Summary of Oral Abstract Session B: Innovating to Improve Care Quality

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The three abstracts selected for oral presentation in this session of the Quality Care Symposium illustrated either novel approaches for improving quality care delivery in radiation oncology or the potential challenges of using chemotherapy recommendation and delivery data collected for quality improvement to assess accountability. We summarize these abstracts below, attempt to highlight how they are related and how they are different, and conclude with a discussion regarding how this information could influence practice now and in the future.

Summary

Overuse of costly cancer treatments is one aspect of poor quality. Mamon et al¹ described an approach they developed with a payer to address this issue. Intensity-modulated radiation therapy (IMRT) allows for more precision in the delivery of external beam radiation therapy but at twice the cost to payers and with limited data demonstrating incremental benefit. Rather than unilaterally setting coverage policies for the use of IMRT for its patients, Blue Cross Blue Shield of Massachusetts engaged the radiation oncology community in Massachusetts, and together they developed a system under which IMRT was always covered for certain cancers or for patients on a clinical trial but that required additional justification for use in other settings, on the basis of widely accepted normal tissue tolerance guidelines. There was also a mechanism for internal review using a peer-to-peer system before sending appeals to an external group. Not surprisingly, once this system was implemented, the rate of growth of IMRT in this patient population declined 20% and has now stabilized at this lower rate, with 78% of appeals being handled through internal review.

In another abstract in the session, Hardenbergh² presented a novel concept in quality improvement. Radiation oncology has a long tradition of chart rounds, during which members of a department prospectively review the radiation treatment plan of each patient as they begin treatment. Although this quality assurance step works well in larger departments with many physicians, it is not feasible for solo practitioners. Faced with this situation herself, Hardenbergh described a program she created called Chartrounds.com, which allows radiation oncologists to present their cases to disease-site experts by means of a Web-based conferencing platform. The idea resonated with providers, as indicated by the program's rapid growth to include 33 disease-site experts at 25 institutions and 745 members in all 50 states. On average, the site hosts one session per day (245

over 23 months) with 11 attendees indicating such approaches are clearly practical and feasible. Most sessions have focused on breast cancer, followed by head and neck, GI, and lung cancer as well as six other cancer types. Interestingly, 65% of participants have attended more than one session, and more important, 80% report making changes in their clinical practices as a result of Chartrounds.com, thereby suggesting that the program has the potential to improve the quality of radiation oncology nationwide.

Because earlier work by Malin et al³ suggested that patients receive recommended adjuvant chemotherapy between 78% and 86% of the time, the ASCO Quality Oncology Practice Initiative (QOPI) includes receipt of such treatment as quality measures. Patients may not always accept the recommended treatment for a variety of reasons, and, consequently, there is controversy as to which measure—recommended or actual receipt—is more appropriately used in settings where accountability is being measured. In their abstract, Jacobson et al⁴ compared the rates at which adjuvant chemotherapy for breast, colorectal, and lung cancer was recommended and received and assessed whether the data could be used not only for quality improvement, QOPI's stated goal, but also for accountability. They found the rates at which chemotherapy was recommended and received to be quite high for breast and colorectal cancer (98% v 94% and 98% v 93%, respectively) but less so for non-small-cell lung cancer (91% v 81%, respectively). However, because the data were being collected for quality improvement and did not include such information as patients' comorbidities, performance status, stage, preferences, or reasons for refusal, they found it difficult to determine whether this difference in the patients with lung cancer was clinically appropriate or not, thereby leading them to question the use of QOPI data alone for accountability.

Conclusion

Although these abstracts review programs in both radiation oncology and medical oncology, in doing so they highlight the multidisciplinary nature of the Quality Care Symposium, which included abstracts from almost every aspect of oncology. They also share common themes. One such similarity is their emphasis on real-world data and discourse with an aim for quality improvement. They are also similar in that they emphasize the need to reach consensus, to collect data for improvement, and to provide feedback to practitioners if we are to improve the quality of care in all disciplines of oncology. How-

ever, most important, they underscore the need for innovation as a means of improving quality. The partnership between Blue Cross Blue Shield of Massachusetts and the radiation oncology community, the Chartounds.com program's success at bringing together disease-site experts and community radiation oncologists virtually, and the QOPI program's ability to collect and feedback data for quality improvement in medical oncology are all highly innovative approaches to addressing shortcomings in our current systems. Going forward, we need to be open to evaluating and embracing such innovations and accelerate their implementation into our daily workflows once they have been validated. We can also learn from one another, as these abstracts contain lessons that can be applied across all disciplines of oncology. In the future, we will need to work more closely with payers and our colleagues to define value; to develop virtual communities for sharing knowledge; and to collect data from, and disseminate data to, clinicians for quality improvement. The abstracts in this session provide shining examples of the way forward.

References

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Acknowledgment

We thank the presenters, Harvey Mamon, Patricia Hardenbergh, and Joseph O. Jacobson, for their assistance in helping us to summarize their work.

Authors' Disclosures of Potential Conflicts of Interest

The author(s) indicated no potential conflicts of interest.

Author Contributions

Conception and design: All authors

Data analysis and interpretation: All authors

Manuscript writing: All authors

Final approval of manuscript: All authors

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DOI: 10.1200/JOP.2013.001012

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