



Colorectal Cancer Care Pathways in Ontario and Quebec

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Speakers

- Barry D. Stein, President and CEO, Colorectal Cancer Canada
- Dr. Gerald Batist, Director, McGill Centre for Translational Research in Cancer
- Dr. Bill Evans, Professor Emeritus, Department of Oncology, McMaster University
- Eva Villalba, Executive Director, Quebec Cancer Coalition

Transcript

KIRA JOHNSTON 00:01

So again, thank you for joining us for today's webinar. I'm pleased to turn it over to Monica Slovenic Dangelo to introduce the panel.

MONICA SLOVENIC DANGELO 00:10

Thank you very much, Kira, and welcome everybody to this webinar session, which is on colorectal cancer care pathways in Ontario and Quebec. As Kira mentioned, I am Monica Slovenic-Dangelo, the director of health or health knowledge area at the Conference Board of Canada. Our team at the Conference Board is hosting this webinar session from Ottawa, and so I would like to acknowledge the land on which we gather. It is the traditional unceded territory of the Algonquin Anishinabeg people, and as this meeting is being held virtually, we would also like to acknowledge all of the nations across Turtle Island. And you may move it to the next slide, please. Thank you. So today's



discussion is a follow-up to our recently released research paper that examines the opportunities for optimizing colorectal cancer care pathways, which will be defined by our panelists in the provinces of Ontario and Quebec. The impact of the COVID-19 pandemic on patient care pathways, as well as on this research, actually cannot be dismissed. And this, you know, the pandemic, as we've seen across different health areas, has and continues to have an enormous impact on healthcare in Canada, and including on colorectal cancer care pathways, our panelists, who are expert in this field, will touch on this as they speak to some of the key findings of the research report, and they will also share their perspectives on the opportunities to get back on track and realize greater value in healthcare for both patients and health systems. I would like to acknowledge, and if you could just go to the next slide, please. Thank you. That this webinar, as well as the underlying research that led to the findings and the information on which this webinar is based, is sponsored by Value-Based Healthcare Canada. This is an initiative that is led by the Conference Board of Canada and is supported by a network of partners and collaborators representing a variety of health stakeholders. This research, specifically in colorectal cancer care, is sponsored by Amgen, Pfizer, and Roche. They are the lead sponsors of this research, and so without further ado, I'm pleased to introduce our panelists for today's session. They represent leaders of patient advocacy groups and clinician champions from Ontario and Quebec. Please welcome to the discussion Dr. Gerald Batiste, who is the director at the McGill Center for Translational Research in Cancer, Dr. Bill Evans, who is Professor Emeritus at the Department of Oncology, McMaster University, Eva Villalba, who is the Executive Director at Quebec Cancer Coalition, and our moderator Barry Stein, who is the President and CEO of Colorectal Cancer Canada. For your reference, their bios are available on our CBoC webinar page. Before I turn it over to Barry, I would just like to mention to our audience that after the panel discussion, there will be opportunity for Q and A, and this is planned to begin at about 245. So please do remember to submit any questions you may have to our panelists in the chat box. You can type them in, and Kira and myself will will will track these and then present them at 245. Thank you very much, and over to you, Barry.

BARRY D. STEIN 04:01

Thanks so much, Monica, and thank you to all our panelists who are here today. We're going to jump right into it to make the most of our time, and we're going to start with Dr. Bill Evans with some questions about colorectal cancer care pathways. So, first of all, perhaps you could explain to our audience what a cancer care pathway is. I know that's something that not everybody is familiar with, at least in terminology.

DR. BILL EVANS 04:29

Right, Barry. Well, it's a good place to start. So a care pathway is really a flowchart that shows you what a typical patient might experience over the continuum of care, and in fact, it's not just meant to include treatment, but actually starts with prevention, how screening is done, is screenings



relevant for the particular tumor type, and then the various diagnostic procedures that the patient might expect to go through, and then the treatment modality. That are available by stage of cancer, and it's all meant to be evidence based and disease specific. So you have a colorectal cancer care pathway, then you have lung cancer pathways and breast cancer, etc. So to undertake such work, it really starts with looking at the evidentiary basis for how patients are treated, and in Ontario we've had a pretty long history of actually producing evidence-based guidelines and recommendations through the program and evidence-based care that's based at McMaster University, and we did that work for quite a while and amassed a lot of individual evidence-based recommendations, but we'd have to say they weren't knit together in any particular way until we introduced the disease pathway management program within Cancer Care Ontario, and also patients themselves would say Care that exists seems to be fragmented and not well connected, and there wasn't a good understanding of how various diagnostic procedures led to various treatments, etc. So there's a couple of goals here. One is to try and ensure through care pathways that you're documenting across the full continuum from screening to palliation, the best evidence for care, and who should be involved in that care, and this is where it gets really rather complex, because to undertake care pathway development involves an awful lot of individuals. Cancer Care Ontario's focused primarily its development of pathways on the healthcare providers themselves. I'm sure that isn't music to your ears as a patient advocate. We like to think the patients are front and center in their development, but really in the beginning it was to try and standardize treatment across the providers, and just when you think about colorectal cancer, think of all the people involved. The screening you have gastroenterologists, you have internists, you have family physicians. When you get into diagnostic phase, you bring in the imagers. They may be CT, the MRI imagers, the other radiologists, nuclear medicine physicians, and then when you get into treatment, you have a whole cast of characters from general surgeons to surgical oncologists to hepatobiliary surgeons, radiation oncologists, Medical oncologists, supportive care workers of various types, and palliative care. So you really have a huge number of people to bring together, and that's why undertaking disease pathway management is a complex undertaking. And you get some indication of that. Encourage people to actually go to Cancer Care Ontario and look at a care pathway. They tend to look a bit like an electronic diagram, and they're color coded by the types of people who should be involved at each step. Often, multiple people in multidisciplinary groups, and then there are a lot of symbols used to indicate what's taking place at each of these interactions? So, it's really a complex undertaking, and not something you can just sort of easily pull together and undertake. You need some leadership, and that's where it always starts. So actually,

BARRY D. STEIN 08:42

I did pull out those, and it was just posted in the chat the link to the pathway maps, and I did pull them out and take a look at them, and they are indeed extremely complex. And not only do they deal with this separate pathway maps for screening, diagnosis, and treatment, but also separately for rectal cancer, which, as you know, obviously there's a different treatment paradigm for those



types of patients, and which include radiology and so forth, and also for follow-up care, which was nice to see, and that's always a challenge to know, you know, when those follow-up care, you know, periods should be from the patient perspective. But you did mention something that really piqued my interest, and you said they were created really from the perspective of the physician or the healthcare provider. So, how could we make these pathways more patient-centric in your mind?

DR. BILL EVANS 09:38

Well, I think that they become more patient-centric when you sit down with patient groups and work on how are you going to improve the pathway. You've created the pathway, and actually, I led the lung cancer pathway. I don't have experience with the colorectal one specifically. But we had a large group meeting and brought quite a number of patients to that meeting. We also had all the specialists in the room as well. And when we looked at the steps in the pathway and focused in where could we make improvements, what were the issues that were troublesome from a patient perspective and from a provider perspective? It's using the pathways that I think makes them valuable, and using them in diverse ways, and patients critiquing them, and telling them where we're falling short in the integration of our care, using them administratively to see where we're not actually delivering the care we say we're supposed to deliver, and in fact, that does occur. And I was surprised as a lung oncologist early on to see that the uptake of adjuvant chemotherapy for lung cancer was very non-uniform in our province. I'm sure the same was true with adjuvant chemotherapy for stage three colorectal cancer. And by measuring it,

BARRY D. STEIN 11:01

Notwithstanding the pathways,

DR. BILL EVANS 11:03

Notwithstanding the pathways, and it's another thing. Well, I'm sure you're going to ask me the question about why, but I think before we get there, we we can actually undertake studies of concordance. How close is the care to what we say it should be by region, by institution, and where you see big differences, then it begs the question: What's going on here? Why has the care not been moved forward to the way we say it should be based on the evidence? And often that's a hard thing to come to understand. First of all, there can be differences just in the rate of uptake of a new therapy, we have in our institutions individuals who are early adopters who will quickly take up a new treatment approach because that's just the way the other way they are. And on the other hand, you may have laggards in the institution, and I guess from my experience running a couple of different cancer centers in the province of Ontario, I've seen the spectrum of physicians even within the same institution. But you can have, because of the administrative leadership, sometimes a whole



institution slow to adopt a new treatment approach, and I actually saw that happen as it relates to adjuvant therapy for colorectal cancer earlier in my career, and so that will explain some differences. But then there are other reasons as well. The physicians in large cancer centers are often very specialized, even sub-specialized. They're very up on the information about how to manage patients. They may have been very active in the development of the pathway and in previous guidelines, and so they're likely to have their patients predominantly on the care paths as they're drawn up based on evidence, but in smaller centers, often we're calling on those oncologists to look after three or more tumor types, and they're seeing any tumor type less frequently. They're less likely to be as up on treatment approaches, and they're still very busy, and perhaps don't have the time to actually go and consult CCOs' care pathway and what should be done, or to read an evidence-based guideline from the program in evidence-based care. So there can be differences in physician knowledge, even awareness that the pathways exist, and that applies not just to the oncologists, but think of it: how many primary care physicians would be aware in the province of Ontario that CCO has these care pathways? There's almost 15,000 family doctors in this province, I'd hazard to say that not too many of them are that familiar that the guidelines and pathways are there for them to have a look at if they need them, and I think that's a big challenge. It's to communicate effectively to the wider population of primary care physicians, gastroenterologists, general surgeons, that these tools are there to help them in their practice and to stay current.

BARRY D. STEIN 14:28

So that's a great segue to I'm sure what your key point is that those physicians who know the evidence and who use it will use it in their daily practice, the pathway, and will be more familiar, for example, in the treatment pathway of the new precision medicines coming down the pathway. Perhaps molecular profiling at the right time, maybe reflex. I know there's new rules in Ontario for reflex testing for colorectal stage three and stage four now, which is really exciting. But the challenge, as you put it, seems to be really in communicating that broadly throughout the province, so we can have a more standardized or uniform healthcare throughout the province of Ontario. And we're going to take a look with our next speaker, Dr. Baddes, as to how that translates in Quebec, not only through the pathway, as we have certain algorithms for sure in Quebec, but also how it's been impacted, how the system has been impacted by the shock of COVID. So I'm just going to pass on. We're going to come back to you, Dr. Evans, but passing on to Dr. Battis. How has COVID and the pandemic really challenged the pathways at your institution, at the Jewish General Hospital in Montreal.

DR. GERALD BATIST 15:48

Thank you, Barry. It's very nice to be here and participating in this. Of course, the pandemic has isolated people, but in as has been said by many people in some paradoxical ways. It's also



reconnected people in ways that they hadn't been before, and recognizing this isolation. In fact, for periods of time, physicians were not seeing patients regularly as they would, created a whole other level of connection and the implication of our nurse navigators and our nurses at a greater level. There isn't a physician that I know of who shared their email and text coordinates with their patients, and we're in a different kind of level of communication than we ever have been before. I think so. It's changed. It's changed the way we interact with our patients, and it involves them much much more in reporting outcomes. So, one of the major focuses now is what we call patient reported outcomes, where patients are not waiting until the next doctor's visit to tell us about new symptoms, and this is based on some very good studies that have shown an important impact on outcomes. It's it has to be corralled some kind of structure, or else it becomes unwieldy as patients have to learn what is important to report, what is not, and in the midst of a very generally anxious situation, it becomes difficult. So I think it lays the groundwork, from my point of view, for a much more patient Centric patient trajectory or algorithm to be transmitted to the patient, and I think we learned over the years that physicians are very hard people to educate, re-educate, to change. In fact, that's another thing we learned during the pandemic, and that is even. I mean, we did see that some of the most recalcitrant among our colleagues, with regard to using electronic communication devices, popped on board because there were fewer fewer options. But a big part of introducing people to digital health is change management, and I think we've learned as far back as moving away from mastectomies to lumpectomies that physicians may be harder to change than just educating the patients, the patients can have a lot of impact on changing their physicians' practice. So I think we're now we have because of the pandemic really invited a partnership with the patients to a greater extent than I think we we we ever had before, and and I think now we're in a position to work much better. I think the patients to revise and refine these these pathways.

BARRY D. STEIN 19:12

Do you think do you think that COVID, therefore, and your interaction, you know, through virtual communications with patients and those of the other physicians are impacting the care pathways themselves by making them more patient-centric, or are they still the same pathways just with the addition of more communication? And to Dr. Evans' point, communication in that in that regard is between the patient and the physician, but what about physicians at large knowing more about the pathways? Has this had any impact?

DR. GERALD BATIST 19:51

Yeah. No. Well, I think I think the first part of your your question is my answer. My answer is in the affirmative. I think it does has had an impact, and I'll tell you. Typical, a typical interaction with a patient where I may be talking to a patient and they are trying to understand what comes next. And my response will be, well, as soon as I as I hang up from this this Teams or Zoom or telephone call, I'm going to communicate by text with your surgeon so that I can actually know what the date is, and



then with your nurse, so that we can understand when we're going to stop your treatment before a pending surgery, for example. And more than that, we can also zoom in the nurse navigator, social worker, into the same meeting. Family members, of course, as well, so that we're it's it's actually facilitated linking different aspects of the of the trajectory in a way that we really hadn't anticipated.

BARRY D. STEIN 20:51

So making that that very complicated diagram that we were talking about in the in the pathway, this really helps it to bring it to life and make it easier for the patient to understand and and go through their treatment. Do you think that these modifications and changes will persist post COVID?

DR. GERALD BATIST 21:12

Yes, I do. I think I think we've seen a benefit from it ourselves. I think you know all of my colleagues, all the all physicians really want their patients to do well and not to fall through any kind of cracks or to be struggling to navigate the system, and the patients want a feeling of empowerment and understand can understand very easily what what are the what are the pathways, and so working together and understanding now that we can do this using a lot of tools, and there's some apps that we're we're bringing online that make this a little bit more automated. I think this this is something that will will will persist.

BARRY D. STEIN 21:53

Do you think this will make care more standardized across the province, or is it just you think within Your institution,

DR. GERALD BATIST 22:02

You know the the the the care each step each leg of the treatment needs some standardization, but the trajectory needs to be personalized, and there shouldn't be a tension between standardization and personalization of care. But there are elements certainly that need to be standardized, adjuvant therapy for stage three colorectal cancer. But even there, there's some room, and all of the algorithms have exceptions. So I think I think understanding context and broadening the context is so that the patient understands is helpful. One of my colleagues here just say briefly, Carmel Wazell has done a lot of work on transmitting information to patients, and it's striking that not everybody takes up information in the same way. Some people need visual information. Some people need a family member to hear it and then play it back to them for emotional and cognitive reasons. Other people need to get it, and she has a way of recognizing pretty quickly who needs what. That's



another level of personalization. We need to be able to share information with each person in a way that will be useful to them in decision making.

BARRY D. STEIN 23:27

I'm glad you mentioned personalized because when you talk about personalized, to me that means precision medicine, and you know how I feel about that. And I want to talk to you about precision medicine and personalizing a patient's treatment through molecular profiling, next-generation sequencing, and so forth. We recently just had three drugs: pembrolizumab, an immunotherapy; a larotrectinib, an intravenous drug; and entrectinib, a BRAF B600E drug. Both all recommended in some shape or form or another at Pcoder for a positive recommendation for reimbursement. So it looks like in the near future patients will start getting greater access to some of these precision medicines. Do you think that the advent of molecular profiling, next generation sequencing and the use of precision medicines will change the treatment trajectories and pathways in Quebec.

DR. GERALD BATIST 24:30

Absolutely, absolutely.

BARRY D. STEIN 24:32

How do you think that will be standardized across the province?

DR. GERALD BATIST 24:36

Well, well ...

BARRY D. STEIN 24:39

Sorry, just given the fact, that sorry, just to add, given the fact that not everybody can do that type of profiling.

DR. GERALD BATIST 24:45

Well, I think that that's you know a big challenge, and we we most of us find a way of doing this, but we're we're used to working the systems, and that's not ideal. But there's a lot of us agitating, and



this. Physicians and patients to make next generation sequencing and biomarker biomarker assays available to the patients. The next step is teaching the clinicians how to use them, and then the third part is being able to access the drugs, but I think that, and I think that this is something that again the patients need to be educated about and ask about. This is going to be this does already dramatically change outcomes of treatment for lots of patients. The main point, though, is it's redefining cancer not as not as a treatment for all patients. This is precision medicine, which means that for colon cancer, really that's a an accumulation a collection of rare, uncommon, and even rare sub subtypes, and so identifying these subtypes, which may in some cases be less than a percent of the cases, and guiding them to the matched therapy is the name of the game. And now,

BARRY D. STEIN 26:13

Would you say that sort of a key message of yours would be that we have to really take into account this new world of precision medicine and the screening for the molecular profiles or tumor mutations as being one of the biggest challenges in the in the existing treatment pathways.

DR. GERALD BATIST 26:34

Yeah, I think I think so. Precision personalized medicine in terms of recognizing how the patient Decodes information. That's precision medicine as well, and then the biological biomarkers to guide the therapy. That's precision medicine as well, and all of this is what we're facing, and we're all working very hard to bring to the bedside. And I think we are largely and. in most places, able to do that. But I think it could be easier for everyone if we're working together to reach these goals.

BARRY D. STEIN 27:12

Thanks so much. We're going to come back to that as well. But right now, we're going to move on to Eva Belalva from the Quebec Cancer Coalition and talk a little bit about patient centricity and how we can best measure value in colorectal cancer care. So remember, we are very concerned about patient outcomes, but we want to have the best value there, so we are we can maximize the output from our current system. So Eva, I wanted to ask you, how can the colorectal cancer pathways be made more patient-centric, and why should we care about that at all? Or maybe the doctor knows best. Well, that's

EVA VILLALBA 27:51

That's exactly what I wanted to touch on. So to echo Dr. Batts's point, you know, it's important to have a standardized pathway, but the pathway is made with the provider in mind, not with the patient



in mind. And we do need these standardized pathways. But then, what what would make it more patient centric is to actually acknowledge that the clinicians the clinicians are currently assuming what matters most to patients, and what we're inviting to do and and what value-based care proposes is to actually ask the patients what do you want besides not having cancer, what other outcomes matter most to you, and then to measure that not just at the beginning and at the end but throughout. And so the care trajectories are really a trajectory of a flow of the services to deliver, but patients want more than just healthcare services; they want health. And so, in order to give them the health outcomes and provide the value that is necessary, we need to actually ensure that we deliver the health, not just the services. And and I really believe that we can only do that by by asking them and start with the end in mind from the beginning. What outcomes do we want to achieve, and then how do we personalize the trajectory? Like Dr. Baptist was saying, that personalization of the trajectory based on what the patient's desired outcomes are—that's actually more equitable, more patient-centric. It allows for everyone to actually achieve the outcomes that are important to them. Besides having cancer or not having cancer, which is very binary choice, I want to be able to have healthy relationships with my spouse. I want to be able to run again. I want to not be incontinent. What can I do? Are there things that I can insert into the trajectory, like prehab before a surgery, to reduce incontinence or to reduce pain, or how do I integrate psychosocial support earlier on into the care trajectory so that I'm not experiencing acute distress later on? And so that proactive approach is much more patient centric, but it requires a measurement not only of the outcomes. From the clinician point of view, but also from the patient point of view, with patient-reported outcome measures and also patient-reported experience measures. But also, what is currently missing in our system right now is the measurement of costs over the entire trajectory of care, because we're currently making decisions based on discrete interventions. Oh, maybe this is too expensive for us right now, and so we'll do it in second or third line. You know, to your point about precision medicine. But if we were actually able to demonstrate that the cost over the entire trajectory of care of giving the right treatment to the right patient at the right time would save money overall and deliver better outcomes, then we would be able to prove value for patients and for society.

BARRY D. STEIN 30:43

Right. So, you know, there's an expression: "Price is what you pay, and value is what you get. Perhaps, maybe not everybody on on this webinar knows what value-based healthcare is, both from the cost perspective and from the outcomes perspective. Maybe you could just give a very short, you know, review of what value-based healthcare is.

EVA VILLALBA 31:05

Sure. So, according to Porter and Tiesburg in their in their seminal book in 2006, value is really the outcomes that matter to patients divided by the cost over the entire trajectory of care, and so currently, we're making decisions in our healthcare system based on what's convenient for the



healthcare system, or at best, what's convenient for the hospital. But that's all about managing services, healthcare services, and healthcare. Whereas it's not really about providing the best health to the population. And so, value-based healthcare posits that by achieving best outcomes for the best price, that is truly value not only for patients but also for the entire healthcare system. And if you think of you know in in in business in a in a more consumer type industry, companies are always trying to listen to their clients and and understand their clients' needs and then deliver what they need, but our healthcare systems were not so much organized for that. And just to give an example, our healthcare system is has been very focused on the hospital and not so much on care to the patient in the community and using all of the resources in the healthcare system. So, a value based approach focuses much more on what are the outcomes that we want to attain, and measuring the entire costs, not just of one discrete intervention like chemotherapy or surgery, but by giving the the right treatment, are we able to, for example, avoid unnecessary expenses, unnecessary resources, unnecessary hospitalizations,

BARRY D. STEIN 32:44

And whose role do you think it is to measure this value in this proposition? Is it going to be the provincial government? Is it going to be the cancer agency? Is it going to be the individual institution? Who's going to be calling the shots on value-based healthcare?

EVA VILLALBA 33:00

Well, certainly there has to be, like Dr. Evans had mentioned, leadership. You know, there has to be a desire to measure value from the perspective of what matters most to patients, and and and the cost over the entire trajectory of care. This kind of global vision of how much does it cost us to deliver a healthy community, and so the ministry has to have that mandate. But in terms of the actual data collection, it has to be done at the at the local level. So the the clinicians are responsible for collecting the the clinical outcomes data. I think that there's a lot of promise now with patient reported outcomes and patient reported experience, and there's different ways of doing that, and there's many new patient portals and applications and platforms that are starting to be developed to collect that in a more regular fashion and to improve communication with the care team. The other important element is it's not just the doctor's responsibility. There's a larger care team that can actually contribute to the collection of outcomes data: nurses, social workers, psychosocial support of many kinds, physiotherapy, etc. Nutrition is an important professional, and then for the cost, that's the part that the government really has to ensure that they're measuring properly. So in Quebec, there's a very interesting initiative that just began last year called Coupa Patur de Suy or cost per care trajectory or care pathway, and they're currently measuring how much does it actually cost us for a hospital bed, how much does it cost us for lung cancer diagnosis. But it's it's still a little bit too segmented, and they're missing the two most important cost elements, which are how much do



doctor salaries play into this? How what is the cost of the doctors in the equation, and what is the cost of medications? So ...

BARRY D. STEIN 34:52

And I get the cost part. I get the cost part, and I can see how a province could easily manage that because there's central billing to that. But outcomes is a whole different matter. How can we really assess the value, or you know, from the perspective of the patient outcomes systematically throughout the province? This is a challenge, and very difficult to follow. I'm sure, let alone within an institution, but have some capabilities to do that, but to track that throughout an entire care pathway within an entire province really poses a challenge. How do you think that that might be done?

EVA VILLALBA 35:30

So, I do think that the collection has to be done within, ideally not just in the hospitals, at the fam at the family practice in the community with pharmacists, and if you know we're currently having some some issues, but also we have a theoretical vision of how the data should follow the patient. In Quebec, there's some you know work underway to to get a centralized patient health record, but ideally all the different providers would be able to collect aspects of that of those outcomes and centralize it so that it does follow the patient. And ideally, the ministry would be able to match the outcomes data collected with the cost outcomes that they have in order to to really prove the value of of different interventions for different patient segments.

BARRY D. STEIN 36:24

I think that this is going to be a huge challenge to bring into the province, but certainly a worthy challenge that we all have to undertake if we're going to improve, for the most part, outcomes for patients, particularly as we see rising costs from the types of treatments, rising costs in screening interruptions to the system really difficult to track these type of changes and have an impact today there was for example a report on these let's call it on the screening screening track where we know that there's as a consequence of the interruption to the screening programs in all provinces, we're likely to see a big increase in advanced cancers and ultimately in mortality as a consequence of these interruptions. And the modeling demonstrates that we could actually reduce some of this, the impact of this, and reduce mortality by 20% if we could increase throughout the country screening through HIPS by the fecal immunochemical test by 25% But that poses a major challenge, given the fact that even pre-COVID, only three provinces have attained the 60% Mark for the target population between 50 and 74 years old. So we're going to allow some questions for sure. I see that Dr. Battis wants to wants to ask a question. So let's go ahead with that first. And Monica, please let me know



when we have some questions. Otherwise, the panel will, I am sure, have a lot to say about what each other has been talking about. So go ahead.

DR. GERALD BATIST 38:11

I just wanted to make a brief point about screening. I think all the modeling data is telling us about this post-COVID or COVID-related cancer surge, that the that that we expect that we're already in, that we're seeing it dramatically. We expect an increased mortality, and that we to mitigate that we have to increase our capacity by 20 to 30 percent, which is, as you say, an incredibly difficult mountain to climb. I think we're going to have to approach this the way we've approached COVID, and that is innovation and research. And so we're going to have to think of new ways to screen. And there are some liquid biopsy-based cDNA approaches and a variety of innovations that are not far on the horizon, already actually in the works and being studied, so I think we're going to have to ramp up clinical research in every aspect of this, including in screening.

BARRY D. STEIN 39:08

I think that's an excellent point. The there is, for those that don't know, there is a test by a company called Conexia, which is federally funded right now, so offered to late stage colon cancer patients for liquid biopsy, so blood biopsy and ctDNA, looking for some of the mutations, and that panel will be expanded in the very near future. There are also opportunities that we've seen in the United States on ctDNA for early stage cancer in deciding whether adjuvant treatment should be done along along the for early stage pathways based on the results of ctDNA as well, and these are all thing factors which impact with which do impact the trajectory. That's absolutely in the different pathways. I see doctor. Evans, you wanted to interject on that.

DR. BILL EVANS 40:03

Yeah, first of all, just to underscore the importance of screening, and I think the existing methodologies for for screening colorectal cancer are still quite robust. Our challenge with COVID is, but we've had to cancel a lot of elective surgery, and now we have a backlog. And as we ramp up screening again, we're going to have a will identify individuals who require surgical interventions, and I think it's going to be very challenging to the provincial cancer agencies to to meet the volume that will be be confronted with. I know CCO is working very hard on that. It's a it's a big issue to address. But I also want to comment a bit on the what Eva was saying about the value-based care and how we can measure it. And I think in Ontario we have some of the building blocks, actually quite a few of the building blocks, in place. And what you need is access to numerous administrative data sets, and through ICES, it's possible to link numerous of these data sets. So I believe there's like 13 different databases that can be linked that include things like the Ontario Drug Benefits, the



Ontario Health Insurance Program, the cancer or the Ontario Cancer Registry, the Kaihai data for hospitals, etc. etc. and a lot of work has been done on creating costing algorithms in oncology, particularly led by Nicole Mittman, who's now a chemist, but there's a cost algorithm for chemotherapy and a cost algorithm for radiotherapy, so I think we're moving along a trajectory where these elements and pieces are coming into play that we will be able to use so that we can actually get at the cost per delivering units of care, or across a spectrum of care, whether that really gets at true value, as Ava was speaking of it, you know, the the quality of life that the patient has, the ability to avoid certain side effects, and so on. That's a even more complicated issue. But I think over the years in this province, we've been moving incrementally from defining certain activities by evidence to building care pathways based on evidence and and the knowledge and wisdom of care providers, and integrating into that the many different aspects of that make up quality care by engaging with the the social workers, the nurses, and and other care providers, so that we're not just delivering technically good care, but empathetic care. And a final piece is actually, as has been said already, listening to our patients and Cancer Care Ontario has at its provincial level and at each region a patient and family advisory council, and I don't think there's anything that's done at Cancer Care Ontario these days that doesn't go to the provincial PFAC to get their input as to whether it is going to be presented in a way that's suitable to patients, so a real effort's been made to engage patients in shaping how program programs are delivered within this province. I'm sure we can always do better, but I think a real sincere effort has been made to hear what patients want and need, and to try to address those needs.

BARRY D. STEIN 43:39

A frightening statistic that you alluded to is was recently reported in an article by Tim Hanna at Alcrim Kingston in the British British Medical Journal, which showed that for every month delay in surgery in colorectal cancer, there is a 10 percent increase in mortality, and that really is, you know, is when you think of the numbers of people surgery, really has a very chilling effect. You know, we talked about this a little bit, Dr. Battis, before on creating a more resilient healthcare system, in particular, you know, with regard to colorectal cancer pathways. Do you think that there's what do you think might be done in order to create not only value-based healthcare but also a more resilient healthcare system at the same time for the colorectal cancer patient?

DR. GERALD BATIST 44:37

Well, I mean, we need usual elements. We need we need funding and administrative support. It's great if we're not duplicating reporting to the ministry and and this work that we're all doing among ourselves. We're missing an agency in Quebec that would be kind of a central focus, and put those two together. But at the same time, we have a program that that is that is working, and so I think I think it I think it's as as as Bill as Dr. Evans has suggested. Lots of these elements are in place. I think bringing the patient patient advocacy organizations into the not just okaying what we're



doing, but to kind of lead the way here and militate. There's no voice louder or more effective than the patient's voice, especially when we're talking to government and people have the resources to generate guidelines and approaches. I think that that's a very important partnership that we that we have.

BARRY D. STEIN 45:48

Right, and you know, while in the past our former minister of health at the time, Philip Clear, made a very distinct decision not to have a cancer agency in Quebec because he felt that that would create too much bureaucracy, but I know that Eva has some very strong feelings about having a cancer agency in Quebec as well. So I'll turn it over to Eva to hear your perspective on that.

EVA VILLALBA 46:11

Yeah, so like more than 10 years ago, the Quebec Cancer Coalition had really lobbied hard with Philip Pillar, amongst others. But at the time, there was really no appetite for another administrative structure. It was perceived as you know it's just a structure. It's not going to solve our problems. But we saw what was happening in Ontario, and we were getting very jealous. And now we see that you know we had a you could basically call it a department for oncology. It's changed names five times. Now it's the Quebec Cancer program-it's slightly better, but if we look at Ontario and other provinces that have agencies, they've been able to create structures that enable speedy implementation of pathways, of screening programs, of transparency in data and registries. I mean, it's an embarrassment in Quebec that we just got 2012 data out of our cancer registry, and we've been promised that we'll get 2017 by the end of the year, but it's still not acceptable. And we do believe that if we had a cancer agency, things might have been different. But what we really need is we've seen during COVID the importance of data, the importance of mobilizing all of the resources of the healthcare system towards one goal, and that's really what we want for oncology. And we do believe that it could come with an agency. An agency would have power to have to actually implement its vision, which our current program doesn't. Our current cancer program can give guidelines, can give recommendations, but they don't actually have the power to execute and implement what they what they recommend, or even to work across the different ministerial silos. So either we get a cancer agency, or at least if we give more power to actually implement the recommendations and the guidelines, and to have one clear vision for oncology in Quebec, then that would really help and enable us to actually have the information that we have, because we saw in COVID the importance of having up-to-date data in order to make better healthcare decisions for the population, and that's really what we need in oncology as well.



BARRY D. STEIN 48:11

Thanks, Eva, and I see we have a great question in the chat. I was going to ask it, but it says that Monica is going to ask the questions. This is a question that I think Raymond West is asking, and I think it's something I thought about very often. Perfect.

MONICA SLOVENIC DANGELO 48:27

I'm just about to interrupt you, Barry. So, thank you for putting it out. So the question states that part of the value part of value is getting the right level of professional to to do the right tasks. I've observed that some tasks done by doctors could be done just as well by nurses or other professionals, would better delegation and matching of the nature of the service to the level of the health professional help reduce costs and increase the capacity to deal with the patient backlog. And Barry, if I may, a related question is: you know, what is the how can the care pathway facilitate assessment of value, and also how can the pathways be implemented equitably across healthcare settings?

BARRY D. STEIN 49:13

So I'm going to maybe direct the first question to Dr. Battist and the second to Dr. Evans. The first just the

DR. BILL EVANS 49:21

Other way, other way around. You want to

BARRY D. STEIN 49:24

Do it the other way around?

DR. BILL EVANS 49:26

Yeah.



BARRY D. STEIN 49:27

All right. So my first question, my first question then is: Do you think, for example, that that if we had the right different professionals involved, so for example, a nurse practitioner or a trained technician to do colonoscopies, for example, or endoscopies. Do we need to have a gastroenterologist do it all the time, or maybe it could be done such as Dr. Linda Ravenick suggested by nurse practitioners for? Or sigmoid osteomies, and we use other health professionals, in other words, to help to reduce the costs and increase capacity in the system.

DR. BILL EVANS 50:09

Well, the short answer is absolutely: we should be using healthcare professionals to the maximum of their skill level, and we could do a lot better if we redistributed a lot of the things that physicians do that others could do equally competently. You mentioned the the screening of colorectal cancer with nurse-led sigmoidoscopy, which was a program we had in Ontario for a period of time, and I think a very effective one. But you know, the difficulty is often it's seen as encroaching on traditional physician activities, and I know from my personal experience in one of my cancer centers that I was responsible for that we had a number of nurse practitioners who, in the end, felt they were not being used to their full capacity because the physicians were reluctant to give up things that they were doing, and one of the initiatives that CCO has undertaken, which I think is a great use of other resources, is to discharge patients from the cancer center back to primary care after they have been reviewed carefully as to the appropriateness of referral back, and also given a set of direction, or given the primary care physician a set of directions, and we've had nurse-led clinics that facilitate that referral back to the primary care physician. This will then decongest the the cancer center substantially, and work done by Dr. Ava Grunfeld is clearly showing that family physicians do as well at following up their cancer patients as do specialist doctors for breast cancer and other cancers. And so, I think it's a very good, a better use of physician expertise in a cancer center, if well follow-ups are managed by their primary care physicians in their communities, and I think we could look across the full spectrum of activity and find places like that where we could decant some of the work that specialist physicians are doing and have nurses undertake that work. Just another quick example would be just the standard adjuvant chemotherapy. If a specialist prescribes it, the patient tolerates it well through a cycle. Why shouldn't a nurse take over in prescribing that in subsequent cycles and supervising the patient and just drawing back the specialist physician when there's a need because there's an unexpected side effect or some other issue arises, so we could be using our healthcare professionals more wisely. I'm quite sure, and we could look at our care pathways and and and and kind of discuss where that those changes might be made and be an interesting use of care pathways.



BARRY D. STEIN 53:00

So just to handle that, that's a really excellent answer. And in fact, a lot of work in the past has been done on so-called survivorship clinics, so follow-up care and so forth, in the past throughout Ontario and some of the other provinces as well. And it kind of fell by the by the side a bit, but perhaps now, because of the pandemic, this may become more of a reality and and a solution to some of the ongoing problems. So, Monica, I know that the second part of the question was a little bit more challenging in terms of the value. Maybe you could repeat that part, and and Dr. Battis could give a response to that. So, yep, we can't hear you.

MONICA SLOVENIC DANGELO 53:47

Of course, I'm unmuted. How can how can care pathways facilitate assessment of value, and how can they be implemented equitably across healthcare settings?

BARRY D. STEIN 54:03

So, Dr. Battis, do you want to give that one a shot?

DR. GERALD BATIST 54:08

Well, again, I think you know, implicating the patients is it provides the opportunity for the most equitable Distribution of of the resources and the the the value of of a care pathway. It should be possible that every patient access the knowledge related to their their care pathway. And as I said, I think the information has to be tailored to each individual. We've learned an awful lot again during the pandemic. That you know, we used to offhandedly say, "Well, you know, people that are at a certain age are really not going to be computer literate, so count them out. The truth is that they, during this time, you know, a lot of those people had their. Children and grandchildren next to their side who are managing this just quite fine. So I think we have to kind of adjust to the reality and and make it so we really reach out to all of the patient community to to make sure that they can access the information that empowers them in in in the in these pathway projects,

BARRY D. STEIN 55:25

Eva. I know that you want to add to this, and we've got a few minutes left before we wrap up. So I'd love to hear your comments on this.



MONICA SLOVENIC DANGELO 55:32

And bear there is just one other related question that I would like to share after Eva.

BARRY D. STEIN 55:40

Yep, Eva, you're on mute.

EVA VILLALBA 55:44

Yes, sorry. Just quickly to add to Raymond's question, I would also add that integrated practice units, value-based care can actually help to implicate some of these other healthcare professionals in the healthcare team in the trajectory, and also distribute the tasks in a way that isn't standard necessarily. Like there's there's a lot of burden, let's say, or a lot of focus on what the doctor has to do with the patient. But in a value based approach, an integrated practice unit, so a multidisciplinary team that follows the patient throughout, and that really addresses some of those quality of life outcomes proactively from the beginning and throughout. That is another way to really ensure that all the healthcare providers are implicated, and that it's not just the doctor and the patient, but that a lot of the other resources in the healthcare system are being used, and often at lower cost. So ultimately, that improves the value equation as well.

BARRY D. STEIN 56:44

So we have three minutes left. So a quick question for the question,

MONICA SLOVENIC DANGELO 56:47

and it is related to to the previous question, and it's actually directed at Dr. Evans. The question is that cancer cancer pathways are extremely complex, and the volume of data and evidence is exponential. Is CCO and other cancer agencies adequately resourced to keep pathways up to date and relevant? Many guidelines on CCO are outdated, and for the gap between pathways and the care delivered, does CCO have the data infrastructure and resources for a timely assessment and quality improvement.

DR. BILL EVANS 57:23

Well, it's a long question, but with a short answer, and I think you can guess what it is: is no, there's not adequate resources, and I think part of that's been made worse by the situation with the



pandemic, because really a lot of the work that is done in doing evidence-based guidelines and care pathways, is done by physicians who are active in the field and they're busy. And getting them together for meetings to discuss the the documents and and the creation of the care pathways is is challenging. So, in the last year and a half, two years, it really has not been possible to do that to the same degree, and it is very work intensive. There's no question about it, and I, I think that probably there's never going to be enough resource to stay on top of each and every one of the tumor types and phases of care, to keep them optimally up to date. And I hate to say that, but I think that's the reality. I think we just have to work as hard as we can to keep them as current as possible, so they're relevant and used by the providers and helpful to the patients.

BARRY D. STEIN 58:29

So, just a couple of minutes to wrap up. I want to thank first of all all our speakers today, Dr. Battis, Dr. Evans, and Deva Vilala for great presentations, really power-packed hour that we've had on talking about value-based healthcare and really how that would impact the care pathways that have been traditional both in Ontario and in Quebec, and how COVID has really impacted these pathways, coupled with some of the new things that are coming down the pipeline in terms of precision medicines, molecular profiling, and really some of the new advents in terms of treatment for colorectal cancer screening, diagnosis, treatment, and follow-up care, and we haven't even talked about the the differences between colon cancer and rectal cancer, and and all the different aspects of that pathway. So really, a tremendous amount to improve upon. We have a fantastic base, and let's hope that some of the new things that we learned from this pandemic can be used to help improve this pathway, and that we we don't stop here. So, like we say at Colorectal Cancer Canada, we're ready for the next round. We're looking how to make a more resilient healthcare system. We definitely want to work with. The Conference Board of Canada, the Jewish General Hospital, and and the programs across the country, not only to create a more resilient healthcare system, but one that is value-based, so we can not only control costs, but most importantly improve outcomes. So with that, I'll just hand it back over to Monica, and and thank everybody for their participation and our wonderful audience today.

MONICA SLOVENIC DANGELO 1:00:25

Yes, and thank you very much to you, Barry, for facilitating a very stimulating and insightful conversation, and and all the effort that you have been doing and supporting this research. So thank you very kindly to you to the entire panel.