
Conclusions: Successful administration of cancer care for curable cervical cancer. Road to Care supports these patients with baseline workup and monitoring investigations, transportation, accommodations, subsistence and by covering the cost of treatment which totals up to 470 CAD per patient. This program runs through partnerships, networks and collaborations with local agencies such as Hospice Africa Uganda (HAU), the Kigezi Health Care Foundation (KIEFO) and the Uganda Cancer Institute (UCI). Patients are identified through HAU and KIEFO, and once investigations have been completed, they are referred to the UCI for treatment.

Results: Over the past 10 years (December 2009 to December 2019), a total of 1,163 patients were enrolled onto the Road to Care program. Eight hundred thirty-eight (72.1%) patients were stage IB2-IIIB and were referred to the UCI for treatment. Of those referred, 803 (95.8%) received radical chemoradiation while 35(4.2%) received palliative radiotherapy. Of the 325(27.9%) patients that were not referred to the UCI, 18(5.5%) received supportive care only due to advanced disease.

Conclusions: International collaboration and the creation of a financially supported care pathway has enabled 803 Ugandan women to access radical chemoradiotherapy for curable cervical cancer.


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ENABLING ACCESS TO CERVICAL CANCER RADIOTHERAPY IN UGANDA: 10 YEAR UPDATE ON ROAD TO CARE

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Purpose: Uganda has one of the highest incidence rates for cervical cancer in the world with an age-standardized rate of 54.8 per 100,000 women, and mortality rate of 40.5 per 100,000 women [1]. Many women are not able to access treatment for their cancer, due to financial, logistical and social barriers. Road to Care, a Canadian charity dedicated to working with local partners, provides patients diagnosed with curable cervical cancer in south western Uganda, the financial and logistical means to access radiotherapy treatment.

Materials and Methods: Road to Care supports these patients with baseline workup and monitoring investigations, transportation, accommodations, subsistence and by covering the cost of treatment which totals up to 470 CAD per patient. This program runs through partnerships, networks and collaborations with local agencies such as Hospice Africa Uganda (HAU), the Kigezi Health Care Foundation (KIEFO) and the Uganda Cancer Institute (UCI). Patients are identified through HAU and KIEFO, and once investigations have been completed, they are referred to the UCI for treatment.

Results: Over the past 10 years (December 2009 to December 2019), a total of 1,163 patients were enrolled onto the Road to Care program. Eight hundred thirty-eight (72.1%) patients were stage IB2-IIIB and were referred to the UCI for treatment. Of those referred, 803 (95.8%) received radical chemoradiation while 35(4.2%) received palliative radiotherapy. Of the 325(27.9%) patients that were not referred to the UCI, 18(5.5%) received supportive care only due to advanced disease.

Conclusions: Successful administration of cancer care for Indigenous populations demands involvement of Indigenous leadership. Pan-Canadian infrastructure to support and facilitate feedback mechanisms that promote locally-driven cancer policies are required to improve cancer care among these populations.

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THE LAY OF THE LAND: CANCER CARE FOR FIRST NATIONS, INUIT, AND MÉTIS PEOPLES OF CANADA

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Purpose: Cancer rates among Indigenous peoples of Canada (First Nations, Inuit, and Métis) are increasing dramatically. Indigenous peoples are at higher risk of cancers associated with known modifiable risk factors and face poorer survival rates. Generations of jurisdictional disagreement and systemic disenfranchisement have left Indigenous Canadians a vulnerable population burdened by numerous health disparities, and pervasive barriers in their pursuit of appropriate cancer care. This review explores the current Canadian cancer system for Indigenous people.

Materials and Methods: We searched databases for studies published between 1946 to February 2020 reporting on cancer policies and programs related to indigenous communities in Canada. The grey literature was also reviewed.

Results: Jurisdictional and administrative challenges to Indigenous health care date back to the country’s inception. While the provincial governments provide universal insured services to their citizens, including Indigenous peoples, the federal government administers health promotion and public health services, such as cancer screening, on First Nations reserves and in Inuit communities. Indigenous Canadians face challenges at every step of the cancer care continuum, from preventative care to end of life care and survivorship. These challenges are largely geographic, administrative, and cultural in nature. The nuances of these challenges differ between specific Indigenous groups and communities but share major commonalities. Collaborative, multidisciplinary initiatives and careful coordination of interconnected services are being undertaken in effort to close these gaps and improve care.

Conclusions: Successful administration of cancer care for Indigenous populations demands involvement of Indigenous leadership. Pan-Canadian infrastructure to support and facilitate feedback mechanisms that promote locally-driven cancer policies are required to improve cancer care among these populations.

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A PAN-CANADIAN APPROACH TO PATIENT-CENTERED QUALITY IMPROVEMENT INITIATIVES: DEVELOPMENT AND PROMOTION OF PATIENT EDUCATION, ENGAGEMENT AND PATIENT REPORTED OUTCOME GUIDANCE DOCUMENTS

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Purpose: In 2011 the Canadian Partnership for Quality in Radiotherapy (CPQR) released its seminal document Quality Assurance Guidelines for Canadian Radiation Treatment Programs outlining the overarching elements of quality that are important in all radiation treatment (RT) programs. Since that time, there has been an interest expressed by the radiotherapy community to expand upon these guidelines with an increased emphasis on the patient focus which would promote alignment with accreditation standards and patient-centred practice. To this end, the CPQR initiated the development of a new suite of complementary documents to provide guidance for RT programs in the development and implementation of patient-centred quality improvement initiatives.
Materials and Methods: The CPQR, working with an interprofessional team of experts with pan-Canadian representation used a stepwise, iterative process of guideline development to promote system-level change, including: 1) an initial literature review augmented by expert opinion, including patient representatives from CPQR’s Steering Committee and the Canadian Association of Radiation Oncology (CARO)’s Education and Patient Education/Engagement Committees; 2) draft guideline versions made available to the national community, providing an opportunity for widespread review and input (an integral step for all CPQR-supported initiatives); and 3) the planned release of three new guidance documents in 2020 to support all Canadian RT programs in their efforts to promote patient-centred practice.

Results: In order to promote a pan-Canadian approach to patient-centered quality improvement initiatives, the CPQR has expanded upon their original quality assurance guidelines to develop: 1) Patient Engagement Guidelines for Canadian Radiation Treatment Programs outlining overarching elements of quality that are important to ensure patients and family members are engaged in the care process and satisfied with all aspects of care; 2) Patient Education Guidelines for Canadian Radiation Treatment Programs providing guidance on activities RT programs can incorporate to ensure that patients and family members are adequately and appropriately educated in their care; and 3) Patient Reported Outcomes Guidelines for Canadian Radiation Treatment Programs informing RT programs on optimal collection and use of patient reported outcomes (PROs) in routine clinical practice.

Conclusions: The CPQR model for promoting system-level change has been used to build a pan-Canadian approach to patient-centered QI initiatives, through both top-down guidance for practice harmonization and the promotion of local grass roots efforts.

187 MAMMOGRAPHIC SURVEILLANCE IN OLDER WOMEN WITH BREAST CANCER IN CANADA AND THE UNITED STATES: ARE WE CHOOSING WISELY?
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Purpose: Guidelines on mammographic surveillance following breast cancer treatment have been disseminated internationally and incorporated into Choosing Wisely recommendations. The extent to which there is adherence within different health systems is unknown. The objective of this study is to measure and compare the extent to which there is adherence within different health systems and incorporated into Choosing Wisely recommendations. The CPQR has been used to build a pan-Canadian approach to patient-centered QI initiatives, through both top-down guidance for practice harmonization and the promotion of local grass roots efforts.

Materials and Methods: Our cohort included women ≥65 years of age diagnosed with breast cancer between 2010-2013 who underwent lumpectomy and adjuvant radiation within 12 months of diagnosis (N =19,715 in US, 6,479 in Ontario). The primary outcome was receipt of guideline-discordant low-value mammography, defined as: 1) mammography within six months of radiation (“short-interval”); or 2) ≥1 mammogram within 12 months of radiation, (“high-frequency”). Secondary outcomes were patient and provider characteristics associated with discordance.

Results: The proportion of women with short-interval mammography in the US was higher than in Ontario (55.9% versus 38%, p<0.001) as was the proportion with high-frequency mammography (39.6% versus 7.9%, p<0.001). In Ontario, older age (42% ≥85 years versus 58% <74, p<0.001) and chemotherapy use (69% versus 51%, p<0.001) predicted for a greater probability of short-interval mammography; in the US, younger age, earlier diagnosis year, earlier stage, chemotherapy use, rurality and academic center treatment were associated with greater use. Women who received chemotherapy also had a greater likelihood of high-frequency mammography (13% versus 7% in Ontario, p=0.001; 69% versus 51% in US, p=0.02); in the US, younger age, earlier diagnosis year, earlier stage, and treatment at a non-academic center were also significant predictors. In both countries, radiation oncologists were most commonly responsible for high-frequency and short-interval mammography.

Conclusions: Despite a large body of evidence guiding surveillance mammography recommendations, there are high rates of discordance with short-interval mammography in both the US and in Ontario and high rates of high-frequency mammography in the US. Overall, there was greater guideline adherence to the Choosing Wisely recommendations in Ontario compared to the US. Further international efforts are needed, with targeted attention in the US to decreasing the use of high-frequency mammography through continuing education and value-based policy levers.