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National Board of Health

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National Board of Health

Danish Experience on developing and implementing Integrated Cancer Pathways

HSPRN Conference Toronto March 29 2011

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Integrated Clinical Pathways
Political agreement October 2007

- **Problem**

  Huge waiting times and low survival rates for cancer patients
- **Aim**

  Acute treatment for all patients with cancer or suspected
- **Task**

  Develop and implement Integrated Pathways for all Cancers by end of 2008
  - Waiting times only allowed if health professionally grounded
  - Pathways based on National Clinical Guidelines
  - Monitoring of timeliness of diagnosis and treatment
  - All cancer patients must have a contact person in hospital part
  - Implementation must be finalized within three months after release

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What does an integrated clinical pathway comprise?

- Focus on the patient journey
- Responsible medical specialty clearly defined
- Defined suspicion based criteria for GP's referral of patients suspected for cancer to hospital integrated pathway
- Pathways to be based on national clinical guidelines
- Standard time for each phase of the pathway specified for the standard patient
- Predefined steps in diagnostics and treatment with pre-booked slots for all procedures
- Set time points for patient information when clinical decisions are made
- Multidisciplinary team approach
- Primary contact person and pathway coordinator
- Fixed time points in the monitoring of all patients

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Transforming political agreement into practice

National Task Force for Cancer

- National Board of Health
- Ministry of Health
- The Association of Danish Regions + 5 Health Directors
- The Association of Danish Municipalities

Cancer Unit across the Ministry of Health and National Board of Health reporting to Minister

14 Clinical working groups

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14 Clinical Working Groups

Objective: Develop 34 integrated cancer pathways

All 14 groups followed a common template for each of 34 cancers

Members of a clinical working group

Ex: Gynecological Cancers: Uterus Ovary Cervix Vulva

- National Board of Health
- Gynecological surgeons –
  - Gyn scientific society + each of 5 regions + DMCG
- Gynecological oncologist
- Gynecological pathologist
- Gynecological radiologist
- General Practitioner

Time table for the implementation of the agreement of *integrated clinical pathways for cancer diseases*

Disease specific groups (multidisciplinary)	**National implementation**	**Cancer diseases**
1 Colorectal	April 2008	Colonic cancer, rectal cancer
2 Lung cancer	April 2008	Lung cancer
3 Head and neck cancer	April 2008	Head and neck cancer
4 Breast cancer	April 2008	Breast cancer
5 Gynecologic cancer diseases	August 2008	Cancer in cervix, ovary and uterus. Vulva cancer (January 2009)
6 Leukemia	September 2008	Myelomatosis, acute leukemia, lymphomas and myelodysplastic syndrome
7 Cancer in the urinary system	November 2008	Cancer in the urinary bladder and kidney
8 Skin cancer	November 2008	Malignant melanoma, non malignant melanoma (January 2009)
9 Cerebral cancer and in the nervous system	November 2008	Cerebral cancer
10 Masculine cancer diseases	January 2009	Cancer in testicle, prostate and penis
11 Upper gastrointestinal cancer	January 2009	Cancer in the liver and cystic duct, cancer in esophagus, cardia, stomach, pancreas and metastases in the liver
12 Cancer diseases in children	January 2009	Tumor in the brain and spine, leukemia, lymphatic cancer, tumor in the chest, abdominal cavity, musculoskeletal system, abdominal and chest wall
13 Cancer of the eye	January 2009	Malignant melanoma i uvea, tumor orbital, retinoblastoma
14 Cancer – orthopedic surgery and others	January 2009	Osteosarcomas, soft tissue sarcomas (cancer in the connective tissue)

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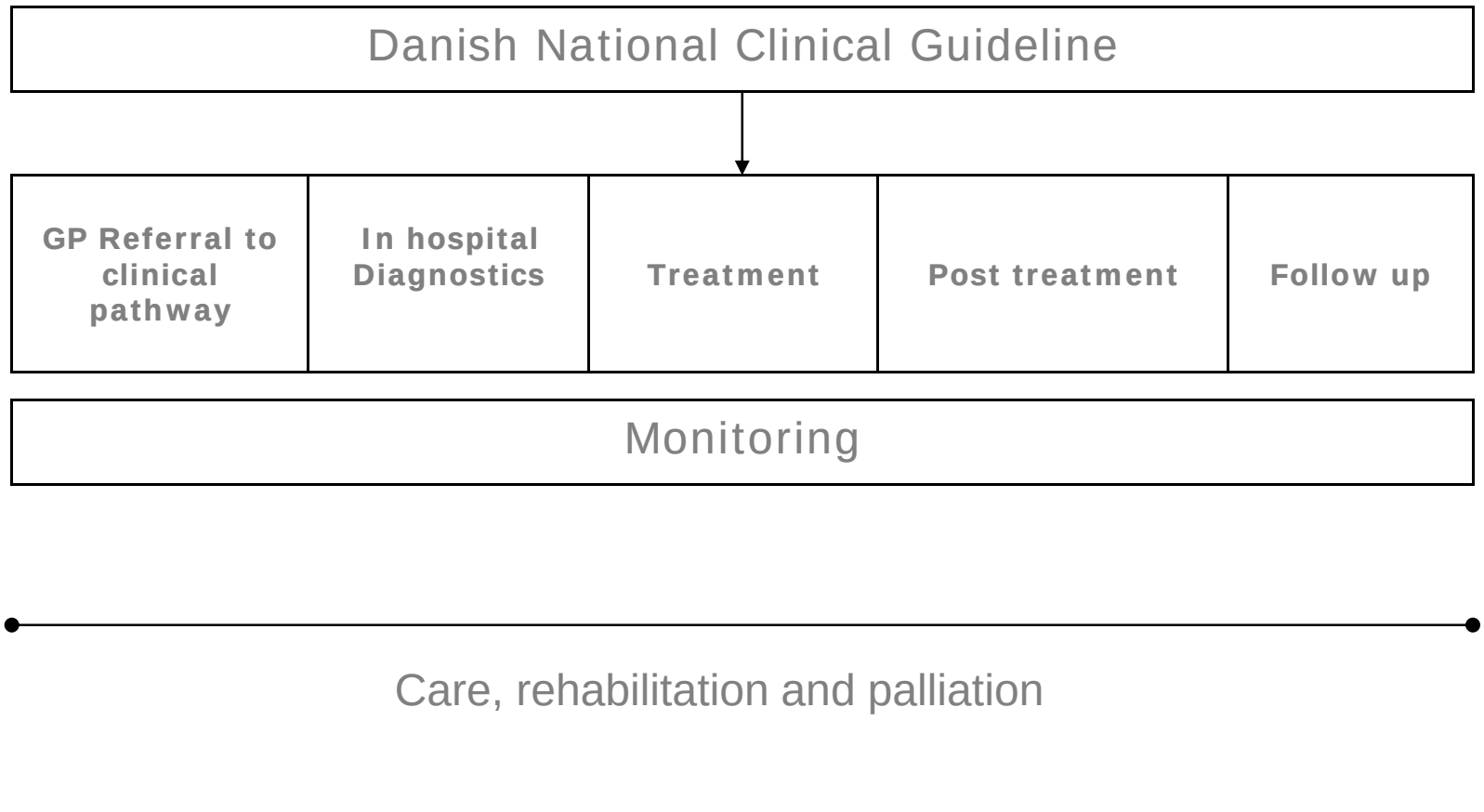
An integrated clinical cancer pathway

From National Clinical Guidelines to Integrated Clinical Pathways



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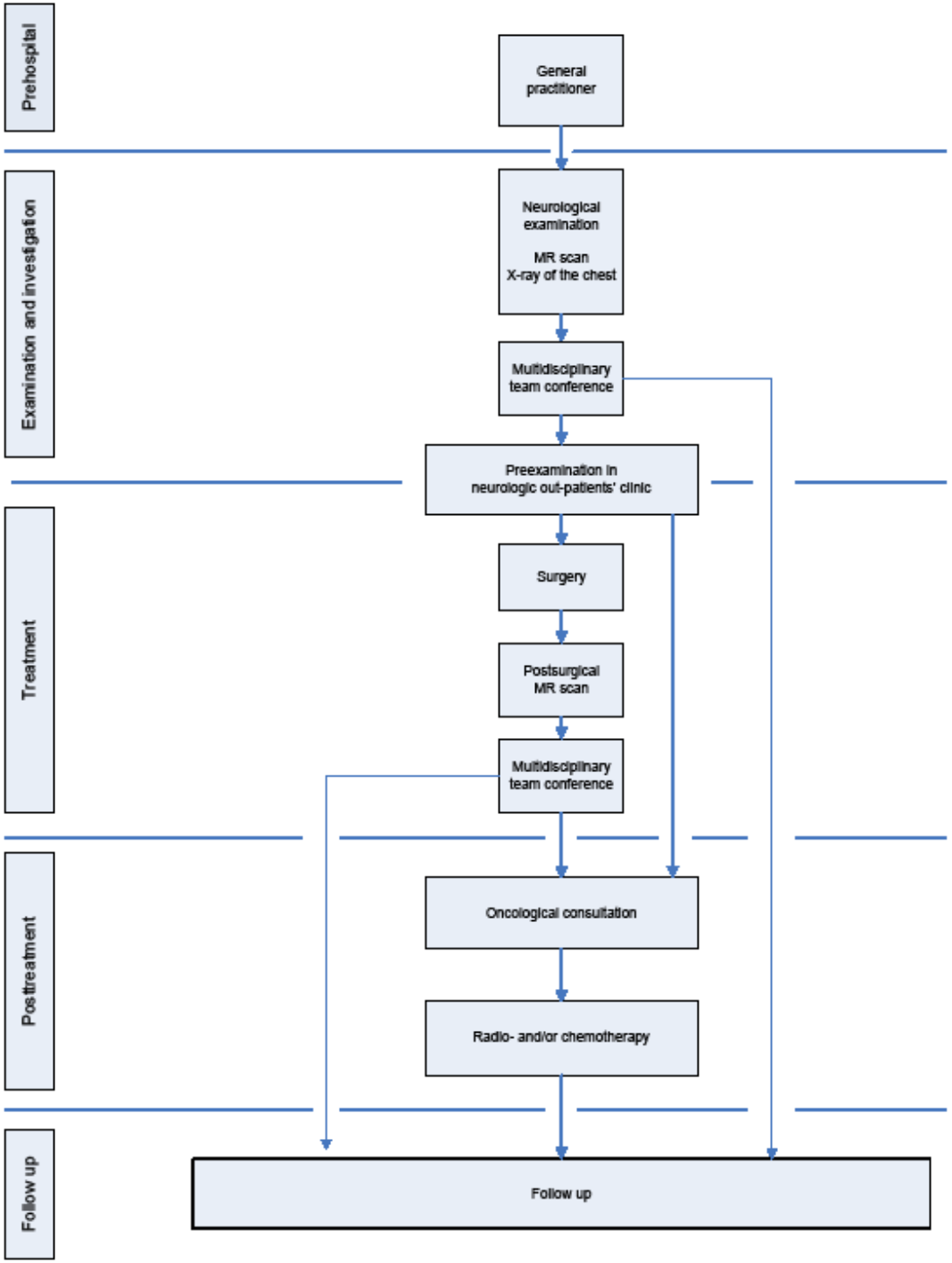
Flow chart

Clinical pathway for the standard cerebral cancer patient



Overview of an integrated pathways for cancer patients - *cerebral cancer*

Clinical action	Logistic action	Information of the patient	Specialty	Registration & Monitoring
Pre hospital				
Decision: General practitioner finds *criterion based suspicion* of cancer	▪Referral form is transmitted ▪Additional information, if any, is transmitted to department of neurology	▪Exclusion of cancer ▪Further planning of pathway	General Practitioner	
Referral to start at integrated pathway	▪Referral form received ▪Booking: Investigation and examination program	▪Call in: Investigation and examination and program	Neurologist	**A: Referral form received**
Investigation and examination program: ▪Neurological examination ▪Electrocardiogram (ECG) ▪Blood tests ▪MR scan ▪X-ray of the chest		▪Further planning of pathway	Neurologist Radiologist	**B: Diagnosing begins** (first consultation)
Decision: ▪Referral to neurosurgeon	▪Booking: Pre investigation and examination in neurosurgical out-patients' clinic ▪Booking: out-patients' neurological treatment	▪Determination of diagnosis ▪Further planning of pathway ▪Call in: pre investigation and pre examination in neurological out-patients' clinic ▪Call in: follow up in neurological out-patients' clinic	Multi-disciplinary team	**C1: Diagnosis is confirmed and disproved**

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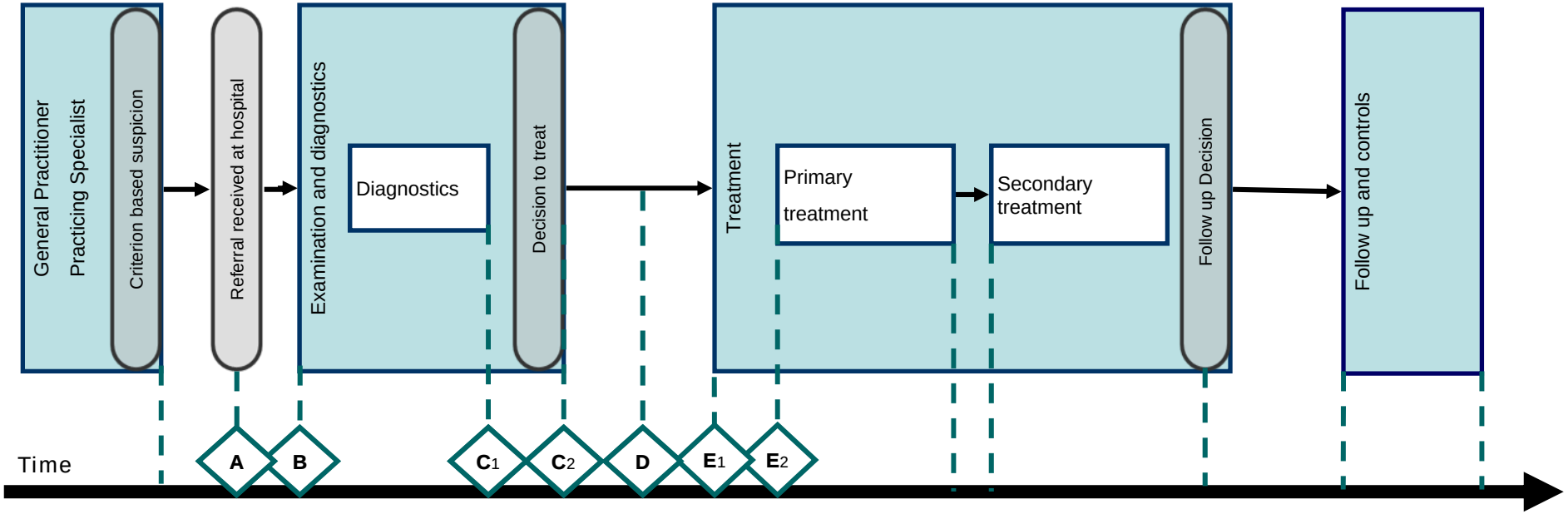
Clinical Working Groups – Standard Timeframes

- Standard time for each phase of the pathway specified for the standard patient

  Ideal (i.e. if no capacity constraints) timeframes with regards to factual processing times

  - surgeons
  - anesthesiologist
  - oncologists
  - pathologists
  - radiologists
  - General Physician

Integrated pathways for cancer patients
– *fixed monitoring points*



A : Referral received
B : Diagnostics start
C1: Diagnosis (dis-)confirmed
C2: Decision to treat
D : Informed consent
E1: Treatment start, organizational
E2: Treatment start, clinical

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Successes and Why

- Appropriate political attention and commitment to enter into joint agreement was important
- Added funding essential
- Use of national clinical guidelines expected to increase quality of care (lower mortality)
- Increased focus on the Multi Disciplinary Team
- Increased focus on GP pre referral procedures
- Reduced waiting times for cancer patient for diagnosis and treatment – Monitoring essential
- However : Total pressure on health system makes it hard to keep up the good results

Lessons learned (1/2)

- Important from an early stage to include the development and integration of a registration and monitoring system of the integrated clinical pathways
- Awareness and common understanding of strengths and weaknesses, possibilities and limitation of using exiting registry is essential
- Cooperation with clinical quality databases should be prioritized from early on in the process
- Overall success criteria should be formulated early in the process
- Important to think patient involvement into the process

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Lessons learned (2/2)

- Criteria for necessary patient load/population to justify a standard clinical pathway necessary
- Important to integrate the handling of co-morbidity into the integrated pathways from an early stage
- Important to clearly define when a pathway begins and ends
- Finding a balance between what is clinically optimal and capacity (staffing situation, equipment)
- Awareness of the priority discussion (across diseases and health sectors) the introduction of clinical pathways opens up for

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Integrated Clinical Pathways for Cancer Patients

Questions and comments

Thank you

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