

American Society of Clinical Oncology Quality Care Symposium 2012: Re-Engineering Your Practice to Deliver Quality and Value

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The final session of the American Society of Clinical Oncology (ASCO) Quality Care Symposium dealt with practical steps used by practices and institutions to enhance the provision of high-quality, efficient, patient-centered care. Speakers and podium presentations were chosen to demonstrate that such initiatives are achievable regardless of whether the enterprise involved is a health care system or single-physician practice. Each delivery system provides its own unique challenges to the implementation of quality improvement programs. Minimizing such challenges, however, is the goal of these interventions. Our speakers highlighted the importance of the development of standards, continuous monitoring of adherence, and ongoing efforts to improve on prior achievements.

Joseph O. Jacobson, MD, MSc, Chief Quality Officer for the Dana-Farber Cancer Institute, initiated the discussion with his presentation “Cancer Care: Moving From a Craft-Based to a Profession-Based Model.” He described our historical approach to medical care as a craft-based process relying heavily on the individual practitioner’s knowledge, intuition, and experience. Yet the individuality in craft-based medical care is also its most profound limitation. It results in a care system based on varied experience, preconceptions, and the associated uncertainty of what constitutes an optimal approach to individual patients and conditions in the absence of level-one data. Jacobson indicated that physicians need to embrace empirical medicine based on the development of algorithms and evidence-based approaches to clinical scenarios rather than case-by-case intuition. Empiricism in turn is one of the key elements of profession-based medicine, a care delivery concept that relies not only on evidence-based approaches but also on the establishment of a team-based model and integrated system fostering ongoing learning and iterative improvement. Such systems by nature require robust informatics to enhance communication and decision support.

If profession-based medicine is the goal, how does one best create an environment that systematizes the approach to illness and optimizes the adherence to standards while facilitating outcome measurement, learning, and self-improvement? The remaining speakers offered a variety of approaches to these issues.

Peter W.T. Pisters, MD, Vice President and Medical Director of the MD Anderson Regional Care System, presented the MD Anderson Cancer Center (MDACC) experience in disseminating its programmatic approach to other institutions. The primary objective of this multitiered program is “to transfer

programs representative of the MDACC mission to the broad community.” MDACC has a three-tiered approach to the dissemination of its programs. Most tightly linked are the regional centers in and around Houston, which are licensed and operated by MDACC. In contrast, the certified members of the regional network are smaller hospitals largely aiming to enhance the quality of their cancer programs. These programs benefit by modeling the MDACC approach to multidisciplinary care (MDC) and clinical practice guideline adherence. Before being approved for certification, all institutions undergo a round of self-assessment of their delivery system followed by an evaluation by members of the MDACC team. Subsequent to approval, certified institutions undergo alternating self-evaluations and external assessment by MDACC staff to assess adherence to a variety of quality indicators. Such efforts provide feedback and opportunity to evaluate, learn, and evolve in a manner that might not have been feasible for the institution without the affiliation. The third approach is that of a partnership model bringing the full services of MDACC to communities outside of Houston. In this case, quality assessment is done in the form of a monthly data exchange between MDACC and the partner institution on a variety of clinical outcomes.

Although the MDACC approach targets institutions, individual practices also need to raise the bar of their quality efforts. Carolyn B. Hendricks, MD, a solo practitioner, described her use of the ASCO Quality Oncology Practice Initiative (QOPI) in her office. Dr Hendricks recognized that her practice did not have the resources to develop and support a complex and potentially burdensome quality initiative. She chose QOPI as one of her main quality assessment strategies. The QOPI mission, relative simplicity of the process, and timely feedback were all part of its appeal. Participation has resulted in measurable improvements in a variety of parameters and strategies that have enhanced data collection and facilitated abstraction. An additional unanticipated benefit of QOPI participation has been the involvement of virtually all of her staff in the quality improvement process, thereby emulating the team approach so essential to quality enhancement.

Peter Ellis, MD, Deputy Director of Clinical Services at the University of Pittsburgh Medical Center, a pioneer institution in the creation of standardized clinical pathways, discussed the University of Pittsburgh Cancer Center journey in developing these clinical roadmaps. Like many enterprises involving multiple institutions, there was a need to standardize care across the

University of Pittsburgh consortium, assess and compare outcomes, and increase efficiency while minimizing potential errors. These rationales remain pertinent, but pathway development and adherence also position institutions more favorably in the development of accountable care organizations as well as in discussions with payers attempting to decrease cost. Given the rapidly changing science of oncology, pathways provide a framework for the incorporation of new data as they become available. Dr Ellis outlined the prerequisites for pathways in development, specifically that they are capable of evolution as data change, managed and supported by the physicians using them, patient specific, and deliverable with the least amount of disruption at the point of care. Clinical trials are often the preferred strategy for many of these pathways. Given the lack of level-one data for most decisions, pathways often result from, and in fact require, consensus. Perhaps equally important is the underlying assumption in the creation of these pathways that they will be appropriate for only 80% of patients covered, and individualized therapy may still be necessary for the rest. Pathway adherence can be monitored and benchmarked and serve as a source of self-assessment as well as an ongoing commentary on the relevance of each pathway.

An alternative approach to quality improvement at the institutional level is the creation and development of programs that facilitate seamless MDC. Eliot Friedman, MD, Cochair of the Quality of Care Subcommittee of the National Cancer Institute Community Cancer Centers Program (NCCCP), outlined the efforts of that organization in raising the caliber of MDC within institutions of the NCCCP consortium.¹ However, defining and analyzing the qualities of MDC programs spread across the country were potentially daunting tasks. The organization developed a self-assessment tool measuring nine parameters, mutually agreed on by the constituent sites, which were believed to be integral to the MDC process. Specifically, these consisted of case planning, physician engagement, coordination of care, infrastructure, financial integration, clinical trial implementation, medical record integration, use of care coordinators, and quality improvement. A cohort of 14 network sites participated in a performance improvement project; each of these institutions graded itself from 1 to 5 on each of these parameters, with 5 representing the highest level of quality achievable for the factor in question. These measurements were made at three separate time points between 2010 and 2012. The data showed continued improvement of MDC in the NCCCP institutions, with particular advances made in case planning, integration of care coordinators, physician engagement, and quality improvement efforts. Optimizing the provision of MDC within NCCCP has been perceived as a foundation for providing integrated high-quality care. MDC maximizes the expertise of care providers, enhances adherence to evidence-based

guidelines, and simplifies the journey of patients through the gauntlet of providers, diagnostics, and therapeutics.

The last presentation of the session was by Michael Fung-Kee-Fung, MB, FRCSC, Professor of Surgical Oncology at Ottawa Hospital, whose topic was “Use of a Community of Practice (CoP) Platform As a Model in Regional Quality Improvements in Cancer Surgery: The Ottawa Model.”² He defined the CoP platform as a bottom-up “voluntary network/social platform to promote change and transformation.” This network was created to enhance connectivity among various stakeholders in the cancer care system and facilitate collaboration. The intent was to create a system that linked practitioners and administrators directly to the patient care experience and to have this continually evolve, undergo reassessment, and evolve again as required by the realities of the process. Fundamental to the effective working of the CoP platform, in addition to having a widely representative group structure, is the need to collaboratively determine a shared sense of value in the program and mutual agreement regarding processes appropriate for change. To accomplish this, it was imperative to have access to tools and data necessary for analyzing the performance gap in question as well as the authority and ability to implement the changes that arise from these analyses. Processes requiring modification were identified by the practitioners themselves rather than those dictated by management. With the CoP platform, initiatives were rolled out across nine collaborating hospitals, enhancing access to care and resulting in measurable changes in quality in a variety of diseases.

In concluding his opening remarks, Dr Jacobson touched on the next phase of the medical care delivery, specifically moving from a profession-based model to a production-based model. Such a transition requires four things, three of which practitioners do not immediately control—specifically, the development of more-robust informatics, greater precision in subclassifying the heterogeneity of disease, and true target-based personalized medicine. The fourth, however, is the creation of a reliable system-based health care delivery system. Our speakers highlighted the early steps in creating such a delivery system, one that is team based, continually evolving, and provides the highest quality and efficient care for our patients.

Author's Disclosures of Potential Conflicts of Interest

The author indicated no potential conflicts of interest.

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