], Coates A[1], and Simunovic M [1 2]

Division of General Surgery[1], and Trauma [2]

McMaster University, Hamilton, Ontario, Canada

BACKGROUND

- Canadian Association of Gastroenterology (CAG) consensus group established acceptable maximum wait time guidelines[1]
- CAG wait time guidelines are consistent with the Cancer Care Ontario (CCO) guidelines for the care of patients suspected to have colorectal cancer[5]
- Since CAG wait time guidelines have been established wait times reported in practice audits have exceeded these recommendations[2,3,4]
- Over the past decade there has been a trend toward endoscopy services being provided in community independent healthcare facilities (IHF) to aid in resource accessibility

PURPOSE

- To determine if an urban IHF provides care to patients referred from a primary healthcare provider that meets the acceptable maximum wait times established by CAG and CCO
- To determine if CCO supported endoscopy quality indicators were met by the IHF

METHODS

- Retrospective review of prospectively collected and maintained database for endoscopic procedures performed between June 2014 and May 2015
- Inclusion criteria
  - Primary care referral
  - Colonoscopy
  - Indication consistent with CCO and CAG for colonoscopy in symptomatic patients
  - Patient's first endoscopy
- Exclusion Criteria
  - Incomplete chart
  - Referral from specialist

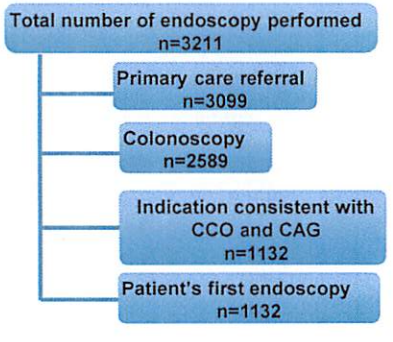

Diagram 1: Study design; all entries into the database reviewed and inclusion and exclusion criteria applied

Quality indicators of colonoscopy	IHF	Recommended
Cecal intubation rate	97%	≥95%
Adenoma detection rate in men	25%	≥25%
Adenoma detection rate in women	15%	≥15%
Inadequate bowel preparation	6%	≤10%

Table 1: Quality indicators as supported by a work group for the CCO[6].

RESULTS

		Time (days)		
Indication	**Study**	**To Consultation**	**To Procedure**	**Total Wait**
Chronic Abdominal Pain	Current	26 (23-28) (n=235)	18 (16-22) (n=235)	43 (41-49) (n=235)
	2012 Sage	102 (89-140) (n=156)	67 (43-91) (n=42)	153 (109-219) (n=42)
	2008 Sage	105 (91-119) (n=195)	44 (28-72) (n=54)	152 (104-198) (n=54)
New onset change in bowel habits	Current	16 (14-21) (n=95)	18 (16-21) (n=95)	36 (32-44) (n=95)
	2012 Sage	84 (48-110) (n=54)	49 (18-68) (n=21)	103 (84-215) (n=21)
	2008 Sage	75 (63-90) (n=95)	38 (19-68) (n=39)	148 (98-210) (n=39)
Bright red rectal bleeding	Current	24 (22-26) (n=476)	17 (16-19) (n=476)	42 (41-44) (n=476)
	2012 Sage	82 (52-104) (n=127)	44 (32-64) (n=64)	142 (92-181) (n=64)
	2008 Sage	58 (46-75) (n=159)	54 (34-67) (n=81)	136 (107-161) (n=81)
Documented iron deficiency anemia	Current	24 (22-27) (n=194)	19 (18-21) (n=194)	43 (40-46) (n=194)
	2012 Sage	55(40-73) (n=77)	42 (29-58) (n=39)	97 (62-160) (n=39)
	2008 Sage	56 (38-71) (n=104)	35 (25-64) (n=50)	90 (70-137) (n=50)
Fecal occult blood test positive	Current	17 (14-22) (n=111)	15 (13-20) (n=111)	38 (34-42) (n=111)
	2012 Sage	56 (34-97) (n=44)	50 (28-62) (n=31)	105 (68-182) (n=31)
	2008 Sage	77 (61-92) (n=65)	41 (30-82) (n=30)	143 (122-219) (n=30)
Cancer likely based on imaging/physical exam	Current	8 (7-22) (n=21)	13 (6-15) (n=21)	23 (20-43) (n=21)
	2012 Sage	24 (8-59) (n=23)	13 (1-42) (n=8)	22 (6-182) (n=8)
	2008 Sage	72 (33-107) (n=37)	36 (12-57) (n=16)	82 (34-170) (n=16)

Table 2: Wait times for indications outlined by both CAG and CCO. For "Cancer likely base on imaging or physical exam", guidelines indicate **consultation by 14 days and diagnosis by 28 days**, for all other indications, **consultation by 28 days, diagnosis by 56 days**[1]. = within guidelines = exceeds guidelines

Conclusion

- **The IHF in the study was able to meet the acceptable maximum wait times set forth by both the CAG and CCO for primary care referred patients who are suspected to have malignancy.**
- **The IHF met the standards of quality supported by the CCO**
- **Appropriate utilization and optimization of IHF who adhere to a quality assurance program may allow for a provincial reduction in wait times.**

References

1. Paterson WG, et al. Canadian consensus on medically acceptable wait times for digestive health care. Can J Gastroenterol. 2006;20(6):411–23.
2. Armstrong D, et al. Access to specialist gastroenterology care in Canada: the Practice Audit in Gastroenterology (PAGE) Wait Times Program. Can J Gastroenterol. 2008;22(2):155–60.
3. Leddin D, et al. Survey of access to gastroenterology in Canada: the SAGE wait times program. Can J Gastroenterol. 2010;24(1):20–5.
4. Leddin D, et al. The 2012 SAGE wait times program: Survey of Access to Gastroenterology in Canada. Can J Gastroenterol. 2013;27(2):83–9.
5. Harris W, et al. Guideline for referral of patients with suspected colorectal cancer by family physicians. Can Fam Physician. 2014;60:717–23.
6. Tinmouth J, Mhsc EBK, Baron D, Rn MB, Feinberg S, Gould M, et al. Colonoscopy quality assurance in Ontario : Systematic review and clinical practice guideline. 2014;28(5):251–74.