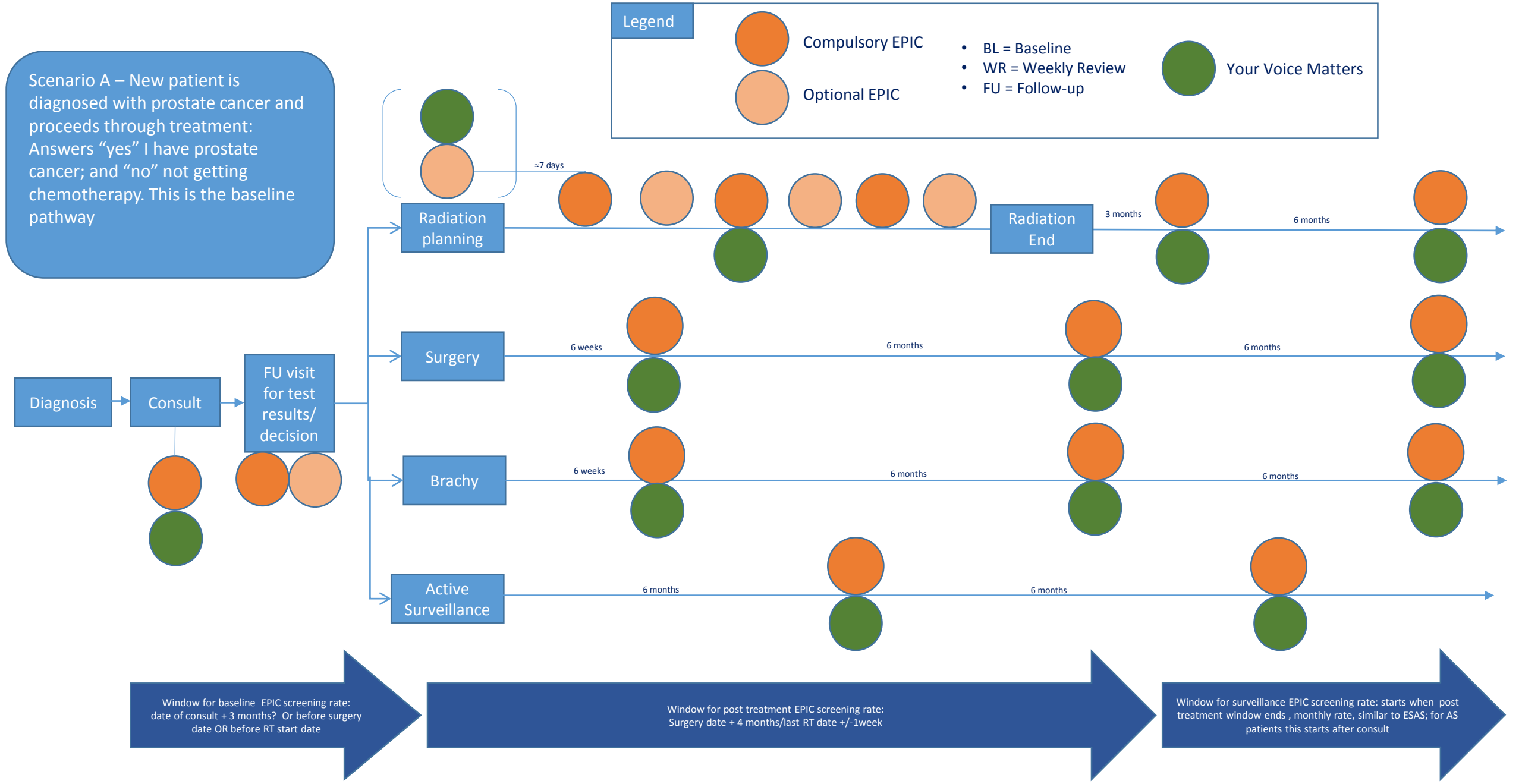
Cancer Care Ontario

Possible Patient Scenarios – Your Symptoms Matter – Prostate Cancer (EPIC-CP)

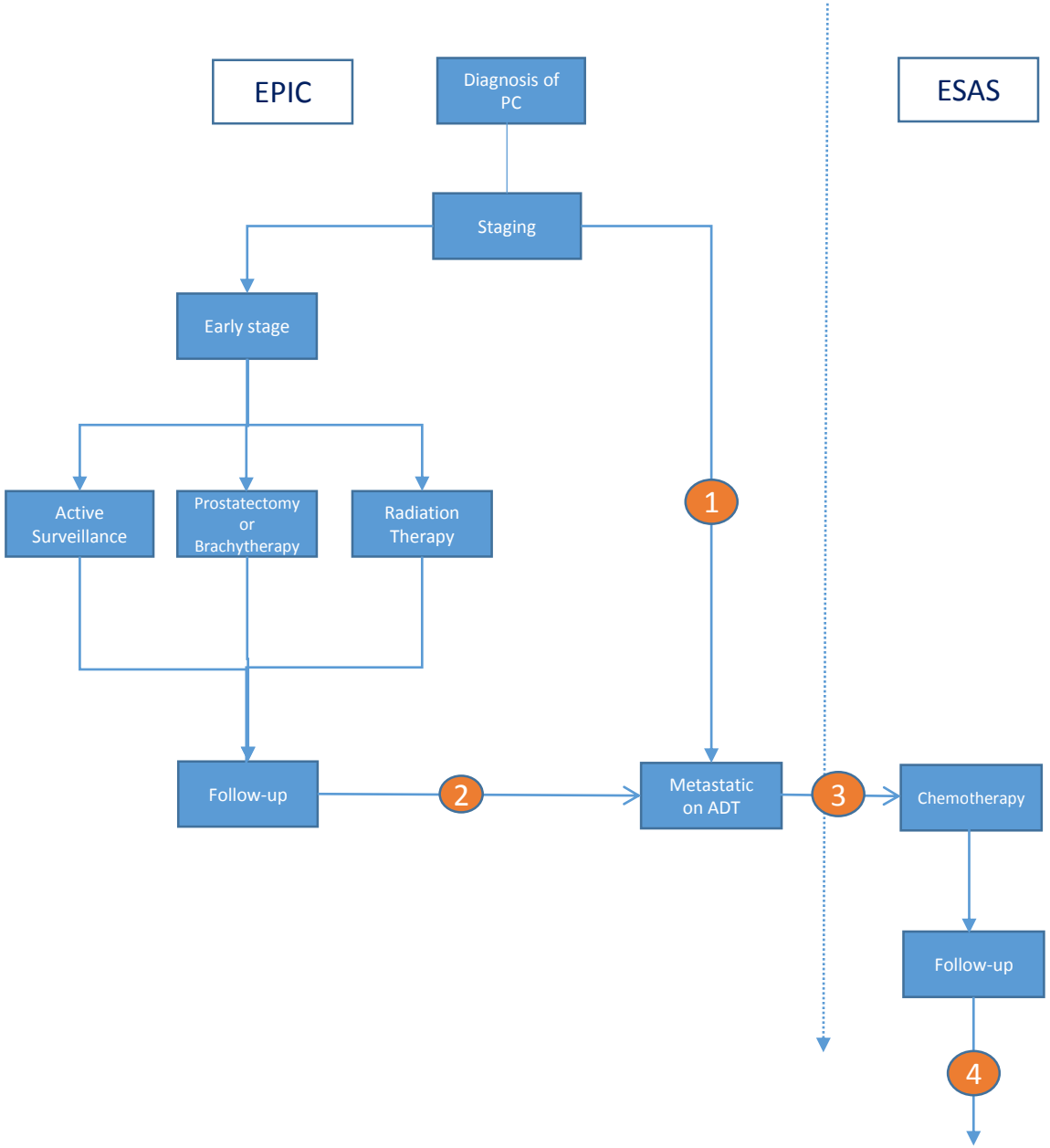
For Staff Education and Planning

Ontario
Cancer Care Ontario


Scenario A – New patient is diagnosed with prostate cancer and proceeds through treatment: Answers “yes” I have prostate cancer; and “no” not getting chemotherapy. This is the baseline pathway
Legend
Compulsory EPIC
Optional EPIC
BL = Baseline
WR = Weekly Review
FU = Follow-up
Your Voice Matters
Diagnosis
Consult
FU visit for test results/ decision
Radiation planning
Surgery
Brachy
Active Surveillance
≈7 days
Radiation End
3 months
6 months
6 weeks
6 months
6 months
6 weeks
6 months
6 months
6 months
6 months
Window for baseline EPIC screening rate: date of consult + 3 months? Or before surgery date OR before RT start date
Window for post treatment EPIC screening rate: Surgery date + 4 months/last RT date +/-1week
Window for surveillance EPIC screening rate: starts when post treatment window ends , monthly rate, similar to ESAS; for AS patients this starts after consult

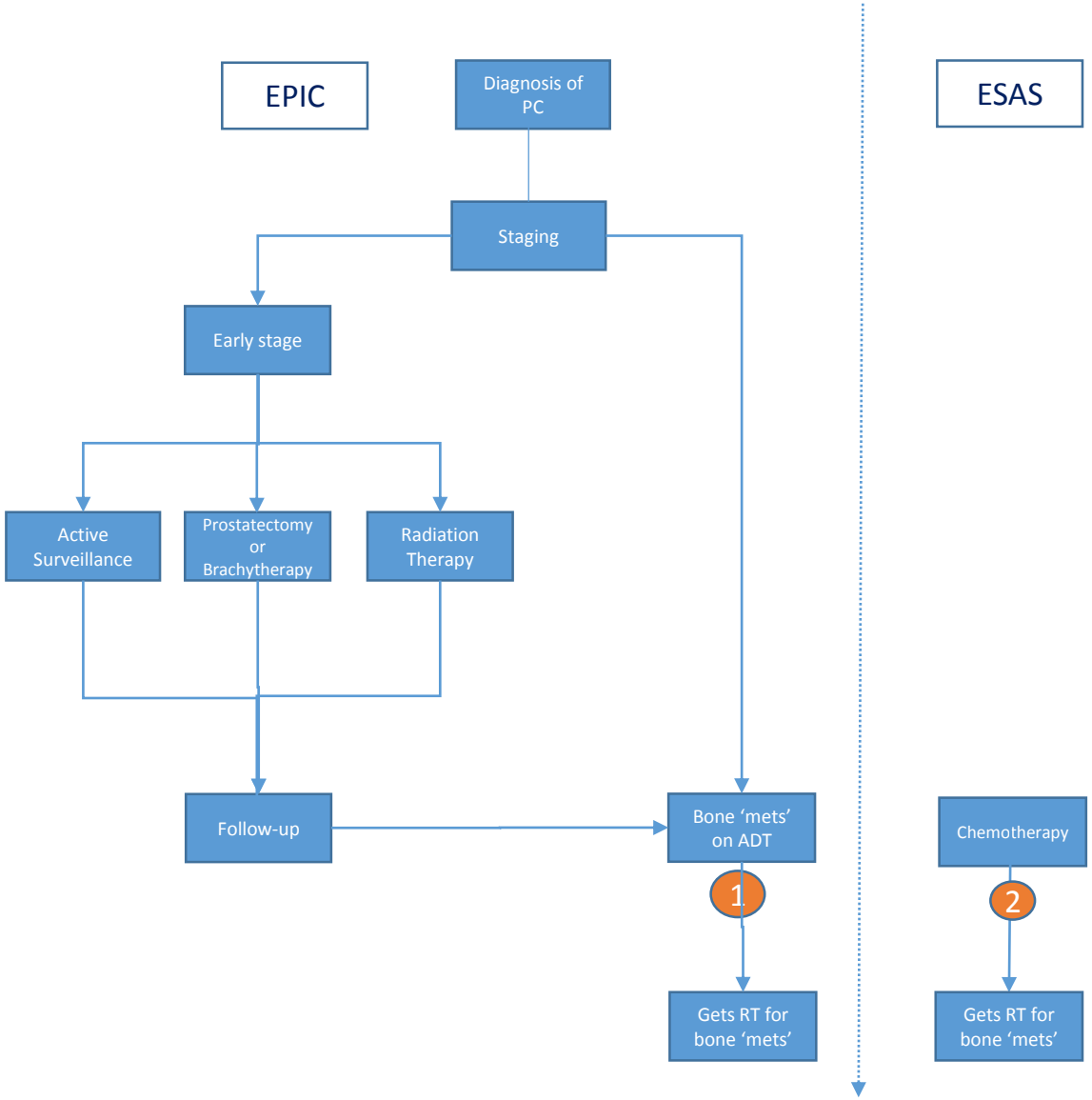
Scenario B – Development of metastatic disease or metastatic disease at presentation

Risk	Description	Impacts	Monitoring	Potential Mitigation(s)
1 2 Patients present with or develop metastatic disease	First line therapy is usually ADT; EPIC addresses several symptoms specific to ADT; permits capture of patients on adjuvant ADT Implementation committee felt it was preferable to capture metastatic patients on ADT with EPIC (not ESAS) in order to ensure patients on adjuvant ADT received EPIC.	*Screening rate* Will depend on how denominator is defined *Patient Experience* Hormone-refractory metastatic patients not on chemotherapy might be better candidates for ESAS, but will still receive EPIC	- Investigate feasibility of measuring frequency of this occurrence (w/ CCO analytics)	- Revise self-identification process and/or modify system on back-end - Create process so that health care team can identify patients who are better candidates for ESAS and update this in system
3 Metastatic disease progresses on ADT and patients switched to chemotherapy	The majority of patients will get trial of chemotherapy. Depending on health literacy and/or level of involvement in own care, patients may not recognize the difference between ADT and chemotherapy.	*Screening rate* By completing EPIC, patients on chemotherapy may positively skew the screening indicator. *Patient Experience* Potential for confusion over what is and isn't chemotherapy, and unrealized benefits of symptom screening with most appropriate tool	- Determine a) Proportion of patients who start on ADT and progress v. patients who start on chemo. b) Patients on chemotherapy completing EPIC - In order to assess whether or not patients of this type are more likely to incorrectly complete EPIC	- Tools/materials to improve patient understanding of self-selection criteria - Information for providers on how to proceed if they identify a patient doing ESAS who should be doing EPIC
4 After answering "yes" to the chemotherapy question	Once this question has been answered 'yes' all future kiosk visits will offer ESAS only with no further prompting or selection questions. ESAS is felt to be the more relevant tool in a palliative population on palliative chemotherapy	*Screening rate* If patient answers wrong they can't correct next time so could decrease rate perpetually	- CCO to track how many prostate cancer patients answer Question 1 correctly, and question 2 incorrectly according to ALR or other databases (these patients would get ESAS instead of EPIC)	- If frequent, can change screening question to be more specific/informative and/or change ISAAC logic that blocks self-selection perpetually - Information for patients can explain how to proceed if they feel they might have made an error - Information for providers on how to proceed if they identify a patient doing ESAS who should be doing EPIC



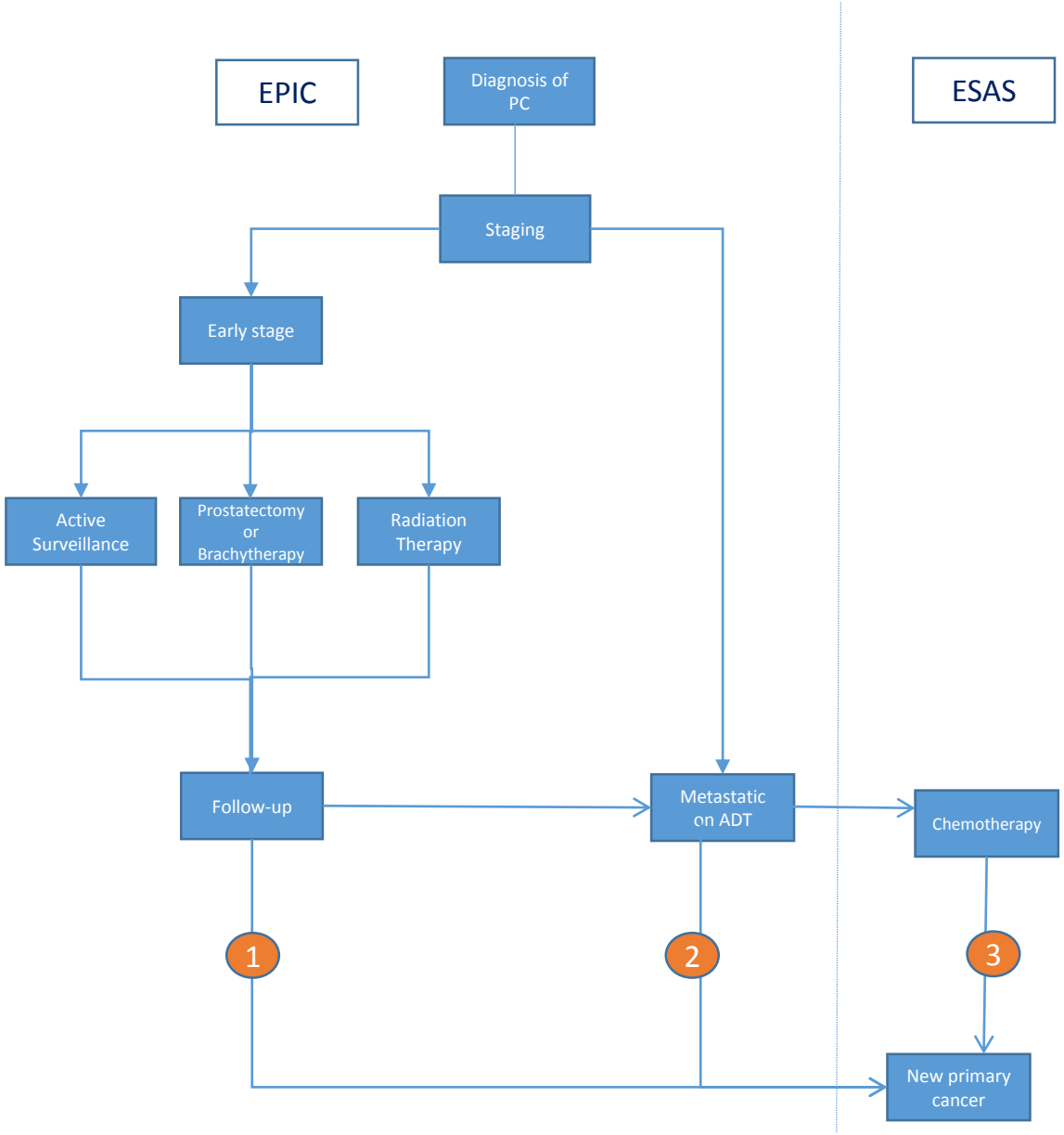
Scenario C – Development of bone metastases needing palliative radiation

Risk	Description	Impacts	Monitoring	Potential Mitigation(s)
1 Patients present with or develop metastatic bone disease	These patients may get short course radiation for bone pain They will likely be in review only once. They would be expected to answer "yes" when asked if the visit if for prostate cancer, and will answer "no" when asked about chemotherapy. These patients will get EPIC.	*Screening rate* Will depend on how denominator is defined (i.e. will it be sum of all eligible patients, or total patient population minus ineligible patients) *Patient Experience* Patients responding to EPIC survey may expect it to be more relevant in clinical conversations (EPIC doesn't address bone pain)	- CCO will monitor incidence of palliative intent radiation therapy for prostate cancer patients to assess impact on screening rate (ALR, no chemotherapy, on hormones but also coming for radiation therapy) - CCO to evaluate feasibility of looking at palliative intent radiation therapy flag on ALR and/or site of radiation as bony metastases	- Revise self-identification process and/or modify system on back-end to 'switch-off' EPIC for patients who should only be seeing ESAS - Information for patients and providers explaining that symptoms not captured by assessments should still be raised with HCT (i.e. if patient is completing EPIC but is experiencing pain from bony metastases)
2 After answering "yes" to the chemotherapy question	First line therapy is usually ADT; EPIC addresses several symptoms specific to ADT; permits capture of patients on adjuvant ADT Implementation committee felt it was preferable to capture metastatic patients on ADT with EPIC (not ESAS) in order to ensure patients on adjuvant ADT received EPIC.	*Screening rate* Will depend on how denominator is defined *Patient Experience* Hormone-refractory metastatic patients not on chemotherapy might be better candidates for ESAS, but will still receive EPIC	- Investigate feasibility of measuring frequency of this occurrence (w/ CCO analytics)	- Revise self-identification process and/or modify system on back-end for patients who should only be seeing ESAS - Create process so that health care team can identify patients who are better candidates for ESAS and update this in system



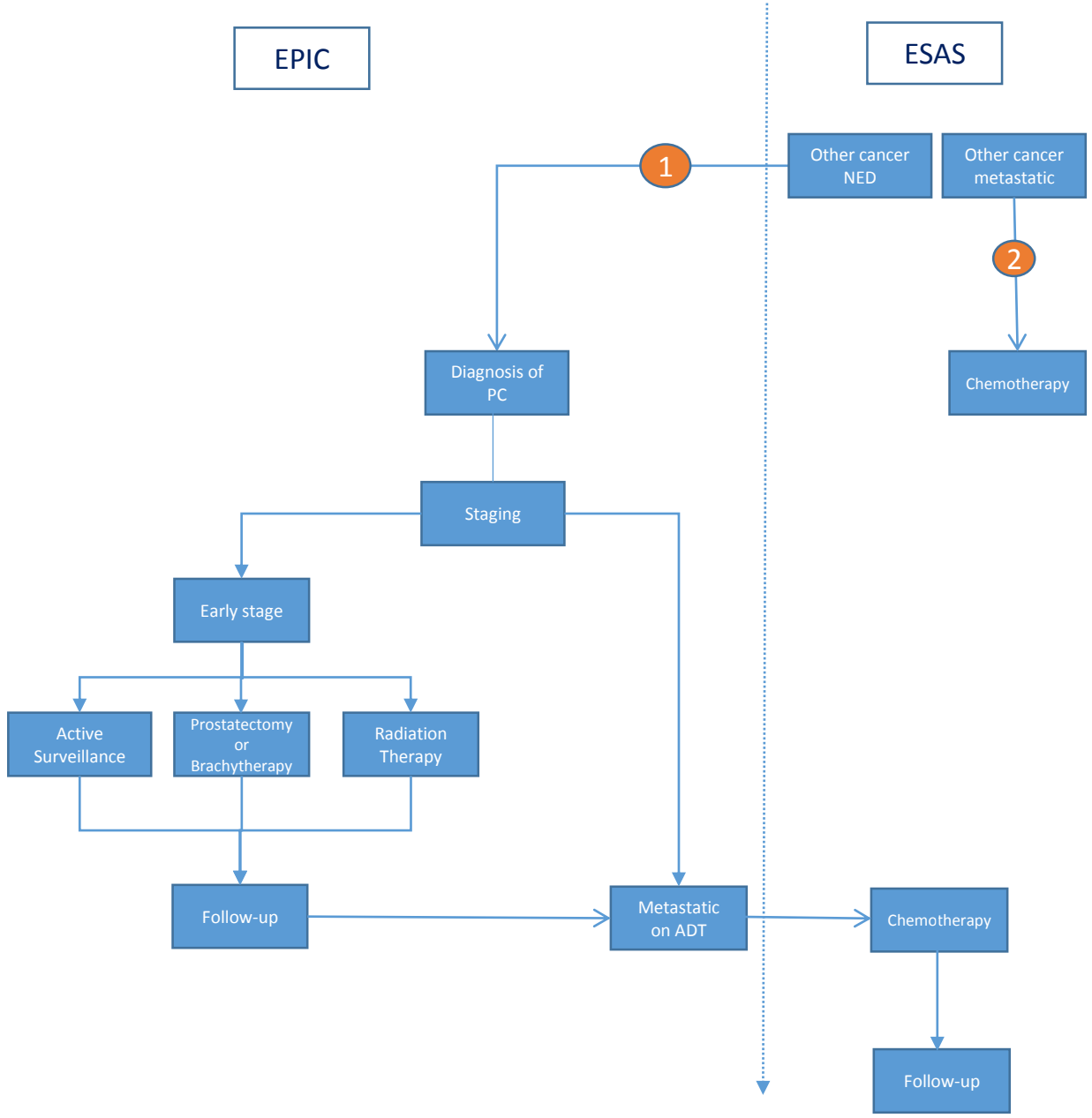
Scenario D– Development of new primary site

Risk	Description	Impact	Monitoring	Potential Mitigation(s)
1 Well (asymptomatic) prostate cancer patient develops a new primary	After prostate cancer treatment, patient receives diagnosis for an additional cancer. It is expected that at first visit for their new cancer, the patient will answer 'no' to the first self selection question. In this case the patient will get ESAS. Should the patient return later for a prostate cancer related visit, it is expected they would answer 'yes', and receive EPIC	*Screening rate* Heavy reliance on patient recall and understanding of next steps in care for proper allocation to EPIC/ESAS indicators. Possibility that patient completed ESAS for prostate cancer visit and/or EPIC for non-prostate visit *Patient Experience* Increased burden of information recall for patient/family members as well as potential issues reporting symptoms/outcomes based on ability to navigate self-selection process	- CCO to assess frequency of diagnosis of new cancer during well follow up for prostate cancer in order to assess magnitude of impact and inform future mitigation strategies - May also be able to use ALR to determine if patients got EPIC on prostate visit days and ESAS on other site visit days	- Patient and provider education to emphasis utility of EPIC for prostate visits and ESAS for new cancer visits - If patients incorrectly self-identify can hit 'back' button - Education for volunteers to assist with self-select
2 Prostate cancer patient on hormones for metastatic disease develops a new primary	Patient on hormone therapy for metastatic or advanced prostate cancer receives diagnosis for an additional cancer. It is expected that at first visit for their new cancer, the patient will answer no to the first self selection question. In this case the patient will get ESAS. Should the patient return later for a prostate cancer related visit, it is expected they would answer yes, and receive EPIC.	-*Screening rate* Heavy reliance on patient recall and understanding of next steps in care for proper allocation to EPIC/ESAS indicators. Possibility that patient completed ESAS for prostate cancer visit and/or EPIC for non-prostate visit *Patient Experience* Relevance of ESAS v. EPIC for prostate cancer treatment will depend on patient. Will need guidance from providers to navigate to the right tool.	- CCO to assess frequency of patient receiving hormone therapy for prostate cancer and then receiving an additional diagnosis in order to assess magnitude of impact and inform future mitigation strategies - May also be able to use ALR to determine if patients got EPIC on prostate visit days and ESAS on other site visit days	- Patient and provider education to emphasis utility of EPIC for prostate visits and ESAS for new cancer visits - If patients incorrectly self-identify can hit 'back' button - Education for volunteers to assist with self-select
3 Prostate cancer patients with metastases on chemo develops a new primary	This patient will already be screening with ESAS. No change brought by new diagnosis.	• None	• None	• None



Scenario E – Prostate cancer diagnosed after a pre-existing cancer diagnosis

Risk	Description	Impact	Monitoring	Potential Mitigation(s)
1 Patient has a previous diagnosis but has been treated and has no evidence of disease	Treatment for prostate cancer will consider the prior diagnosis but may be still administered as if there were no prior cancer diagnosis. The screening question, is your visit for prostate cancer should ensure the patient gets EPIC	*Patient Experience* Patient, having undergone previous treatment, may be familiar with ESAS tool and discussions based on symptoms it reports.	- CCO will also track this occurrence to understand incidence of prostate cancer following successful treatment for another cancer: pull patients with multiple primaries, figure out if prostate came first or was second and look at which screen they completed from here	- Patient education will need to emphasize why the EPIC tool is more relevant than ESAS for prostate cancer treatment - Volunteer training
2 Patient has a previous diagnosis and has metastatic disease	The pre-existing cancer will dictate prognosis and it is unlikely the prostate cancer will be treated if asymptomatic (most likely scenario). However, patient may experience prostate cancer symptoms and receive some treatment for these symptoms. When asked if visit is related to prostate, most likely answer will be "no' and ESAS will be given. In the event the patient has a prostate cancer visit, the answer might be yes, and they will get EPIC, this might help evaluate symptoms requiring palliation (e.g. urinary symptoms).	*Screening rate* Heavy reliance on patient recall and understanding of next steps in care for proper allocation to EPIC/ESAS indicators. Also need to recall intent of prostate cancer treatment to answer self-selection questions properly *Patient Experience* Experience of prostate cancer symptoms may not align with prostate cancer visits, as such patient may not have adequate opportunity to report prostate symptoms and discuss them with HCT.	- CCO to track incidence of patients with pre-existing metastatic disease who receive diagnosis and treatment for prostate cancer - CCO to track how often patients who are in active treatment for metastatic cancer complete ESAS at non-chemotherapy prostate cancer visits	- Providers and patients will require tools on how to select most appropriate assessment given individual disease profile - Process may need to be identified to automatically triage these patients to ESAS (pending results of monitoring) to alleviate recall burden on patients



Responses and Resources

Need	Addressed?	Plan
Volunteer resources	Yes	Volunteer guide
Clinician resources	Yes	Clinical guidelines FAQs for clinicians
Patient resources	Yes	Patient guidelines FAQs for patients
Clerical staff resources	No	Team to develop one-page resource for clerical/administrative staff to assist with patient identification and navigation at intake/registration
ISAAC maintenance	No	Team to consult with ISAAC user-group to determine best process for resolving issues
Monitoring/measurement	No	Team to consult with analytics/informatics to assess frequency/impact of each scenario and inform future interventions