



Organizations Collaborate to Improve the Quality of Cancer Care

The organizations comprising the recently developed Cancer Quality Alliance are assuming “joint custody” of the task of improving the quality of care for patients with cancer. Established through a partnership between ASCO and the National Coalition for Cancer Survivorship (NCCS), the Alliance is designed to foster collaboration among a wide variety of organizations with a shared goal of addressing the challenges of defining, measuring, and implementing high-quality care in oncology.

“Everybody has a big investment in quality, and joint custody implies shared responsibility, which is what is needed to make this initiative successful,” says Ellen Stovall, president of the NCCS and co-chair of the Alliance. The Alliance includes representatives from government agencies, oncology-related organizations, other health care–related associations, and third-party payers. Through its diverse constituencies, the Alliance enables participants to learn about innovative ways of approaching quality in a variety of settings and to discuss ways to adapt approaches to oncology. “The Alliance is a forum where some of the best evidence of what can be done to ensure high-quality care for patients with cancer can be discussed and promoted among diverse stakeholders,” says Stovall.

ASCO and the NCCS invited a host of organizations to the first meeting of the Alliance, held in January 2005. “We cast a wide net,” says Patricia Ganz, MD, of the University of California, Los Angeles, Schools of Medicine and Public Health and co-chair of the Alliance. The result was a broad representation of nearly 25 organizations at the inaugural and subsequent meetings. These first meetings have been introductory, as the participants work together to establish a mission, process, and goals.

The meetings have also provided a valuable opportunity to learn from guest speakers. “Everyone in the Alliance is encouraged to invite speakers who can share what they are doing in the quality-improvement arena,” says Ganz. “We’ve had some tremendously valuable presentations.”

Both Ganz and Stovall point out that the purpose of the Alliance is not to develop guidelines or quality measures. Rather, Stovall explains, “The Alliance is a practical, hands-on approach. We want to look at what measures are ready to put into practice and we want to understand how practicing oncologists apply guidelines.”

The formation of the Alliance is the result of several incremental steps. In the fall of 2004, then-ASCO President David H. Johnson, MD, established the ASCO Quality Advisory Group, which was charged with providing oversight and coordination of the Society’s quality initiatives and translating outcomes into policies and actions. This group, which included Ganz and Stovall, also worked with the Centers for Medicare & Medicaid Services (CMS) on the 2006 Oncology Demonstration Project. “The Alliance grew out of conversations with CMS about a more systematic way for process measures to be incorporated into the Project,” says Stovall.

Instrumental in these conversations was Peter B. Bach, MD, MAPP, who joined CMS in February 2005 as a senior adviser on Health Care Quality and Cancer Policy. Bach helped to shape the current Oncology Demonstration Project, and, according to Ganz and Stovall, he has displayed a deep commitment to advancing the quality of cancer care. Bach has represented CMS at all of the Alliance meetings to date. (As a government agency, CMS cannot become an official member of the Alliance.)

Commenting on his experience with the Alliance, Bach says, “The room is full of people who fundamentally agree both on the problems with where we are in cancer care and the promise of where we could be. The representatives bring to the table all sorts of potential mechanisms for affecting care . . . What I’ve observed is that important cross fertilization occurs during the meetings, and small, intermediate, and large collaborations and pilot projects are emerging from it. I believe that this sort of on-the-ground,

“The benefit of the Alliance is networking with interested parties about quality issues and working together to identify solutions.”

—James A. Hayman, MD, American Society for Therapeutic and Radiation Oncology

practical experimentation is an effective way of driving change.”

The participants are unanimous in noting that the best feature of the Alliance is that it brings all interested parties into the same room to share ideas and build partnerships and collaborations. “At NCCN [the National Comprehensive Cancer Network], we’ve been addressing quality of care for a long time through our guidelines and outcomes programs,” says Joan S. McClure, who represents NCCN. “But now, we are collaborating more closely with groups outside the NCCN member institutions. We’re harmonizing with other people’s efforts.”

Other organizations, such as the National Committee for Quality Assurance (NCQA) and the Agency for Healthcare Research and Quality (AHRQ), have focused on the quality of health care, but none has addressed oncology specifically. As a result, methods of defining and measuring quality in cancer care are in the early stages. “There’s not a lot of infrastructure in oncology to measure quality,” says James A. Hayman, MD, who represents the American Society for Therapeutic and Radiation Oncology (ASTRO) in the Alliance. “We need feedback from practitioners, payers, and patients before we can develop solutions to improve the quality of care.”

The many dimensions of quality in cancer care create a continuing challenge to measure it. Defining quality is a first step. “Quality is the extent to which best outcomes are achieved,” says Stephen B. Edge, MD, FACS, who is the American College of Surgeons representative to the Alliance. “It’s doing the right thing at the right time.” Although the “right thing” is defined primarily by adherence to guidelines and standards of care, other quality indicators are needed. Bach notes, “The challenge is to measure the things that matter the most to patients.”

The source of data used to measure quality is another challenge. “You can’t use claims data alone,” says Lee N. Newcomer, MD, MHA, who represents UnitedHealth Group in the Alliance. He explains that the stage of disease and subtype—two important factors in determining appropriate care—are not included on claims data. Tumor registries provide the best information about stage and type of disease but do not include enough complete information

about nonsurgical care. “Each has a piece of the picture, but neither is complete,” adds McClure. “We need an informatics system to link data so we can evaluate care more efficiently.” Until then, medical records must be included as a source of data.

Stovall notes that two ASCO initiatives have helped to provide an evidence base for measuring and evaluating quality, and these initiatives are serving as foundations for collaborations among Alliance members. One effort is the National Initiative on Cancer Care Quality (NICCCQ), the first ASCO program developed to measure the quality of cancer care. The NICCCQ provided an evaluation of 62 measures of high-quality care for patients with breast or colorectal cancer in five metropolitan areas. The NICCCQ included complex chart review and patient surveys in an attempt to determine patient-oriented indicators of quality.

“Members of the Alliance have a shared goal but disparate resources and varied constituencies. The Alliance can help to catalyze collaborations that might not otherwise be possible.”

—Stephen B. Edge, MD, FACS, American College of Surgeons

Also helping to provide a framework for measuring and improving quality is ASCO’s Quality Oncology Practice Initiative (QOPI), a practice-based system of quality self-assessment. Participants in QOPI abstract data regarding adherence to practice guidelines and consensus-supported indicators of quality care from medical records and can use these data to compare the quality of care they provide in their own practice over time or with that of other practices.

Implementing high-quality care remains the biggest challenge. “It’s easy to think about quality and to decide you need it. Implementing it is another story. In our huge health care system, it’s hard to do,” says Roger C. Herdman, MD, who is the liaison from the National Cancer Policy Forum (formerly the National Cancer Policy Board). Another issue is interpretation, explains Stovall. “Quality measures must be translated into best practices for community oncologists. We need to include process measures, not just outcome measures, and we need to evaluate how physicians look at quality and how they apply it.”

Bach agrees that how physicians apply evidence is an important factor. “The centerpiece of the 2006 Demonstration Project is to capture whether or not care is adherent to clinical practice guidelines. Knowing this about care is important, but equally important is understanding

why care is different from practice guidelines, and we are now capturing this important information as well. Then, we can follow the path we've followed with other quality measurement activities at CMS—to determine the best way to provide feedback to physicians about what they are doing in comparison to their peers. This sort of feedback should encourage quality improvement just through the sheer act of comparison. That's certainly what has been seen in ASCO's QOPI.”

Currently, more than 100 practices are participating in QOPI. “Some of the most important steps in achieving high-quality cancer care involve oncologists' measuring their performance to include outcome and process measures and taking deliberate action to improve performance on these

measures,” notes F. Daniel Duffy, MD, who represents the American Board of Internal Medicine (ABIM) in the Alliance. He adds, “We encourage Board diplomates to participate in QOPI as a way of obtaining oncology practice performance measures and engaging in quality improvement.” As of January 2006, oncologists can satisfy the ABIM Maintenance of Certification requirement for self-evaluation of practice performance by participating in QOPI.

Bach believes that the Alliance will have a substantial impact on CMS and its efforts to measure and improve quality. “As CMS moves forward with quality measurement, then quality reporting, and, ultimately, payment linked to quality, we will need guidance from diverse groups of stakeholders, as are represented in the Alliance.”

Profiles of Selected Members of the Cancer Quality Alliance

*American Board of Internal Medicine (ABIM)
F. Daniel Duffy, MD, Executive Vice President*

According to Duffy, the ABIM joined the Alliance “both to help advance the field of quality measurement in oncology and to incorporate quality improvement activities of Alliance members into the Maintenance of Certification Program.” Duffy led the development of the new self-evaluation modules used in the ABIM Maintenance of Certification Program, including the Practice Improvement Modules, which guides diplomates through completing a quality improvement plan. The program includes a requirement that all diplomates who have direct or supervised patient care must measure their performance in practice and use that measurement to apply the principles of quality improvement to one aspect of their practice. The ABIM provides diplomates with a variety of tools to help them collect data from chart review and patient surveys and use these data to calculate performance measures. Because no Practice Improvement Module is oncology specific, the ABIM encourages oncologists to participate in QOPI, which, as of January 1, 2006, meets the requirement for self-evaluation of practice performance.

*American College of Surgeons
Stephen B. Edge, MD, FACS, Chair, Quality Integration Committee, American College of Surgeons Commission on Cancer*

“The American College of Surgeons is committed to collaborating with others to achieve high-quality cancer care,” says Edge, adding that he believes that the Alliance has the potential to foster an understanding of research in quality improvement. Another advantage is that the Alliance has already facilitated the College's collaboration with federal agencies.

Edge notes that the College has been a “forward thinker” on the issue of quality, with the Commission on Cancer being responsible for establishing the National Cancer Data Base [NCDB] to serve as a comprehensive clinical surveillance resource for cancer care in the United States. “This database is by far the largest repository of cancer care information in the world,” says Edge. The NCDB helps to improve the quality of cancer care by providing physicians, cancer registrars, and others with a way to compare their management of patients with cancer with that of physicians at other cancer care centers around the country. More than 1 million cancer cases are entered into the NCDB each year.

*American Society for Therapeutic Radiology and Oncology (ASTRO)
James A. Hayman, MD, Chair ASTRO Task Force on Quality of Care*

“ASTRO hopes to leverage the expertise in the Alliance to help us move forward as radiation oncologists,” says Hayman. “We are a small organization, but we want to contribute wherever possible to measuring and improving the quality of care.” ASTRO represents the voice of radiation oncologists in the United States, and as such, brings specific expertise to the table as part of the Alliance.

Hayman was asked to serve as chair of the ASTRO Task Force on Quality of Care when it was established in April 2005. The Task Force was charged with addressing such issues as identifying quality measures specific for radiation oncology to use in pay-for-performance programs and with the Centers for Medicare & Medicaid Services (CMS). Currently, Hayman and the Task Force are working with ASCO to develop a version of QOPI that is specific to radiation oncology.

(Continued)

Profiles of Selected Members of the Cancer Quality Alliance (continued)

National Cancer Policy Forum

Roger C. Herdman, MD, Director

The National Cancer Policy Forum is the successor to the National Cancer Policy Board (effective May 1, 2005), established by the Institute of Medicine (IOM). Herdman says that the Forum “is happy to do what it can to provide support to the Cancer Quality Alliance and to share in the exchange of ideas on the issue of quality.” In addition, the Alliance meetings have provided valuable information for the development of activities within the Forum.

The 22-member Forum includes representatives from government sponsors, such as the National Cancer Institute (NCI), the Centers for Disease Control and Prevention (CDC), CMS, the Agency for Healthcare Research and Quality (AHRQ), the U.S. Food and Drug Administration (FDA), and the Health Resources and Services Administration (HRSA), as well as nongovernment sponsors that include the American Cancer Society (www.cancer.org), ASCO, C-Change (www.c-change.together.org), and UnitedHealth Group (www.unitedhealthgroup.com). Herdman notes that “quality is high on the agenda” for the Forum, with the Forum sponsoring two recent workshops designed to provide education to help physicians enhance the quality of care for patients with cancer. One workshop, held in March, focused on new technology for biomarkers for cancer, screening, diagnosis, and treatment.

The other workshop, to be held in mid-May, focuses on creating a survivorship care plan. This workshop is in direct response to the recent IOM report *From Cancer Patient to Cancer Survivor: Lost in Transition*, which called for improved care for cancer survivors.

National Comprehensive Cancer Network (NCCN)

Joan S. McClure, Senior Vice President of Clinical Information and Publications

McClure says that the “strength in numbers” provided by the Alliance will help to promote NCCN’s goal of improving patient care. “The NCCN is a relatively new organization, but it is influential in cancer care.” The more than 100 guidelines for cancer-related treatment developed by the NCCN already enhance the quality of care by reducing variations in practice and providing a standard of care by which to measure quality.

McClure notes that the NCCN has been involved in a variety of quality initiatives in addition to guideline development. The organization assisted CMS in the development of the 2006 Oncology Demonstration Project, assessing guideline adherence. NCCN now offers tools that assign G codes to relevant patient management recommendations in the 13

cancer diagnoses included in the Demonstration Project. Guidelines-adherence codes provide an opportunity for physicians to indicate whether care was adherent to guidelines and, if not, why. “There are legitimate reasons why a patient might not be treated according to guidelines recommendations, and an important feature of the Demonstration Project is acknowledging this fact,” says McClure. In March, the NCCN sent a CD-ROM with coding linked to the guidelines to all oncologists. The coded guidelines are also available on the NCCN Web site, www.nccn.org/professionals/physician_gls/default.asp.

NCCN also is collaborating with ASCO to develop a set of quality measures. The initiative involves evaluating quality measures defined in ASCO’s National Initiative on Cancer Care Quality (NICCCQ) and current NCCN guidelines to synthesize a set of current, practical quality measures in breast, colon, and rectal cancer. “The NCCN is composed of academic cancer centers,” says McClure. “Working with ASCO enables us to incorporate the perspective of community physicians more completely in the development of these quality measures.” McClure and Joseph S. Bailes, MD, interim ASCO executive vice president, presented information on the joint project at the October 2005 Alliance meeting.

UnitedHealth Group

Lee N. Newcomer, MD, Business Leader, Oncology Services

As a member of the Alliance, UnitedHealth Group brings the perspective of third-party payers to the table. The Group is a diversified health and well-being company that serves approximately 65 million individuals through its family of businesses. Promoting the quality of care is integral to its mission. Newcomer says that the benefit of the Alliance is learning from other institutions. “We need to look at ideas in a variety of places—the AQA [Ambulatory care Quality Alliance], physicians, health plans, and others—and adopt as many as possible in the oncology setting,” he says.

One recent UnitedHealth Group quality initiative is a chart audit to determine how many women with breast cancer who were being treated with trastuzumab had documentation of HER2 expression. According to the study, 12% of the charts had no record of HER2 expression testing or had low expression recorded. Because of these findings, UnitedHealth Group now requires documentation of HER2 testing before approving treatment with trastuzumab. In another project, UnitedHealth Group is asking approximately 1,600 surgeons in four metropolitan areas to demonstrate adherence to the standard of care for colorectal cancer surgery by submitting five cases that document that at least 12 nodes were included in the surgical specimen. Such surgeons will then be designated as providers of high-quality care.