

## ASCO QUALITY CARE SYMPOSIUM SUMMARY

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September 6-7, 2019 | San Diego, CA

The [American Society of Clinical Oncology \(ASCO\) Quality Care Symposium](#) encompasses the latest strategies and methods for quantification of patient experience, provider efficiency, clinical outcomes, and quality and safety in the cancer care field. The focus areas for this year's symposium were quality of care across multi-site networks, solutions to address equity in cancer care, standardizing care with pathways, and de-implementation of low-value care. Other topics presented at the symposium included physician burnout, quality improvement interventions, clinical trials utilization, improvement on outcomes following implementation of Alternative Payment Models (APM), patient-reported outcomes measurement, financial toxicity, and process efficiency in cancer care delivery.

Friday, September 6

### Panel 1: Building High Quality Cancer Care Across Multi-site Networks

#### Presentation 1: Medical Home impact on quality in a large community oncology practice (Natalie Dickson, Tennessee Oncology)

- Tennessee Oncology adopted the Oncology Care Model (OCM) with a commitment to provide quality care, including a focus on evidence-based medical judgment and staff engagement.
  - They conducted 3 QI projects to achieve:
    - Clinical Pathways Program Objectives
    - Access to Palliative Care – embedded within outpatient clinic with note templates for future quality reporting
    - Telephone triage using customized software
- They also revised care coordination by piloting emergency department new patient intake, financial counseling, survivorship, urgent care, navigation.
- They adopted new technology products such as a patient management platform that integrates with EMR.
- Key outcomes from OCM
  - 70<sup>th</sup>-90<sup>th</sup> percentile for patient experiences (above median)
  - Top quartile for quality measures
  - No reduction for drug costs
  - Reduced inpatient hospitalizations and emergency department use

#### Presentation 2: Medically integrated pharmacy quality initiatives in large multi-site oncology networks (Gury Doshi, Texas Oncology)

- Oral oncolytics are a new paradigm to quality patient care: 25-35% of all new cancer drugs in development are oral drugs.
- Oral drugs impact several aspects of cancer treatment – drug accessibility, financial burden, shifting traditional provider roles and responsibilities to patients and caregivers, safety monitoring, and adherence concerns.

- Medically integrated pharmacy care (MIPC) represent the true integration of pharmacy and medical care. They:
  - Increase access to therapy
  - Decrease financial burden
  - Coordinated care by their medical team
  - Improve management/care of your patient
  - Control/delivery of high-quality oncology care in a value-based world
- Prior authorization is laborious. Patient gets copay information; clinic has to try and get financial assistance.
  - 18% overall abandonment rate of medicines due to cost
- Introduced patient assistance as a default part of the prescription pathway
- Benefits of MIPC
  - Improved patient satisfaction and outcomes
  - Reduced time to obtain medication from days/week to 24/48 hours
  - Prior authorization used to take days and involved multiple people and steps. Now it takes a few hours when performed by MIPC team.
  - Patient assistance used to be provided only when there was burden expressed by a patient. Now financial screening is done for all patients and financial assistance is offered to all who need it.
  - Concurrent medication checks (medication reconciliation) was not conducted routinely but can now be done routinely because the same EMR is used by the clinical and pharmacy teams.
  - Adverse events can be evaluated and managed in a timely manner.
  - Care delivery is coordinated vs fragmented.
- Future goals
  - Value based care – Avoid ER visits, decrease hospitalization
  - Adherence – Demonstrate value to payers
  - Decrease costs – Can begin with “starter” 14-day packs, partial fills to assess side effects of a medication before a full month of medication that might be wasted due to adverse events.

**Presentation 3: Formation of academically-based practice networks for quality cancer care (Anne Chiang, Yale)**

- Hallmarks of a successful franchise
  - Quality: Measurement across a network
  - Standardization: QOPI
  - Customer service: Patient satisfaction
  - Culture: Clinician integration and research
  - Innovation: Quality improvement
- Undertook integration/change transformation process
  - Engagement of staff is key
  - Regular meetings on transition issues
  - Onboarding curriculum
  - Teambuilding and leadership training
  - Include multidisciplinary members
- Chemo volume has increased in community-based locations

- Used QOPI to measure network quality pre/post transformation—2012 vs 2016—some quality measures improved significantly .
- Conducted a pilot for community QI – how to train practices to complete and sustain QI
- Conclusions
  - Onboarding faculty was the key to engagement.
  - Integration of practices can lead to improvements in multiple domains.
  - QOPI can be used to drive standardization and improvement.
  - Large-scale QI efforts across multiple community locations builds a culture of quality and teamwork.

#### Presentation 4: Governmental Supported Networks for Quality Care (Robin McLeod, Cancer Care Ontario)

- Cancer Care Ontario doesn't provide care, it oversees cancer care and is the primary advisor.
- They conducted quality improvement processes to:
  - Identify gaps in quality and access
  - Initiate knowledge, transfer strategies and projects
  - Create and support strategic funding initiatives
  - Measure and provide feedback
- Established clinical leads, both provincial and regional to:
  - Identify areas where outcomes are suboptimal and provide advice when there are new treatments which should be adopted
  - Lead implementation
  - Participate in performance management
- Example of a QI project: Implementation of thoracic surgery standards
  - Guideline developed
    - Outlined volume requirement, human and institutional resources
    - Expert panel of thoracic surgeons, other disciplines and administrators
  - Implementation
    - Modelling and requested regional cancer plans
    - Surgeon engagement
    - LHIN and institutional engagement
    - CSA funding - incentives (incremental funding)
    - Public reporting
  - Results: Decrease in post-operative mortality from 10.9% in 2004 to 1.7% in 2015
- Another example of a QI project: Toxicity management project
  - Self-management
  - Nurse-led urgent care clinics
  - Established tools for communication between patients and a nurse
  - Established after hours: Oncology nurse on call from 5 PM to 8 AM and weekends.
- Results
  - Number of after-hours support calls increased over time
  - Only 7% of patients went to emergency department (of which about 80% were admitted)

## Presentation 5: Implementation and efficacy of a large-scale radiation oncology case-based peer review quality program across a multinational cancer network (Ethan Ludmir, MD Anderson Cancer Center)

- MD Anderson underwent rapid expansion of academic cancer center networks.
- Importance of ensuring high-quality care
- Undertook a QI project to do radiation oncology peer-review to assess quality and standardization
  - This entailed weekly radiation oncology peer-review between network centers and main campus of MD Anderson cancer center
  - Peer reviewers looked for reasons for nonconcordance classified by dose, fields, contours.
- Results
  - Nonconcordance for CNS – 67% due to dose
  - Nonconcordance for breast – 67% due to field
  - Nonconcordance for head and neck – 69% due to contours
  - Nonconcordance over time – Established centers had less nonconcordance. Centers added to the network later had higher nonconcordance.
- Conclusions
  - Demonstrated feasibility of a large-scale multinational cancer network radiation oncology peer-review program.
  - Nonconcordance rates were highest for head and neck cases.
  - There were differential bases for nonconcordance between disease sites.
  - We need to work on improving nonconcordance rates after joining the network.

## Panel 2: Oral Abstract Session

### Part 1. Risk prediction and quality improvement for hospitalizations (2 papers)

- Key takeaways
  - Risk stratification identifies patients who may benefit from more intensive management.
  - Risk information is most useful when risk is modifiable i.e. when you have an effective intervention.
  - Risk information is most useful when information is timely i.e. when lead time is sufficient.
  - A machine-learning model using random forests, decision trees, and logistic regressions based on EHR-data provides excellent risk stratification.
  - We can reliably identify patients at increased risk for hospitalization.
  - There is little evidence that risk stratification is facilitating the use of interventions.

### Part 2. Recruitment of minority and under-insured patients to clinical trials (2 papers)

- Key takeaways
  - The first paper compares attitudes about clinical trials between cancer patients and providers/researchers.
  - Results
    - Patients
      - 73.3% know what a clinical trial is, 21% patients were ever invited to join a trial, 66% were invited to join a trial and did
      - Most common reasons for refusal included lack of interest, concerns about randomization, and preference for proven treatment.

- Providers/researchers
  - 73% found it hard to keep track of eligibility criteria, 67% found it hard to make time to talk about clinical trials during treatment planning
  - Most common reasons that providers/researchers think that patients refuse are language/culture, lack of understanding, issues with toxicity, concerns about randomization, mistrust, and preference for proven treatment.
- There is little alignment between the reasons providers/staff think that patients refuse vs why patients say they refuse.
- The second paper examined survival benefits for patients with Medicaid or no insurance.
- Research question – Do treatment effects for positive trials apply to all demographic and insurance types?
- 4 key variables
  - Age
  - Minority race/ethnicity
  - Sex
  - Insurance status (collected 1991 onward)
    - Private insurance vs Medicaid or none (proxy for low SES)
- Primary endpoint was overall survival
- Adjusted for patient-level risk and study-level prognosis
- Results – Patients with private insurance had a much greater benefit for overall survival, although no significant benefit was shown from the actual intervention in the RCT.
- Conclusions
  - The magnitude of treatment benefits from experimental therapies may not be uniform for patients with Medicaid or no insurance.
  - The patients likely are at greater risk of experiences competing risks of death.
  - This can reduce power to identify the benefits of new experimental therapies.
  - Trial designs should account for the risk of non-cancer deaths in important patient groups.

### Key Note Talk by Tait Shanafelt (Stanford University) – Physician Burnout

- Burnout erodes quality of care.
- Improvement work requires engaged physicians.
- Burnout = depersonalization, emotional exhaustion, and low personal accomplishment leading to decreased quality of work
- Age is a protective factor. Younger age results in more burned out. Marriage is protective.
- Professional and personal consequences
  - Personal – Broken relationships, alcohol/substance use, depression, suicide
  - Professional – Decreased quality of care and medical errors
- Nurse burnout increases rates of associated infection
- Risk factors for burnout – Higher % time devoted to clinical work, higher patient satisfaction with communication
- Outcomes – Turnover is double among physicians with emotional exhaustion
- Unsolicited patient complaints double the depersonalization
- Physician personality – Doubt, guilt, and exaggerated sense of responsibility

### Panel 3: Equity and Cancer

#### Presentation 1: Policy and business solutions to address cancer disparities (Karen Winkfield, Wake Forest, NC)

- Biggest risk factor for inequities is SES – Income, occupation, and education
- At risk populations – Race/ethnic minorities including immigrant populations
- Rural, urban, sexual and gender minorities, adolescent, young adult, older adult
- Barriers to cancer care – Competing survival priorities, lack of information, and system level factors
- Financial toxicity of cancer care – Who should intervene?
- Precision oncology – Are we inadvertently widening the disparity gap in pursuit on precision medicine?
- Solutions to help
  - Awareness
  - Advocacy
  - Ambassadors

#### Presentation 2: EHR data interventions for cancer screening and Survivorship care (Heather Angier, OHSU)

- Community-based HIT tools for Cancer Screening and Health Insurance Promotion (CATCH-UP) – Purpose was to increase screening for cancer.
- Tool implementation – OR, CA, and OH are Medicaid expansion states
- Seven community health center organizations participated with 23 clinic sites.
- Clinics decided how to incorporate the tools into their workflow.
- Barriers/facilitators to tool use – CFIR framework
  - Relative advantage
  - Implementation support
  - Leadership support
- 37% of patients have no cancer history, so CHCs don't know if their patients have cancer.
- The tool increased insurance continuity.
- In the future, we can link HER to claims registry.

#### Presentation 3: Ensuring diversity in precision oncology (Elena Martinez, UCSD)

- Precision medicine is health care that is based on you as an individual. It takes into account factors like where you live, what you do, and your family health history. It also uses the genetic changes in a patient's tumor to determine their treatment.
- Objective: To compare informed consent for biospecimen collection and a data sharing obtained by a physician vs a research assistant for Hispanic women.
- Results
  - High consent rates among medically underserved Hispanic women, regardless of who administered informed consent
  - Hispanics' unwillingness to share data and donate biospecimens is a myth not supported by data.
- Implications – We need to engage patients from under-represented groups for clinical trials and research.

#### Presentation 4: Cultural barriers to equity in sexual and gender minorities (Matt Schabath)

- Lack of data – There is a consistent lack of data collection on sexual orientation and gender identity. No federal health survey collects this information.
- Cancer – Seven specific cancer sites disproportionately affect LGBTQ populations.
- Risk factors – Alcohol and tobacco use is higher. BMI is higher among lesbians.
- Colonoscopy – Higher among gay and bisexual men
- Health seeking behaviors differ from mainstream – LGBTQ populations tend to avoid care, delay seeking care, lack of insurance, perceived or actual discrimination, misconceptions of risk, delay or not filing a Rx, more likely to receive health care services in ER
- Mental health issues – Depression, anxiety, eating disorders, suicide attempts
- Limited knowledge of LGBTQ health care needs or have negative attitudes
- Lack of trust cause fears of substandard care or confidentiality issues.
- Lack of knowledge about insurance
- What can we do?
  - A welcoming and inclusive environment, training
  - Ask open-ended questions.
  - Make no assumptions.
  - When you don't know, please ask.

#### Presentation 5: Comparing Nonconscious nonverbal synchrony in racially concordant and racially discordant cancer care (Lauren Hamel)

- Patient-provider communications, attitudes
- Clinical communication in racially discordant dyads – Communication is poor quality.
- Black patients ask less questions and have less understanding of their diagnosis and treatment.
- Importance of nonverbal communication
- Hypotheses – Interactions with black patients with have lower levels of nonverbal synchrony.
- Results – Nonverbal synchrony differed in racially concordant (white patients) and racially-discordant (black patients) interactions.
- Nonverbal synchrony was associated with higher observed physician patient-centered communication.

#### Panel 4: Rapid abstract session

- Two papers on patient-reported outcomes measures
  - Stover et al showed that it is feasible to collect PROs from home electronically.
    - Four PRO-PMs were developed – Nausea, insomnia, pain, and constipation
  - Buzaglo et al showed that it is possible to collect ePRO data on a tablet for Patient Care Monitor (PCM) core symptom survey and PHQ2/PHQ9 depression screening.
    - It was effective at screening and documenting pain and depression, as well as monitor symptoms and enhance provider/patient communication.
    - Data were used to report metrics to QOPI, OCM, MIPS, etc.

Saturday, September 7

**Panel 5: Standardizing Care with Pathways and Decision Aids**

**Presentation 1: Pathways for personalized medicine and value (Linda Bosserman, City of Hope)**

- A clinical pathway is defined as an evidence-based care plan detailing the essential steps needed in the care of patients with a specific clinical characteristics and diagnosis.
- Whereas guidelines frequently offer multiple recommendations, clinical pathways translate guidelines or evidence into local structure and aim to delineate a single best treatment often inclusive of dosing, time frames, and sequencing of therapies.
- Patient preference, co-morbidities, and toxicities can determine preferred vs alternate pathway choice.
- Objective of clinical pathways is to facilitate quality care in all aspects of the patient interaction to include evaluation, treatment, education, supportive care, and end-of-life care.
- There are internally developed pathways (local, network use), value pathways (NCCN, VIA), and payer pathways.
- City of Hope – adopted VIA pathways and integrated into EPIC, integrated clinical trials into pathway tool
- Molecular diagnostics are challenging but key to personalizing a patient’s pathway.
- Clinicals will use genomic testing when incorporated into pathway guidance.
- Supportive and multimodality pathways are critical to value-based care.
  - These are real time tools to share personalized patient information and impact of therapy choices for shared decision making.
  - They incorporate the latest information on therapy choices by tumor subtypes, molecular information, treatment sequencing, toxicities, patient health, and preferences to achieve value-based outcomes.
- Challenges remain to adoption of pathways
  - Criteria standardized for order of national pathway choices (efficacy, safety, cost)
  - Data is based on clinical trial population, not real-world patients.
  - Patients value costs differently.
  - Need tools to present clinical outcomes and toxicities for patients with costs for shared decision-making.
  - Big data could provide insights from common data element entry across patient journeys as patients live longer.

**Presentation 2: Evaluating the value of oncology pathways (Scott Ramsay, Fred Hutchinson Cancer Center)**

- Operational definition of value: Does a medical intervention, when used to prevent or treat a condition, improve health outcomes in patients enough to justify the additional dollars spent compared to another intervention or doing nothing?
- Cost Effectiveness: Pathways vs business as usual
- Cochrane collaboration definition of a pathway
  - Structured multidisciplinary plan of care
  - Used to translate guidelines or evidence into local structures
  - Detailed steps in a course of treatment or care in a plan



- Aims to standardize care for a specific population
- Evaluating Value for Pathways: What if the pathway was a pill?
  - What are the benefits?
  - What does it cost?
  - What are the adverse effects?
  - What are the alternative approaches if any?
  - What is the cost-effectiveness vs. alternatives?
- Proposed benefits of clinical pathways
  - Reduced variability in care
  - Improved quality of care
    - Increased use of recommended services
    - Fewer adverse events
    - Improved outcomes
  - Lowers cost of care
    - For delivery system
    - For payers
    - For patients
- Costs of pathways
  - Development
    - Expert panel
    - Lit review
    - Writing pathway
    - Disseminating results
- Implementation
  - Workflow disruption, decrease efficiency (e.g. waiting for approval of regimens)
  - Cost to incorporate into EHR
- Maintenance
  - Updates
  - Monitoring
- Unintended adverse consequences
  - Possible dip in clinical trial enrollment

### Presentation 3: Creating and implemented clinical pathways: Where is the patient voice? (Carey Gross)

- Evidence based for NCCN guidelines – evidence is shaky – very little Level 1, lots of off-label indications
- Conducted a qualitative study of 22 patients with breast cancer – 18+, stages 1-3
- Asked about factors affecting decision-making
- Themes
  - Physical – Appearance, efficacy
  - Psychosocial – Emotional and social issues, decisional regret, QoL, ability to perform roles
  - Family – Achieving milestones, critical role in treatment decisions
  - Treatment decisions – Treatment options, expectations, pros/cons of different treatments
- Pathways may reduce unwarranted variation but will not increase patient-centeredness by default.
- Strengthen evidence base
  - Answer questions that are relevant to patients.

- Ensure real world data are available.
- Incorporate trials in clinical care.
- Reconcile pathways with need for decision aids
  - Need greater flexibility in terms of patient preferences and priorities
  - Pathway tools should incorporate patient-identified factors that impact decision-making.

#### **Presentation 4: Can utilization of clinical pathway effectively reduce drug spend in OCM (Vijay Damarla)**

- Cancer Care Specialists of Illinois established a strong relationship with risk-bearing pathway organization to help manage drug spend (New Century Health).
- Goal of keeping people out of the hospital
- Drugs comprise a majority of the cost in an OCM episode, highlighting the need to curb growth in drug spend.
- Adherence to level 1 pathways increased in post-performance period.
- Drug spend reduced by 13.5% over 15-month period = 250K saving per clinician
- 5% reduction in spending for total cost of care compared to OCM median
- Conclusions
  - Curbing drug spend within value-based care model (OCM) is possible.
  - Use of evidence-based clinical pathways has been proven to drive drug spend reduction.

#### **Panel 6 : De-implementation of low-value cancer care**

##### **Presentation 1: Overuse of health services in the management of cancer care (Deborah Korenstein)**

- Quality problems in health care
  - Underuse – Needed care is not delivered
  - Misuse – Care is needed and delivered but there is a preventable complication.
  - Overuse – Potential for harm exceeds potential for benefit
- Need to characterize overused services and identify drivers
- Conducted a literature search on cancer overuse literature
  - It is skewed toward diagnostic testing. Over half are about breast and a third are about prostate.
  - Under-represents all other cancers
- Drivers of overuse (physician-identified)
  - Malpractice concerns
  - Time
  - FFS system
  - To be safe
  - Personal reassurance
  - Patient demand
  - To keep patients happy
  - Patient should decide
  - Technology
- People are poor judges of their own motivations.
- Physician report of divers only addresses recognized overuse.
- People don't realize what they are doing isn't right.

- Domains of factors for overuse
  - Setting/societal
  - Patient
  - Provider
- Setting/societal factors
  - Fear of malpractice – Malpractice concern correlates with higher testing rates.
  - Misaligned financial incentives – System of care correlates with some non-recommended care.
  - Culture of doing more – Levels of low-value services vary across practices and regions.
  - Patient satisfaction – More imaging by MDs whose incentives include patient satisfaction
- Patient factors
  - Patient demand – Influenced by drug advertising, local culture
- Clinician factors
  - Large variation in low value service use among clinicians within organizations
  - Some doctors are global over-users
  - Variations are not attributable to demographic differences
- Errors in analytic thinking can lead to overuse
  - Poor understanding of basic risk information
  - Overestimation of benefits and underestimation of harms of test and treatments
  - Poor application of clinical trial results
- Cognitive biases that drive overuse
  - Availability heuristic
  - Framing – Half empty, half full
- To optimize de-implementation efforts, we should determine methods for prioritizing services and to better understand the relative importance of different drivers.

### Presentation 2: Overview of approaches to de-implementation (Wynne Norton, NCI)

- What is de-implementation? Study of how to remove, replace, reduce, or restrict the use of ineffective, untested, harmful, overused, inappropriate, and/or low value health services and practices (interventions) delivered to patients by health care providers and health systems.
  - Different types of actions
  - Different types of interventions
  - Different types of delivery mechanisms
- Types of actions
  - Remove – Stop
  - Replace – Stop one intervention, start another (similar) intervention
  - Reduce – Reduce frequency and/or intensity of intervention
  - Restrict – Use intervention with narrower scope
- Intervention
  - Complexity
  - Interdependence
  - Strength of evidence
- Barriers
  - Patient-level – Inaccurate cognitions, beliefs (e.g. more is better), and negative emotions (confusion, frustration, distrust of medical establishment)

- Provider-level – Negative past experience, cognitive dissonance, fear of malpractice
- Setting-level – Loss of revenue, reduced competitive advantage, defensive organizational culture
- Societal-level – Health policy, reimbursement, societal norms
- De-implementation strategies
  - Change order sets
  - Revoke FDA approval
  - Shared decision-making
  - Education
- De-implementation outcomes
  - Intervention removed, replaced, reduced, or restricted?
  - Time to de-implement?
  - Multi-level barriers attenuated by multi-level strategies?
  - Unintended negative consequences?