ASCO's Clinical Practice Committee

The Means Lead to (and justify) the End

Peter Paul Yu, MD

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Quality improvement and pay-for-performance are the coin of the realm these days. The press of politicians and payers alike is for standards of care that can be easily measured as indicators of quality. Professional societies face the urgent need to establish these measures first, lest others define quality in ways that hide reduction in services in the name

of quality improvement. In fact, ASCO has led the charge with projects designed to identify areas that need improvement (ie, National Initiative on Cancer Care Quality, the Quality Oncology Practice Initiative), measure development in partnership with NCCN, guideline development by ASCO's Health Services Committee, and creative new tools under development such as treatment summary templates. These efforts will be refined over time and are appropriate responses to the need for indicators of quality that are defined by health care providers themselves.

While these are crucial steps, I submit that measurement and other quality efforts will only make a lasting impact if they result in true process redesign. Safety and efficiency must be included in the quality equation and in redesign efforts. Meeting quality targets in a costly and time-consuming manner will not be sustainable. The financial survival of our practices in the face of reimbursement reductions will depend heavily on providing quality care with the least consumption of resources.

Quality improvement must move beyond "quick fixes," to practice solutions built on thoughtful consideration of the unique amalgam of local politics; finances; human resources; physical plants; and equipment in each of our offices, clinics, and hospitals. Each local environment demands custom-fitted processes. This may seem to be bad news to those who hope for an off-the-shelf solution to improve practice quality, but in reality an externally imposed solution will inevitably fail once it encounters the resistance of people asked to submit to

a new process that is a poor fit. We can and should learn from models that work for others, but we must be prepared to adapt those models for our own situation.

One tool that has been proposed to redesign work processes is the electronic health record (EHR). Is an EHR a means to the end of improved quality, safety, and efficiency, or are the process changes that lead to these improvements the means to the goal of a successful implementation of an EHR? I think it is the latter.

An EHR can be an unrelenting driver of progress when it comes to leading one's practice. Embedded in the architecture of any EHR are assumptions on what your work process should be. In the case of some EHR products, those assumptions may be fixed. Meanwhile in other situations, customization to the user's needs is possible, providing that the user truly understands his or her requirements. A successful EHR implementation requires the input of three critical human resources. The first is a clinician who understands the quality, safety, and efficiency issues of the practice and the local environmental constraints of personalities, finances, politics, and infrastructure. The second is an IT resource, preferably from the vendor, who has an intimate knowledge of the system architecture and understands what changes are technically feasible. The third person is an individual who is responsible for the training and motivation of the health care provider team.

For my many colleagues considering EHR implementation, the Clinical Practice Committee, in conjunction with the Cancer Education Committee, has planned an Educational Session for the 2007 ASCO Annual Meeting titled, "Working Smarter: First Steps Along the Path to Acquiring an EHR." This session will present examples of how evaluating the process of chemotherapy selection and administration can lead to improvements in quality, safety, and efficiency and prepare the way for a successful EHR implementation. See you in Chicago!

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