Institute for Healthcare Improvement Community-Based Cancer Care Studies

Quality of patient care remains the primary concern for oncologists. So, what are the main objectives? Primarily these include ensuring access to appropriate care and improving patient outcomes despite the challenges of managing cancer in the midst of an often tumultuous regulatory, financial, and political environment.

With this in mind, the Institute for Healthcare Improvement (IHI; Cambridge, MA) undertook a series of 90-day studies focusing on community-based cancer care. IHI is a nonprofit research organization dedicated to promoting quality improvement both in the United States and worldwide. IHI Senior Research Associate and Improvement Advisor Lindsay Martin, MSPH, describes the process this way: “We look for needs and try to fill them with the ultimate goal of health care that is safe, timely, effective, efficient, equitable, and patient centered.”

Integral to the studies’ execution and indeed to IHI’s mission is the organization’s IHI’s Quality Improvement Fellows. “The Fellowship Program at IHI was developed to train midcareer professionals in quality improvement methods and leadership for improvement,” said IHI Fellowship Director Joelle Baehrend. “Fellows spend 1 year on-site at the IHI office in Cambridge, MA, working with the IHI management team, staff, and faculty with the goal of returning to their home organization to lead transformative change.” According to Baehrend, IHI has trained 29 Fellows to date.

David Gozzard, MD, MBA, is executive medical director at Conwy & Denbighshire NHS Trust in North Wales, United Kingdom, and was one of six Fellows for 2007 to 2008. “The interesting thing about cancer care,” said Gozzard, “is that it occurs in the community. IHI is an organization that doesn’t deal with the community—mostly with hospitals—so this is a large area of health care that they have no knowledge of.” But community cancer care is exactly where Gozzard’s experience lies; he has more than 30 years in clinical and laboratory hematology under his belt and has been medical director of his trust for the last 5 years. “We didn’t go into the academic centers; we just wanted to talk about the majority of patient care,” he said.

ASCO was among the organizations first approached by Dr Gozzard and his team as they collected information to direct their cancer project work. “We had several discussions with [IHI] prior to and during the project,” said Kristen McNiff, MPH ASCO’s Quality Division director within the Cancer Policy and Clinical Affairs Department. “We helped them identify relevant published literature, contacts to talk to during the project. ASCO’s work in quality improvement,

and helped them with the an environmental scan to know what resources and programs are already underway.

McNiff noted that discussions focused on five key areas that also have been emphasized in ASCO’s activities:

- Care team communication and coordination and transition to survivorship care.
- Issues relating to cost of care.
- Symptom management and palliative care.
- Clinical trial enrollment.
- Total patient care, including psychosocial as well as physical health.

Gozzard said that some themes quickly emerged. “Patients want to survive, there is no doubt about that. They want reliable evidence-based care. . . and an experience that feels respectful, informative, supported, and coordinated. It’s obvious when you measure cancer care against those two needs that those two priorities did not stack up,” he said. “I don’t think there is recognition about the things that go on. The doctors see the result of their surgery, chemotherapy, radiation. But patients aren’t complaining to doctors. There is nobody collecting information about experiences that patients have. There doesn’t seem to be anybody who owns the cancer care for the person going through it. . . nobody there to collect the data, no national database.”

The purpose of the IHI studies was to take those ideas—survival and a care experience informed by both physical and psychosocial health—and see what practices meet those needs and provided coordinated care for their patients. “We found lots of great practice,” said Gozzard, “but it’s all in silos. There’s something happening in Kansas that nobody knows about in Washington, or something happening in North Boston that nobody knows about in South Boston. It works in their practice and provides patient benefits in terms of reliability and patient care, but can we take this practice and transfer it to another [institution] and see if it works there?”

Gozzard shared an example of oncology nurses in South Boston who called patients the day after chemotherapy infusions to see how they were feeling. “It’s common in the UK, but I understand that it’s not a general practice in the US,” said Gozzard. “When you think about it, it’s such a simple thing to do that can overcome so many problems. A simple phone call can actually improve the quality of care for patients.”

The bottom line is that exceptional solutions and approaches to quality care exist in pockets throughout the United States,

but they are not pervasive, and that's the problem. "IHI is acting as a facilitator across the US. In 90 days you can't do anything but scratch the surface, [but] we've found lots and lots of good practice benefiting patients in certain situations but not widely known," said Gozzard. "What we would like to do is see these things implemented elsewhere to test them and see if the patients would be benefited."

The use of breast cancer navigators—often nurses trained to support breast cancer patients by connecting with them at diagnosis and serving as their point of contact throughout treatment—is a practice that Gozzard said is producing obvious improvement in some sites. Kaiser Permanente in California is one group to institute their use. The question is, can it work in other cancers and diverse practice settings? Can it become a widely adopted practice? "Care in cancer is generally fragmented, a series of handoffs from specialist to another specialist to another specialist," said Gozzard. "With there not being a plan, the patient doesn't know what's involved. They don't know whether the care they're getting is the best possible care."

Another challenge, he said, is what he called the commercial aspect of US cancer care. "That's a difficult thing when you're dealing with compensation based on the treatment you give to a patient. There's always a temptation to give that additional treatment. If a patient comes to me [in the United Kingdom], I know I'm not going to earn anything from them. I have a certain amount of money I can spend to treat them, but there's no commercial aspect of this. It's actually a rather negative thing from the point of view of care in the US. I think people are overinvestigated and overtreated." Gozzard also shared concerns about low clinical trial enrollment in the United States. "Very few patients in the community get access to clinical trials," he said. "It almost depends on whether the first person you see has an interest in clinical trials or a connection to an academic cancer center."

That being said, US cancer care has some advantages that Gozzard admires. "Some of the buildings patients are treated in are absolutely superb," he said. "I have seen a few oncology centers that I would give my right arm for. If you've got a nice environment for a patient, that has got to be beneficial." He is also impressed by information systems in the United States. But unfortunately, there are a variety of factors that make delivering quality cancer care challenging within the United States that even the best facilities and the best technologies cannot combat.

"One thing for patients is they feel so terribly alone at the start of the cancer journey," said Gozzard. "In the UK, if somebody thinks they have cancer, they have to be seen within 10 working days. It's a standard by the UK government. In the US, that can occur only if you've got money, you've got insurance. There are other people who are uninsured who may not be seen for weeks. There's a sort of

ASCO'S CONTRIBUTIONS TO QUALITY

In addition to contributing to projects like the IHI studies, ASCO works to improve the quality of cancer care through numerous venues in the Society, among them advocacy efforts, the Quality of Care Committee, the ASCO Cost of Care Taskforce, the Cancer Research Committee, and, notably, the Quality Oncology Practice Initiative (QOPI).

Said Quality Division Director Kristen McNiff, MPH, "A primary area of focus for communication and coordination is the treatment plan and summary template, developed by ASCO's Quality of Care Committee and discussed in previous *JOP* articles. These documentation resources that oncology practices can use to help patients better understand what the intent and plan of care is. . . . The goal is, by doing the treatment plan and discussing it with the patient, the patient will be a more informed decision maker and know better what to expect during treatment."

The templates also include a treatment summary component for consistent end-of-treatment documentation that empowers patients to leave the oncologist's office knowing exactly what treatment they received, what follow-up care they need, and likely long-term effects. ASCO's EHR Workgroup is working with electronic health record vendors to incorporate the templates into their products so templates can be generated dynamically by office staff.

QOPI, which has also been discussed previously in *JOP*, now has more than 380 registered practices. "QOPI is continuing to grow, with more and more practices across the country that are systematically self-assessing against as many as 74 quality measures and receiving data back about the quality of care they're providing," said McNiff. "It really has been a quickly growing way for practices to have concrete data to focus their improvement efforts."

inequity there. People can feel alone, deserted, out of control, anxious, really unaware of what the next step in their journey is." Even after care is initiated, those fears and uncertainties often remain, and are exacerbated by the handoffs Gozzard cited. Navigators can be the best way to provide consistency and continuum of care.

In, the United Kingdom, Gozzard said, there are navigators for every cancer type, usually a specialist nurse, as another government standard. "It's expensive, but my goodness, it helps to reduce the anxiety of the patient and provides a point of contact that doesn't have to be medically led." Other

differences Gozzard highlighted between care in the States and in the United Kingdom are the coordination of treatment planning and the speed with which patients are seen. “It is socialized medicine, there’s no doubt about that. We’ll see you in 10 days or you’ll get treated in 31,” Gozzard said. He contrasted this rapidity with the US health care system, where sometimes only those with private insurance can be seen quickly by a specialist. “There’s a certain reliability of care that has been forced on us by government-led targets that’s missing in the US.”

“What I see are exactly these same things in the US [as I see in the UK], but they’re in little pockets. And because nobody’s saying, ‘It shall be done,’ it is not done,” Gozzard said. “People don’t know about these things that are going on that are really little gems—real little gems of excellence. Of course, what you have to say is, ‘They work in Rhode Island; will they work in Washington, or is there something different about the health system there that they won’t work?’”

The study culminated in a 21-page report detailing encouraging and discouraging trends identified throughout the 90 days and outlined key factors to improving cancer care in the community. Like Gozzard, McNiff hopes the study will form the basis for large-scale improvements by identifying and disseminating best practices, and ASCO will continue to work to improve quality alongside other organizations like IHI. Said Gozzard, “We have these ideas

and now I guess we have to see if anyone is interested in them. Let’s broadcast [them].”

Additional Reading

Treatment Plans & Summaries

- Developing the medical oncology treatment plan and summary. J Oncol Pract 2:95-96, 2006
- ASCO’s library of treatment plans and summaries expands. J Oncol Pract 4:31-36, 2008
- ASCO.org/treatmentsummary

QOPI

- McNiff K: The Quality Oncology Practice Initiative: Assessing and improving care within the medical oncology practice. J Oncol Pract 2:26-30, 2006
- Physicians guided by first-round data from QOPI. J Oncol Pract 2:251, 2006
- ASCO.org/QOPI

Clinical Trials

- Zon R, Meropol NJ, Catalano RB, et al: American Society of Clinical Oncology statement on minimum standards and exemplary attributes of clinical trial sites. J Clin Oncol 26:2562-2567, 2008

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REGISTRATION DEADLINE APPROACHING FOR THE ASCO-EORTC-NCI ANNUAL MEETING ON MOLECULAR MARKERS IN CANCER

The second Annual Meeting on Molecular Markers in Cancer (October 30-November 1, 2008, Hollywood, FL) will bring together clinicians, pathologists, researchers, and others to accelerate progress in the rapidly advancing field of cancer markers. Hosted by ASCO, NCI, and EORTC, it will feature discussions on contemporary issues in molecular pathology, assay development, clinical trial design, and the development of promising fluid and tissue markers as research tools and laboratory tests. Register by Friday, September 26, 2008, to take advantage of reduced registration fees, www.molecularcancmeeting.org

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