

Improving the Quality of Lung Cancer Care in Ontario

The Lung Cancer Disease Pathway Initiative

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Background: Before 2008, Cancer Care Ontario (CCO) undertook provincial cancer control quality-improvement initiatives on a programmatic basis. CCO has now added Disease Pathway Management (DPM) to its quality improvement strategy, with the intent of achieving high-quality care, processes, and patient experience across the patient pathway for specific cancers.

Objectives: The three goals of DPM are: to describe and share evidence-based best practice along the cancer continuum for specific cancers; identify quality-improvement priorities for specific cancers and catalyze action; monitor performance against best practice for specific cancers. The objective of this article is to describe the process by which the CCO lung cancer (LC) DPM was initiated and some of its early successes.

Methods: In 2009, LC DPM began with a draft LC disease pathway map and the establishment of five multidisciplinary working groups, each focused on a phase of the LC patient journey: prevention, screening, and early detection; diagnosis; treatment; palliative care, end-of-life care, and survivorship; and patient experience. The working groups held 25 meetings of 2-hour duration and developed concepts for 17 quality-improvement projects across the patient journey. Eight were selected for detailed discussion at a provincial consensus conference, which provided input on priorities for action. A report on the priorities for action was prepared and widely circulated, and regional *roadshows* were held in all 14 regions of the province of Ontario. Region-specific data on incidence, stage, treatment compliance, and wait times among other issues relevant to LC, were shared with the regional care providers at these roadshows. Funding was provided by CCO to address opportunities for regional improvement based on the data and the priorities identified.

Results: The LC disease pathways were refined through substantial multidisciplinary discussion, and the diagnostic pathway was posted

on CCO's Web site in February 2012. The treatment pathways for small-cell LC and non-small-cell LC were posted in November 2012. LC Diagnostic Assessment Units/Programs have been initiated in 14 regions, and educational materials on dyspnea management, including a patient video, are available on CCO's Web site. An audit has been undertaken to better understand the barriers to the uniform uptake of specific evidence-based practices across the province, and the results will be reported shortly. The proportion of LC patients, whose symptoms are assessed at least once a month, using a standardized symptom assessment instrument (Edmonton Symptom Assessment System), has improved through the DPM.

Conclusion: Through CCO's LC DPM initiative, Regional Cancer Programs have become aware of their performance on a range of LC-specific performance and quality metrics and have been motivated to undertake quality-improvement initiatives. Standardized diagnostic and treatment pathways have been developed. Ongoing measurement of a broad range of metrics, including stage-specific survival, guideline concordance, and measures of the patient experience will help determine the benefit of this major initiative.

Key Words: Lung cancer, Management, Quality improvement, Pathways.

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Lung cancer (LC), a predominantly smoking-related cancer, is a growing global health problem because of its high mortality rate. In Canada, which has a population of only 33 million, it was estimated that there would be 26,500 individuals diagnosed with LC in 2012, and 20,100 deaths.¹ In both Canadian men and women, LC is the second-most common cancer after cancer of the prostate and breast. In Ontario, the poor 5-year survival rate of 16% is attributable to the fact that LC typically presents in an advanced stage, with 60% of non-small-cell and 84% of small-cell LCs diagnosed as either stage III or IV.² The unique stigma associated with LC may also contribute to the poor survival outcomes because patients and their families tend to be less aggressive in seeking optimal care.³

Nevertheless, the picture is not entirely negative. In Ontario, there has been a 20% reduction in the smoking rate of the population from the early 1960s to 2000.⁴ Clinical trials have demonstrated a dramatic improvement in 5-year survivorship for some stages of surgically resected LC with the use of adjuvant chemotherapy.⁵ Modest survival improvements have been achieved with combined modality

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therapy for locally advanced cancer, and quality of life and overall survival have improved with palliative chemotherapy and good supportive care for stage IV LC.⁶ Advances in molecular oncology have identified subpopulations of patients who derive greater benefit with targeted therapies.⁷ Recently, evidence has been presented that LC mortality can be reduced with low-dose CT screening.⁸ Clearly, progress has occurred and more is imminent, but adoption of new approaches tends to be slow and uneven across large jurisdictions.

Undertaking Disease Pathway Management for Quality Improvement in Ontario

Cancer Care Ontario (CCO) is the provincial government agency with the mandate to improve the quality of cancer services and ensure that patients in Ontario receive the right care at the right time in the right location by the right care provider, at every step of the cancer journey. To improve quality in Ontario's 14 regional cancer programs, CCO has used a defined performance improvement cycle on a programmatic basis, which includes active clinical engagement and funding levers supported by an integrated clinical/administrative accountability framework.

In 2008, with the support of senior management and the CCO Board of Directors, CCO launched a new approach to quality improvement—Disease Pathway Management (DPM)—designed to complement the existing specialty program-based approach. Besides supporting the mission and mandate of CCO, the goal of DPM is to develop, implement, and evaluate an integrated series of activities aimed at advancing system-wide improvements for a specific cancer type across the continuum of cancer control. Specifically, DPM focuses on ways to improve the quality and processes of care and the patient experience for each type of cancer.

Other jurisdictions have implemented disease-management strategies for quality improvement, with care pathways being the sole driver for quality improvement.^{9–12} CCO's DPM program is unique in that it incorporates quantitative data from the pathways with qualitative inputs from multidisciplinary group discussions, to identify opportunities for improvement. The LC DPM was launched in 2009. This article describes how the LC DPM initiative was organized, the opportunities for improvement that were identified, and the early successes that have been achieved to date.

LC DPM, Phase 1: Identifying Priorities for Action

Clinical leadership for the DPM initiative was sought from within the Ontario thoracic oncology community, in accordance with CCO's established approach of seeking clinical engagement in quality-improvement initiatives. Invitations were extended to two medical experts, who were the co-leads of the existing provincial LC disease site group, which produces clinical practice guidelines. These individuals had established credibility with their peers through their provincial leadership roles and had a network of care providers who could be engaged for the work.

The LC DPM co-Chairs invited a broad spectrum of multidisciplinary stakeholders from across the province and

the cancer continuum to participate in the initiative. In total, 48 individuals agreed to participate, including clinical representatives from primary care, public health, occupational medicine, oncology, and supportive services, as well as patients and caregivers. At an introductory workshop, the participants were organized into four working groups to focus on the separate phases of the patient's journey: prevention and screening/early detection; diagnosis; treatment; palliative care, end-of-life care, and survivorship. In addition, a patient and family advisory group was established. Over the course of 6 months, each multidisciplinary working group was asked to use their experience and the data provided by CCO to identify gaps in service provision and quality-of-care issues, which impacted patient satisfaction. The data that CCO was able to provide on aspects of LC management, included wait times for treatment, concordance of practice with guidelines, LC symptom burden, patient satisfaction, regional LC incidence, and smoking rates. The five working groups met for a total of 50 hours, and generated 17 priorities for action (Priorities).

In addition to identifying the Priorities, the clinical membership of the LC DPM team worked with CCO staff, to develop disease pathway maps (pathways) of recommended diagnostic procedures and treatment approaches for typical small-cell and non-small-cell LC patients. These were based to the extent possible on the practice guidelines developed through the provincial lung disease site group and CCO's Program in Evidence-based Care. Links to the practice guidelines have been embedded in the pathway maps. Wherever evidence was not available, the pathways were informed by expert opinion. The pathways have become an important byproduct of the DPM work because they are now a valuable resource for CCO use in managing the performance of each of the province's regions, planning new quality-improvement activities, promoting best practice, and the use of currently available resources (e.g., guidelines, symptom-management aids). Figure 1 depicts a portion of the lung diagnosis clinical pathway and the integration of best practice guidelines into the pathway. The complete pathway can be viewed on the CCO Web site.¹³

After identification of the Priorities, a provincial symposium was organized to share the Priorities with a larger LC community and to solicit feedback on how to move forward. Recognizing that it would be impossible to solicit input on all 17 Priorities in a single day, the LC DPM leadership team further prioritized the Priorities list, and identified eight topics to be discussed at the symposium (Table 1).

One hundred fifteen individuals attended the event, including frontline clinical experts involved in the diagnosis and care of LC patients, health care administrators, ministry of health representatives, patients, and caregivers. The interactive and multidisciplinary day yielded fruitful discussions regarding the relative importance of each priority and a set of concrete suggestions on the implementation of the eight Priorities.

A key output of this first phase of the LC DPM initiative was the production of a Priorities report, in which each of the identified Priorities from the working groups was summarized, along with the recommendations for implementation from the provincial symposium.

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