Beyond Chapter 4: Defining and Leveraging Your Quality Program
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Allegheny Health Network Cancer Institute

Today’s Discussion
- Session Objectives
- About the Allegheny Health Network Cancer Institute
- My Story
- Making the Most of Chapter 4, A Focus on Quality
- Systematizing Quality: The AHN Cancer Institute Approach
- Q & A

Disclosure and Conflict of Interest
- I do not have relevant financial relationships with commercial interests that pertain to the content of my presentation, nor have I accepted honorarium, travel expenses, in-kind contributions, or any other support from commercial companies in connection with today’s presentation.
- The Commission on Cancer has provided reimbursement for travel and expenses related to the 2014 COC Workshop.
Learning Objectives

1. Participants will review and understand the required quality reporting components for chapter four of the COC standards.
2. Participants will review oncology-specific accreditations and novel ways to simplify reporting requirements through a streamlined approach to quality management.
3. Participants will discuss the integration of multiple constituents in quality and operations management including physicians and hospital executives while leveraging quality reporting as a communication tool.

About The Allegheny Health Network

A New Day in Pittsburgh

- March 1, 2013: Highmark/ Jefferson Regional Medical Center Affiliation Complete
- April 29, 2013: Highmark/ West Penn Allegheny System Affiliation Approved by PA State Insurance Commission forming:
  - Allegheny Health Network
  - Allegheny Clinic
- May 31, 2013: AHN/ Saint Vincent Health System Affiliation
- Created a very unique regional healthcare environment...

Allegheny Health Network “By the Numbers”

- 7 Hospital Network PSA serving Western PA, Northern WV, and Eastern OH
- 200 Free-Standing Locations
- 2,100+ Physicians
- 17,500 Employees
- Over 50 Cancer Institute Locations
  - 125,000 Visits Annually
  - 8,500 Analytic Cases/year
- 168 Solid Organ Transplants
- 5,000 Babies Delivered/year
- 39 Women’s Health Locations
- 299,000 ED visits
The Allegheny Health Network Cancer Institute

Comprehensive Oncology Services including:
- Medical Oncology: 18 Free-Standing Outpatient Centers, QIIP Certified
- Radiation Oncology: 12 Free-Standing Outpatient Centers, Largest - ASTRO/ACR Accredited Program in the United States
- Surgical Oncology: 24 Embedded Clinics/Outpatient Areas: 6 of 7 AHN Hospitals QIIP Certified
- Gynecologic Oncology: 3 Free-Standing Outpatient Centers
- Benign and Malignant Hematology and Cellular Transplant: West Penn Hospital as Hub, FACT Accredited, NMDP Donor Site
- 150 Physicians
- Over 200 Active Clinical Research Trials (currently open for accrual)

Integrated Supportive Services including:
- multidisciplinary clinic structure, in- and outpatient care coordination, pain and palliative care, home care, hospice services, social work, behavioral medicine, pastoral care, nutrition, genetics, lay and nurse navigation

"My name is Kyle Bird, and I'm a Quality Coordinator."
- Prior [limited] registry oversight experience
- Recruited to AHN November 2012
  - CDC Survey Schedule:
    - Saint Vincent: June 10, 2013
    - Jefferson: July 18, 2013
    - West Penn Hospital: August 16, 2013
    - AHN: September 16, 2013
    - Forbes: September 30, 2014
- Prior to 2/4/2013 no PMH of Anxiety, panic attacks

"Oncology Committee" Documentation (Page 1 of 1)
Initial Registry Org Structure

Initial Barriers to Registry Integration:
1. Siloed Approach
2. Reporting through different hospital departments
3. Lack of integration and oversight
4. Various JDs across the system
5. No productivity standards
6. Consistent 30% staff turnover
7. Zero work communication between registrars
8. Too much paper
9. Backlog of Cases > 3,000

The AHN Cancer Institute Registry, Now

On-Going Integration & Consolidation:
1. Integration through shared/float staffing
2. Streamlined Reporting
3. Tumor Registrar reporting required in senior-level meetings (class of case 00)
4. Standardize JDs
   - Certified Tumor Registrar
   - Data Analyst
   - Coordinator
5. Defined Productivity Standard Set
6. Registry Appreciation Day and Ongoing External QA
7. Gradual Transition to paper-lite
8. One-time approval for external abstraction group

Standardized Documentation

[Diagram showing standardized documentation]
Standard 4.3: CLP Responsibilities and the Power of the NCDB

Compliance
- Each year, the CLP evaluates and interprets the program's performance using the NCDB data
- Each year, the CLP or an equivalent designee, reports this information to the cancer committee at least four times a year
- The CLP is present during the CoC survey and meets with the surveyor

NCDB Hospital Comparison Benchmark Report

Standard 4.4: Accountability Measures

Compliance
- Each year, the cancer committee reviews the program's performance using the CoC quality reporting tools
- Each year, the review activity is reported in cancer committee
- For every measure selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC in each year since the program's last survey, or the program has implemented an action plan that reviews and addresses program performance

Standard 4.5: Quality Improvement Measures

Compliance
- Each year, the cancer committee monitors the program's performance using the CoC quality reporting tools
- Each year, the monitoring activity is reported in cancer committee minutes
- For the measure(s) selected by the CoC, the quality reporting tools show a performance rate equal to or greater than the rate specified by the CoC, or the program has implemented an action plan that reviews and addresses program performance
Standard 4.8 Quality Improvements

Standard 4.7: Studies of Quality Compliance
- Based on category, the QI coordinator, under the direction of the cancer committee, develops the required number of cancer patient care studies
- The results of the required number of studies are analyzed by the QI coordinator, under the direction of the cancer committee
- The results of the required number of studies are documented by the QI coordinator in cancer committee minutes

Standard 4.8: Quality Improvements Compliance
- The QI coordinator, under the direction of the cancer committee, implements 1 patient care improvement based on the results of a completed study
- The QI coordinator, under the direction of the cancer committee, implements 1 patient care improvement based on any source.
- The improvements are documented in the cancer committee minutes
- The improvements are shared with medical staff and administration

The LIST

Defining “Quality?”
- QOPI
- ASTRO
- Joint Commission Requirements
- VBP
- Patient Engagement
- FACT
- NAPBC
- COC/Third-party Payor
- OUTCOMES
- Rapid Cycle Improvement and Lean
- OPPE/FPPE
- Risk Management
- Complaints and Grievances
2014 Cancer Committee Goals

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
<th>Goal</th>
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<tbody>
<tr>
<td>1.5</td>
<td>Clinical Improvement Goal focuses on outcomes</td>
<td>Develop the national rapid response in surgical care quality measures assessing hospital, center, and surgeon performance for the cancer program.</td>
</tr>
</tbody>
</table>
| 1.5 | Programmatic Goal focused on the development of a multidisciplinary team focused on improving patient care | Expand navigation services directed to other disease sites, and implementation of CentralCare

4.1 Prevention Programs (1 program offered to address the needs of the community and reduce the incidence of specified cancer. The program is consistent with evidence-based national guidelines for cancer prevention)

AGH: STV: AVH: JEFF: FOR: WPH:

4.2 Screening Programs (1 program offered to decrease number of patients with late-stage disease. The program is based on community needs and is consistent with evidence-based national guidelines for cancer screening)

AGH: STV: AVH: JEFF: FOR: WPH:

4.6 Compliance with Evidence-Based Guidelines (A physician member of the Cancer Committee performs a study to assess that nationally recognized treatment guidelines are used in the formation of the first course of treatment for patients newly diagnosed with cancer each year)

- Treatment of late-stage (IIII and IV) NSCLC cases will be reviewed and compared to NCCN guidelines. Additionally, genetic testing % in all reviewed NSCLC cases will be reported.

4.7 Studies of Quality (2 studies of cancer patient care quality and outcomes)

- Measurement of the newly implemented patient satisfaction outpatient survey tool to identify the top three areas for further monitoring – PG Priority Index
- Evaluate how hypersensitivity and anaphylactic reactions are documented – reporting % in risk management software

4.8 Quality Improvements (2 improvements in cancer patient care. 1 must be based on a study of quality)

- Select one survey measure not previously selected in subsequent years for improvement based upon PG Priority Index
- Implement a standardized plan to define, report, and analyze chemotherapy-related near misses, errors, and hypersensitivity reactions

<table>
<thead>
<tr>
<th>Quality, Defined?</th>
<th>Structure → Process → Outcomes</th>
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<tbody>
<tr>
<td>Quality Forums</td>
<td>- Chemotherapy Council - Radiation Oncology/Medical Oncology QA Committees - Incident Learning/PI Safety Committees - Cancer Committee - Tumor Boards - Patient Advisory Boards - Hospital Quality Reporting - Quality Collaborative</td>
</tr>
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Value Based Purchasing

FY 2014 Finalized Domains and Measures/Dimensions

- Clinical Processes of Care Measures
- outcomes
- Clinical Outcomes
- Satisfaction

- Domain Weights
- Clinical Processes of Care Measures (50%)
- Clinical Outcomes (30%)
- Patient Experience of Care (20%)

- Measure Experience of Care Dimensions
- 1. Physical Comfort
- 2. Physical Wellbeing
- 3. Emotional Wellbeing
- 4. Communication
- 5. Discharge Disposition
THE GOAL

“A paradigm shift from non-expert, unnecessary or potentially harmful variation to standardization emphasizing clinical outcomes, patient experience, and cost optimization.”

The AHN Cancer Institute Quality Hybrid

NEW MODELS OF CARE
• Personalized Medicine/Genomics
• No-Shows/Retention
• Access
• PCMH
• Clinical Pathways and Standardized Orders
• Readmissions
• Care Transitions
• Site of Service

CLINICAL OUTCOMES
• Focused Survival Initiatives
• Clinical Trial Accrual
• Standardized RO/MO Education
• Value Based Purchasing
• Efficacy, Toxicity and Cost

PATIENT EXPERIENCE
• Standardized Measurement, Press Ganey
• Standardized Reporting of Pt. Sat
• Problem Identification & Targeted Interventions
• Patient Advisory
• Complaints and Grievances
• HCAHPS
• Pt. Delays and Wait Times, Chemo TAT

TRANSPARENCY
• Use of third-party QA
• Public Reporting through COC Requirements
• Care Alignment
• Adverse Event Tracking and Trending
• Failure Mode and Effects Analysis
• Quality Fair

DATA/ANALYTICS
• Registry: Standardization, QA, Quality Goal
• Efficient Use of Health Services:
  • Ranking Efficacy, Toxicity, QOL, and Cost
  • Utilization of Specialty Pharmacy
  • Tracking Pt. Adherence
  • Monitoring Drug Utilization
• Use of Lean tools
• Active Internal Reporting of Selected Measures
• NQF Measures

QUALITY COLLABORATIVE

AHN Board of Directors
  
Cancer Direction and Strategy Committee
  
Hospital Quality Committees
  
Physician Oversight Committee

QUALITY PLANS

AHN Board of Directors
  
Cancer Direction and Strategy Committee
  
Hospital Quality Committees
  
Physician Oversight Committee
A Team Approach

The Quality Collaborative

<table>
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<tr>
<td>Catalog and Inventory Phase</td>
<td>Quality U: 15 Minutes</td>
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<tr>
<td>External Agencies</td>
<td>Problem Identification, Problem Statements and Project Aims, Brainstorming Tools, Fishbone, 5Why, Introduction to Root Causes, Methodologies for Pre/Post-data collection and Patient Surveys, Goal Setting/SMART Objectives, Introduction to Root Cause and Sentinel Events</td>
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The Tenets of Our Collaborative

- GPS (AND BPS): Good patient story/Bad patient story
- Quality U: 15 Minutes
- Current Topics in Cancer Care: 30 Minutes
- Workgroup Report-Out: 20 Minutes
- Continuous Patient Feedback
- Team Work: Multidisciplinary team approach across all levels of staff
- CALL TO ACTION

Our Collaborative Environment

The Catalog and Inventory Phase

Internal/ANR Processors
- RD Quality Management Process
- CTP Quality Management Process
- Hospital Reporting (ICU)
- MO Quality Management
- Complaints and Grievances
- Adverse Events

External Agencies
- QOPI
- ASTRO
- NAPRC
- FACT
- Joint Commission
- ODH
- OPP/Fringe

Quality U
- Problem Identification, Problem Statements and Project Aims
- Brainstorming Tools
- Fishbone, 5Why, Introduction to Root Causes
- Methodologies for Pre/Post-data collection and Patient Surveys
- Goal Setting/SMART Objectives
- Introduction to Root Cause and Sentinel Events
Thank you.

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