Models That Work: Incorporating Quality Principles in Different Clinical Settings

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Introduction

Part 2 of the ASCO Quality Care Symposium session, “Models That Work: Integration Across the Spectrum,” featured three speakers from diverse clinical settings who described their experiences with the use of quality measurement and improvement principles to drive quality cancer care. The first presentation by Terrence James Sullivan, PhD, past President and Chief Executive Officer of Cancer Care Ontario, described Ontario’s experience with implementation of a cancer-specific public reporting program. Douglas W. Blayney, MD, who has experience as a medical director of two academic medical centers, shared some of his lessons in engaging academic centers in quality. The last presentation by Linda D. Bosserman, MD, FACP, president of Wilshire Oncology Medical Group, focused on her group’s pioneering work in piloting what they call the medical oncology home care model. This article summarizes their presentations and briefly discusses common themes.

International Perspective: Public Reporting as a Means to Improve Quality and Performance

At the turn of the millennium, Ontario and many other Canadian provinces faced a serious wait-time crisis arising from policy failures to expand radiation therapy capacity for cancer services at a pace consistent with growing incidence and prevalence.¹ One part of the solution to improving access was the launch of the Cancer Quality Council of Ontario, a quality council for cancer services that has a jurisdiction-wide mandate within the province.

One of the quality council’s first tasks was to establish a framework for collecting and publicly reporting on quality measures for cancer services within the jurisdiction. They began by conducting an environmental scan of existing quality efforts and data systems to support such efforts.² A list of potential quality indicators was then developed and prioritized, with input from clinical teams using a modified Delphi process to develop a “strategy map” approach to the collection and reporting based on the larger goals for cancer control within Ontario.³

The first public reporting of the Cancer System Quality Index (CSQI)⁴ began in 2005 and has proceeded annually, with reporting of ≥ 30 well-specified and defined measures each year that track over time and regularly feature new indicator development. Recently, the quality framework was updated to a new

two-dimensional version that maps Institute of Medicine quality dimensions against the trajectory of care from prevention to palliation.⁵

It is important to note that the culture of evidence has been well planted within the cancer system in Ontario for quite some time through the evolution of the Program in Evidence Based Care. This program has played a key role in building high-quality disease state guidance rooted in extensive engagement of clinicians, beginning with a summary of the evidence for the state’s investigation and treatment of specific cancers.⁶ Once initial evidence tables are presented to disease site groups, an initial guideline is produced and widely distributed among the practice community within Ontario. This important knowledge transfer effort has paid off significantly in the rapid cycle adoption and improvement of care by medical oncologists, surgeons, radiation oncologists, and other professionals over the last decade in particular. Indeed, CSQI compares regional patterns of practice against appropriate guidelines as a regular feature of its annual reporting, which allows for target setting for improvement in a number of specific areas across the cancer continuum, as well as public reporting year by year against such targets.

With well-aligned clinical and administrative leadership at both the local and provincial levels, Ontario has built a strong culture of clinical accountability among oncology professionals that allows the jurisdiction to set credible improvement targets and move toward them on an annual basis.⁷ The jurisdiction has aspects that resemble a high-performing delivery system,⁸ one that organizes the journey; aligns the leadership; and improves the processes of care on an ongoing basis, with resulting internationally competitive cancer outcomes.⁹

Academic Perspective: Engaging Academic Physicians in Quality

Because of their three-part mission—education, research, and patient care—measuring and improving patient care quality in the academic setting presents unique challenges. Physicians who work in academic medical centers (AMCs) often do not view patient care as their own primary mission, and they are often evaluated and promoted on the basis of criteria other than quality in clinical care. Many AMCs serve patients with complex or refractory medical problems and act as safety-net hospi-

tals. Finally, these centers are not immune from the financial pressures facing cancer care in the United States today. All of these competing secular forces require reconciliation if AMCs are to continue their societal role.

The fulfillment of the training mission of an AMC, during which fellows, residents, and medical students provide patient care, provides an opportunity to build lifelong attitudes and skills of these physicians with regard to quality. Exposing trainees early in their careers to techniques for measuring quality, building teams, and eliminating systemic waste in patient care adds an extra, and often ignored, dimension to the training mission but can influence career-long practice. Just as medical education has changed from the top down, command and control method in which many senior clinicians were trained, to the current collaborative, consensus- and team-based approach to care—and has also adapted to accommodate resident work hour restrictions—we need to adopt training in quality as one of our missions.

Physicians who are drawn to professional careers in AMCs are often motivated by research and discovery or the teaching mission, and may not view patient care as the most important of their duties. The proportion of the promotion and compensation criteria for academic faculty may not be well aligned with provision of quality patient care and can be seen as de-emphasizing its value. Providing incentives to these physicians and aligning them with the quality mission can present challenges different from those of a community practice or another hospital-based practice.

Finally, the structure of AMCs, which includes components of a hospital, a medical school, and a faculty practice plan, can also present challenges. Hospitals, which are often governed by lay boards of directors or by regents or trustees who are recruited to oversee the larger university, may have only a superficial acquaintance with quality care. Professional administrators may focus on system-wide measures of quality and not be familiar with measures relevant to oncology. Diffusion of decision making between the medical school structure and the more financially oriented practice plan may also make quality improvement efforts difficult.

Community Perspective: Innovating to Bring Value

The medical oncology home care model is based on the hypothesis that achieving value-based, patient-centered cancer care requires a culture change among cancer providers, payers, and patients. Each stakeholder needs to become fully engaged in re-engineered processes and relationships that are informed by structured data collected as part of the care processes.

On the physician side, physicians need to become leaders of teams that work together to develop, deliver, and report on evidenced-based care with nationally recognized quality measures. This begins with a foundation of agreed-on care pathways for specific cancers and programming of those preferences into discrete data elements for capture at the time of service. Reports from these data are then shared regularly to discuss compliance and appropriate warranted variations, as well as updates when validated.

Payers re-engineer their culture from one of just contracting with providers for lowest cost of care to one of active engagement and relationship development with oncology leaders. They need to understand, review, and evolve the payment system to facilitate the desired high-quality cancer care for their members on the basis of accountable and transparent reports, with agreed-on metrics for measurements at the practice level and validation via claims data at the payer level.

On the patient side, patients play a key role in providing data on medication compliance, toxicities, and interval care (emergency room, hospital, and other care between visits) as well as ensuring they have and understand their care plans during and after active therapy. Patients have welcomed early management of symptoms by their oncology team to minimize avoidable emergency room visits and hospital admissions, and they have welcomed additional educational support and proactive calls from oncology nurses after therapy to ensure they have maximum symptom control to improve their health.

In 2008, the Wilshire Oncology Medical Group approached Anthem Blue Cross of California, the largest health plan provider in California, to develop a medical oncology home pilot based on the above principles. Over a 4-5-year period, the health plan leadership met with the group leaders to understand the philosophy and the deliverable data from the practice and the plan, as well as to agree on national quality measures for benchmarking and an outcome-base payment approach to contracting. Both sides identified key components of medical oncology home care as involving care planning, care coordination, and care management from first diagnosis through survivorship and/or end of life, across all sites of care. They identified that additional payments for care planning, care management, and care coordination in addition to the standard fee-for-service payments could align incentives for the clinicians to focus on improving the value of care rather than the volume of care. With more generic and lower cost regimens with equal efficacy provided to patients, the payments for desired work would replace those previously funded by drug margins. The pilot was launched August 1, 2011, and has been extended for 2 more years.

The first-year results of this pilot are encouraging. There has been evidence of cost savings while ensuring evidence-based, patient centered care. Some of the changes that have taken place include standardization of medications such as hormonal therapy for breast cancer and avoidance of white growth cell factors use in metastatic disease for which these supportive medications are not recommended. There have been trends toward better end-of-life care and fewer hospital admissions among patients receiving chemotherapy. The pilot is continuing, with more results expected in the next 2 years.

Comment

This session showcased several successful examples of how different clinical settings have responded to the challenge of delivering high-quality cancer care. Despite significant differences in the care settings between the three speakers, a number of shared themes were evident. First, ongoing quality measurement using

recognized indicators is the foundation of high-quality care systems. Measurement is important to drive improvement, track progress and ensure accountability. Second, early and ongoing engagement of clinicians, payers, and patients is essential for success. Last, alignment of incentives to ensure appropriate recognition and payment for high-quality care across all settings is necessary to create a sustainable culture change.

Authors' Disclosures of Potential Conflicts of Interest

Although all authors completed the disclosure declaration, the following author(s) and/or an author's immediate family member(s) indicated a financial or other interest that is relevant to the subject matter under consideration in this article. Certain relationships marked with a "U" are those for which no compensation was received; those relationships marked with a "C" were compensated. For a detailed description of the disclosure categories, or for more information about ASCO's conflict of interest policy, please refer to the Author Disclosure Declaration and the Disclosures of Potential Conflicts of Interest section in Information for Contributors.

Employment or Leadership Position: Monika K. Krzyzanowska, Cancer Care Ontario (C); Douglas W. Blayney, Stanford Cancer Center (C); Linda D. Bosserman, Wilshire Medical Oncology Group (C) **Consultant or Advisory Role:** Douglas W. Blayney, United Healthcare (C), National Oncology Consultants (C), Bristol Myers Squibb (C), Astellus Pharmaceuticals (C), Cellgene (C), Xcenda Pharmaceuticals (C) **Stock Ownership:** Douglas W. Blayney, Abvie, Abbot Laboratories, Au-

todesk, Citrix Systems, EMC Corporation, Google, International Business Machines, Oracle Corporation, QUALCOMM, Amgen, Bristol-Myers Squibb, Coviden PLC, Express Scripts Holding Company, Johnson & Johnson, UnitedHealth Group, Apple, Automatic Data Processing **Honoraria:** Douglas W. Blayney, American Society of Clinical Oncology, University of Michigan, Saudi Cancer Foundation **Research Funding:** Douglas W. Blayney, Blue Cross Blue Shield of Michigan **Expert Testimony:** None **Other Remuneration:** None

Author Contributions

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DOI: 10.1200/JOP.2013.001028

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