



# Access




CancerCare Manitoba manages three provincial screening programs as part of a comprehensive strategy to find breast, cervical and colorectal cancer at the earliest, and most treatable, stage. Using evidence-based testing and approaches, the programs serve to educate the population about the benefits of regular screening.

For example, ColonCheck Manitoba encourages every eligible Manitoban to be screened for colorectal cancer. In partnership with Manitoba Health and the CancerCare Manitoba Foundation, the program continues to raise awareness about screening and its effectiveness through public information initiatives. Tej Bains was part of the *It Matters to You* campaign.

At her annual check-up, Bains was given a Fecal Occult Blood Test or FOBT, the same test ColonCheck Manitoba mails to eligible Manitobans, to do at home to screen for colorectal cancer. After receiving abnormal results, a colonoscopy was scheduled. During the procedure polyps were found and removed before they turned cancerous.

Often people will wait to see a doctor until there is problem, which is why Bains is glad ColonCheck Manitoba aims to help detect colorectal cancer early and reduce the number of Manitobans who die from the disease. "It is great that the program is there to offer screening tests to those who might not see a doctor regularly."

# Screening

SCREENING RATES		Past Estimate	Current Estimate	Time Trend	Range of Current Estimates <i>(Lowest RHA - Highest RHA)</i>
	<p><b>Colorectal Cancer</b></p> <p><b>NEW</b> FOBT: percent of men and women (ages 50 – 74) who completed a FOBT in the last two years.<sup>b</sup></p>	N/A	36.3%	NEW	15.7% - 62.5%
	<p><b>Cervical Cancer</b></p> <p>percent of women (ages 18 – 69) who had a Pap test in the last three years.<sup>c</sup></p>	69.4%	64.6%	→	55.5% - 69.1%
	<p><b>Breast Cancer</b></p> <p>percent of women (ages 50 – 69) who had a mammogram within the last two years.<sup>d</sup></p>	61.7%	62.5%	→	50.4% - 68.1%
	<p>percent of women (ages 50 – 69) who had a routine screening mammogram within the last two years through the Manitoba Breast Screening Program.<sup>e</sup></p>	51.1%	52.1%	→	46.3% - 60.2%

Source: <sup>b</sup>Colorectal Cancer Screening: Results of a Survey of Manitobans 50 to 74. Supported by the Canadian Partnership Against Cancer and CancerCare Manitoba. PRA Inc., 2008.

<sup>c</sup>Manitoba Cervical Cancer Screening Program Database, women (ages 18 – 69) screened April 1, 2002 – March 31, 2005, April 1, 2006 – March 31, 2009.

<sup>d</sup>Manitoba Health fee for service billing data for mammography, women (ages 50 – 69) April 1, 2004 – March 31, 2006, April 1, 2006 – March 31, 2008.

<sup>e</sup>Manitoba Breast Screening Program Database, women (ages 50 – 69) screened April 1, 2004 – March 31, 2006, April 1, 2006 – March 31, 2008.

Note: Trend arrow is based on + or - 10% of the past value. Colour indicates if the trend is good (green), neutral (yellow) or needs to improve (red).

RHA refers to Regional Health Authority.

## What does this tell us?

### Screening rates could be improved.

- ▶ Use of the Fecal Occult Blood Test or FOBT for colorectal cancer are expected to increase as the provincial screening program is implemented.
- ▶ Cervical cancer screening rates have dropped slightly in recent years.
- ▶ Breast cancer screening rates have remained about the same over the past few years.

## Why is this important?

### Colorectal, cervical and breast cancer screening aims to find cancers early in people *without any symptoms*.

#### **By detecting cancer at an early stage, screening programs improve the likelihood of successful treatment ultimately saving lives.**

- ▶ Screening using the FOBT, along with recommended follow-up, can reduce the chance of dying from colorectal cancer by up to 25% for men and women 50 to 74 years of age.<sup>1</sup>
- ▶ Regular screening with Pap tests can prevent up to 80% of cervical cancer.<sup>2</sup>
- ▶ Regular screening mammograms can lower deaths from breast cancer by up to 25% in women 50 to 69 years of age.<sup>3</sup>

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## How do we compare?

### Cancer screening rates in Manitoba are as good as or higher than rates across the country.

- ✔ Based on self-report, Manitoba has the highest colorectal cancer screening rates in Canada.<sup>4</sup>
- ⊖ Recent data on cervical screening for the provinces is limited, but in 2005 Manitoba had a similar percentage of women having Pap tests compared to the national average.<sup>5</sup>
- ⊖ Breast screening rates are also similar to the national average.<sup>6</sup>

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## What is CancerCare Manitoba doing to encourage screening?

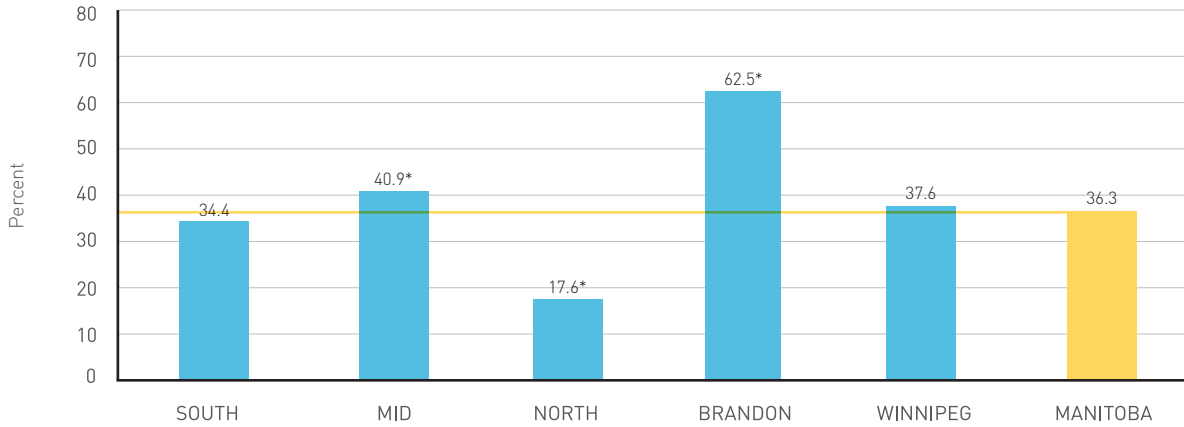
### CancerCare Manitoba operates three screening programs (breast, cervical and colorectal) designed to detect cancer at its earliest stage.

- ▶ Our provincial screening programs are helping to fulfill our commitment to provide public education and promote early detection.
- ▶ All these programs use a community-based approach to provide valuable links between CCMB, other organizations, and the public as we work together to achieve greater cancer control and cancer care excellence.
- ▶ In partnership with the CancerCare Manitoba Foundation, the programs developed the *It Matters to You* advertising campaign which outlines the importance of screening, the tests that are available and how to access screening services.

# Colorectal Cancer

Figure 2.1

Percent of men and women (ages 50 – 74) who completed a Fecal Occult Blood Test (FOBT) in the last two years, by regional groupings

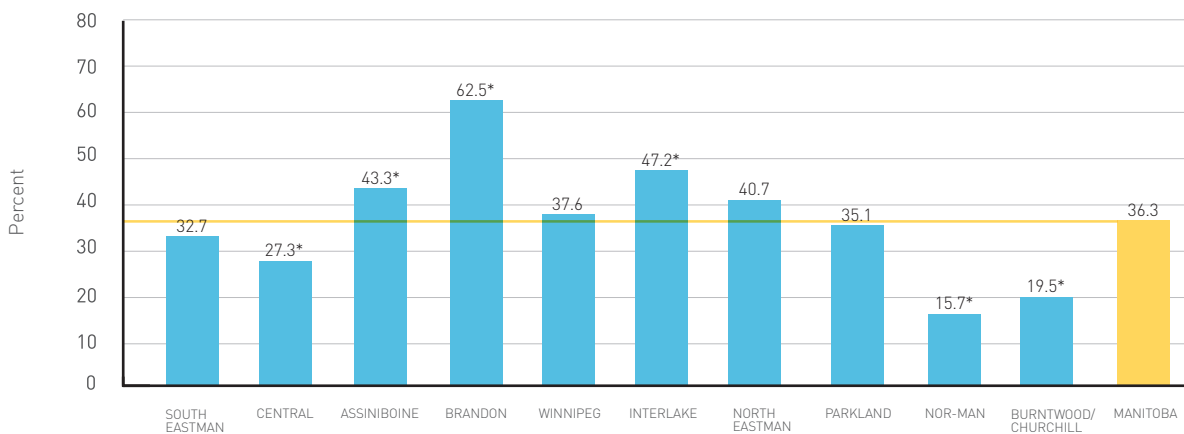


Source: Colorectal Cancer Screening: Results of a Survey of Manitobans 50 – 74. Supported by the Canadian Partnership Against Cancer and CancerCare Manitoba PRA Inc., 2008.

\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.2

Percent of men and women (ages 50 – 74) who completed a Fecal Occult Blood Test (FOBT) in the last two years, by Regional Health Authority



Source: Colorectal Cancer Screening: Results of a Survey of Manitobans 50 – 74. Supported by the Canadian Partnership Against Cancer and CancerCare Manitoba PRA Inc., 2008.

\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

Colorectal screening rates are much lower in some regions and could be improved in all regions.

- ▶ Figures 2.1 and 2.2 show that the use of the Fecal Occult Blood Test or FOBT varies across regions. The lowest rates are in the North (17.6%) and the highest rates are in Brandon (62.5%).

## What else do we know?

- ▶ Our survey data show that screening rates are slightly higher for females at 37.3% than males at 34.5%.
- ▶ Another survey, the Canadian Community Health Survey used three measures of colorectal cancer testing – an FOBT in the past two years or a sigmoidoscopy or colonoscopy in the past five years. Based on this definition, 39.8% of Canadians over the age of 50 have been tested compared to 53.5% in Manitoba.
- ▶ Recent analysis of physician billing data by ColonCheck Manitoba shows that using this broader definition of screening, 48.9% of Manitobans aged 50-74 have been tested.

## Why is this important?

Colorectal cancer is the second leading cause of cancer death.

- ▶ In Manitoba, it is estimated that over 800 men and women will be diagnosed with colorectal cancer and about 360 will die from colorectal cancer every year.<sup>7</sup>
- ▶ Screening using the FOBT, along with recommended follow-up can reduce the chance of dying from colorectal cancer up to 25%.<sup>1</sup>
- ▶ Colorectal cancer is treated successfully up to 90% of the time when detected early.<sup>8</sup>

## How do we compare?

- ✔ Manitoba has the highest level of testing for CRC compared to other provinces.<sup>4</sup>
- ✘ Colorectal cancer screening rates are lower than breast and cervical screening rates in Manitoba.

## What is CancerCare Manitoba doing to help improve FOBT screening rates?

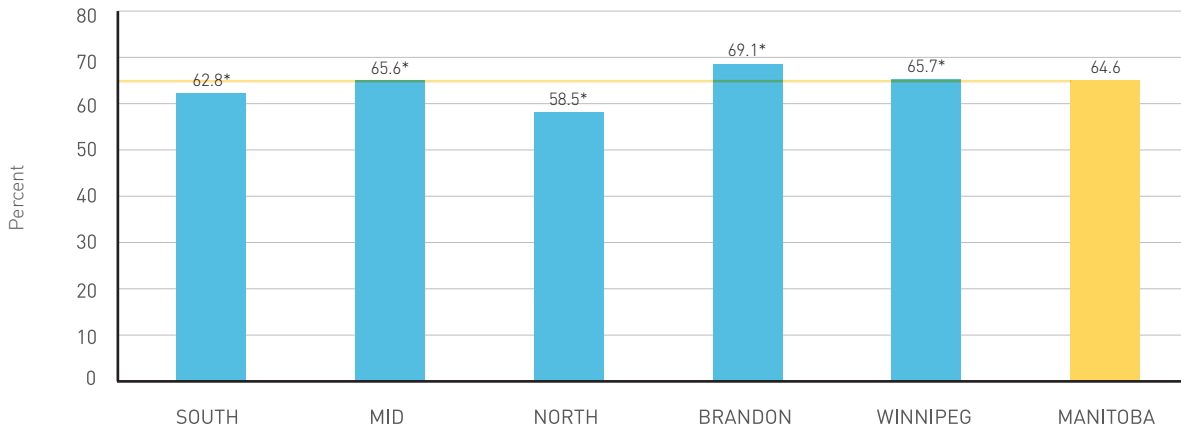
In April 2007, CCMB established one of the first provincial colorectal cancer screening programs in Canada.

- ▶ During the first phase, FOBTs and information packages were distributed to 25,000 people between the ages of 50 and 74 in the Winnipeg and Assiniboine Regional Health Authorities.
- ▶ In 2009, Manitoba Health increased funding to allow the program, now known as ColonCheck Manitoba, to expand province-wide.
- ▶ The program's key priorities are:
  - ▶ to help detect colorectal cancer early and reduce the number of Manitobans who die from the disease.
  - ▶ to work collaboratively with primary care providers (doctors, nurse practitioners) to encourage testing and increase screening rates.

# Cervical Cancer

Figure 2.3

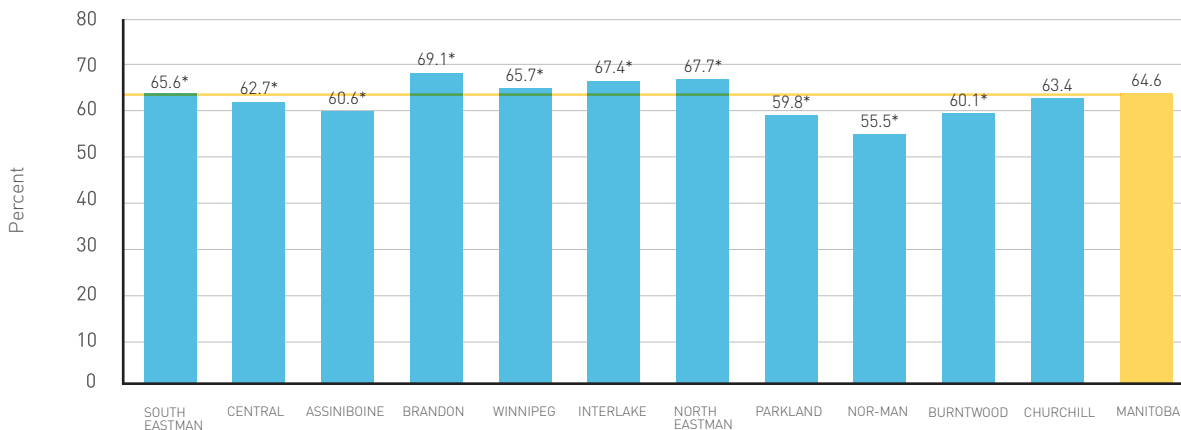
Percent of women (ages 18 – 69) who had a Pap test in the last three years, by regional groupings



Source: Manitoba Cervical Cancer Screening Program Database, women (ages 18 – 69) screened April 1, 2006 – March 31, 2009.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.4

Percent of women (ages 18 – 69) who had a Pap test in the last three years, by Regional Health Authority



Source: Manitoba Cervical Cancer Screening Program Database, women (ages 18 – 69) screened April 1, 2006 – March 31, 2009.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

Screening rates for cervical cancer vary across regions and can be improved.

- ▶ Figure 2.3 shows the lowest rate for cervical cancer screening is in the North at 58.5%.
- ▶ Figure 2.4 shows the lowest rate for cervical cancer screening was reported in the NOR-MAN region at 55.5% with the highest rate in Brandon at 69.1%.

## What else do we know?

- ▶ Cervical cancer screening rates have declined slightly over the most recent three-year period from 69.4% to 64.6%.
- ▶ Cervical cancer screening rates are highest among 20 to 29 year olds.
- ▶ Screening rates decrease with increasing age.
- ▶ About 8% of women who have Pap tests have an abnormal result and require follow-up testing.

## Why is this important?

Regular Pap tests reduce the risk of cervical cancer.

- ▶ Most women who are diagnosed with cervical cancer have never had a Pap test or haven't had one in over five years.<sup>9</sup>
- ▶ Regular screening can prevent up to 80% of cervical cancer.<sup>2</sup>
- ▶ Data from the Manitoba Cancer Registry shows that about 50 Manitoba women are diagnosed with invasive cervical cancer every year.

## How do we compare?

Women in Manitoba have similar cervical screening rates as women in other provinces.

- ⊖ Survey data shows that Manitoba's cervical screening rate is consistent with the national rate.<sup>5</sup>
- ⊖ For the period 2005-2007, British Columbia reported that 63% of women 20-69 years of age had a Pap test. Participation in Manitoba during this time period was 66%.<sup>10</sup>

## What is CancerCare Manitoba doing to help improve cervical screening rates?

CancerCare Manitoba operates the Manitoba Cervical Cancer Screening Program which aims to increase screening participation and reduce deaths from cervical cancer.

- ▶ To increase the number of unscreened women having Pap tests, the program works with health care providers to increase access to cervical cancer screening services and provides education about all aspects of cervical cancer screening including the importance of Pap tests for the prevention of cancer.
- ▶ The program also:
  - ▶ manages centralized collection of all Pap test and colposcopy results in Manitoba. This registry enables the program to notify health care providers and women when recommended follow-up has not occurred, allows health care providers and women to access screening histories and supports quality assurance activities.
  - ▶ developed a Pap Test Learning Module for health care providers. This module supports the development of local training initiatives to increase the number of health care providers able to perform Pap tests, thus increasing access.
  - ▶ will be sending letters to underscreened women to notify them of the importance of Pap testing and how to access services.
  - ▶ works with Manitoba Health to monitor and evaluate the human papilloma virus (HPV) vaccination program and newer methods of detecting cervical cancer.

# Breast Cancer

Figure 2.5

Percent of women (ages 50 – 69) receiving a mammogram in the past two years, by regional groupings

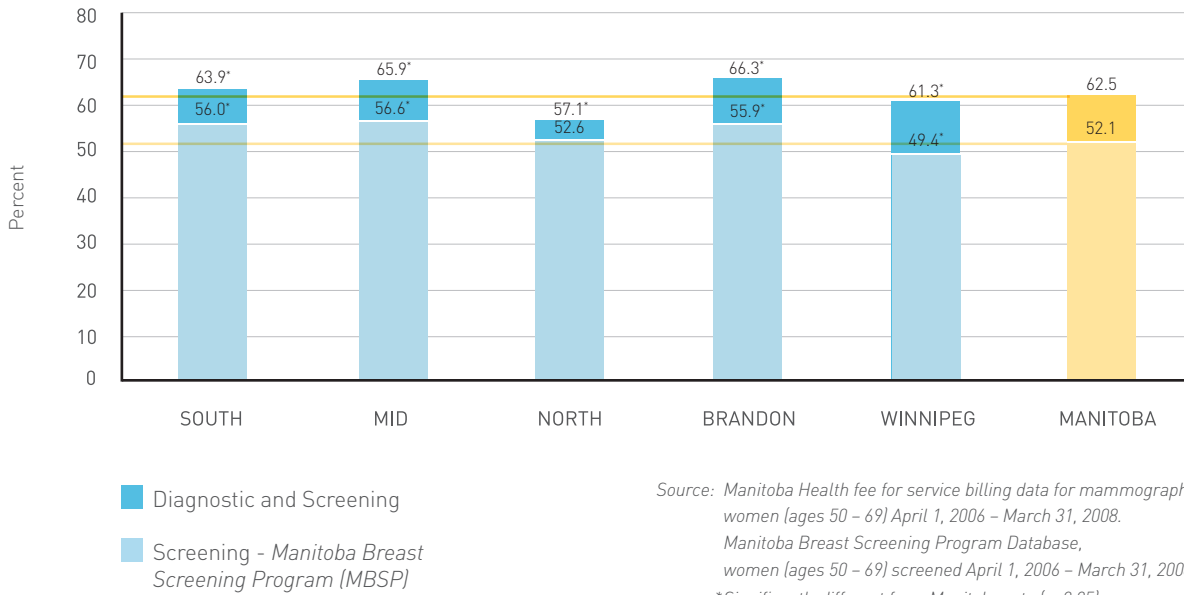
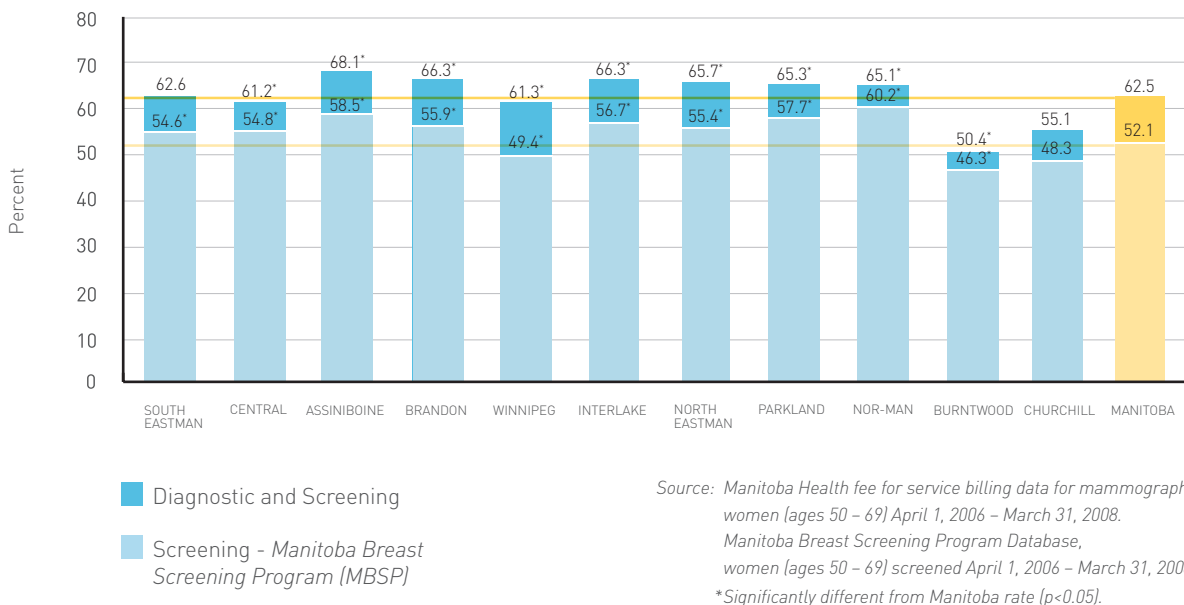


Figure 2.6

Percent of women (ages 50 – 69) receiving a mammogram in the past two years, by Regional Health Authority





## What does this tell us?

Breast screening rates are approaching the 70% target in many, but not all, RHAs.

- ▶ The majority of women aged 50 to 69 have a mammogram through the Manitoba Breast Screening Program. An additional 10% of women in this age group have a mammogram, either diagnostic or screening outside the program.
- ▶ Figure 2.5 shows mammography rates are lowest in the North at 57.1%.
- ▶ Figure 2.6 shows the lowest mammography rate is in the Burntwood region at 50.4% and the highest rate is in Assiniboine at 68.1%.

## What else do we know?

- ▶ Breast cancer screening rates have remained the same until recently. Additional funding and increased capacity for the Manitoba Breast Screening Program will increase the percentage of women screened starting in 2009/2010.
- ▶ The mortality rate for breast cancer was reduced by 24% for women 50 to 69 years of age who attended the Manitoba Breast Screening Program.<sup>11</sup>

## Why is this important?

Regular mammograms can reduce the risk of breast cancer.

- ▶ As women grow older, the chance of getting breast cancer increases.
- ▶ Research has shown that regular screening mammograms can lower breast cancer deaths in women 50 to 69 years of age by up to 25%.<sup>3</sup>

## How do we compare?

Manitoba's breast screening rates compare favourably to other provinces.









- ⊖ The mammography rate in Manitoba is similar to the national average and the majority of provinces.<sup>6</sup>
- ✔ Of all Canadian provinces, Manitoba has the third highest rate for women screened through an organized breast cancer screening program.<sup>12</sup>

## What is CancerCare Manitoba doing to help improve breast screening rates?

CancerCare Manitoba operates the Manitoba Breast Screening Program for women aged 50 and older with no symptoms and checks for early signs of breast cancer.

- ▶ Our goal is to continue to reduce mortality from breast cancer by screening 70% of women aged 50 – 69 every two years.
- ▶ To improve breast screening rates, the program:
  - ▶ provides mammograms and information on breast health through four sites located in Winnipeg, Brandon, Thompson and Morden/Winkler.
  - ▶ operates two mobile units that visit over 89 community sites throughout the province.
  - ▶ recently added 9,000 screening appointments to its yearly schedule, an increase of 23% to meet the needs of the growing population in the target age group.
  - ▶ enhances services in the North by providing transportation for women in ten remote, fly-in locations.
  - ▶ works with women from immigrant communities to address barriers to screening related to culture, access, transportation and language. Many breast health information products are available in a variety of languages.
  - ▶ partners with the colorectal and cervical screening programs to increase awareness about risk reduction and screening guidelines.

# Wait Times

WAIT TIMES		Past Estimate	Current Estimate	Time Trend	Range of Current Estimates <i>(Lowest RHA - Highest RHA)</i>
	<p><b>Breast Assessment Waits</b> median waiting time (in days) for women (ages 50 – 69), from screening by mammogram to final diagnosis.<sup>f</sup></p>	28.0 days	26.0 days		22.0 - 41.5 days
	<p><b>Radiation Therapy Waits</b> percent of patients treated with radiation therapy within four weeks from ready to treat to start of treatment.<sup>g</sup></p> <p>percent of patients treated with radiation therapy, within four weeks, from ready to treat to start of treatment, by cancer type:<sup>g</sup></p>	86.0%	97.1%		93.2% - 100.0%
	<b>lung</b>	85.5%	95.8%		75.0% - 100.0%
	<b>rectal</b>	90.1%	98.5%		97.5% - 100.0%
	<b>breast (f)</b>	72.9%	96.8%		87.0% - 100.0%
	<b>prostate</b>	57.9%	86.6%		70.0% - 100.0%

Source: <sup>f</sup>Data from the Manitoba Breast Screening Program, women (ages 50 – 69) with an abnormal screen, April 1, 2004 – March 31, 2006, April 1, 2006 – March 31, 2008

<sup>g</sup>Data from CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2005 – March 31, 2006, April 1, 2007 – March 31, 2008.

Note: Trend arrow is based on + or - 10% of the past value. Colour indicates if the trend is good (green), neutral (yellow) or needs to improve (red).

RHA refers to Regional Health Authority.

## What does this tell us?

Wait times for breast cancer assessment and radiation therapy are improving.

- ▶ Currently, these are the only two complete measures CCMB has for points along the cancer care journey.
  - ▶ One represents diagnostic workup and the other is treatment based.
  - ▶ These are not comprehensive, but provide a starting point as we continue to map the patient journey.

## What else do we know?

- ▶ Breast assessment waits vary by region and radiation therapy waits are consistent across the province.
- ▶ Both measures show improvement over time. Radiation therapy has achieved the national wait time guarantee of four weeks, as of April 1, 2008, though efforts are ongoing to work at shortening it even further. Manitoba wait times are among the shortest in the country.
- ▶ The majority of women who have an abnormal screening mammogram do not have cancer. They receive a diagnosis more quickly than women diagnosed with cancer because they require less additional testing.

## Why is this important?

Cancer services must be delivered in a timely way to reduce patient anxiety and ensure optimal treatment outcomes.

- ▶ Breast cancer assessment and radiation therapy treatment are only two of many components of the patient journey that require measurement.

## How do we compare?

- ⊖ The wait times from an abnormal mammogram to diagnosis for women attending the Manitoba Breast Screening Program are similar to those reported in other provinces.
- ✔ Wait times for radiation therapy are among the best in Canada.

## What is CancerCare Manitoba doing to improve wait times?

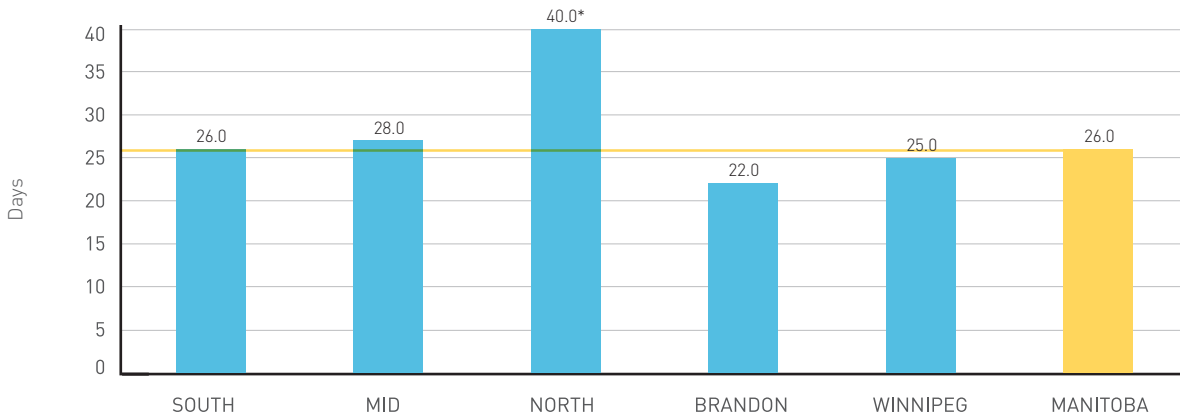
CancerCare Manitoba works with multiple partners across different organizations, a necessary approach due to the complexity of cancer diagnosis and treatment.

- ▶ The Manitoba Breast Screening Program coordinates the recommended testing following an abnormal mammogram which results in shorter wait times.
- ▶ The Radiation Therapy Program has implemented new software systems that help to identify delays in individual patients' progress through radiation therapy. These assist in finding and addressing bottlenecks in the process.
- ▶ The Patient Navigation Program is exploring ways to make the cancer diagnosis and treatment process more efficient and to make the care experience more positive for patients and their families. The program has already identified ways to make improvements, including the move to a centralized referral system, improved communication and tracking mechanisms as well as better alignment of services.
- ▶ Primary care providers have been engaged to assist in identifying wait times early in the patient journey from suspicion of cancer through the early stages of diagnostics to referral to a cancer specialist. The target is to cover the whole journey pathway from early suspicion to treatment across multiple care providers across the province.

# Breast Cancer Assessment Waits

Figure 2.7

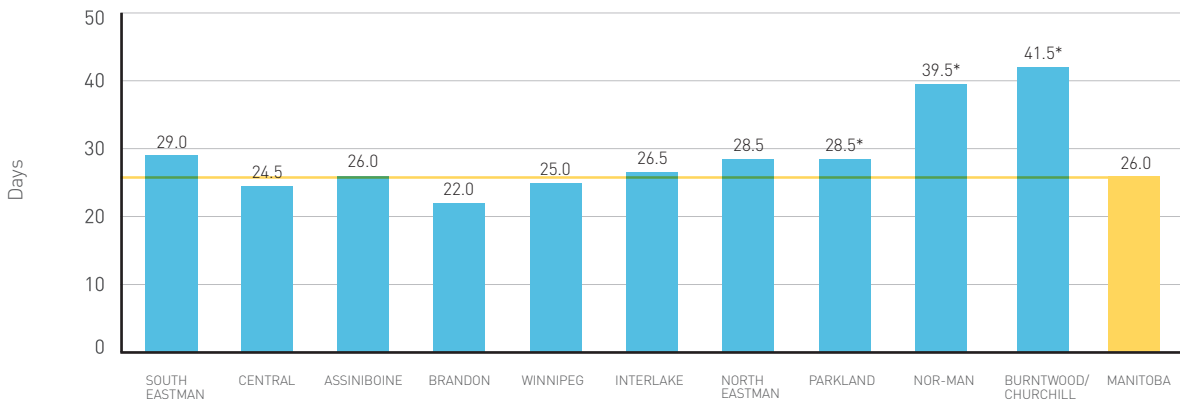
Median waiting time for women from screening by mammogram to final diagnosis in the last two years, by regional groupings



Source: Data from the Manitoba Breast Screening Program, women (ages 50 – 69) with an abnormal screen, April 1, 2006 – March 31, 2008.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.8

Median waiting time for women from screening by mammogram to final diagnosis in the last two years, by Regional Health Authority



Source: Data from the Manitoba Breast Screening Program, women (ages 50 – 69) with an abnormal screen, April 1, 2006 – March 31, 2008.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

- ▶ Figures 2.7 and 2.8 show the longest waits from breast screening by mammogram to diagnosis are in the North, where the median time was 14 days longer compared to provincial median.

## What else do we know?

- ▶ Data from the Manitoba Breast Screening Program show:
  - ▶ About 5% of women who undergo screening require referral for further testing. The majority require only a diagnostic mammogram or ultrasound.
  - ▶ Over 90% of women requiring further testing have a benign outcome. Ten percent will have a cancer diagnosis.
  - ▶ The median wait for the women diagnosed with cancer is 41 days compared to 22 for women with a benign outcome. The longer wait relates to additional tests including biopsies that need to be arranged which can result in delays.

## Why is this important?

Research has found that long waits following an abnormal breast screening result in anxiety.

- ▶ Women commonly experience acute anxiety following an abnormal breast screening result. Reducing the time that women have to wait to complete follow-up testing can reduce this anxiety.<sup>13</sup>

## How do we compare?

- ⊖ The wait times from an abnormal mammogram to diagnosis for women attending the Manitoba Breast Screening program are similar to those reported in other provinces.
- ⊖ The Canadian targets for these indicators are:
  - ▶ 90% of abnormal screens will be resolved within five weeks if no tissue biopsy is required.
  - ▶ 90% within seven weeks if tissue biopsy is required.
  - ▶ in Manitoba 76% of women who needed follow-up without a tissue biopsy had their diagnosis within five weeks of their screening date, similar to the rate of other Canadian provinces overall.
  - ▶ additionally, 41% of Manitoba women who required a tissue biopsy had a final diagnosis within seven weeks compared to 46% for all provincial programs.<sup>12</sup>
  - ▶ there is evidence of recent improvement in Manitoba.<sup>11</sup> In 2007/08, 63% of women requiring a tissue biopsy had a final diagnosis within seven weeks compared to 41% in the previous national report (2003-04).<sup>12</sup>

## What is CancerCare Manitoba doing to improve breast screening waits?

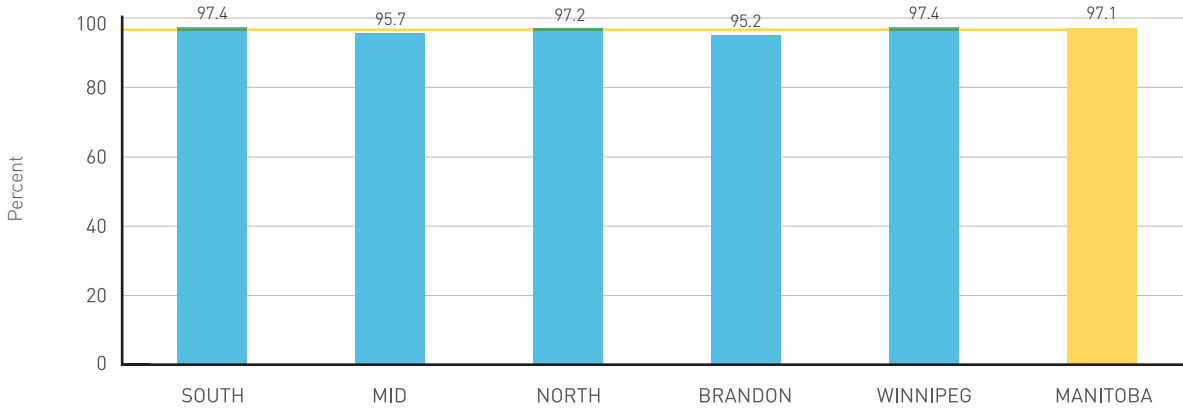
The Manitoba Breast Screening Program can coordinate diagnostic follow-up procedures for women following an abnormal screening mammogram.

- ▶ This process results in a shorter time compared to follow-up coordinated by referral back to a primary care provider.<sup>14</sup>
- ▶ The program also monitors wait times on a continuous basis and will alter referral patterns if necessary to shorten wait times.

# Radiation Therapy Waits

Figure 2.9

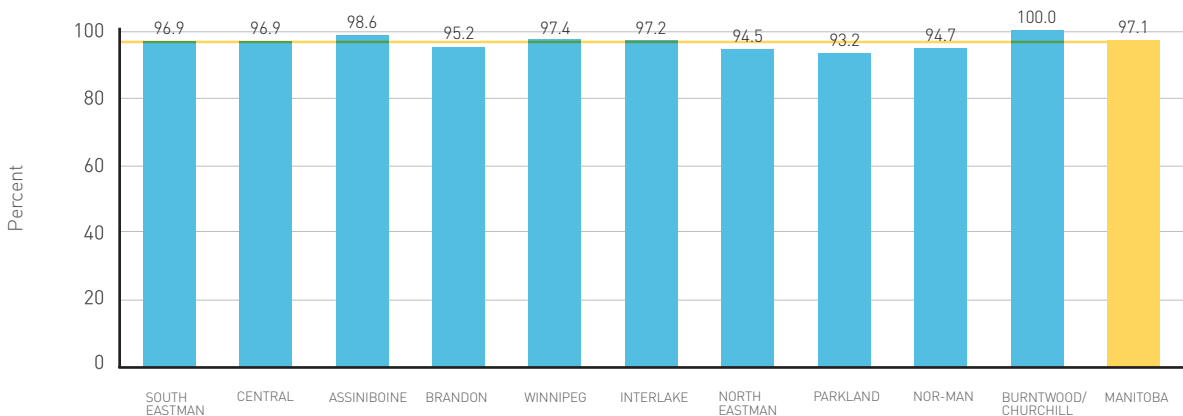
Percent of patients seen within four weeks from ready to treat to start of radiation therapy, by regional groupings



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.

Figure 2.10

Percent of patients seen within four weeks from ready to treat to start of radiation therapy, by Regional Health Authority



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.



## What does this tell us?

Manitobans receive radiation therapy in a timely manner.

- ▶ Figures 2.9 and 2.10 show that there is consistency in radiation therapy wait times across Manitoba, when looking at all the disease sites combined.
- ▶ Figures 2.11 to 2.18 show some variations still exist when the data are broken down by disease site (see following pages).

## What else do we know?

- ▶ Good results were seen in Manitoba even before the implementation of the national wait time guarantee (2008).
- ▶ More recent data (since the implementation of the national wait time guarantee) show rates of 100% across the province and by type of cancer.
- ▶ The development of the Western Manitoba Cancer Centre in Brandon will further address wait times and access in this region, as well as increasing overall capacity for radiation therapy in the province.

## Why is this important?

Wait times are now within the benchmark of four weeks from “ready to treat” to first treatment, and patients are triaged appropriately according to their disease site, stage and condition.

- ▶ However, it is important to continue to reduce wait times across the spectrum of cancer services to improve the overall experience.

## How do we compare?

Wait times for radiation therapy in Manitoba are among the best in Canada.

- ✔ Recent reports show that 99% of Manitoba’s radiation therapy patients begin treatment within the 28 day benchmark. This compares to 90% in Ontario and 95% in British Columbia.<sup>15</sup>

## What is CancerCare Manitoba doing to improve radiation therapy waits?

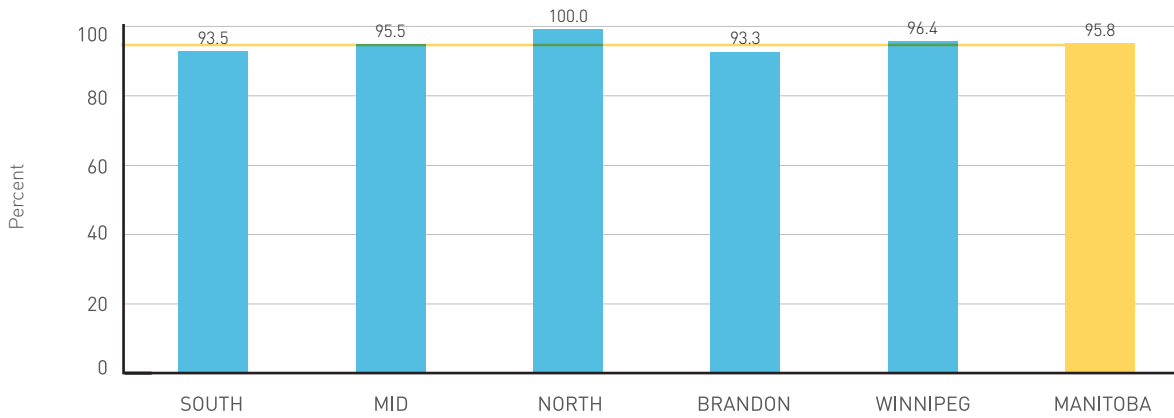
CancerCare Manitoba continually monitors and manages its radiation therapy services to meet the national wait time guarantee.

- ▶ Since April 2008, CCMB has been achieving the national wait time guarantee of four weeks.
- ▶ However, we still want to work at shortening the wait.
- ▶ As technology progresses, treatments get more complex. Planning these treatments requires more time and that affects the start of treatment.
- ▶ The Radiation Therapy Program has implemented new software systems that help to identify delays in individual patients’ progress through the steps in the radiation therapy process. These will assist us in finding and addressing bottlenecks in the process appropriately.

# Radiation Therapy Waits: Lung

Figure 2.11

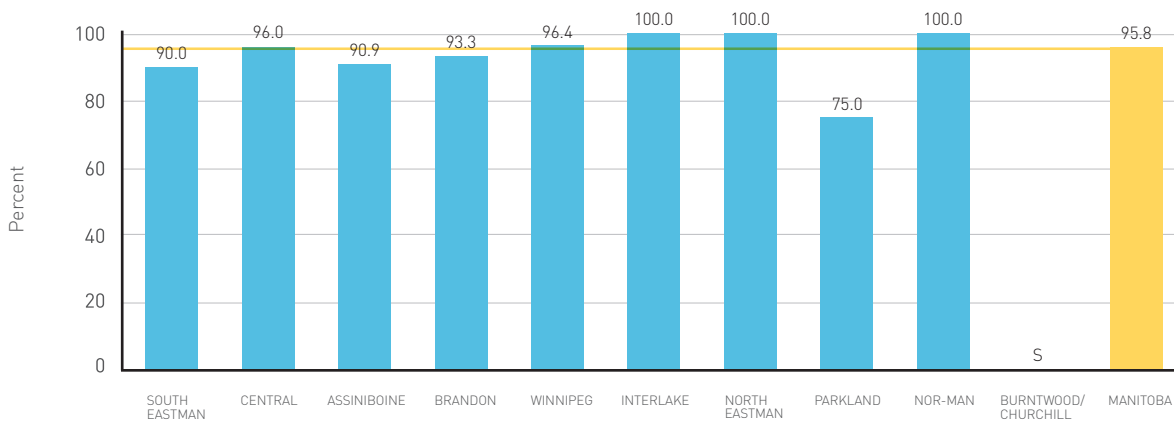
Percent of patients treated for lung cancer within four weeks from ready to treat to start of radiation therapy, by regional groupings



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 - March 31, 2008.

Figure 2.12

Percent of patients treated for lung cancer within four weeks from ready to treat to start of radiation therapy, by Regional Health Authority



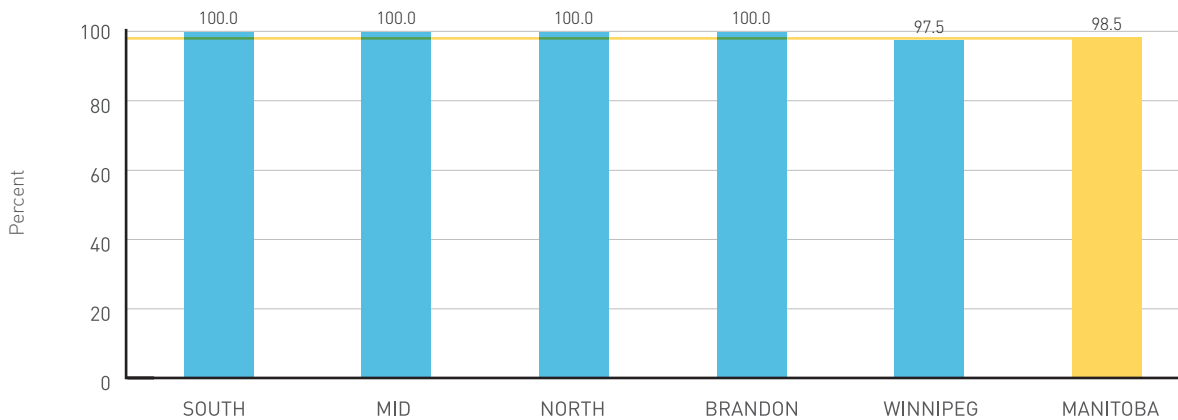
Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 - March 31, 2008.  
s = numbers suppressed where < 6



# Radiation Therapy Waits: Rectal

Figure 2.13

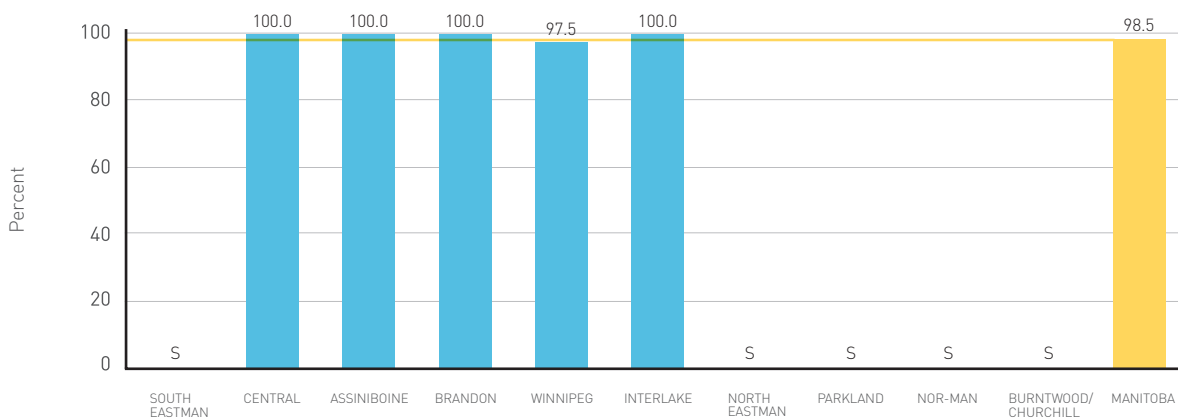
Percent of patients treated for rectal cancer within four weeks from ready to treat to start of radiation therapy, by regional groupings



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.

Figure 2.14

Percent of patients treated for rectal cancer within four weeks from ready to treat to start of radiation therapy, by Regional Health Authority

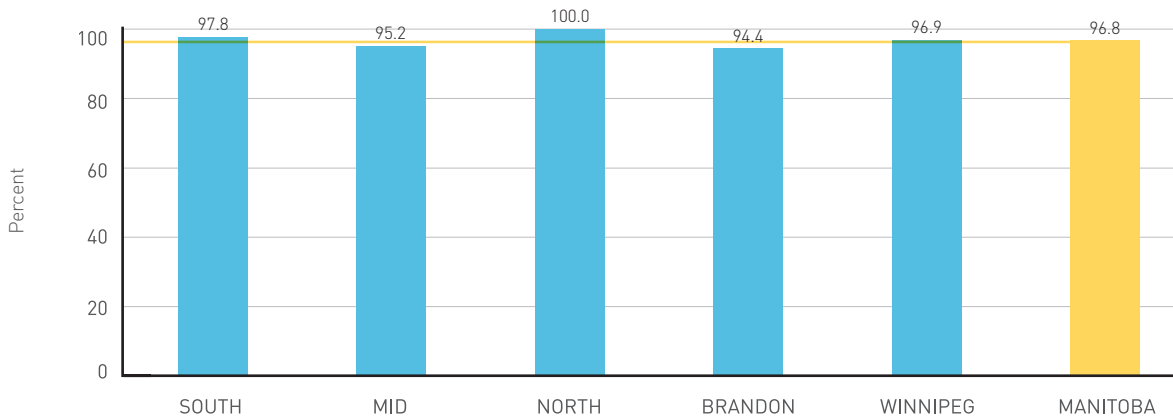


Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.  
s = numbers suppressed where < 6

# Radiation Therapy Waits: Breast

Figure 2.15

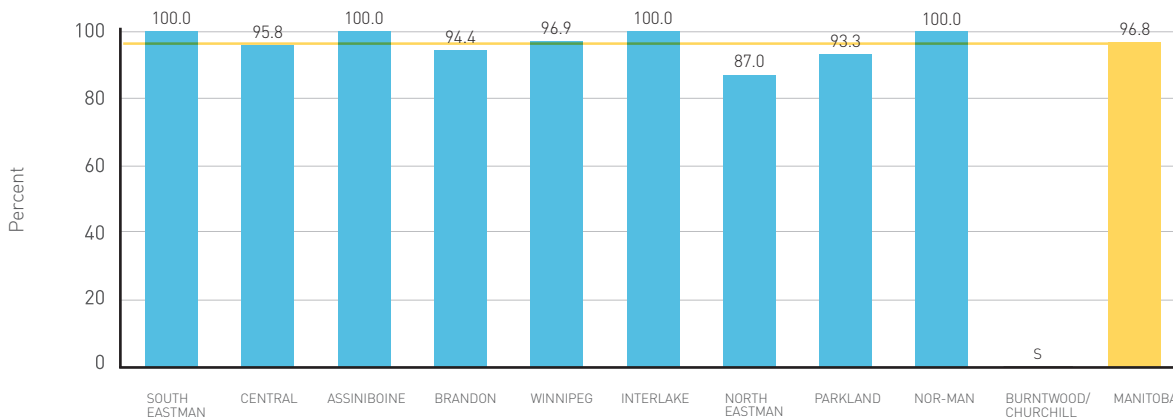
Percent of patients treated for breast cancer within four weeks from ready to treat to start of radiation therapy, by regional groupings



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.

Figure 2.16

Percent of patients treated for breast cancer within four weeks from ready to treat to start of radiation therapy, by Regional Health Authority



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.

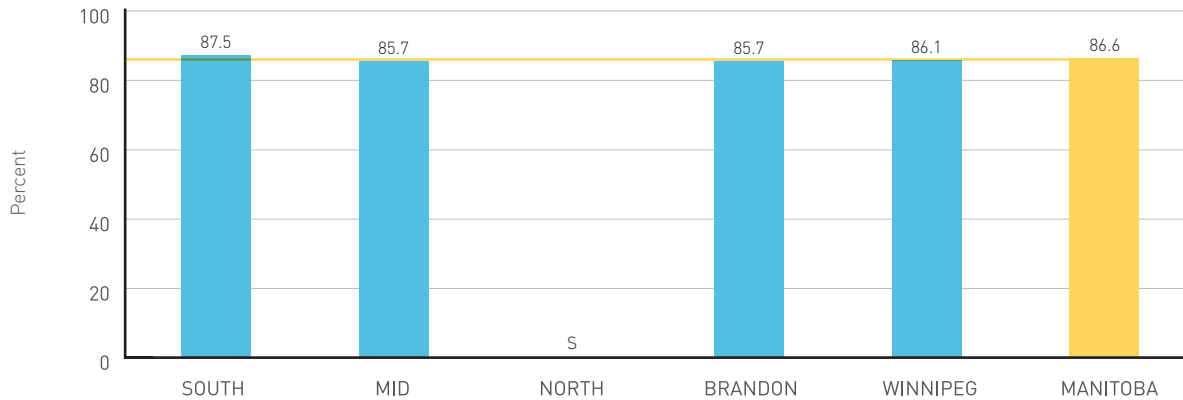
s = numbers suppressed where < 6



# Radiation Therapy Waits: Prostate

Figure 2.17

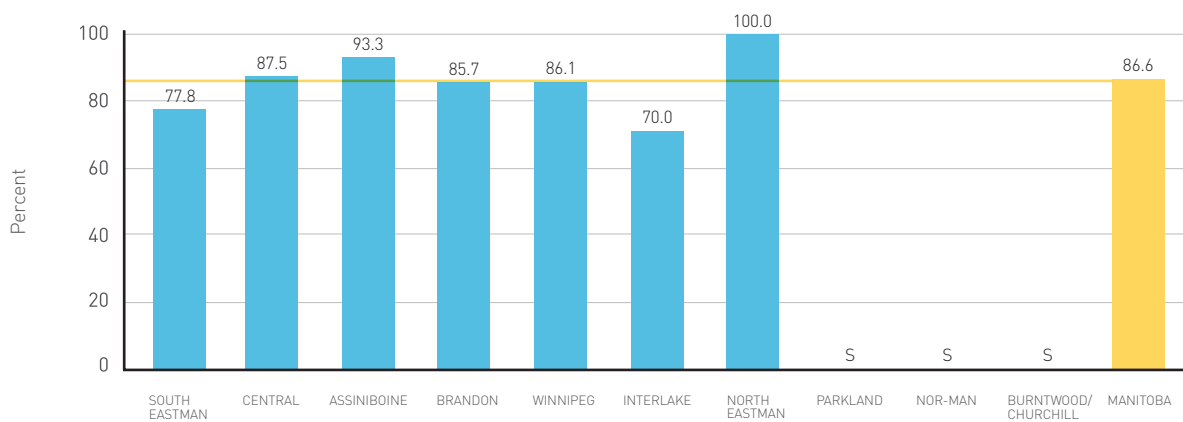
Percent of patients treated for prostate cancer within four weeks from ready to treat to start of radiation therapy, by regional groupings



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.  
s = numbers suppressed where < 6





Figure 2.18

Percentage of patients treated for prostate cancer within four weeks from ready to treat to start of radiation therapy, by Regional Health Authority (RHA)



Source: CancerCare Manitoba, Radiation Therapy Program, patients seen April 1, 2007 – March 31, 2008.  
s = numbers suppressed where < 6

# Treatment

TREATMENT		Past Estimate	Current Estimate	Time Trend	Range of Current Estimates <i>(Lowest RHA - Highest RHA)</i>
 <p><b>Surgery</b> percent of patients treated with surgery, all cancers<sup>h</sup> percent of patients treated with surgery by cancer type<sup>h</sup>:</p>	<b>lung</b>	56.6%	54.9%	→	44.1% - 57.9%
	<b>colorectal</b>	27.4%	24.4%	↓	19.4% - 28.7%
	<b>breast (f)</b>	84.4%	80.5%	→	55.0% - 87.7%
	<b>prostate</b>	93.2%	92.1%	→	89.1% - 96.9%
		50.8%	49.1%	→	33.3% - 67.4%
 <p><b>Radiation Therapy</b> percent of patients receiving radiation therapy, all cancers<sup>i</sup> percent of patients receiving radiation therapy by cancer type:<sup>i</sup></p>	<b>lung</b>	31.3%	30.3%	→	21.8% - 33.8%
	<b>rectal</b>	40.4%	42.5%	→	25.0% - 56.7%
	<b>breast (f)</b>	31.0%	42.0%	↑	26.5% - 56.4%
	<b>prostate</b>	56.9%	59.1%	→	44.6% - 65.5%
		34.4%	28.6%	↓	22.7% - 45.0%
 <p><b>Radiation After Breast Conserving Surgery</b> percent of stage I and II breast cancer patients treated with radiation following breast conserving surgery<sup>i</sup></p>		70.7%	70.8%	→	48.8% - 85.7%
 <p><b>Systemic Therapy</b> percent of patients receiving systemic therapy (cancer drugs)<sup>h</sup> percent of patients receiving systemic therapy (cancer drugs) by cancer type:<sup>h</sup></p>	<b>lung</b>	35.0%	36.0%	→	29.6% - 39.8%
	<b>colon</b>	24.7%	25.4%	→	20.7% - 35.5%
	<b>breast (f)</b>	29.4%	30.1%	→	15.0% - 38.9%
	<b>prostate</b>	75.1%	74.6%	→	60.9% - 79.0%
		33.8%	30.1%	↓	21.2% - 57.1%

Source: <sup>h</sup> Manitoba Cancer Registry, patients diagnosed, 2000-2002, 2006-2007.

<sup>i</sup> Manitoba Cancer Registry, patients diagnosed, 2000-2002, 2005-2006.

Note: Trend arrow is based on + or - 10% of the past value. Colour indicates if the trend is good (green), neutral (yellow) or needs to improve (red). Grey is used where interpretation of trend is not appropriate.

RHA refers to Regional Health Authority.

## What does this tell us?

### Treatment patterns vary by region and type of cancer.

- ▶ Overall, the percent of Manitoba cancer patients who have received surgery, radiation therapy or systemic therapy has remained stable compared to previous years.
- ▶ The percent of women with early stage breast cancer who received radiation treatment after breast conserving surgery (lumpectomy) has remained stable over time.

## What else do we know?

- ▶ A patient's treatment plan is based on several factors, including cancer diagnosis, stage of disease, the patient's medical fitness for treatment and the patient's preference.
- ▶ For most types of cancer, use of each kind of treatment has been steady over time except:
  - ▶ decreased surgery for lung cancer
  - ▶ increased use of radiation therapy for rectal cancer
  - ▶ decreased use of radiation and systemic therapy for prostate cancer

### Recent data tell us that:

- ▶ More than half of all cancer patients undergo surgery, almost a third have radiation therapy and a similar proportion undergo systemic therapy.
- ▶ 70% of early stage breast cancer patients received radiation following their breast conserving surgery as per guidelines.

## Why is this important?

### This information can be used to plan for services and use of resources by cancer patients.

- ▶ Treatment utilization rates do not necessarily indicate the appropriateness of care, but rather reflect the type and stage of disease, patients' medical fitness for treatment and patient choice. It is important to note that care received outside of Manitoba will not be captured in our data sources.
- ▶ Appropriateness of treatment is possible where evidence-based guidelines exist. Some treatments, such as radiation therapy for women with early stage breast cancer who undergo breast conserving surgery, are associated with clinical practice guidelines.
  - ▶ Patterns in these measures identify success and areas for improvement.

## How do we compare?

There are very few Canadian benchmarks because cancer treatment utilization data are not routinely reported.

## What is CancerCare Manitoba doing to improve access to treatment?

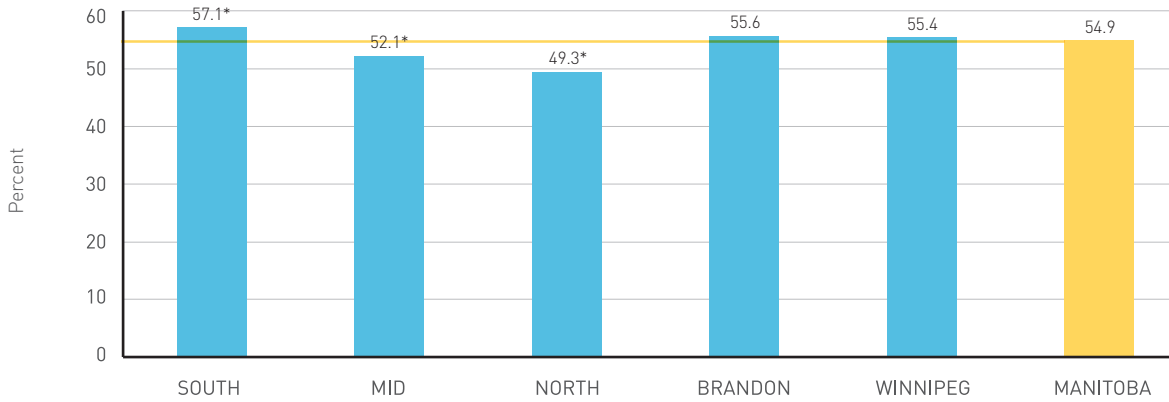
CancerCare Manitoba is involved in several programs to help ensure access to appropriate treatment.

- ▶ These include:
  - ▶ the Clinical Practice Guidelines Initiative involves reviewing the latest research and consensus statements of medical associations to develop standard evidence-based treatment guidelines for use in Manitoba.
  - ▶ CancerCare Manitoba's Disease Site Group structure enables specialists from different disciplines to interact on specific care plans.
  - ▶ the planned *Community Surgical Oncology Network* will share knowledge and standardize treatment protocols across all centres where cancer patients undergo surgery.
  - ▶ the Community Cancer Programs Network (CCPN) is a network of 16 Community Cancer Programs that allows patients to receive systemic therapy in or near their home communities.
  - ▶ Uniting Primary Care and Oncology Network (UPCON) supports the involvement of family physicians and primary health care providers in support and follow-up of cancer patients through networking, education and a help line.
  - ▶ development of the Western Manitoba Cancer Centre in Brandon (opening in 2011) will provide additional capacity for radiation therapy, chemotherapy and outpatient care.

# Surgery

Figure 2.19

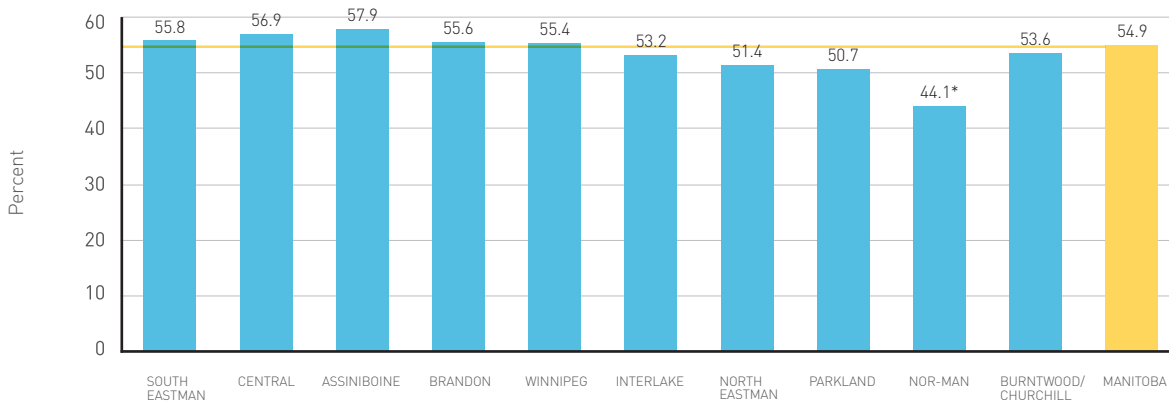
Percent of cancer patients who undergo surgery, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.20

Percent of cancer patients who undergo surgery, by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

The percentage of all cancer patients receiving surgery varies by region and type of cancer.

- ▶ Figures 2.19 and 2.20 show similar use of surgery across regions with a slightly lower percentage in the North.
  - ▶ However, there are a number of contributing factors that have not been accounted for such as the type of cancer, cancer stage, or level of complexity.
- ▶ Figures 2.21 through 2.28 (see following pages) show a fair degree of consistency in use of surgery for each type of cancer, although the North has low rates for colorectal and prostate cancer and the rural south has higher rates for colorectal cancer.

## What else do we know?

Variations in surgery rates for any type of cancer may be due to clinical factors or patient choice.

- ▶ Advances in chemotherapy and radiation therapy have reduced the need for some surgeries.<sup>17</sup>
- ▶ Surgeons are often the first cancer specialist the patient meets.<sup>18</sup>
- ▶ Research has shown that surgical care and outcomes often correlate with the number of cancer operations a surgeon performs annually.<sup>19</sup>

## Why is this important?

Surgery has a major role in the treatment of cancer.

- ▶ Variations in cancer surgery rates may reflect the type and stage of the disease, the patient's medical fitness for treatment, patient choice, and use of treatment outside of Manitoba which may not be recorded in our data sources.
- ▶ Although there are good reasons for differences in surgery rates including clinical factors and patient choice, these variations may affect outcome.
- ▶ We need to better understand the reasons for variations in cancer surgery to ensure the delivery of quality cancer care.
- ▶ Integrating surgical services within provincially accessible multidisciplinary teams is key because variations in surgical oncology practices can be better analyzed and reduced by sharing best practices, and new technologies can be evaluated and promoted.

## How do we compare?

Canadian benchmarks for rates of cancer surgery are not yet available.

## What is CancerCare Manitoba doing to improve access to surgery?

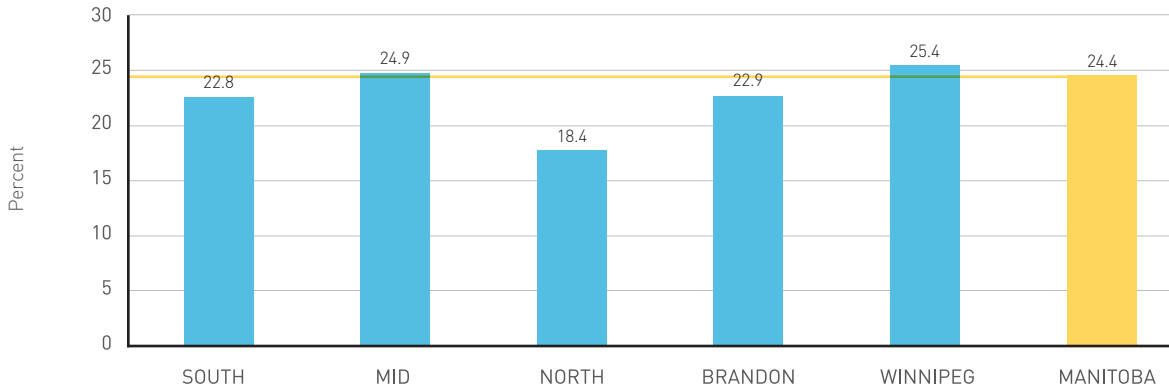
CancerCare Manitoba has plans for a *Community Surgical Oncology Network*.

- ▶ CancerCare Manitoba promotes the highest level of quality care in all aspects of surgical oncology, working to standardize practices to ensure equal care.
- ▶ The planned Network would share knowledge and standardize treatment protocols such that no matter where patients are first seen, they will receive appropriate care in a timely fashion whether they are treated within the community or referred to a larger, more central location.
- ▶ Studies show standard treatment protocols reduce unnecessary variations in care, eliminate duplication of procedures, establish clear lines of communication for all caregivers and reduce the costs of hospital stays.<sup>20-25</sup>

# Surgery: Lung

Figure 2.21.

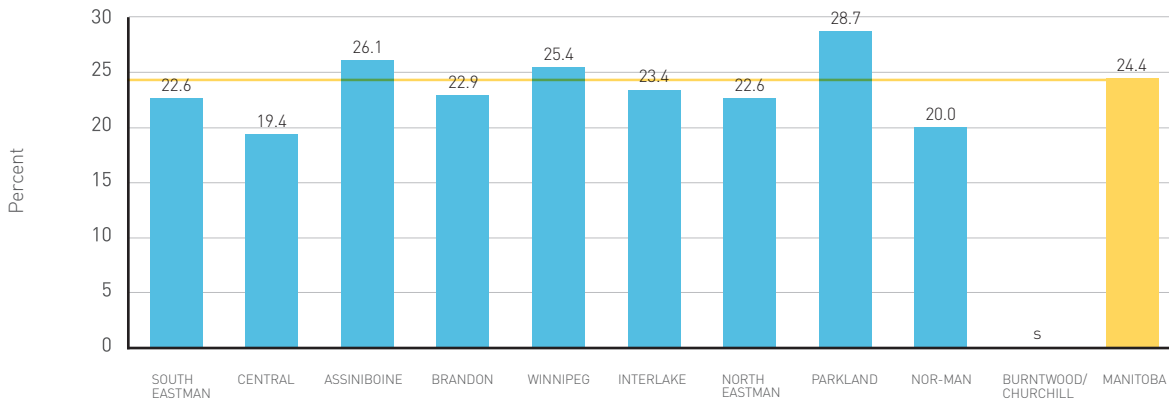
Percent of lung cancer patients who undergo surgery, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.

Figure 2.22.

Percent of lung cancer patients who undergo surgery, by Regional Health Authority



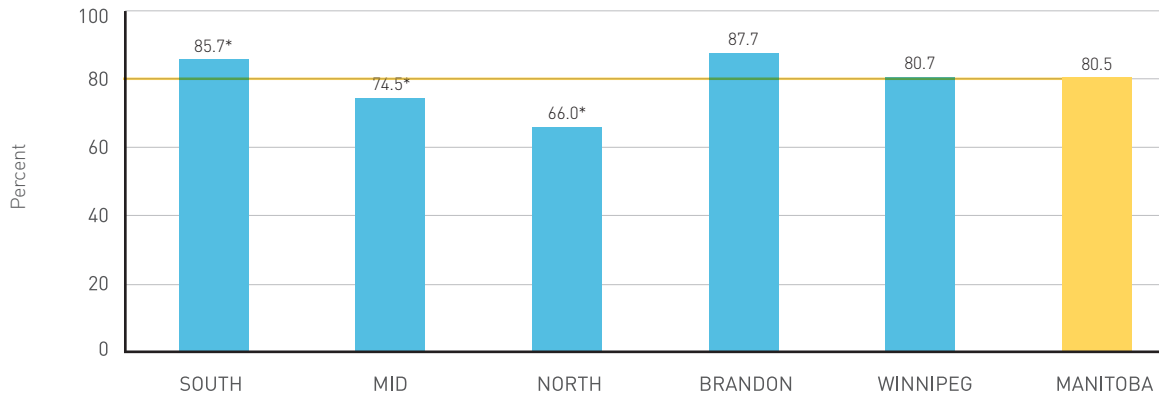
Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
s = numbers suppressed where < 6



# Surgery: Colorectal

Figure 2.23

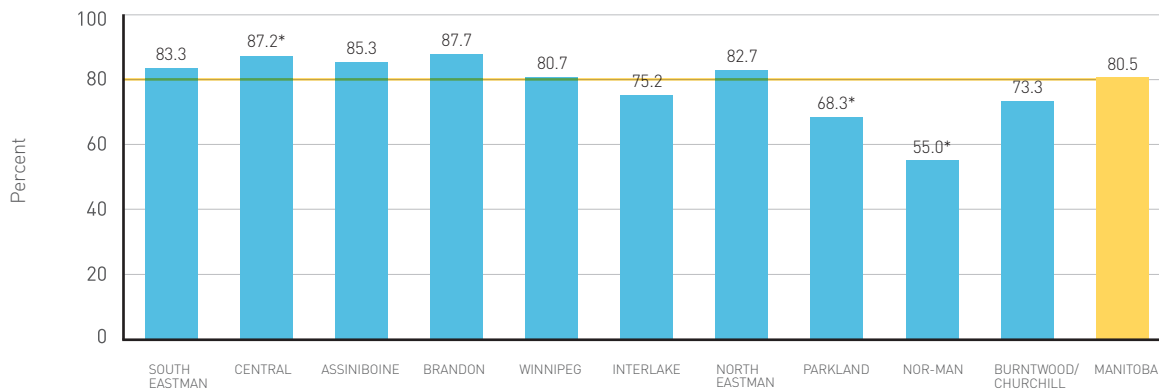
Percent of colorectal cancer patients who undergo surgery, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.24

Percent of colorectal cancer patients who undergo surgery, by Regional Health Authority

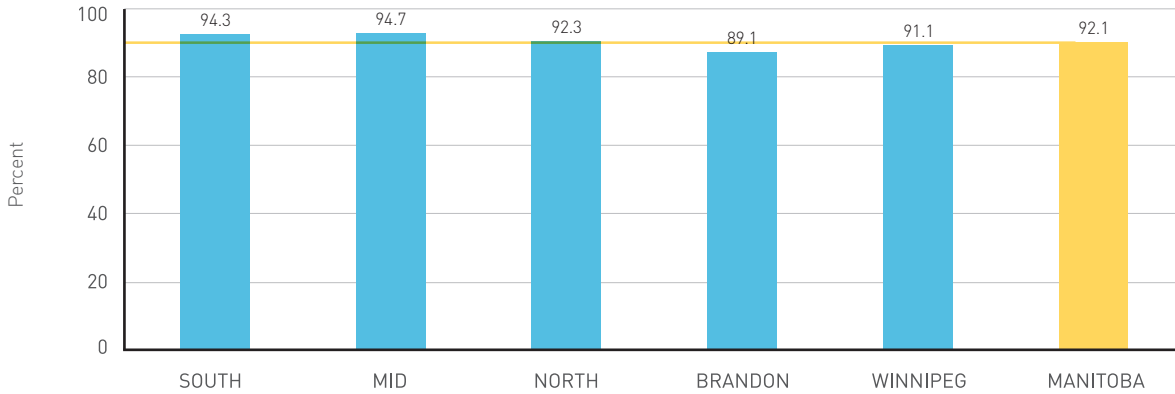


Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

# Surgery: Breast

Figure 2.25

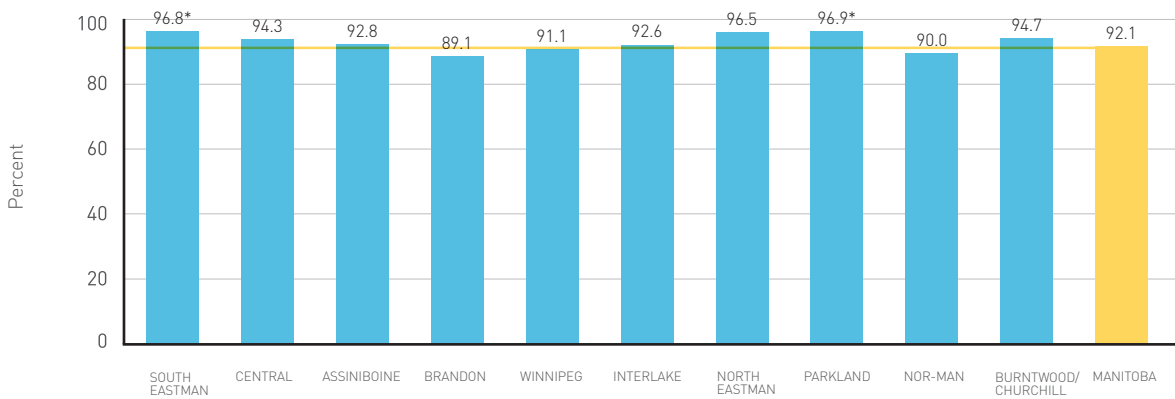
Percent of breast cancer patients who undergo surgery, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.

Figure 2.26

Percent of breast cancer patients who undergo surgery, by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.

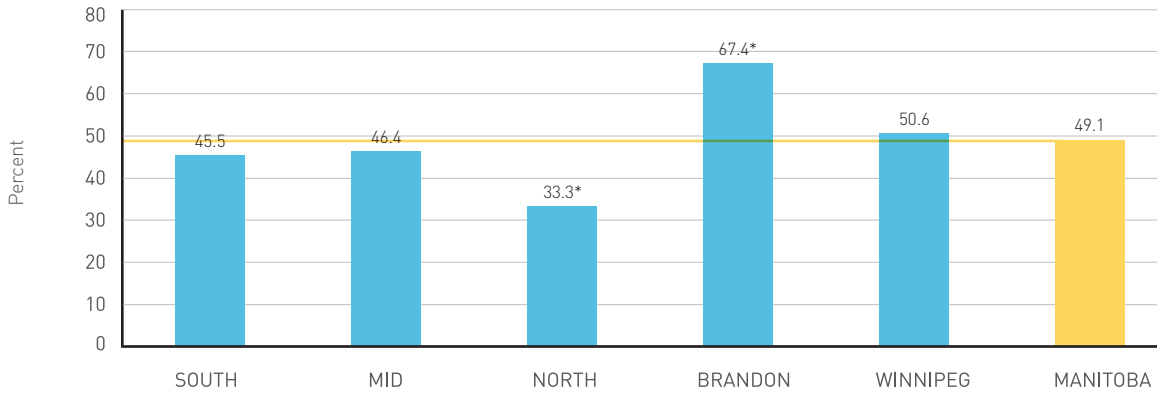
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



# Surgery: Prostate

Figure 2.27

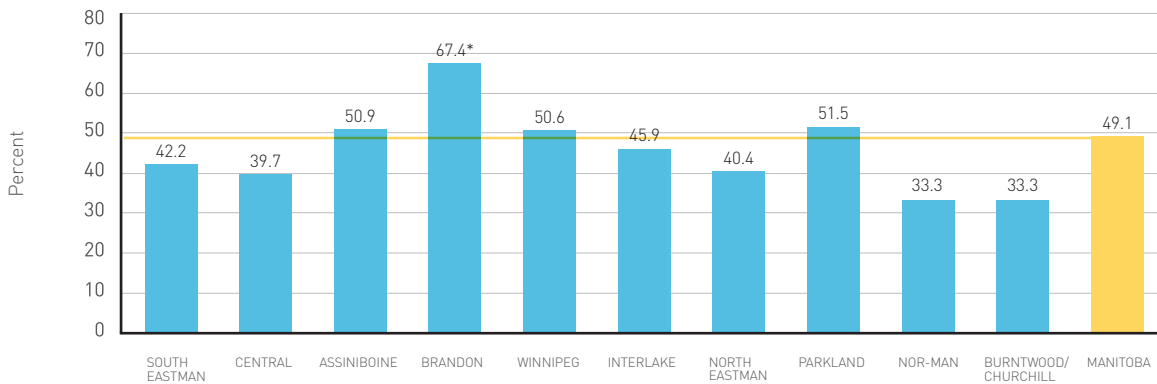
Percent of prostate cancer patients who undergo surgery, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.28

Percent of prostate cancer patients who undergo surgery, by Regional Health Authority

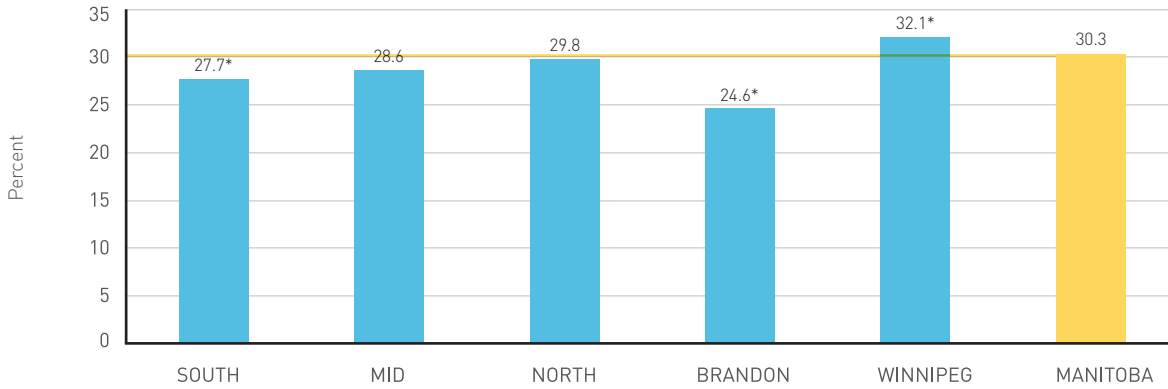


Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

# Radiation Therapy

Figure 2.29

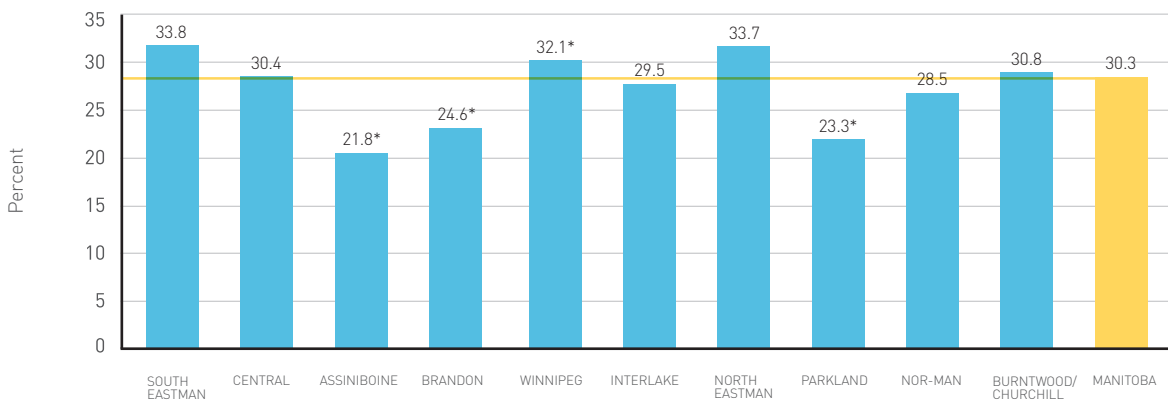
Percent of cancer patients receiving radiation therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.30

Percent of cancer patients receiving radiation therapy, by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

The proportion of all cancer patients receiving radiation therapy varies by region and type of cancer.

- ▶ Figures 2.29 and 2.30 show that radiation therapy use is generally higher in Winnipeg and lowest in the southwest regions.
- ▶ Figures 2.31 to 2.38 (see following pages) show regional variations in radiation therapy use by cancer type.

## What else do we know?

Variations in use of radiation therapy may be due to clinical factors or patient choice.

- ▶ The choice to undergo radiation therapy is also affected by factors including the distance a patient lives from a treatment centre, the length of time away from home and family, and information provided by patients' primary care physicians or surgeons.
- ▶ Currently, Manitobans can only receive radiation therapy at CCMB in Winnipeg.

## Why is this important?

Radiation therapy has a major role in the treatment of some cancers.

- ▶ Variation in radiation therapy rates depend on the type and stage of the disease, the patient's medical fitness for treatment, patient choice and use of radiation therapy outside of Manitoba which may not be recorded in our data sources.
- ▶ Although there are good reasons for differences rates including patient choice and clinical factors, these variations in radiation therapy may affect outcomes.
- ▶ We need to better understand the reasons for variations in radiation therapy to ensure the delivery of quality cancer care.

## How do we compare?

Canadian benchmarks for rates of radiation therapy are not yet available.

- ⊖ Little information on this indicator is available from across the country, but it is expected that the Manitoba experience is similar to provinces with the same geographic challenges (Saskatchewan for example), but may differ from others where there are more cancer centres spread throughout the province (Ontario).
- ⊖ Ontario reports 35% overall for patients receiving radiation treatment at any time during the course of their illness. This varies by region in the province from 32 to 40%.<sup>26</sup>

## What is CancerCare Manitoba doing to improve access to radiation therapy?

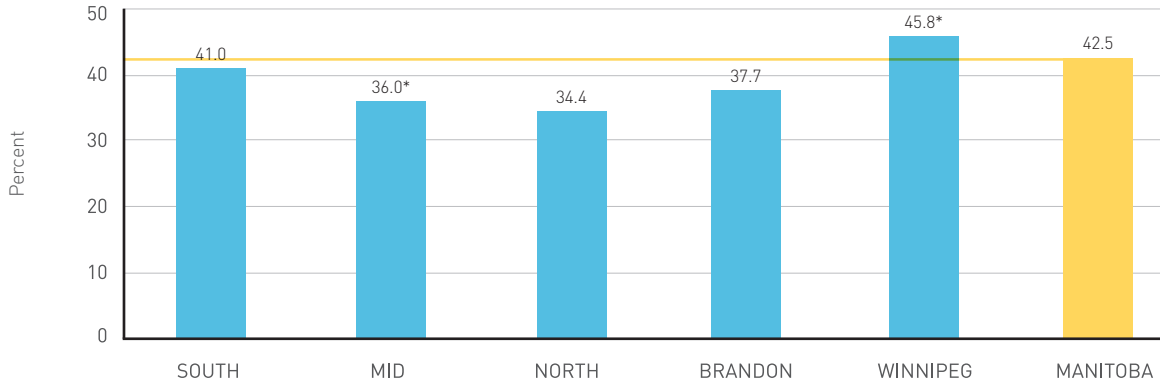
CancerCare Manitoba aims to provide all Manitobans with equal options for treatment, including use of radiation therapy.

- ▶ The opening of the Western Manitoba Cancer Centre in Brandon in 2011 will offer improved access to radiation therapy for Manitobans living in the southwest region of the province.
- ▶ By providing more information to primary care providers and surgeons, we can improve communication and keep people up-to-date on advances in cancer care and treatment. For example, the Uniting Primary Care and Oncology Network (UPCON) provides educational sessions specifically designed for health care providers where radiation therapy experts share information.
- ▶ We are continuing to analyze our data to find ways of making treatment more accessible and have patients making informed choices.

# Radiation Therapy: Lung

Figure 2.31

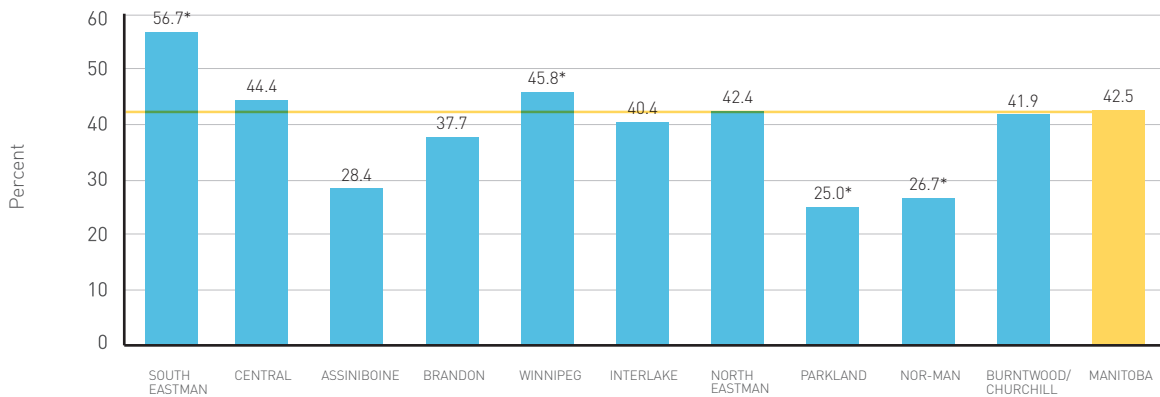
Percent of lung cancer patients receiving radiation therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.32

Percent of lung cancer patients receiving radiation therapy, by Regional Health Authority



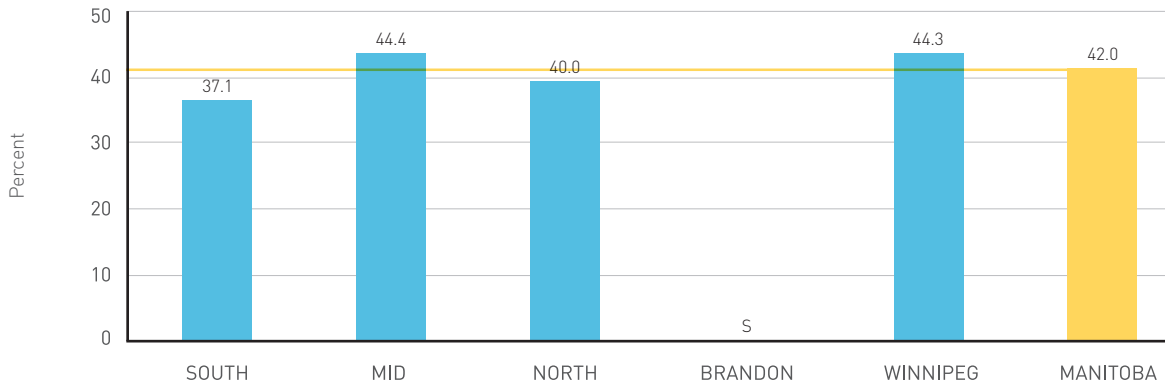
Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



# Radiation Therapy: Rectal

Figure 2.33

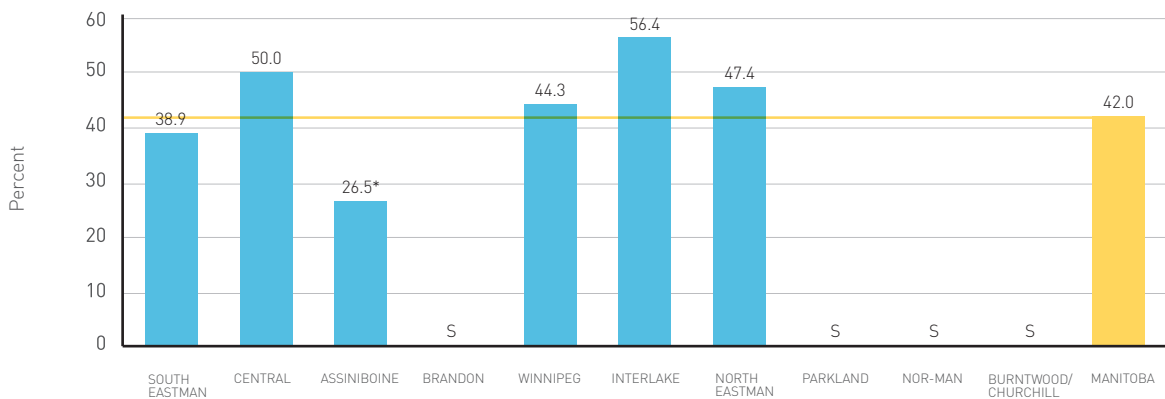
Percent of rectal cancer patients receiving radiation therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
s = numbers suppressed where < 6

Figure 2.34

Percent of rectal cancer patients receiving radiation therapy, by Regional Health Authority

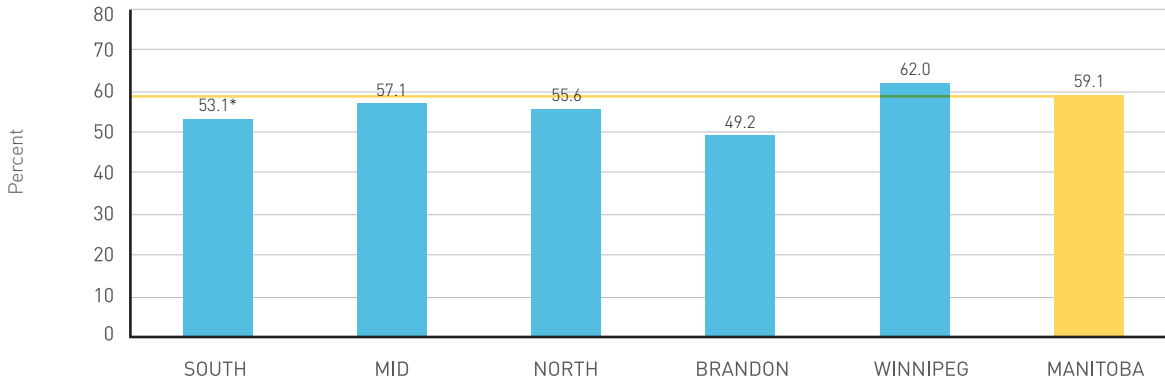


Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).  
s = numbers suppressed where < 6

# Radiation Therapy: Breast

Figure 2.35

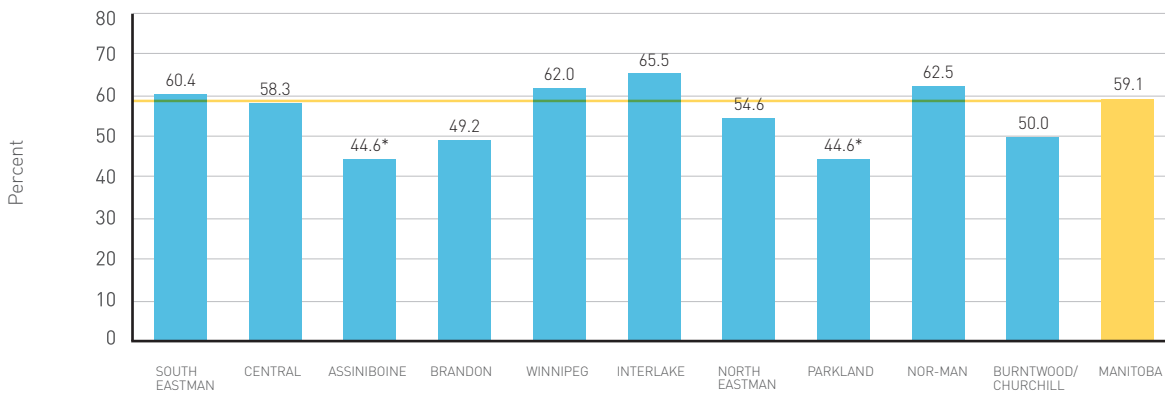
Percent of breast cancer patients receiving radiation therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.36

Percent of breast cancer patients receiving radiation therapy, by Regional Health Authority



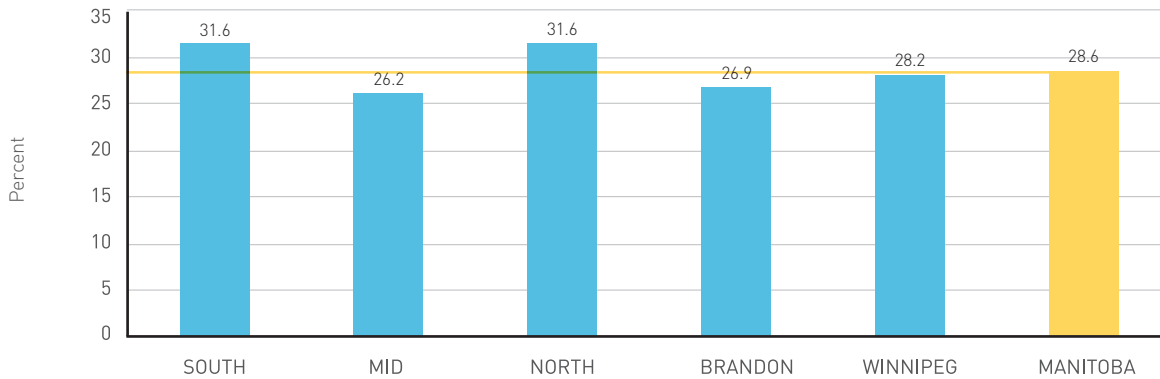
Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



# Radiation Therapy: Prostate

Figure 2.37

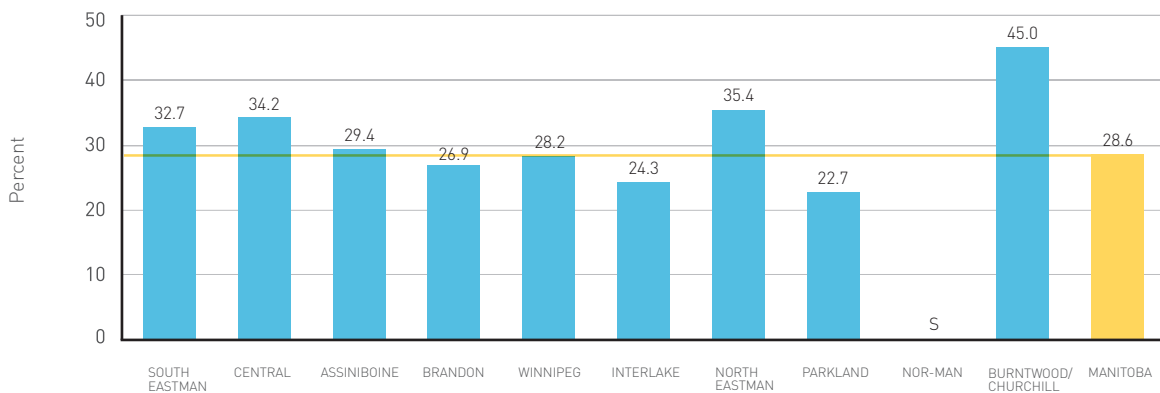
Percent of prostate cancer patients receiving radiation therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.

Figure 2.38

Percent of prostate cancer patients receiving radiation therapy, by Regional Health Authority

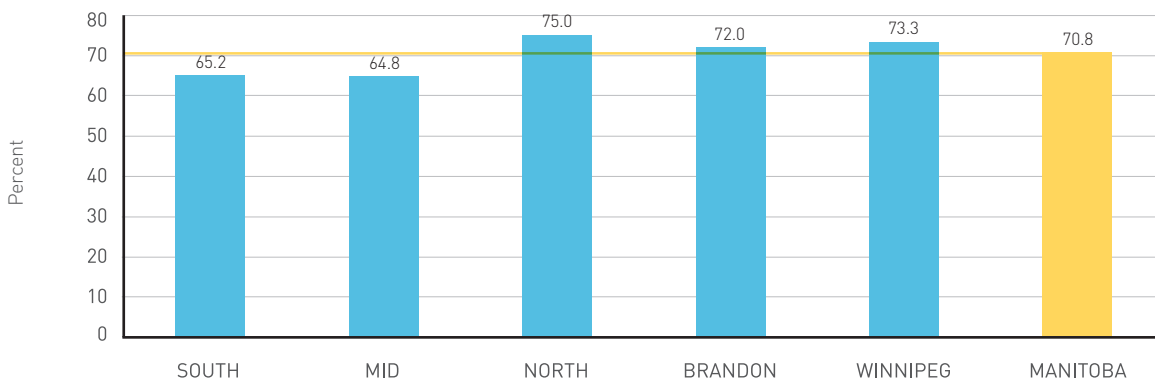


Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.  
s = numbers suppressed where < 6

# Radiation After Breast Conserving Surgery

Figure 2.39

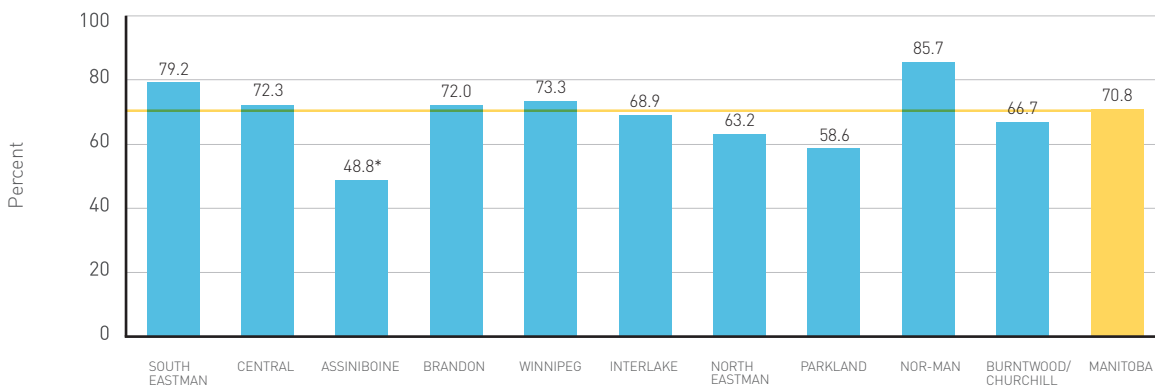
Percent of early stage breast cancer patients treated with radiation within a year of breast conserving surgery, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.

Figure 2.40

Percent of early stage breast cancer patients treated with radiation within a year of breast conserving surgery, by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2005-2006.

\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

### Use of radiation therapy after breast conserving surgery (lumpectomy) varies by region.

- ▶ Figure 2.39 shows lower use of radiation therapy in early stage breast cancer patients after breast conserving surgery (BCS) in the south and mid (rural) regions of the province.
- ▶ Figure 2.40 shows the lowest use of radiation therapy after BCS in early stage breast cancer patients is in the Assiniboine RHA.

## What else do we know?

### Variations in use of radiation therapy may be due to clinical factors or patient choice.

- ▶ Women undergoing BCS for stage I and II breast cancer who do not receive radiation therapy may still be receiving appropriate care. As noted by Cancer Care Ontario<sup>26</sup>, not having radiation therapy after BCS may be due to factors such as:
  - ▶ patients not medically fit for radiation therapy due to factors not recorded in available data sources
  - ▶ patients with very good prognosis (older age, smaller tumour size, low stage) receiving anti-estrogens as a substitute for radiation
  - ▶ patients' refusal of treatment
  - ▶ patients may get radiation therapy outside the province which may not be recorded in available data sources

## Why is this important?

### Women with early stage breast cancer who have BCS without radiation therapy have an increased risk of cancer recurrence.

- ▶ Variation may be due to medical factors, patient choice or use of treatment outside Manitoba.
- ▶ Although there may be good reasons for differences in these treatment rates, these variations may affect outcomes.
- ▶ We need to better understand the reasons for variations in radiation therapy use after BCS to ensure the delivery of quality cancer care.
- ▶ Research has shown that geographic barriers (distance to radiation therapy facilities) are a significant factor in lower rates of radiation therapy after BCS.<sup>27-29</sup>

## How do we compare?

### Canadian benchmarks for rate of radiation therapy after BCS are not yet available.

- ✘ Very little data are available on this measure, but the Manitoba experience is somewhat lower than Ontario.<sup>30</sup>
- ✘ Ontario reports that 80% of patients receiving radiation therapy following breast conserving surgery overall (between April 2005 and March 2008). This ranges from 65 to 88% depending on the region within the province.<sup>30</sup>

## What is CancerCare Manitoba doing to improve access to radiation therapy after breast conserving surgery?

### CancerCare Manitoba aims to provide equal access to treatment options including breast conserving surgery combined with radiation therapy.

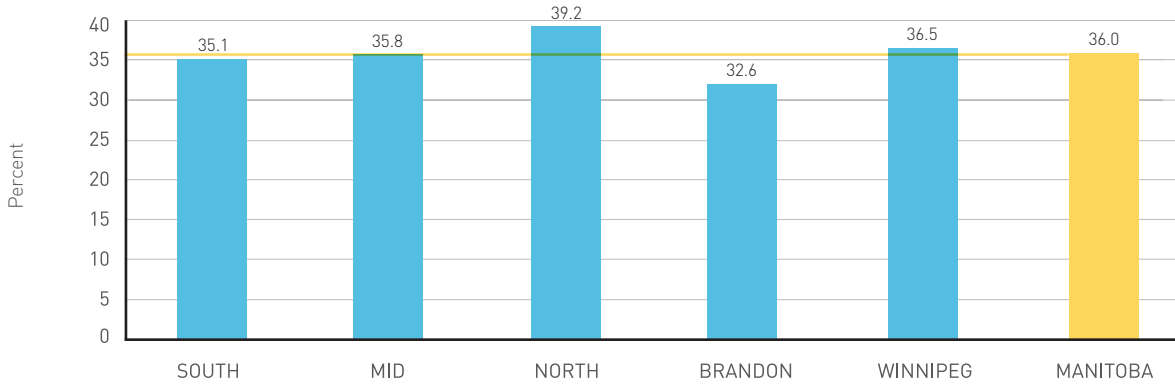
- ▶ The opening of the Western Manitoba Cancer Centre in Brandon in 2011 should greatly increase the convenience and use of radiation therapy for patients in southwest Manitoba with all types of cancer, including breast cancer.
- ▶ Continued work on developing and communicating clinical practice guidelines will ensure equitable access to quality cancer care.

# Systemic Therapy

(Chemotherapy, Hormone Therapy)

Figure 2.41

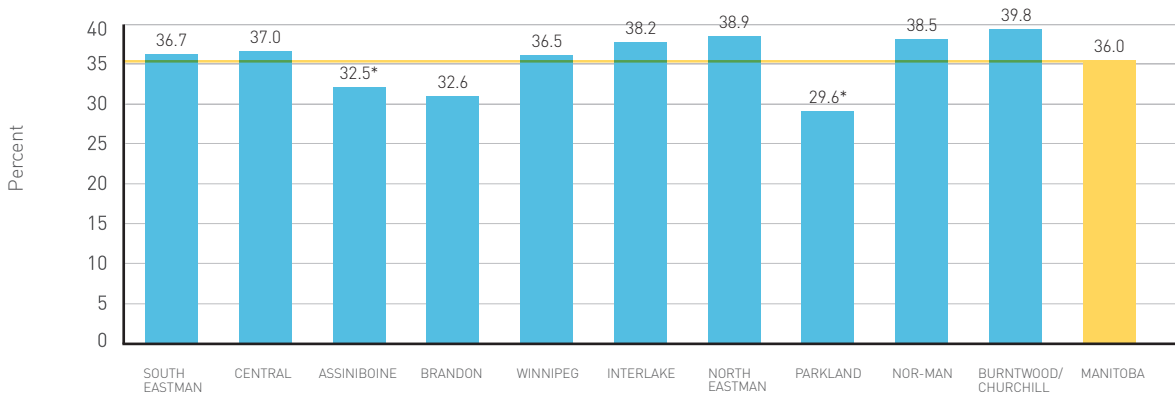
Percent of cancer patients receiving systemic therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.

Figure 2.42

Percent of cancer patients receiving systemic therapy, by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.

\*Significantly different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

The proportion of all cancer patients receiving systemic therapy (cancer drugs) vary by region and type of cancer.

- ▶ Figures 2.41 and 2.42 show that the highest systemic therapy rates are in the North, while some of the RHAs in the southwest have relatively low rates. These low rates may be due to treatments occurring outside the province, which would not be included in our data sources.
- ▶ Figures 2.43 to 2.50 (see following pages) show variation in systemic therapy occurs by type of cancer as well as geography.

## What else do we know?

- ▶ The more advanced the stage of cancer, the greater the chances of needing chemotherapy. Surgery and radiation therapy may not be appropriate for advanced cases.
- ▶ Advances in chemotherapy have improved outcomes for patients by tailoring the treatment to the patient's disease, but this has also increased the complexity of preparing and delivering these treatments.

## Why is this important?

Systemic therapy has a major role in the treatment of some cancers.

- ▶ Variations in systemic therapy rates depend on the type and stage of cancer, the patient's medical fitness for treatment, patient choice, and use of treatment outside of Manitoba which may not be recorded in our data sources.
- ▶ Variations in systemic therapy may affect outcomes.
- ▶ We need more indepth studies to understand the reasons for variations in systemic therapy to ensure the delivery of quality cancer care.

## How do we compare?

Canadian benchmarks for rates of systemic therapy are not yet available.

## What is CancerCare Manitoba doing to improve systemic therapy?

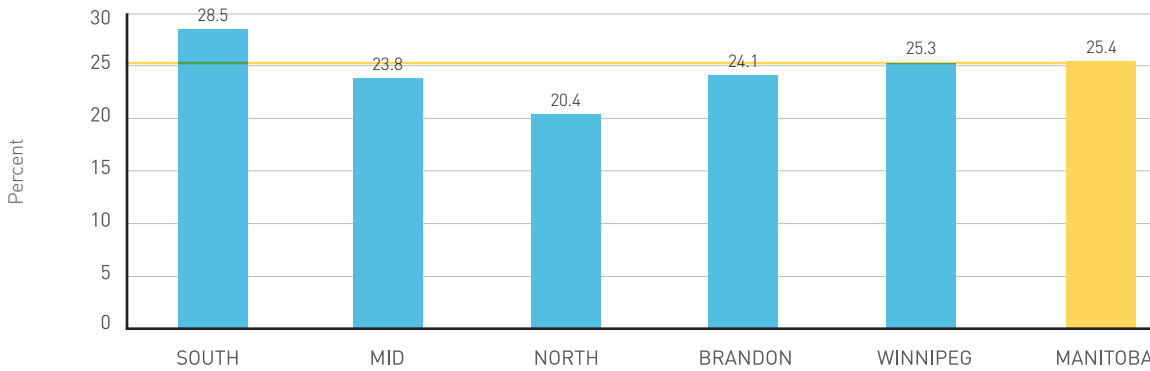
CCMB has launched several initiatives to improve the delivery of chemotherapy in Manitoba.

- ▶ The development of the Provincial Oncology Drug Program (PODP) in 2006 ensures patients in all regions have equal access to new and existing cancer therapies. It has effectively taken the pressure off the budgets of smaller facilities and is managing the use and distribution of oncology drugs as well as planning ahead for future new drug expenses.
- ▶ CancerCare Manitoba is able to capture all chemotherapy treatment data in the province and can study it to determine how well the system is working. For example, a team of clinicians and pharmacy staff is reviewing patient outcomes to ensure there is no over use or under use of chemotherapy drugs.
- ▶ Renovations in 2007 expanded the pharmacy space allowing for centralization and standardization of the preparation of intravenous drug treatments.
- ▶ Physicians can now enter their chemotherapy orders electronically which has been shown to decrease prescription errors.
- ▶ Drug preparation and labeling procedures have been improved to increase safety.
- ▶ A comprehensive training program for nurses and pharmacy staff on the use of ambulatory infusion pumps (devices that allow patients to get chemotherapy at home) is mandatory every two years to ensure the right medications and the right dose are being administered.

# Systemic Therapy: Lung

Figure 2.43

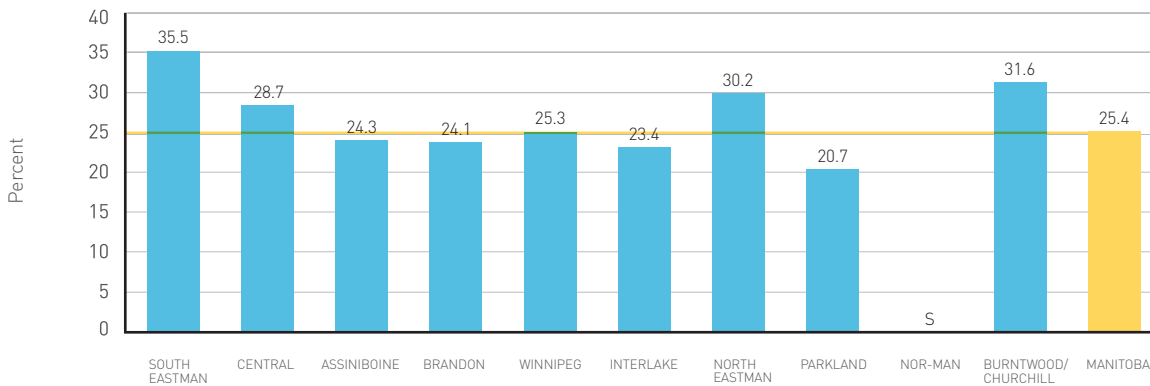
Percent of lung cancer patients receiving systemic therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.

Figure 2.44

Percent of lung cancer patients receiving systemic therapy, by Regional Health Authority



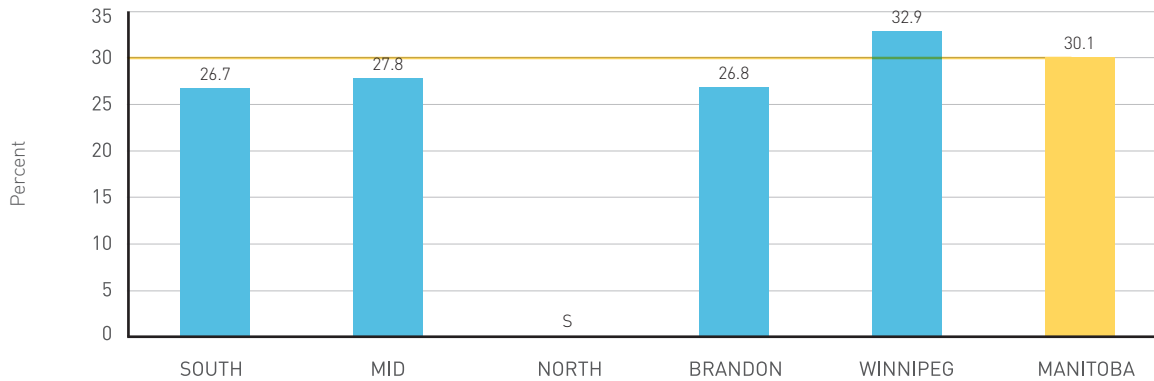
Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
s = numbers suppressed where < 6



# Systemic Therapy: Colon

Figure 2.45

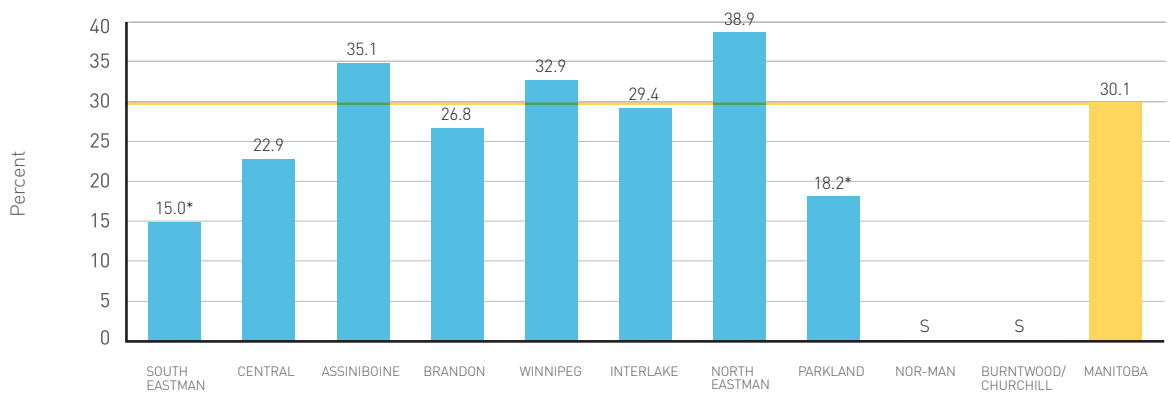
Percent of colon cancer patients receiving systemic therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
s = numbers suppressed where < 6

Figure 2.46

Percent of colon cancer patients receiving systemic therapy, by Regional Health Authority

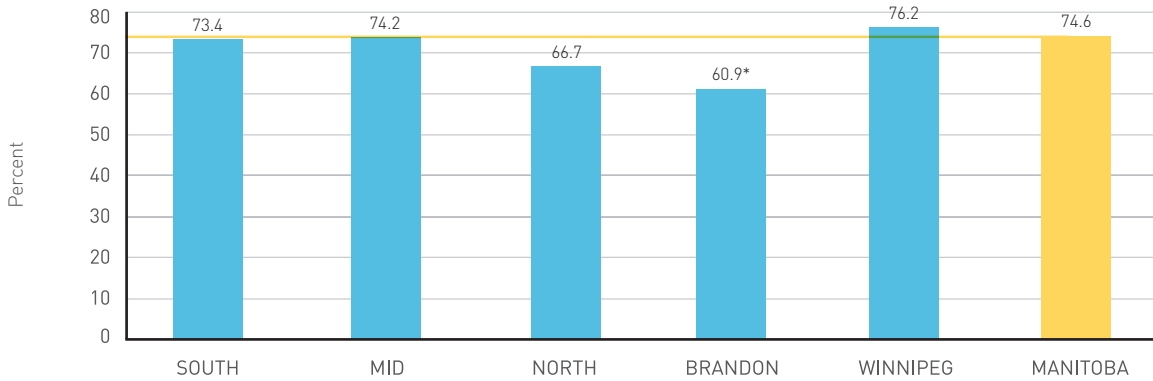


Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).  
s = numbers suppressed where < 6

# Systemic Therapy: Breast

Figure 2.47

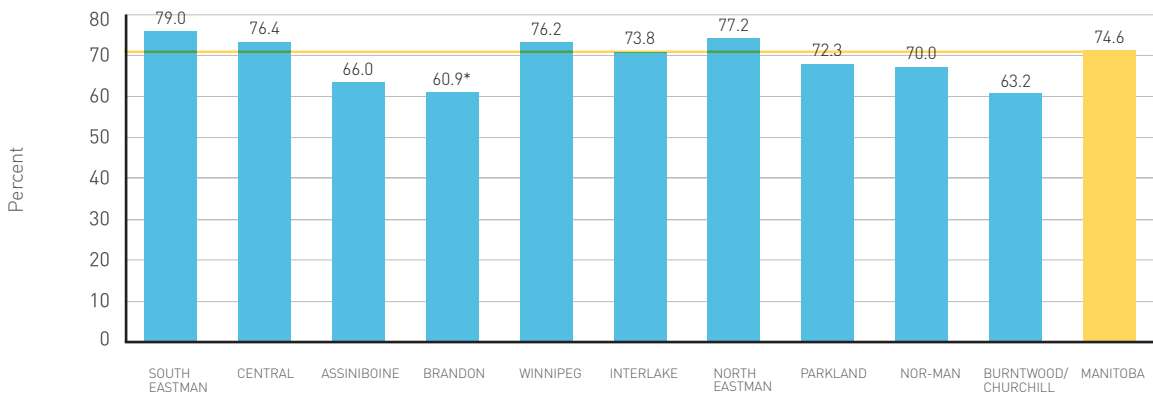
Percent of breast cancer patients receiving systemic therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

Figure 2.48

Percent of breast cancer patients receiving systemic therapy, by Regional Health Authority



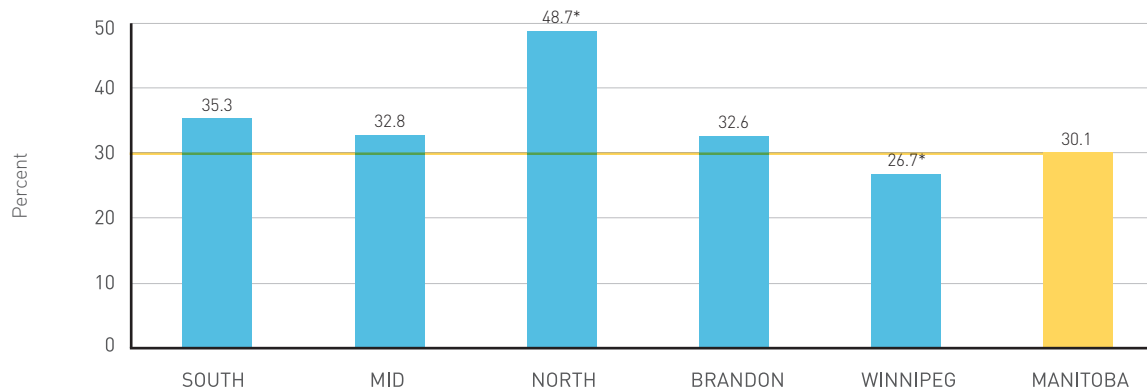
Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



# Systemic Therapy: Prostate

Figure 2.49

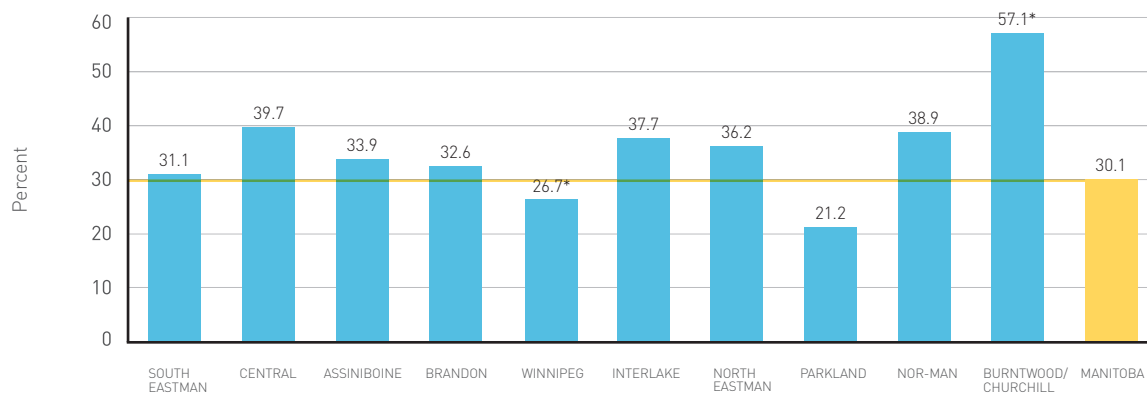
Percent of prostate cancer patients receiving systemic therapy, by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).



Figure 2.50

Percent of prostate cancer patients receiving systemic therapy, by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2006-2007.  
\*Significantly different from Manitoba rate ( $p < 0.05$ ).

# Additional Access Indicators

ADDITIONAL ACCESS INDICATORS	Past Estimate	Current Estimate	Time Trend	Range of Current Estimates <i>(Lowest RHA - Highest RHA)</i>
 <b>Accessing the Cancer System</b> <i>NEW</i> percent of cancer patients diagnosed at late stage (IV), all cancers <i>NEW</i> percent of cancer patients diagnosed at late stage (IV), by cancer type: <ul style="list-style-type: none"> <li><b>lung</b></li> <li><b>colorectal</b></li> <li><b>breast (f)</b></li> <li><b>prostate</b></li> </ul>	N/A	19.7%	NEW	17.5% - 29.2%
 <b>End-of-Life Care</b> percent of patients who die of cancer with an acute care hospital stay in the last two weeks of life	80.4%	77.5%	→	70.1% - 81.0%

Source: <sup>i</sup>Manitoba Cancer Registry, patient diagnosed 2005-2007.

<sup>k</sup>Manitoba Cancer Registry, cancer deaths 2000-2002, 2005-2007; combined with hospital data from Manitoba Health.

Note: Trend arrow is based on + or - 10% of the past value. Colour indicates if the trend is good (green), neutral (yellow) or needs to improve (red). Grey is used where interpretation of trend is not appropriate.

RHA refers to Regional Health Authority.

## What does this tell us?

Some patients enter the system when their disease is advanced and outcomes are poorer; most are hospitalized at end-of-life.

- ▶ Breast cancer is often found early due to screening and an awareness of symptoms; at the other extreme, lung cancer is often found late when the disease has spread to other parts of the body (metastasized).
- ▶ Most patients who are dying of cancer are admitted to acute care hospitals for end-of-life care.

## Why is this important?

The stage at which the cancer is diagnosed can have an impact on survival.

- ▶ Patients with late-stage cancers have the poorest prognosis (chance of survival); the disease is widespread and treatment is least effective.

End-of-life care requires special consideration.

- ▶ By tracking hospital utilization near end-of-life, plans can be made to ensure proper care can be made available to those patients and their families.

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## How do we compare?

Canadian benchmarks for these indicators are not available yet.

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## What is CancerCare Manitoba doing to decrease late-stage diagnoses and improve End-of-life care?

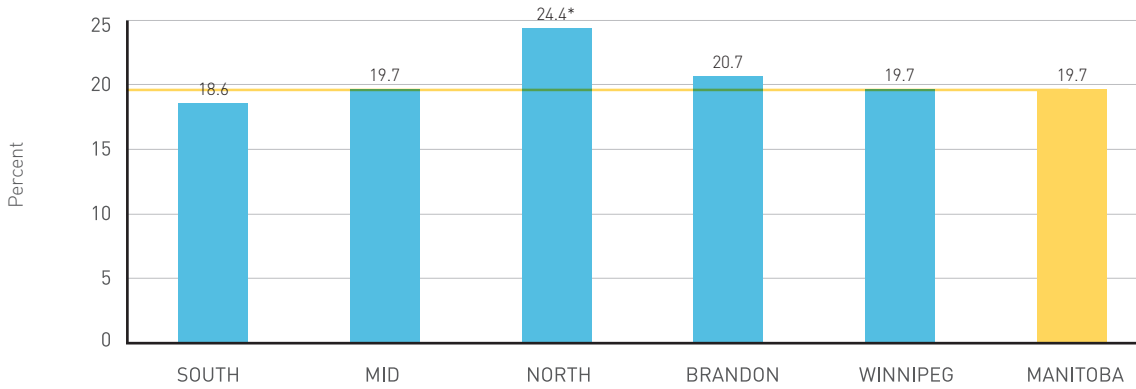
With our partners, CancerCare Manitoba is working to provide services across the cancer spectrum – prevent what we can, find it early if we cannot prevent it, and treat using the most appropriate therapies.

- ▶ Late-stage diagnosis:
  - ▶ CancerCare Manitoba promotes early detection through three provincial screening programs.
  - ▶ the Patient Navigation Program is investigating the patient journey to understand and address system delays.
  - ▶ through Uniting Primary Care and Oncology Network (UPCON), CCMB is educating family physicians and nurse practitioners about early diagnosis and responds to questions regarding efficient work-up of suspected cancer.
- ▶ End-of-life care:
  - ▶ by working together with partners such as the Winnipeg Regional Health Authority Palliative Care Program and the regions, CCMB is furthering our understanding about how services are used and which services could be used as patients approach end-of-life.

# Accessing the Cancer System

Figure 2.51

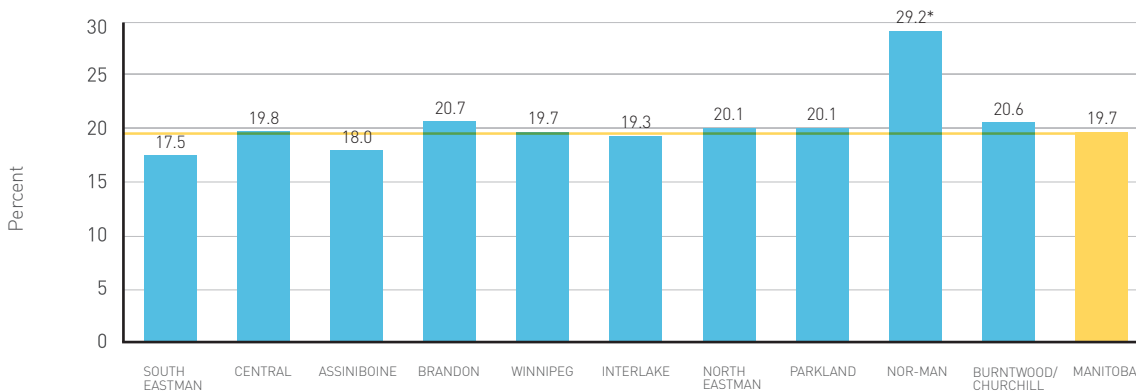
Percent of cancer patients diagnosed at late stage (IV), by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).

Figure 2.52

Percent of cancer patients diagnosed at late stage (IV), by Regional Health Authority



Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).



## What does this tell us?

### Late stage diagnosis varies by region and type of cancer.

- ▶ Figure 2.51 shows the North has the highest percentage of cancer patients diagnosed at a late stage at 24.4%, while the other regions are relatively similar.
- ▶ Figure 2.52 shows NOR-MAN has the highest percentage of cancer patients diagnosed at late stage at 29.2%, and Assiniboine has the lowest rate at 17.5%.
- ▶ Figures 2.53 to 2.60 (see following pages) show that stage at diagnosis varies by type of cancer:
  - ▶ lung cancer is frequently diagnosed at a late stage (41.7%)
  - ▶ breast cancer is rarely diagnosed at a late stage (5.6%)
  - ▶ colorectal cancer and prostate cancer are diagnosed at a late stage more often in the North

## Why is this important?

### Diagnosing a cancer late can lead to poorer survival.

- ▶ Recognizing symptoms and seeking medical help is key to early cancer diagnosis.
- ▶ The health care system’s response to suspected cancers is also critical to timely diagnosis.
- ▶ For some cancers there is scientific evidence supporting screening the population so that cancers are found before symptoms are present. But, not all cancers have scientifically proven screening tests.

## How do we compare?

### Canadian benchmarks for stage at diagnosis are not available yet.

## What is CancerCare Manitoba doing to decrease late stage diagnosis?

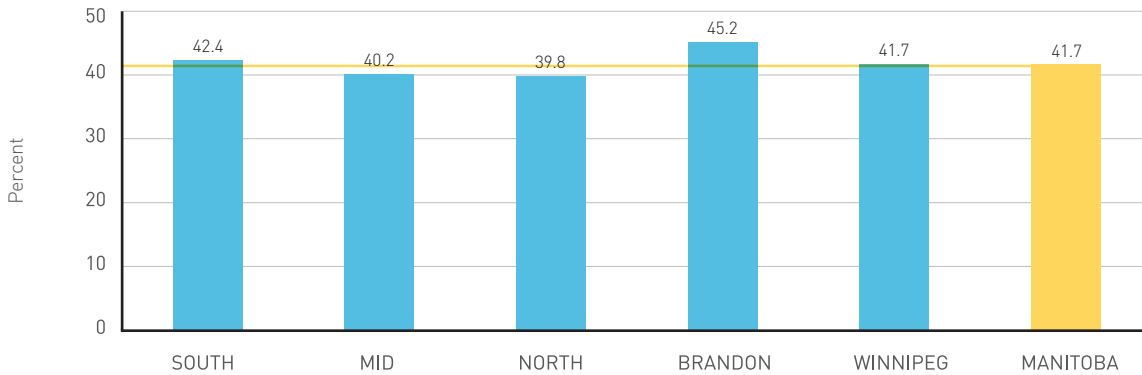
### Longstanding screening programs such as the Manitoba Breast Screening Program have led to more patients being diagnosed early when expected outcomes are good and treatment is most effective.

- ▶ The introduction of ColonCheck Manitoba is expected to have the same effect for colorectal cancer.
- ▶ The Patient Navigation Program is working to ensure rapid system response for cancer diagnosis as well as cancer treatment.

# Accessing the Cancer System: Lung

Figure 2.53

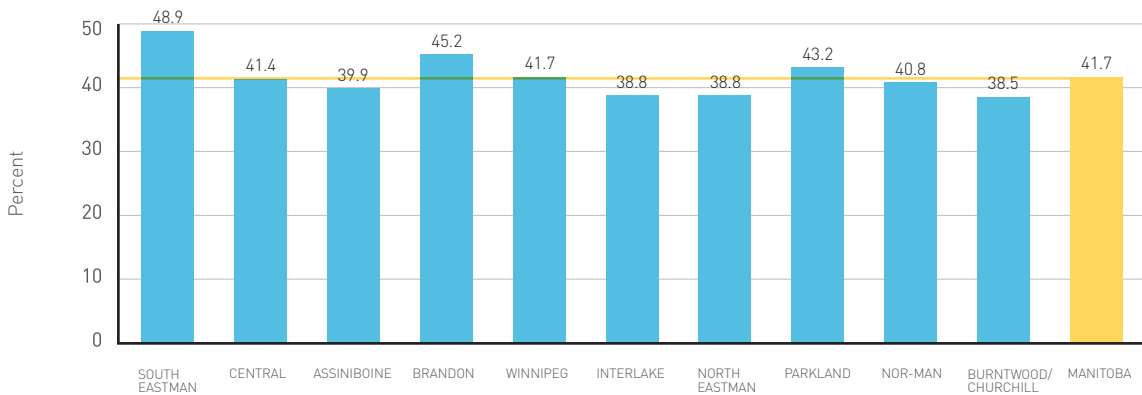
Percent of lung cancer patients diagnosed at late stage (IV), by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.

Figure 2.54

Percent of lung cancer patients diagnosed at late stage (IV), by Regional Health Authority



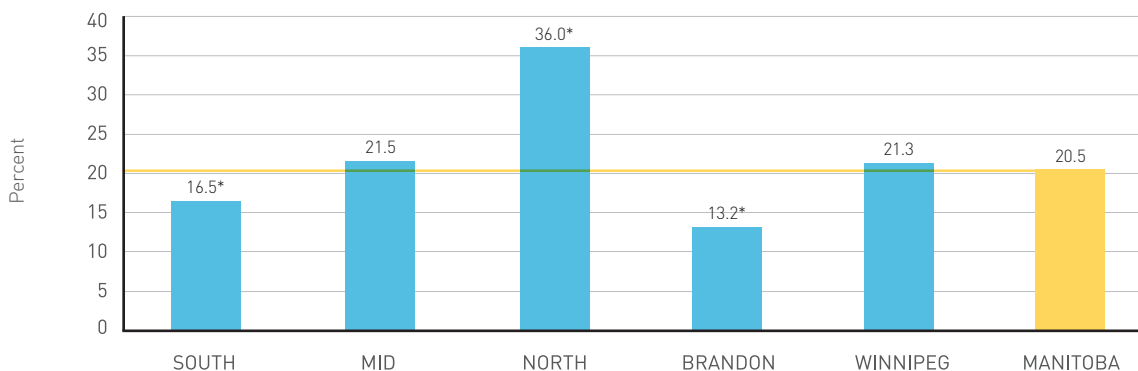
Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.



# Accessing the Cancer System: Colorectal

Figure 2.55

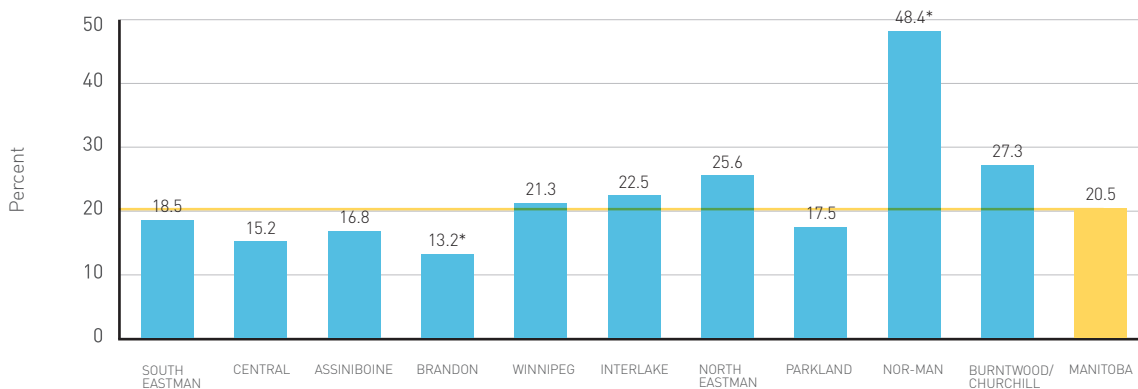
Percent of colorectal cancer patients diagnosed at late stage (IV), by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).

Figure 2.56

Percent of colorectal cancer patients diagnosed at late stage (IV), by Regional Health Authority

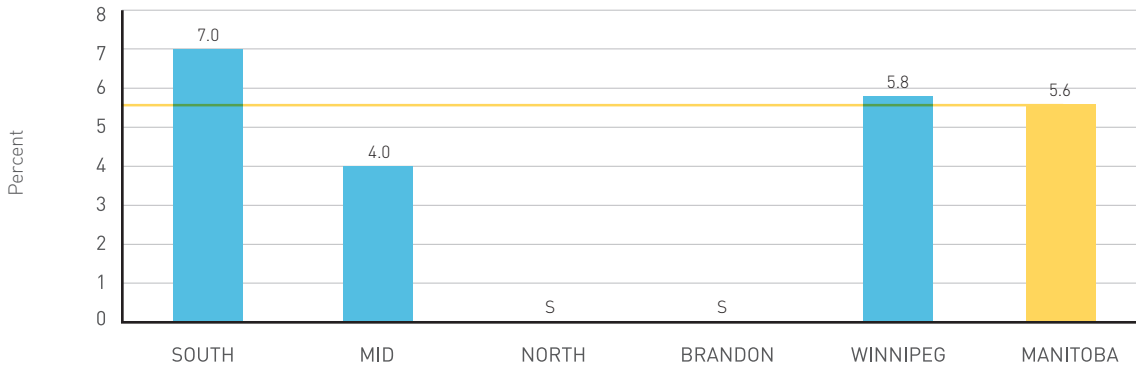


Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).

# Accessing the Cancer System: Breast

Figure 2.57

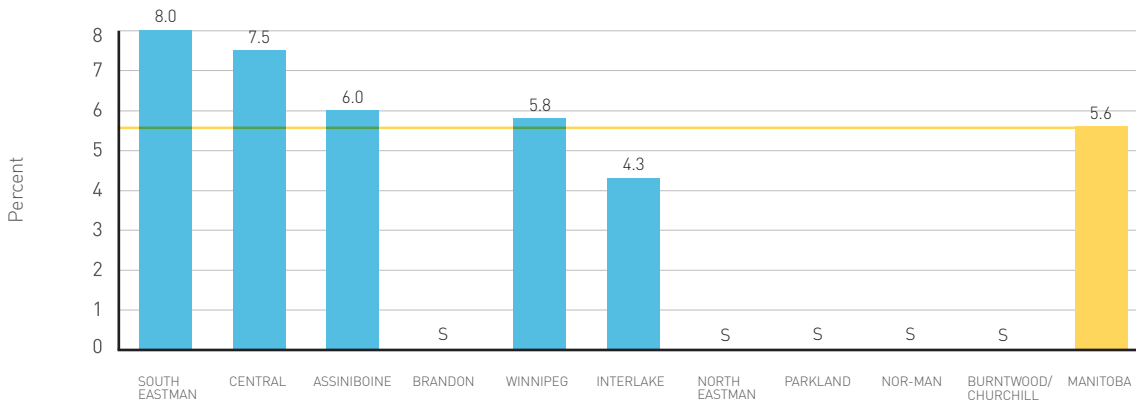
Percent of breast cancer patients diagnosed at late stage (IV), by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
s = numbers suppressed where < 6

Figure 2.58

Percent of breast cancer patients diagnosed at late stage (IV), by Regional Health Authority



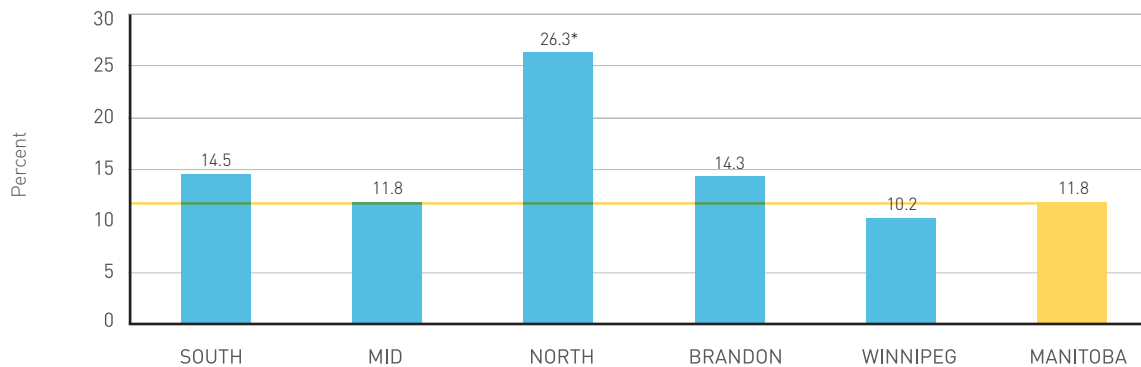
Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).  
s = numbers suppressed where < 6



# Accessing the Cancer System: Prostate

Figure 2.59

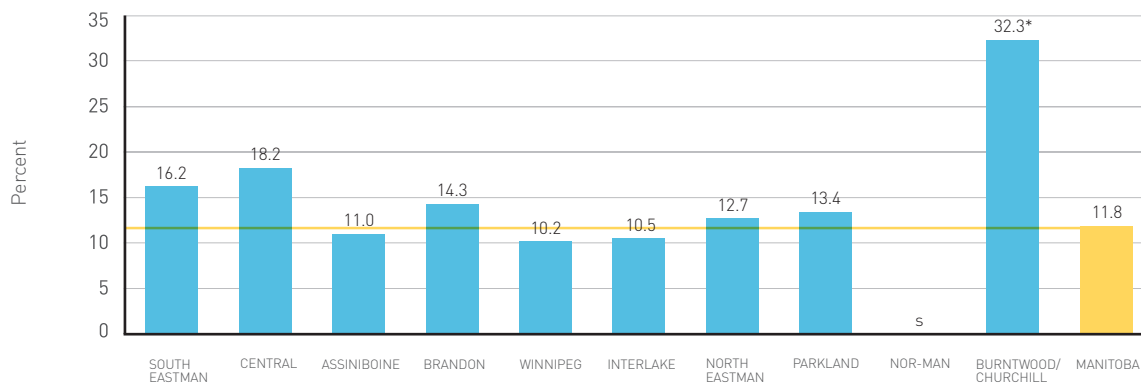
Percent of prostate cancer patients diagnosed at late stage (IV), by regional groupings



Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).

Figure 2.60

Percent of prostate cancer patients diagnosed at late stage (IV), by Regional Health Authority

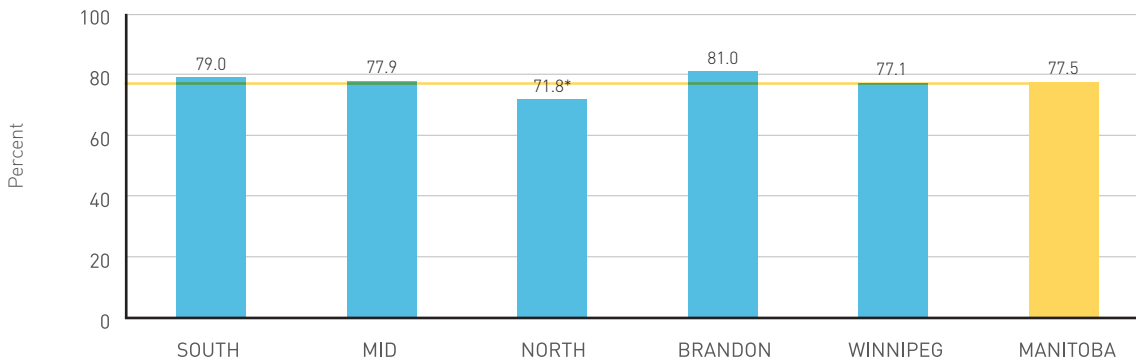


Source: Manitoba Cancer Registry, patients diagnosed 2005-2007.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).  
s = numbers suppressed where  $< 6$

# End-of-Life Care

Figure 2.61

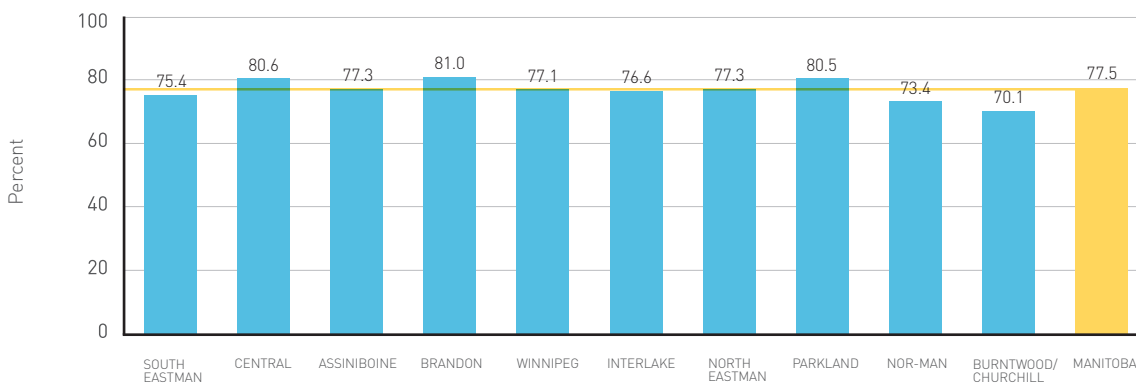
Percent of patients who die of cancer with an acute care hospital stay in the last two weeks of life, by regional groupings



Source: Manitoba Cancer Registry, cancer deaths 2005–2007; combined with hospital data from Manitoba Health.  
\*Statistically different from Manitoba rate ( $p < 0.05$ ).

Figure 2.62

Percent of patients who die of cancer with an acute care hospital stay in the last two weeks of life, by Regional Health Authority



Source: Manitoba Cancer Registry, cancer deaths 2005–2007; combined with hospital data from Manitoba Health.



## What does this tell us?

Overall, a high percentage of patients dying of cancer are spending their final days in a hospital setting.

- ▶ Figure 2.61 shows that patients in the North have a hospital stay at end-of-life less often than other Manitobans (71.8%); Brandon has the highest rate at 81.0%.
- ▶ Figure 2.62 shows the highest percent of patients dying of cancer with an acute care hospital stay at end-of-life is in Brandon at 81.0% and the lowest percentage is in Burntwood/Churchill at 70.1%.

## What else do we know?

- ▶ Research suggests many people approaching end-of-life want to die at home, but only a handful do so.<sup>31-36</sup>
- ▶ Factors associated with dying at home include patient preference, family support and caregiver resources, and a health care system that supports home-based and community palliative services.<sup>31-33, 37-40</sup>

## Why is this important?

Providing options for end-of-life care gives patients and families more choice.

- ▶ Palliative care programs try to facilitate home deaths by way of extending care in the home as long as possible. This can help avoid crisis emergency department visits or patients being transferred to acute care facilities during their final days and often, should the patient and family so desire, enables the patient to die at home.

## How do we compare?

Canadian benchmarks for this measure are not available yet.

## What is CancerCare Manitoba doing to improve access to end-of-life care?

With our partners, CancerCare Manitoba aims to provide support to patients who are dying of cancer and their families.

- ▶ The WHRA Palliative Care Program is a community-based program that provides care at home, in palliative care units or hospices, and supports palliative care in other health care facilities. The program is based on the belief that quality end-of-life care can be provided in a variety of settings.
- ▶ CancerCare Manitoba supports the internationally-recognized Manitoba Palliative Care Research Unit where more is being learned about how to help patients and their families with the end-of-life stage of the cancer journey.

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