Excellence in care and chemotherapy:
Goals and challenges for the oncology team

How do we measure quality in Medical Oncology?

Quality indicators in oncology practice

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Disclosure slide

case 1) any financial interest in, or arrangement with, a company those products or services are discussed in their presentation

Director of the WINHO institute

WINHO is a limited liability company run by the professional association of office-based hematologists and oncologists in Germany

WINHO provides services in the field of quality promotion for office-based oncologists

case 2) any financial interest in, or arrangement with, a competing company

no conflict of interests

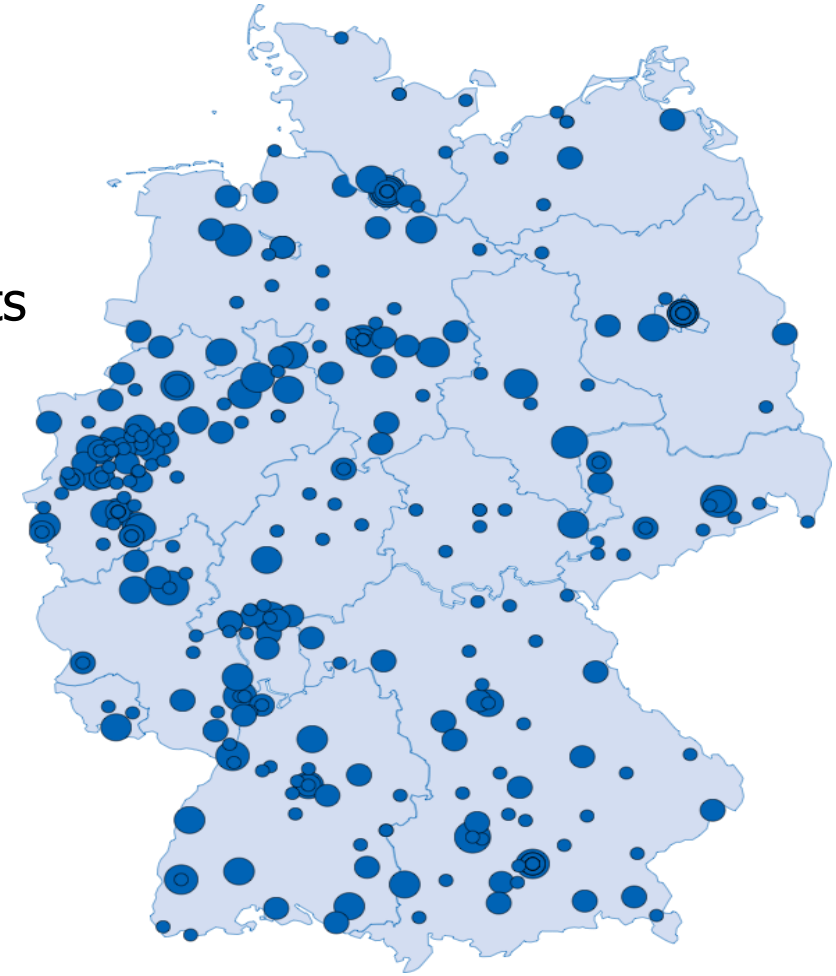
case 3) any other financial connections, direct or indirect

no conflict of interests

The WINHO Network

WINHO
Wissenschaftliches Institut
der Niedergelassenen Hämatologen
und Onkologen GmbH

- Founded in 2004 by the professional association of office-based hematologists and oncologists (BNHO)
- Quality promotion and health services research – without industry sponsoring
- More than 410 BNHO members share in WINHO
- 50% of oncologists in outpatient care represented
- More than 400.000 cancer patients p.a.



The WINHO Project

Development of quality measures for outpatient oncology care in Germany

AIMS

- Enhancing ongoing quality reporting
  - with approach to the core of care in medical oncology
  - moving from description to measurement
- Fair assessment of every outpatient care unit
- Peer-to-peer benchmarking
- Systematic support of practice quality improvement

Quality measurement

Quality indicators may allow to distinguish between proper and poor quality of structures, processes, and outcomes of treatment.

It is a mechanism to quantify

- the quality of a selected aspect of care
- the degree of adherence to a standard of care.

It is an auxiliary quantity for imaging quality indirectly by a numerical ratio.

WINHO measure: (simplified)	Documentation of the therapy goal
Numerator	Number of patients for whom the treatment goal is documented in the chart at baseline.
Denominator	Number of all patients with invasive malignoma or malignant hemoblastosis receiving medical cancer treatment

International Quality Measure Movement

Quality measure work is widely adopted

- as projects in more than 10 European countries
- as a matter of routine in several countries (USA, Can, Aus, etc.)
- with varying scopes and aims

Features of quality measures

Quality measures

- focus on technical aspects of care
- can only be based on issues with high volume of cases
- should be applied to processes rather than to outcomes or structures
- need evidence of a solid impact on outcomes
- can lead to misincentives (e.g. along with public reporting)

What is a good quality measure?

Category	Criterion
Relevance	Importance of the quality characteristic captured with the quality indicator for patients and the health care system
	Benefit
	Consideration of potential risks / side effects
Scientific soundness	Indicator evidence
	Clarity of the definitions (of the indicator and its application)
	Reliability
	Ability of statistical differentiation
	Risk adjustment
	Sensitivity
	Specificity
	Validity
Feasibility	Understandability and interpretability for patients and the interested public
	Understandability for physicians and nurses
	Indicator expression can be influenced by providers
	Data availability
	Data collection effort
	Barriers for implementation considered
	Correctness of data can be verified
	Completeness of data can be verified
	Complete count of data sets can be verified

QUALIFY
Instrument for the Assessment of Quality Indicators

WINHO sources for indicator building

AHRQ (Agency for Healthcare Research and Quality) Evidence Reports: Breast Cancer Evidence Reports: Colorectal Cancer Evidence Reports: Symptoms and End-of-Life Care CMS (Centers for Medicare & Medicaid Services) IOM (Georgia Cancer Coalition & Institute of Medicine) HBI (Health Benchmarks Inc.) NCCN (National Comprehensive Cancer Network) NCI (National Cancer Institute) NCQA (National Committee for Quality Assurance) NICCQ (National Initiative for Cancer Care Quality) NQF (National Quality Forum) NQMC (National Quality Measures Clearinghouse) PCPI (Physician Consortium for Performance Improvement) PQRI (Physician Quality Reporting Initiative) QMIS (Quality Measures Management Information System) QOPI (Quality Oncology Practice Initiative)	USA
BQS (Bundesgeschäftsstelle Qualitätssicherung) WBC (Westdeutsches Brustcentrum) WDC (Westdeutsches Darmcentrum)	Germany
NHS (National Health System)	Great Britain
ACHS (Australian Council on Healthcare Standards)	Australia

What is addressed?

Well covered fields in projects of quality measures:

- early detection of cancer
- diagnosis processes
- cancer surgery
- initial care
- hospital admission

Poorly covered fields:

- core processes in medical oncology
- long time care / survivor care
- rehabilitation services / palliative care
- patient reported outcomes

Limitations of ongoing quality measure projects

- Selected cancer entities; regional frameworks
- Mostly state driven
- Focus on performance of oncology care
- Still under construction
- Incomplete data
- Care providers partially included
- Expert driven - limited patient orientation
- Reference to population - not to care units

The Swedish example

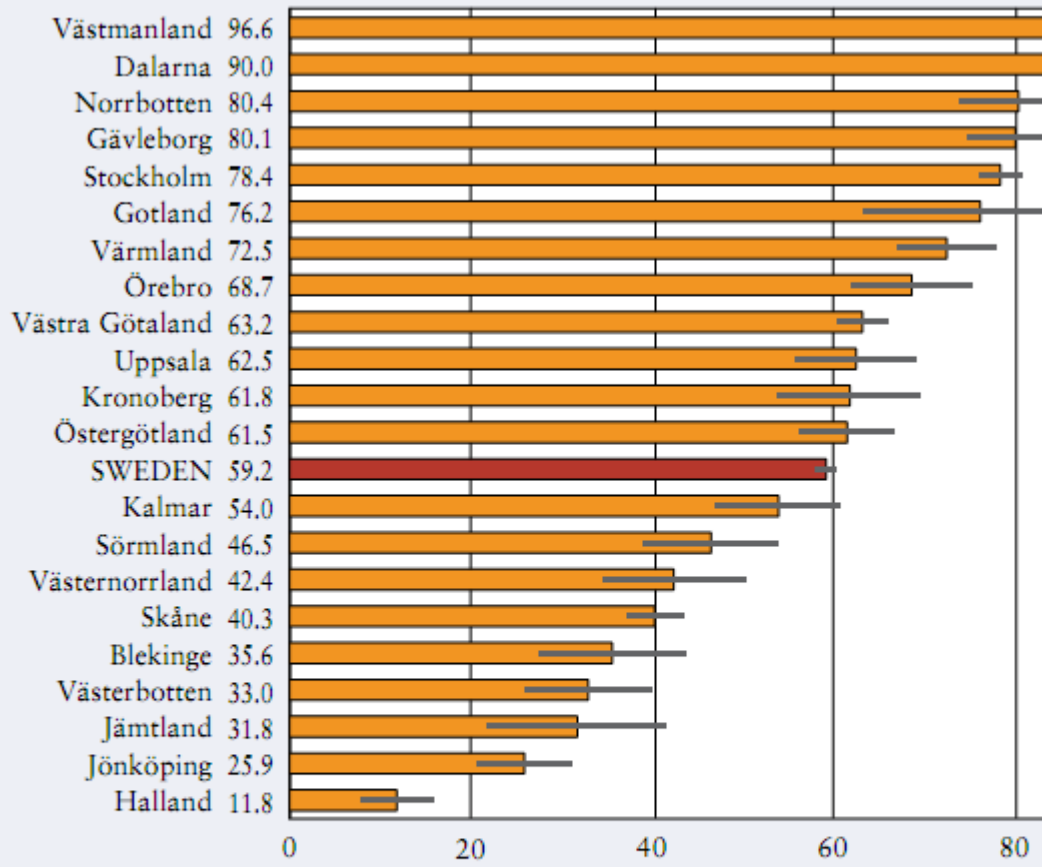


Figure 38
Total

Percentage of patients who had a multidisciplinary team meeting after colon cancer surgery, 2008–2009.

Source: National Colon Cancer Register

BLADDER CANCER

26 Bladder cancer – survival rates
27 Waiting time from receipt of the referral to the initial appointment with a urologist
28 Waiting time from initial appointment with a urologist until transurethral resection
29 Intravesical therapy for T1 tumours of the bladder
30 Curative treatment of T2–T4 tumours

PROSTATE CANCER

31 Waiting time for the initial appointment with a urologist
32 Bone scintigraphy for low-risk prostate cancer
33 Active surveillance of low-risk prostate cancer
34 Curative treatment for medium and high-risk prostate cancer
35 Treatment of locally advanced prostate cancer

COLON CANCER

36 Colon cancer – relative five-year survival rates
37 Multidisciplinary team meetings prior to treatment
38 Multidisciplinary team meetings after surgery
39 At least twelve lymph nodes examined in the tumour sample
40 Perforation of the colon during surgery
41 More than 15 days of hospitalisation after surgery
42 Reoperation due to complications within 30 days of primary surgery
43 Deaths within 30 and 90 days of surgery

RECTAL CANCER

44 Rectal cancer – relative five-year survival rates
45 Multidisciplinary team meetings prior to treatment
46 Multidisciplinary team meetings after surgery
47 At least twelve lymph nodes examined in the tumour sample
48 Preoperative radiotherapy
49 Perforation of the rectum during surgery
50 Anastomosis insufficiency after surgery
51 More than 21 days of hospitalisation after surgery
52 Reoperation due to complications within 30 days of primary surgery
53 New cancer of the pelvis within five years of surgery
54 Deaths within 30 and 90 days of surgery

Data capturing

- Routine data, business and billing data are rarely sufficient for meaningful quality indicators
- Data from cancer registers cover a small scope of measurable care processes
- Data for meaningful quality measures come from predefined items that have to be documented in the care process
- Record abstracting is exhausting but the appropriate technique to date
- In the long run, electronic physician documentation-tools are necessary with parametrical data entry

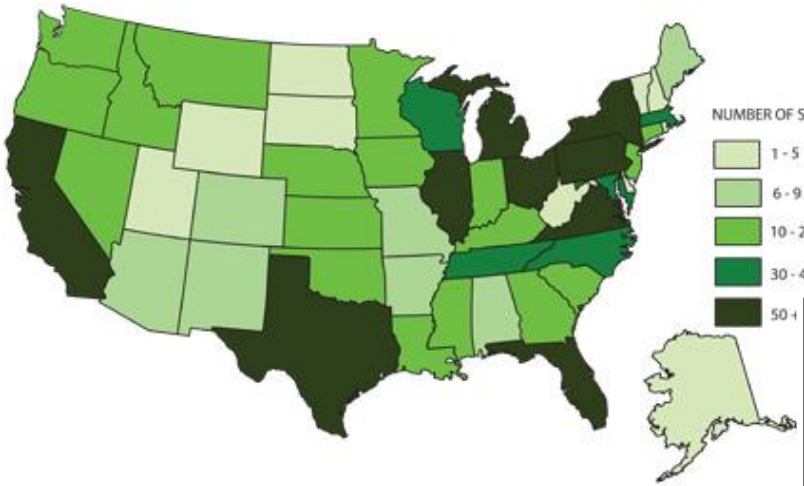
Our role model

QOPI® THE QUALITY ONCOLOGY PRACTICE INITIATIVE

ASCO®

American Society of Clinical Oncology

Making a world of difference in cancer care



QOPI® ASCO THE QUALITY ONCOLOGY PRACTICE INITIATIVE

Summary of Measures, Spring 2009

Core
1. Pathology report confirming malignancy
2. Staging documented within one month of first office visit
3. Pain assessed by second office visit
4. Pain intensity quantified by second office visit
5. Plan of care for pain documented
6. Pain addressed appropriately (combined measure, 3, 4, and 5)
7. Effectiveness of narcotic assessed on visit following prescription
8. Constipation assessed at time of narcotic prescription or following visit
9. Documented
10. Chemotherap
11. Chemotherap
12. Number of ch
13. Signed patien
14. Patient conse
15. Patient conse
16. Chemotherap
17. Chemotherap
18. Chemotherap
19. Chemotherap
64. Number of lymph nodes documented for resected c
65. 12 or more lymph nodes examined for resected col
66. Adjuvant chemotherapy recommended within 9 mo III rectal cancer
67. Adjuvant chemotherapy received within 9 months rectal cancer
68. Colonoscopy before or within 6 months of curative
69. KRAS testing for patients with metastatic colorecta
70. Anti-EGFR MoAb therapy received by patients wit
Non-Hodgkin
71. Granulocytic growth factor administered with CHC
72. Rituximab administered when CD-20 antigen expr Better)
Lung Cancer
73. Adjuvant chemotherapy recommended for patients
74. Adjuvant chemotherapy received by patients with
75. Adjuvant cisplatin-based chemotherapy recommen patients with AJCC stage II or IIIA NSCLC
76. Adjuvant cisplatin-based chemotherapy received w with AJCC stage II or IIIA NSCLC
77. Adjuvant chemotherapy recommended for patients (Lower Score - Better)
78. Adjuvant radiation therapy recommended for patie (Lower Score - Better)

** All measures are reported as percentages.*

Care at End-of-Life
33. Pain assessed on either of the last two visits before death
34. Pain intensity quantified on either of the last two visits before death
35. Plan of care for pain documented on either of the last two visits before death
36. Pain assessed appropriately (combined measure, 33, 34, and 35)
37. Dyspnea assessed on either of the last two visits before death
38. Dyspnea addressed on either of the last two visits before death
39. Dyspnea addressed appropriately (combined measure, 37 and 38)
40. Hospice enrollment
41. Hospice enrollment or palliative care referral
42. Hospice enrollment within 3 days of death (Lower Score – Better)
43. Hospice enrollment within 1 week of death (Lower Score – Better)
44. For patients not referred, hospice or palliative care discussed within the last 2 months of life
45. Chemotherapy administered within the last 2 weeks of life (Lower Score – Better)
Disease Specific Modules
Breast Cancer
46. Family history for patients with breast cancer
47. Medical/surgical history for patients with breast cancer
48. Chemotherapy recommended within 4 months of diagnosis for women under 70 with AJCC stage I (T1c) to III ER/PR negative breast cancer
49. Combination chemotherapy received within 4 months of diagnosis by women under 70 with AJCC stage I (T1c) to III ER/PR negative breast cancer
50. Test for Her-2/neu gene overexpression
51. Trastuzumab recommended for patients with AJCC stage I (T1c) to III Her-2/neu positive breast cancer
52. Trastuzumab received when Her-2/neu is negative or undocumented (Lower Score – Better)
53. Trastuzumab received by patients with AJCC stage I (T1c) to III Her-2/neu positive breast cancer
54. Tamoxifen or AI recommended within 1year of diagnosis for patients with AJCC stage I (T1c) to III ER or PR positive breast cancer
55. Tamoxifen or AI received within 1 year of diagnosis by patients with AJCC stage I (T1c) to III ER or PR positive breast cancer
56. Tamoxifen or AI received when ER/PR status is negative or undocumented (Lower Score – Better)
57. IV bisphosphonates administered for breast cancer bone metastases
58. Renal function assessed between first and second administration of bisphosphonates
Colon and Rectal Cancers
59. Family history for patients with colorectal cancer
60. Medical/surgical history for patients with colorectal cancer
61. CEA within 4 months of curative resection for colorectal cancer
62. Adjuvant chemotherapy recommended within 4 months of diagnosis for patients with AJCC stage III colon cancer
63. Adjuvant chemotherapy received within 4 months of diagnosis by patients with AJCC stage III colon cancer

VIENNA 2012 ESMO congress

WINHO Quality Measures - for outpatient cancer care

Systematic measure developement accomplished:

- With experts from several scientific societies in oncology
- Using modified RAND/UCLA method
- Multi level rating: relevance, patient‘s benefit, oncologist‘s responsibiliy, feasibility
- Exchange with ASCO/QOPI

46 measures endorsed:

Suitable for all ambulatory care sites :

Basic documentation	**10**
Planning and conducting of therapy	**14**
Comprehensive care	**3**
Pain management	**4**
Palliative care	**1**
Breast cancer	**9**
Colorectal cancer	**5**

Feasibility test finished

Pilot is starting

with support of:

BNHO
Berufsverband der Niedergelassenen Hämatologen und Onkologen in Deutschland e.V.

Deutsche Krebshilfe
HELFEN. FORSCHEN. INFORMIEREN.

Best accepted WINHO measures

All_Bascis_3	Special (cancer-specific) anamnesis is documented by second office visit
All_Basics_7	Histological / cytological pathology report is in chart at beginning of treatment
All_Basics_8	pTNM-stage, resection status, grading, vascular infiltration is in chart at beginning of treatment
All_Basics_10	Cancer-specific staging examination is in chart at beginning of treatment
All_Basics_11	Internal-medicine status and basic laboratory examination is in chart before treatment
All_TP_1	Multidisciplinary tumor board review for treatment planning was conducted
All_TP_3	Treatment goals and/or action parameters are in chart at beginning of treatment
All_TP_14	Chemotherapy plan is in chart at beginning of treatment
All_TP_15	Chemotherapy process is documented completly
All_TP_16	Updated treatment report for family doctor is available
Breast_TP_1	Adjuvant endocrine treatment starts within 6 weeks past surgery / 4 weeks past radiatio
Breast_TP_2	Planned endocrine treatment procedure is in chart before treatment
Breast_TP_4	Adjuvant cytostatic treatment starts within 6 weeks past surgery
Breast_TP_7	Trastuzumab treatment in HER-2/neu positive patients starts within 6 weeks past primal therapy
Bowel_TP_1	Adjuvant cytostatic treatment starts within 6 weeks past surgery
Bowel_TP_2	Planning of the procedure of cytostatic therapy in colorectal cancer is in chart by treatment

Lessons learned from the WINHO project

- Translating guidelines into quality measures needs careful attention
  - Guideline-development has to include statements about measurement of the predefined standards
  - All relevant items require clear specifications
- Accountability of oncologists for measured processes is crucial
  - Measures have to focus on processes in the outreach of oncologists
  - Processes that cannot be changed do not need to be monitored
- Measures on treatment planning and conducting are well accepted
  - Documentation counts: what is not in the chart that has not been done
  - Measures on supportive care, pain management, emotional well-beeing etc. need additional efforts for implementation

Questions left

- What do we achieve: better documentation or better care?
- Is the measure approach is the easier way to improve quality?
- How do we open the black box: what is the key element that really leads to better outcome?
- How do we provide feedback? Which data are really helpful for learning and initiating improvement?

Take home message

- The quality measure approach is widely accepted
- Quality measures are applicable in medical oncology
- Quality measures should be implemented in peer-based improvement arrangements
- Affordable documentation tools are crucial
- Community oncologists should not leave the quality measure approach to public health authorities

What ESMO can do:

- Think about: „European oncology quality measures clearing house”
- Initiating research on evaluating of quality measures

The unsung heroes

Thanks to

The WINHO staff:	Dr. Gudrun Klein (2009-2010) Dr. Regina Buschmann-Maiworm (2010-2012) Kerstin Hermes (2012-)
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and in particular:	Prof. Dr. Ulrich R. Kleeberg