

The Continuing Pursuit of Excellence:

Advancing Cancer Care through
Quality Improvement

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Introduction

Ensuring that cancer care delivery is of the highest possible quality is an endeavor that has been readily embraced by the cancer care community and it is easy to understand why. Every administrator, cancer care provider and patient understands that the provision of quality care goes hand and hand with better patient outcomes— and there is little that is more important than that when it comes to cancer care.

Yet, despite its irrefutable value and the cancer community's commitment to the ideal, variances remain in the delivery of quality cancer care in the United States. Though all cancer programs aim to deliver high quality care based on evidence of effectiveness, each is different in its level of success in this endeavor. The road to excellence in cancer care quality is a long one and cancer programs throughout the U.S. are making progress at their own speed, some further along than others. With a growing awareness of these differences and plenty of literature available to make any shortcomings clear, the cancer community has sharpened its focus on quality improvement. In fact, the topic of quality improvement has gained such momentum in recent years that one could easily say that the time for merely discussing quality has passed. The quality tide is rising and those who are not prepared will find themselves struggling to keep their heads above water.

The Nature of Quality in Cancer Care

To be sure, quality is a big topic in healthcare circles. The same is true of those in cancer care and it is easy to see the merit of quality in the delivery of cancer care. Defining what it really means; however, is a little trickier.

According to the Institute of Medicine, quality is defined as, “the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.”¹ This definition encapsulates the core notion of what is meant by quality; however, a mere one sentence summation cannot truly capture the

many subtleties of such an expansive concept. Quality is influenced by a number of other elements, all of which have a profound impact on the delivery of healthcare. In fact, quality is so intertwined with these other elements, like cost and access, that it can be hard to disentangle them from one another. Nonetheless, an effort to evaluate quality as its own entity— separate from the many factors that influence it— must be made.²

Despite the value of using compliance with evidence-based clinical guidelines as a framework for defining quality, it is important to remember that this definition is narrow by design. It intentionally excludes many important facets of quality for the sake of simplicity. It is also important to note that in order for this measure of quality to truly reflect quality in a cancer program, the guidelines selected must be carefully thought out to serve as a critical sampling of each of the essential clinical services provided to the cancer patient. If the measures are too narrow and look only at only one facet of a cancer program they will capture only a “slice” rather than the program in its entirety.

Pinning down an exact definition of quality can also be tricky because it can be assessed using three different measures: structure, process or outcome. As it relates to a cancer program, structure refers to required physical resources, organizational components and professional elements that are conducive to meeting the care needs of the cancer patient. An example of a structural element of quality is an electronic medical record. Process, on the other hand, describes a series of activities undertaken in the care of the patient. An example of a process element of quality is whether or not patients with stage II colon cancer receive chemotherapy. Finally, outcomes provide a method of assessing quality using some defined parameters of the end results of treatment. Examples of outcome measures include five-year mortality and quality of life.

Each of these quality measures can be useful in evaluating the overall quality of a cancer program and can help to better conceptualize what is meant by “quality” in the healthcare community. That said, this publication will refer to quality as it relates to process measures as they are arguably the most important of these three building blocks.

Why? Not only do process measures serve as a reflection of the structure in place to facilitate them but they have also been, in many cases, linked by scientific evidence to better outcomes. As a result, the authors have chosen, for the sake of simplicity, to use compliance with evidence-based clinical guidelines—a well-known indicator of process quality—as their definition of quality, unless otherwise specified.

Cancer Care Quality: Are We Where We Need to Be?

For all its purported importance, the consistent delivery of high-quality cancer care is still something that remains elusive. Studies that evaluate cancer care quality reveal that, all too often, patients do not receive the optimal course of treatment for their condition. Researchers, also growing increasingly aware of quality inconsistencies, have in recent years published a spate of papers pointing to dozens of circumstances in which patients do not receive all of the recommended care for their cancer. In fact, a 2005 study by Harlan et al., which used data from the National Cancer Institute's Patterns of Care study to determine whether patients received care in accordance with nationally accepted guidelines, found that only 63 percent of cancer patients received recommended care.³

While it may be tempting to take the findings of this study at face value and simply declare that on average, only 63 percent of cancer patients receive treatment in accordance with guidelines, a more accurate understanding of quality requires looking at a variety of factors. The above study, for instance, looked at compliance with guidelines by insurance status and found in some cases, other factors play into the equation. The authors did find that insurance status had a significant impact on the percentage of patients treated according to guidelines but also found significant variations based on marital status and stage at diagnosis.

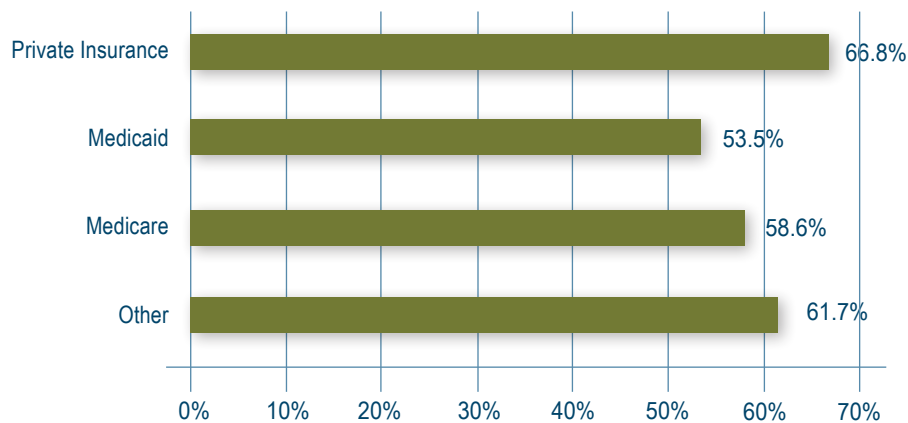
What are Clinical Guidelines?

According to the Institute of Medicine, the term clinical guideline is defined as “systematically developed statements to assist practitioner and patient decisions about appropriate healthcare for specific clinical circumstances.”⁴

Do they really matter?

Without a doubt, they matter! Study after study reveals that adherence to evidence-based clinical guidelines makes a difference in patient outcomes. Researchers conducting a rigorous review of whether (non-cancer) clinical guidelines improved quality of care found that in 55 of 59 published evaluations, explicit guidelines improved the process of care. Similarly, nine of 11 reports found that guidelines led to better outcomes.⁵

Percentage of Patients Receiving Guideline Care



Source: Linda C. Harlan, et al., "Insurance Status and the Use of Guideline Therapy in the Treatment of Selected Cancers," *Journal of Clinical Oncology* 26, no. 36 (2005) 9079-9088.

Note: Only Medicaid patients demonstrated a statistically significant difference in the percentage of guideline therapy received in comparison with privately insured patients.

Sadly, the quality inconsistencies documented by Harlan and her colleagues are far from isolated occurrences. In the last four years, research uncovering quality inconsistencies has accumulated and suggests that treatment quality is influenced by a multitude of factors including type of cancer, region of care delivery,⁷ treatment setting,⁸ insurance status, hospital surgical volume,¹⁰ marital status and stage at diagnosis,¹¹ to name a few. These findings are important not just for what they explicitly tell us but also because they suggest that there is so much to be gained from quality improvement.

Current Research Substantiates Claims of Quality Shortcomings in Cancer Care

- Medicaid patients being treated for cancer receive care in accordance with clinical guidelines only around 53.5 percent of the time.¹²
- Medicare patients being treated for cancer receive care in accordance with clinical guidelines only around 58.6 percent of the time.¹³
- Compliance with prostate cancer documentation standards is as low as 37.1 percent for some measures.¹⁴
- Adherence to 18 of 36 breast cancer quality measures is less than 85 percent.¹⁵
- Adherence to 14 of 25 colorectal cancer quality measures is less than 85 percent.¹⁶
- Breast cancer patients receive 75.7 percent of recommended care.¹⁷
- Colorectal cancer patients receive 53.9 percent of recommended care.¹⁸

Obstacles to Achieving Top-Quality Cancer Care

With the value of high-quality cancer care self evident, some may wonder why many cancer programs still demonstrate less-than-top-quality performance. Not surprisingly, in many cases, it is because the consistent delivery of cancer care of the highest caliber is easier said than done.

The nature of the disease itself lends difficulty to the task of quality care. Cancer is not one disease that can be treated at a single point in time. Rather, the disease known as cancer represents over one-hundred separate illnesses, all with their own treatment protocols, many of which take place over an extended time period in multiple settings by potentially dozens of different healthcare providers. The provision of quality cancer care requires consistent coordination of recommended care in all of these settings by all these practitioners over a long period of time.

The nature of cancer also makes quality care delivery a challenge because few cancers have absolute treatment pathways. In other words, treatment is not as straightforward as simply following a formula. For many cancer patients there is more than one valid treatment option that a clinician could follow that would be classified as quality oncology care. For instance, an effective therapy from the perspective of a urologist may be surgery whereas a radiation oncologist treating a patient with the same condition might recommend radiation. Both practitioners may be following evidence-based guidelines but the course of care is clearly different.

Another wrinkle contributing to the complex nature of cancer care is that clinical guidelines are, after all, only guidelines. While it is true that clinical guidelines are extremely valuable for the scientific validity they bring to the treatment process, they do not simply replace the knowledge and expertise of cancer care practitioners. Clinicians must carefully consider the unique circumstances of each case, including factors like patient preferences, patient compliance and patient history, and then determine the course of treatment that best suits the situation. The clinical expertise required to make those types of treatment decisions— as well as the ability of a practice’s data collection tool to account for these exceptions— must also be factored into the overall quality equation.

Quality Today is not the Same as Quality Tomorrow

Is Your Practice Ready for the Upcoming Quality Changes?

- The CoC is in the process of updating its 36 accrediting standards. In the past, changes to one or two standards were typical. Work currently underway is intended to thoroughly evaluate and make updates for each one. These changes will take effect in 2011.
- The NCCN treatment guidelines are updated yearly based on new scientific evidence of treatment effectiveness.
- ASCO's Quality Oncology Practice Initiative (QOPI) updates quality standards for each cycle of data collection, which occurs each spring and fall. Since its inception in 2002 to the spring of 2009, the number of measures has increased from 37 to 81.¹⁹
- CMS currently has more than 375 quality measures in place and is considering a number of others for future use. A recent report by CMS specifically lists nine new cancer quality measures in the "future" category. Twenty-five measures specific to cancer are listed as "current."²⁰

Complicating matters even further is that quality itself is not a static attribute. Rather, quality in cancer care is constantly changing as new information is gained through research, innovation and consensus building. The guidelines and standards that are the hallmarks of quality — such as those supported and developed by organizations like the National Comprehensive Cancer Network (NCCN), the Commission on Cancer (CoC), American Society of Clinical Oncology (ASCO), and the Centers for Medicare and Medicaid Services (CMS) — are regularly updated with new standards and guidelines. Oncology programs that serve as models of cancer care quality today can quickly fall behind if they do not stay abreast of these changes.

Finally, in order for a cancer program to demonstrate that it delivers care in accordance with guidelines, it must painstakingly and accurately document its compliance throughout the process. The complexity of cancer treatment creates countless opportunities for documentation lapses. In order to reflect that quality care has been provided, it must be accurately and consistently recorded by the many different healthcare providers in all of the treatment settings along the entire cancer treatment journey. Unfortunately, with so many players and so many settings and so much time, it only takes one documentation error or omission to make it appear as though a patient did not receive quality care when, in fact, they did. This challenge almost certainly accounts for at least some of the "quality" lapses revealed in the studies mentioned above.

Quality and Patient Outcomes

Clearly, the pursuit of quality improvement in cancer care is no easy task; however, its associated challenges should not preclude its undertaking. The task to improve the quality of cancer care is a must for its own sake; however, before a cancer program embarks on an ambitious plan of quality improvement, it is reasonable for its leaders to wonder, “Will our efforts even matter?” After all, if the level of quality doesn’t make a significant difference in outcomes, there is little point in exerting a lot of effort in quality initiatives. But the reality is, level of quality does make a difference.

Aware that low-volume hospitals typically have poorer outcomes than high-volume hospitals, researchers in one study looked at 60-day perioperative mortality and five-year survival for cancer surgery to calculate the number of potentially avoidable deaths if low-volume hospitals would have provided care at a quality level commensurate with their large-volume counterparts. The results were eye-opening. Patients at low-volume centers did face a significantly higher risk of death for both perioperative mortality and in the long term for every type of cancer surgery except for in the case of long-term survival after liver resection.

Potentially Avoidable Deaths

Cancer Type	Perioperative	Long Term
Colon	701	2,700
Esophagus	127	522
Liver	245	NS
Lung	596	1,444
Pancreas	225	491
Rectal	134	1,595
Stomach	179	493
TOTAL	2,207	7,245

Source: Karl Y. Bilimoria, et al., “Directing Surgical Quality Improvement Initiatives: Comparison of Perioperative Mortality and Long-Term Survival for Cancer Surgery,” *Journal of Clinical Oncology*.

This study is important not only for what it explicitly tells us but also for what it implies. Explicitly, this study reveals that if low-volume hospitals throughout the U.S. improved their outcomes to the same level as high-volume hospitals, 2,207 perioperative deaths and 7,245 long-term deaths could be avoided each year.²¹ It also implies that the time is right to undertake this sort of initiative. Clearly, knowledge of care processes that result in better outcomes exists. Quality initiatives that lead to the consistent use of this knowledge could result in reducing mortality after cancer surgery by nearly 9,500 patients each year.

While the above study provides a compelling reason to pursue quality initiatives, another group of researchers led by Joseph A. Jacobson conducted a study to determine the answer to an even more basic quality question: Do quality improvement initiatives actually lead to better adherence to guidelines? To find the answer, the team reviewed data submitted by the 71 oncology practices participating in both Quality Oncology Practice Initiative (QOPI) data collection cycles in 2006. They were specifically trying to determine if compliance with quality measures improved once practices had been given feedback about their performance in the first round. The findings revealed that this type of feedback did create a statistically significant improvement in clinicians' quality of care delivery, and particularly so for practices that had initially performed the worst.²² The importance of these findings is clear. Quality improvement initiatives do have the potential to measurably improve quality.

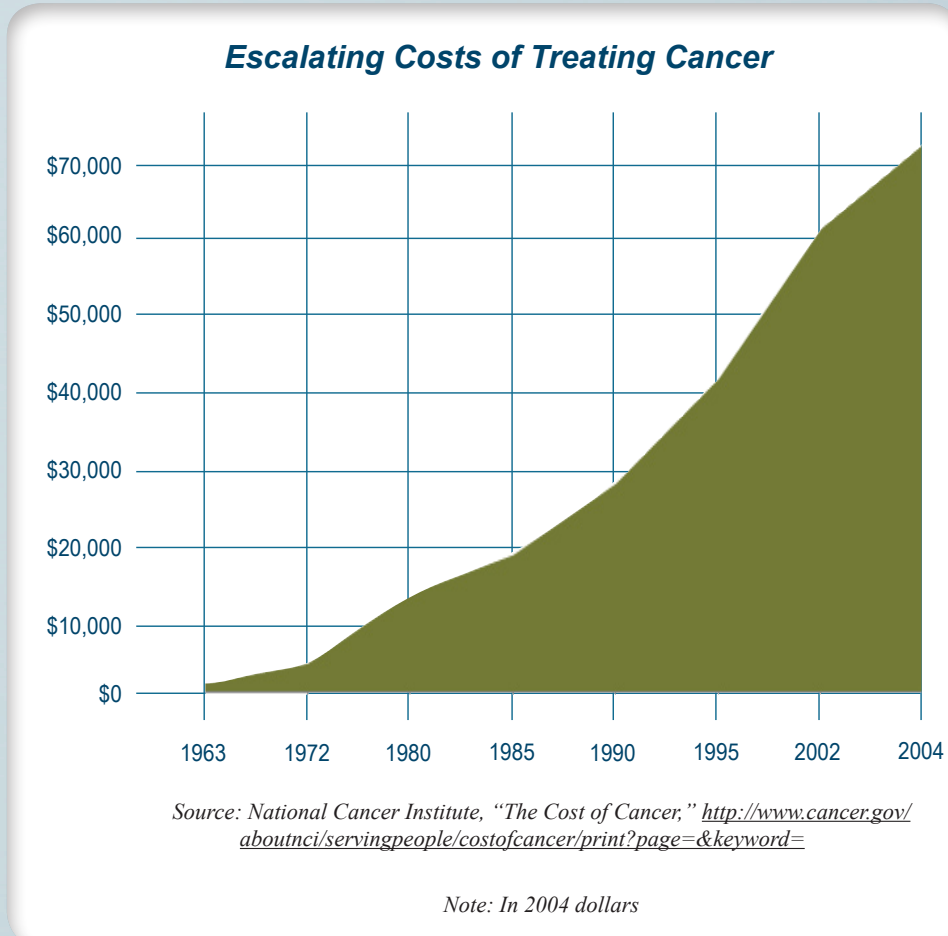
The Business Case for Quality

There is little disagreement about the value of improved patient outcomes that result from high quality cancer care. As physicians, administrators, and cancer care professionals (and simply as people who care about the welfare of other people), there could be little else as important as that. Nonetheless, it is also important to consider quality initiatives with an eye on the bottom line. After all, no cancer program can improve patient outcomes if the costs of running it eventually put it out of business. Quality initiatives that improve adherence to guidelines and make treatment more consistent provide cancer programs with a number of tools that enhance business efficiency and improve cost management.

The Quality Advantage

To be sure, the business of running a successful cancer program is a challenge. Cancer can be extremely expensive to treat. The costs associated with treating cancer accounts for 5 percent of medical treatment costs in the United States today and they are growing at a faster rate than medical treatment in general.²³ Not only are these costs mounting, they are also inconsistent.

One study that evaluated costs associated with treating colorectal cancer, for instance, found per-week cost differences of more than 91 times.²⁴ For a cancer program administrator, these inconsistent and growing costs can be very difficult to manage.



Quality initiatives that successfully promote adherence to clinical guidelines can be a powerful weapon in a cancer program administrator's business tactic arsenal. For one, treating according to standards means that the costs associated with it become more predictable and easier to plan for. Knowing what types of costs are likely to be around the bend means cancer program administrators can do their best to account for rising costs. At the same time, consistent, predictable costs give administrators leverage when they sit down at the negotiating table with payers. Why? Armed with that knowledge of cost consistency, administrators can more accurately forecast the costs they will incur in the future and more convincingly negotiate the terms of reimbursement.

In addition to cost predictability, adhering to standards provides cancer program administrators an unparalleled marketing tool. From a patient standpoint, the marketing value of a documented, high-quality cancer program is obvious: patients will seek the highest quality treatment that is available within their means. But even beyond that, quality care can be used to market a cancer program to payers. It simply makes economic sense that payers would provide more favorable reimbursements to programs that demonstrate high quality cancer care.

Pay for Performance

Also important to consider from a business standpoint is the growing pay-for-performance (P4P) movement and its potential impact on the bottom line. More and more, payers, both public and private, are beginning to tie payment levels to certain predetermined quality measures. Until recently, however, cancer care has been largely immune from the pressures of pay for performance. With its more than 100 separate illnesses, multiple treatment settings, complexity of treatment and lack of consensus on which guidelines to measure, cancer treatment was simply considered too complicated to include in pay-for-performance initiatives.²⁵

Pay for performance is often touted as a tool for realizing cost savings and oftentimes, it is; however, it is important to remember that the primary goal of pay-for-performance initiatives is to provide incentives that encourage quality care.

To be sure, forging pay-for-performance initiatives that account for the complexity of cancer care is a challenge; however, it is one that payers are beginning to undertake. In fact, the number of pay-for-performance initiatives being unveiled by both public and private payers is multiplying every year and some now include components that apply to the delivery of cancer care — a fact that should make hospital administrators, cancer program administrators and anyone with an eye on the bottom line— sit up and take notice.

With nearly two-thirds of those with cancer age 65 or older,²⁶ it is no surprise that CMS, the agency that administers Medicare, has led the charge in the development of P4P initiatives related to cancer care. In 2007, a voluntary quality reporting program for physicians called the Physician Quality Reporting Initiative (PQRI) was rolled out by CMS. Physicians who participate in this initiative submit quality data to CMS on at least three designated quality measures in exchange for a bonus payment. The program itself is young but the growing number of quality measures included in PQRI each year is a testament to CMS' commitment to the P4P movement. In 2007, the number of measures included in PQRI totaled 74 for all health conditions. One year later, the number of measures had grown to 119 and by 2009 the number had increased to 153.²⁷ In 2009, 21 PQRI measures related to cancer care.²⁸

In addition to PQRI, which addresses the quality of care provided by physicians, CMS has also begun to require hospitals to report information on their outpatient services to obtain their full payment update. In 2009 seven measures were collected by CMS for the outpatient P4P program. Though none of those measures related to cancer care, CMS is beginning to consider a number of cancer-related outpatient measures for the future.³⁰ While the number of measures collected for outpatient hospital services is much smaller than PQRI, the influence of the program is indisputable. Unlike PQRI, the structure of the outpatient reporting program is not a bonus payment for participation. Instead, if a hospital fails to report the required measures it no longer qualifies for its annual 2 percent payment update³¹ — a loss that could represent a significant financial blow to an organization.

Legislators Step into the Oncology P4P Ring

Policymakers are also beginning to show an interest in propelling the cancer quality movement forward. In June, 2009 U.S. Representative Joseph Crowley of New York introduced the Oncology Care Quality Improvement (OCQI) program, H.R. 2939, a bill that would establish a voluntary pilot program meant to spur cancer care quality improvement and cost savings. The program would adopt a provider-led approach to improve quality care and outcomes for Medicare beneficiaries while also encouraging the use of practices that foster greater efficiencies and cost savings.

The bill includes language that would encourage the use of evidence-based guideline adherence, promote patient education and care coordination including end-of-life planning and counseling. Participating groups would receive incentive payments based upon meeting performance goals as well as per capita expenditure targets.²⁹

Like CMS, private payers have taken an interest in shaping reimbursement policies that encourage the delivery of cost-effective, quality care. With more than 200 payment reform initiatives currently underway, private payers are clearly embracing the use of pay-for-performance tactics to influence quality performance.³² Though pay-for-performance measures have generally not included oncology metrics, there is growing awareness within the industry that this is not a trend that will continue. Dawn Holcombe, Executive Director of the Connecticut Oncology Association, was recently interviewed for an article in *Oncology Times* and put it this way: “I hear payers saying, ‘We’re doing our own analytics using comparative-based statistics to decide what we think is cost-effective and what we think the doctors should do and we’re going to tell them what they are allowed to do for that Stage 3 metastatic patient or at least what we’re willing to pay for.’”³³

Blue Cross Blue Shield of Michigan (BCBSM) recently took a momentous step forward in the pay-for-performance movement by establishing an initiative specifically for oncology that provides incentive payments for physicians participating in the Quality Oncology Practice Initiative (QOPI). The QOPI is voluntary program of the American Society of Clinical Oncologists in which oncologists submit data regarding their adherence to process measures two times each year. There are currently 81 measures that are reported and results are benchmarked against other practices participating in QOPI and returned to participating practices so that any necessary quality adjustments can be made.³⁴ The move by BCBSM to provide incentive payments to providers for QOPI participation is important because it represents one of the first private payer initiatives specifically aimed at improving the quality of cancer care.³⁵ It is also important because it demonstrates that payers are becoming more willing to take on the challenges associated with initiatives related to cancer care.

Healthcare Quality Innovators: Implications for Cancer Care

As mentioned above, despite the significant progress that has been made, the complexity of cancer care delivery makes it a difficult target for quality initiatives. As a result, innovative quality initiatives that address quality care for other illnesses today may well evolve into the cancer care initiatives of tomorrow. Leaders in the cancer field are aware that in order to meet the quality demands of the future, they must begin to prepare their programs today. Innovative quality programs already in existence today can serve as a roadmap for these forward-thinking leaders.

Geisinger ProvenCare

Geisinger Health System in Pennsylvania initially developed a highly successful quality initiative known as ProvenCare to improve coronary artery bypass graft (CABG) surgery. This initiative aimed to improve quality by implementing 40 distinct steps based on professional society guidelines across an entire episode of care. These steps were then embedded into both the daily workflow and electronic health records, which would automatically alert providers if a step was incomplete. The electronic health records also allowed for easier communication among the care delivery team.

In addition to the improved care process pioneered by the Geisinger ProvenCare team, this initiative also adopted a novel payment strategy to encourage even greater attention to quality.³⁶ With a health insurance plan of its own and 600 doctors employed directly by the healthcare system, Geisinger decided to experiment with a novel new payment strategy.³⁷ Specifically, instead of charging patients for each individual service rendered, as is customary elsewhere in the healthcare system, ProvenCare charges one bundled price for an entire episode, including preoperative evaluation and work-up, all hospital and professional fees, all routine post-discharge care, and management of any related complications occurring within 90 days of elective CABG surgery. Many perceived this payment structure as a “warranty” on the care provided since no additional payment would be expected should complications occur. While this model is not considered a traditional pay-for-performance model, there is certainly financial incentive to provide high-quality care.

The model has been very successful. After implementation, compliance with the 40 clinical best-practice steps improved from 59 percent to 100 percent.³⁸ The bundled payment structure and improved care processes have also saved money for payers and more than paid for the costs of implementation. As a result, Geisinger has expanded the initiative to include hip replacement, cataract surgery, and percutaneous coronary intervention and plans to eventually include bariatric surgery, lower back surgery, perinatal care, angioplasty and **cancer care**.³⁹

Pennsylvania Health Care Cost Containment Council

While Geisinger ProvenCare has improved quality using its own carefully crafted strategy, the Pennsylvania State Legislature also met with success by pursuing a very different approach. Created by statute in 1986, the Pennsylvania Health Care Cost Containment Council (PHC4) was the state legislature's answer to the growing demand for increased healthcare quality and restrained costs. This independent state agency was charged with the collection, analysis and public dissemination of quality and cost data with the understanding that doing so would boost transparency and spur competition in the Pennsylvania healthcare market.⁴⁰

As of January 2010, Ohio can boast that it too has entered a more transparent age, similar to its eastern neighbor. In accordance with House Bill 197, passed in 2006, the Ohio Department of Health launched an interactive Web site known as Hospital Compare that allows the public to access hospital performance data for several types of medical care. The comparisons display hospitals on best-to-worst quality lists, along with the state average, for each selected measure.

Currently, there are 13 quality indicators measured including heart attack care, pneumonia, patient safety, and infection measures.⁴¹

Today PHC4 collects a wealth of information from the healthcare industry ranging from detailed financial information by sector to outcome information relating to cardiac care, diabetes, hip and knee replacements and hospital acquired infections. But what may be even more pertinent in terms of quality improvement is the fact that the information it collects is highly specific and includes the number of cases treated, readmissions, readmissions due to complications, mortality, length of stay and average charge by both hospital and physician. This information is posted publically on the PHC4 Web site each year.

The unprecedented level of transparency created by sharing very specific information— including outcome information— with the public has led to impressive improvements for patients. There has been an overall decline in mortality rate for all conditions evaluated by the program. Mortality rates for CABG, for example, have shown significant improvement, dropping by 45.8 percent since 1994. In 2005, PHC4 began collecting data on valve surgeries (those with and without CABG) and in just two years, in-hospital mortality associated with this surgery dropped by 23.9 percent. Other indicators have also shown improvement since the start of PHC4, including a decrease in the rate of readmissions.⁴²

Innovation in Cancer Care Quality

Certainly it is important for those in the cancer care field to be aware of what is happening in the larger healthcare arena but not all innovation is taking place outside the cancer environment. The American College of Surgeons Commission on Cancer, for instance, has been paving the way for decades and continues to innovate with initiatives that are sure to impact the quality of cancer care well into the future.

The Commission on Cancer

Founded in 1922 and comprised of a collection of professional organizations, the CoC has been paving the way in cancer care quality for decades. The CoC aims to improve outcomes for people with cancer, including survival and quality of life, through a number of strategies including standard setting and monitoring comprehensive quality care.⁴³ While the CoC's commitment to quality is evident in its mission, its accreditation program and reporting initiatives truly distinguish the CoC as a quality innovator.

For a cancer program, achieving CoC accreditation is widely recognized as a symbol of its high quality. That CoC accreditation has become all but synonymous with high quality care is no accident. To achieve CoC accreditation, a cancer program is carefully scrutinized for its performance on 36 standards by on-site surveyors every three years. The 36 accrediting standards and the rigorous survey process are specifically tailored to ensure that programs receiving accreditation have the structure and process in place to provide high quality cancer care.⁴⁴

For cancer programs that are ready to make a serious commitment to quality improvement, pursuing and achieving CoC accreditation can help to build a strong foundation. The accreditation process is comprehensive and accounts for the entire range of services provided by a cancer program, from diagnostics and treatment to rehabilitation and support.

The 36 standards set out an almost step-by-step set of instructions on how to build a quality cancer program. Attaining CoC accreditation means that a cancer program has adopted a set of strategies, based on the 36 standards, that are hallmarks of quality including:

- Setting annual goals and objectives related to cancer care,
- Measuring patient outcomes and ensuring that they are reviewed by medical staff and administrators,
- Monitoring physicians to ensure proper staging and compliance with evidence-based, nationally accepted treatment guidelines,
- Engaging in regular review of the quality of patient care,
- Conducting annual studies that measure quality and outcomes and
- Implementing at least two improvements that directly affect patient care each year.⁴⁵

Today, more than 1,400 cancer programs across the United States have earned CoC accreditation. Not only does this accreditation give cancer programs leverage in the marketplace, it also gives them access to two powerful quality tools: the Cancer Program Practice Profile Report (CP3R) and the Rapid Quality Reporting System (RQRS). The CP3R is a reporting tool that evaluates a cancer program's adherence to seven National Quality Forum (NQF) measures for breast and colorectal cancer. This report provides feedback on a program's performance and also allows for benchmarking against state and national statistics, as well as by type of cancer program (e.g. community hospital, teaching and research, or comprehensive cancer center).⁴⁶ The value of this type of benchmarking is that it allows programs to evaluate their performance relative to their peers and make quality adjustments as necessary.

The latest reporting tool developed by the CoC, the RQRS, which is still in beta testing, goes even further in facilitating cancer programs' efforts to achieve top quality breast and colorectal cancer care. Other data reporting tools, including CP3R rely on historical data that is 18 to 24 months old. This type of reporting allows for broad quality improvements that impact the delivery of care within a program in the long term but do not address quality concerns as they occur. The RQRS, on the other hand, allows cancer programs to collect data on patients concurrently, notify hospitals of treatment expectations for each patient and show a hospital its year-to-date concordance rate relative to other similar hospitals at the local, state and national level.

The RQRS is an invaluable new tool in the quality movement for a number of reasons. First, the daily updating of information allows for real-time benchmarking, which means cancer programs no longer have to wait an entire year before they can begin to evaluate their performance against their peers. Next, its Web-based design means that the RQRS is an integral, structural piece of a cancer program's work flow rather than just an extraneous reporting tool. Perhaps most significantly, the RQRS actively promotes evidence-based care delivery by alerting care providers of care expectations that align with clinical guidelines in real time. If, for instance, a patient requires chemotherapy within 90 days of diagnosis, RQRS will alert care providers that this guideline has not yet been fulfilled — as well as how much time is left before the requirement must be met— when they check the RQRS Web site (e.g. Mrs. Smith requires chemotherapy within 47 days).

This local-level focus on the delivery of care was specifically designed to improve the level of compliance with clinical guidelines on a facility-by-facility basis, thereby improving the overall level of cancer care quality in CoC accredited programs. To be sure, this thoughtfully designed quality reporting initiative represents a technology innovation in cancer care that is sure to serve as a roadmap for future quality initiatives. The CoC is currently conducting a second round of beta tests with the intention of rolling out RQRS on a voluntary basis to accredited members once testing is complete.⁴⁷

Conclusion

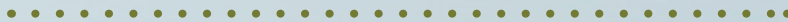
The delivery of quality cancer care today is caught in the middle of a contradiction. On one hand, everyone agrees that quality cancer care leads to better outcomes and that for the sake of patients, cancer programs should have no greater goal than to maximize the quality of their care. But on the other hand, there is ample evidence to suggest that far too many cancer programs do not provide care of the highest possible quality. Until recently, the sheer complexity of cancer care, which encompasses the treatment of more than 100 different illnesses in multiple settings with multiple care providers over a long period of time, has made quality improvement initiatives a challenge to implement. As a result, the quality of some cancer programs has stagnated.

Given the growing quality movement, how can cancer program administrators be sure that their program is poised not only to survive but to excel? Though there is no one path to success, there are a number of actions cancer program administrators can take to contribute to the development of a successful quality improvement program. Many of these actions are laid out in the “roadmaps” provided by the quality innovators detailed above.

- Find ways to embed quality into the workflow (such as Geisinger ProvenCare’s 40 distinct care steps based on clinical guidelines across an episode of care in conjunction with the electronic health record).
- Incentivize delivery of quality care (such as Geisinger ProvenCare which only charges one price for an entire episode of care regardless of complications and readmissions).
- Embrace transparency. It gives providers and practitioners good cause to be vigilant in the quality of their care delivery (such as PHC4, which publishes quality scores for hospitals and surgeons on its Web site).
- Provide a means for evaluating quality by benchmarking (such as programs that utilize the CP3R and the RQRS from the CoC). Benchmarking provides a means of comparison, which allows a cancer program to know where it stands, where it needs to focus its attention and whether existing quality initiatives are making a difference.

As quality improvement initiatives throughout the healthcare system have taken root and stakeholders have seen the positive results of these endeavors, a sea change in cancer care has occurred. High quality care that delivers treatment in accordance with clinical guidelines is no longer seen as merely a market differentiator — it is seen as a necessary component of a program's survival.

Patients today are more educated and have more resources at their disposal when selecting where they will be treated for their cancer. With health insurance costs rising and patients shouldering ever more of the cost of care, patients want to know that the money they spend on treatment is money well-spent. At the same time, payers have become active participants in the quality movement for the same reason as patients: they want to make sure the money they spend on treatment for their beneficiaries is money well-spent. As this trend continues, cancer programs that do not respond to the call for quality will simply be unable to draw the patient volume necessary to stay viable. As important as these considerations are, the heart of the reason for cancer care quality remains the patient. Cancer programs that deliver quality care are invaluable because they maximize patient outcomes and improve the lives of the patients they serve.



About the Authors

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Dr. Valeriy Moysaenko, a graduate of the Ohio State University Medical School, is a Board Certified General Surgeon who had been in a solo general surgical practice for over 20 years. He served as the Medical Director of the Cancer Program at Upper Valley Medical Center in Troy, Ohio and as a member of the Board of Trustees, Hospice of Miami County. Dr. Moysaenko serves on the Board of the American Cancer Society, Ohio Division.

Dr. Moysaenko believes that carefully developed cancer control strategies are extremely important in the fight against cancer. Toward that end, Dr. Moysaenko is the Co-chair of the American College of Surgeons, Ohio Chapter Cancer Committee, working to coordinate control efforts among the American College of Surgeons Physician Liaisons in Ohio. Dr. Moysaenko also sits on the Executive Committee of the Ohio Partners for Cancer Control. This organization has formulated and is currently implementing a statewide cancer control plan for Ohio.

A champion for progress in the cancer care quality movement, Dr. Moysaenko is also a surveyor for the American College of Surgeons' Commission on Cancer, which sets the standards for quality cancer care delivered primarily through hospital settings. Dr. Moysaenko surveys hospitals to assess compliance with those standards and uses data to improve cancer care outcomes at the national and local level.

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Toni Hare is the Vice President of CHAMPS Oncology Data Services (ODS), a Cleveland-based national provider of cancer registry and cancer program services. With more than 25 years' experience in cancer data collection, management and consulting, she is one of 29 nationally recognized Commission on Cancer-trained Independent Consultants. She holds an associate of applied science degree in health information management and is a Registered Health Information Technician (RHIT), a Certified Tumor Registrar (CTR), and a certified instructor in cancer data collection.

A progressive enthusiast for quality cancer data, Ms. Hare never stops promoting the importance of accuracy and education within the profession. To that extent, she developed and implemented a training program on cancer data collection and reporting for the Ohio Department of Health's Ohio Cancer Incidence Surveillance System. She also developed and implemented the Cancer Data Management Course through the Health Information Management Program, and has been an instructor at Cuyahoga Community College for over 20 years.

A well-respected expert in the field, Ms. Hare regularly presents at local, regional and national conferences including at the Cleveland Cancer Registrars Association Annual Meeting, the Ohio Cancer Registrars Association Annual Meeting, the Association of Community Cancer Center's National Oncology Economics Conference, and the National Cancer Registrars Association Annual Meeting. In 2008, Ms. Hare published an editorial in *Executive Health Management* entitled, "Quality Cancer Data is Key to National Quality and Hospital Planning Initiatives."

Ms. Hare served as a member and Chair of the Education Committee for the Ohio Cancer Registrar Association (OCRA) and served on a special task force to promote the cancer registry profession. Ms. Hare is currently an active member of the American Health Information Management Association, the National Cancer Registrars Association, the Cleveland Cancer Registrars Association, and OCRA.

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Web Link Resource Guide

- Commission on Cancer. Provides access to current Cancer Program Standards: <http://www.facs.org/cancer/coc/programstandards.html>
- Geisinger Health System ProvenCare: <http://www.geisinger.org/provencare/index.html>
- Pennsylvania Health Care Cost Containment Council. Provides access to all reports including most recent performance reports. <http://www.phc4.org/>

- The Joint Commission Quality Check. This link directs you to the public database of Joint Commission accreditation status as well as “accreditation quality reports” available by individual facility, zip code or state. These reports include comparative performance on a variety of medical procedures. <http://www.qualitycheck.org/consumer/searchOCR.aspx>
- Quality Oncology Practice Initiative. This is the home page for ASCO’s QOPI initiative including a link to a page where practices can register to participate. http://qopi.asco.org/Health_Plan_Program
- Physician Quality Reporting Initiative. This is the Center for Medicare and Medicaid Services’ Web page detailing the most up-to-date quality measures required under the PQRI program. http://www.cms.hhs.gov/PORI/15_MeasuresCodes.asp
- National Comprehensive Cancer Network. This is a link to the NCCN site where cancer programs or providers can obtain free access to all NCCN guidelines at no cost. Registration is required. http://www.nccn.org/professionals/physician_gls/f_guidelines.asp
- Oncology Care Quality Improvement Program. This is a link to the Library of Congress Web site, which allows users to search for all bills by key word or bill number. To see the status and bill text of the OCQI legislation, select search by bill number and enter “H.R. 2939” in the search box. <http://thomas.loc.gov/>
- Ohio Hospital Compare. This is a link to the Ohio Department of Health’s new hospital comparison tool for the state of Ohio. <http://publicapps.odh.ohio.gov/facilityinformation/>
- The Leapfrog Group. The Leapfrog Group is an organization that has developed a number of initiatives intended to “alert America’s health industry that big leaps in health care safety, quality and customer value will be recognized and rewarded.” This is a link to the Leapfrog Group’s Compendium of pay-for-performance initiatives. <http://www.leapfroggroup.org/compendium2>

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