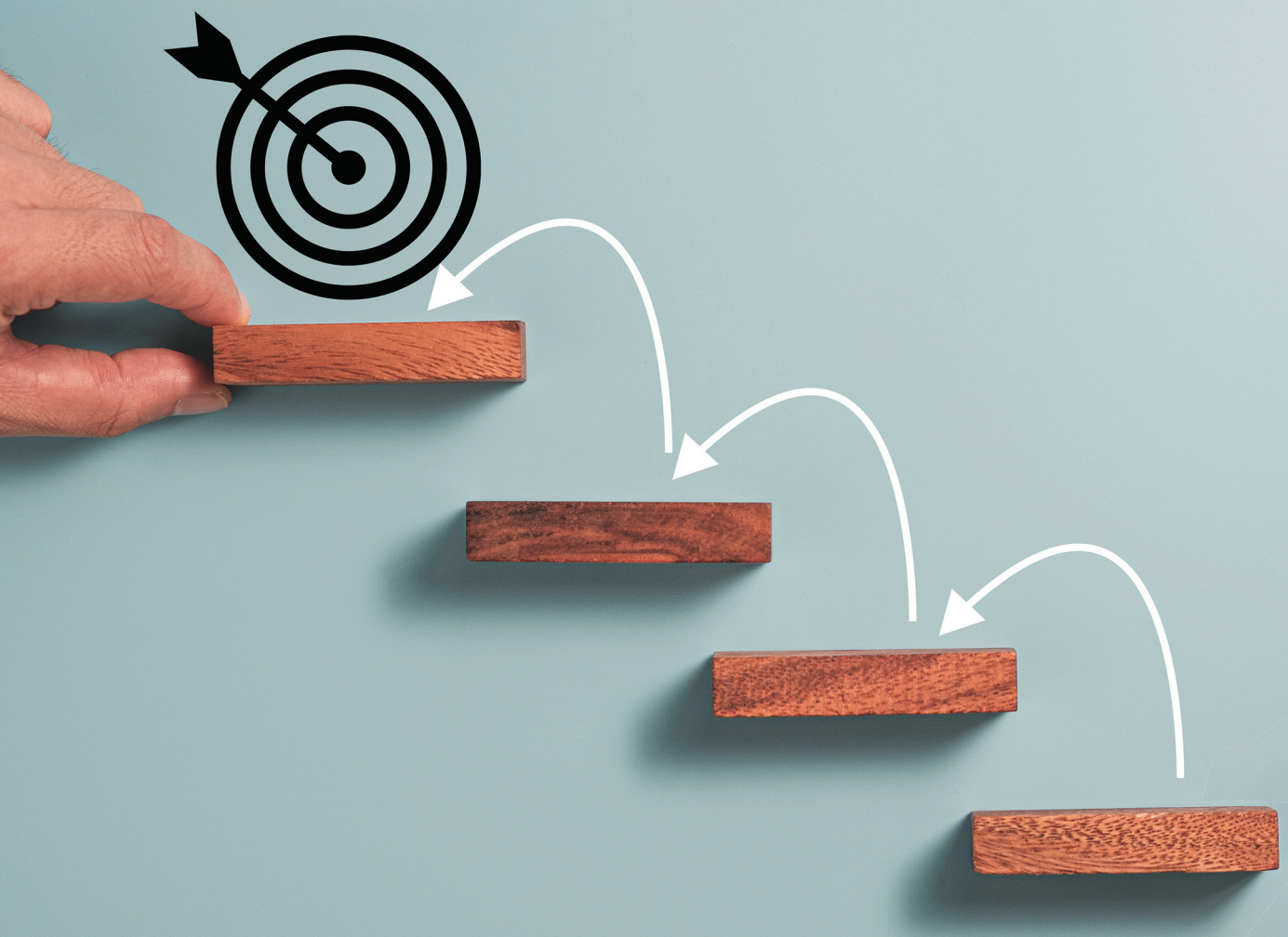
Quality Improvement Officers: Key Members of the Multidisciplinary Cancer Care Team



BY PENNY D. MARCH, PSYD

The concept of quality improvement (QI) in patient care dates back to Hippocrates of Kos, founder of ancient Greek medicine, who lived from 460 BC to 375 BC.[1] Over the centuries, pioneering figures have championed advances in systems of care, including:[2]

- Ignaz Semmelweis, the 19th-century obstetrician who championed the importance of hand washing in medical care.
- Ernest Amory Codman, a Bostonian surgeon who pioneered process-and-outcome measures to improve health safety and quality.
- Florence Nightingale, English reformer of modern nursing, whose use of basic sanitation and call to reduce human pain set standards for compassionate, patient-centered care.

In the early 20th century, American engineer, statistician, and scholar Dr. W. Edwards Deming introduced the idea of using statistics to improve quality control through systematic collection and assessment of data, emphasizing the value of total quality management.

To understand the role of QI as an integral part of cancer care today, *Oncology Issues* reached out to two experts in the field of quality and compliance. Hailing from Clearview Cancer Institute in Huntsville, Ala., Anne Marie Rainey, MSN, RN, CH, is the director of quality and value-based care, where she is responsible for quality initiatives' development, implementation, and monitoring, as well as advanced practice provider education initiatives. On the West coast, Amy Ellis was chief quality officer at Northwest Medical Specialties, a physician-run cancer care practice in Tacoma, Wash., before becoming the practice's chief operating officer (COO). As COO, Ellis is tasked with overseeing day-to-day operations, such as monitoring, strategizing, and implementing value-based care while improving quality of care for oncology patients and providers.

Anne Marie Rainey

Amy Ellis

Clearview Cancer Institute

Not all who work in the field of oncology come from a cancer care background. That was the case with Rainey, whose background in government quality programming initially led her to oversee Health Insurance Portability and Accountability Act (HIPAA) policies and procedures at Clearview Cancer Institute as a government contractor. Over time, Rainey transitioned into the role of compliance and quality control officer at the institute, where she actively developed and organized facility policies and procedures, directed internal audit processes, and oversaw and maintained compliance programs. In her current position as the director of quality and value-based care, Rainey focuses on internal quality programming—whether directed by different departments or by the institute's physician board, in response to incidents or risk management needs, or as a component of value-based care models like the Center for Medicare & Medicaid Services' Merit-Based Incentive Payment System or Oncology Care Model (OCM).

"We have chosen to split my role, so we now have a dedicated compliance officer," Rainey shared. "It's hard to wear multiple hats in any situation, but compliance and quality are two very separate silos, [and] it was hard to jump between the two roles."

When she first began at Clearview Cancer Institute, Rainey and one other staff made up the quality and value-based care department. Eventually, as the institute grew, with enough demand for projects—both payer and internally driven—a third, full-time staff member was hired to create a dedicated department for quality control and a separate department for compliance. To justify non-reimbursed full-time equivalent positions, the practice determined it would be more cost-effective to absorb the cost by

hiring additional internal staff instead of paying great sums of money to external entities to perform the same roles—something the practice had been doing up until this point. "Because OCM was managed by the quality department, we were considered a revenue generating department," Rainey says. "That was the argument that was made for the last five years or so because of the MEOS [monthly enhanced oncology services] dollars that came in and other performance-based payments that are potential revenue from programs we implement, oversee, and help run on a daily basis. We actually are revenue generating like many other departments or disciplines."

In an effort to continue providing certain services at a high-quality level, Clearview Cancer Institute plans to take additional steps in implementing chronic care management and transitional care management. Although these initiatives are not comparable to MEOS, these services will provide a revenue stream, as well as much-needed services to its patients that align with the institute's quality of care goals.

Northwest Medical Specialties

Amy Ellis has been in healthcare her entire working life. Before joining Northwest Medical Specialties, she worked at an outpatient radiology practice where one of her roles involved supporting the Northwest Medical Specialties practice and its radiology readings for oncology research, where patients enrolled in clinical trials had computed tomography scans to track the growth and response of cancerous tumors. "It was fascinating for me in my role in radiology to understand, here's what they're trying to do, and this is my role in it."

Ellis experienced the devastation of cancer closer to home, having lost several family members to the disease, leading her to the realization that she wanted to be professionally involved in some aspect of oncology practice. "My first year at Northwest Medical Specialties was in the clinical research department, so that grew my passion for understanding the disease," Ellis said. "Couple that with truly being impacted on a personal level, and it was a recipe for this is where I was meant to be."

Ellis began her quality cancer care journey at Northwest Medical Specialties as a value-based care manager and, as the practice grew into additional programs and infrastructures, so did her role at the practice, where she transitioned to director of quality and value-based care, then chief quality officer, and currently as the practice's COO. The practice is not only part of the OCM but also the American Society for Clinical Oncology's Quality Oncology Practice Initiative and is certified by the National Committee for Quality Assurance. "For many years, even before my time here, the practice knew it wanted to go this [value-based care] route. Tracking [data] and the [reporting] requirements had a lot to do with it, but this was a long-term strategy the practice had put in place 10 years ago," Ellis shared in response to whether her role was created in response to accreditation requirements. In addition to her role, the practice is staffed with a patient care coordination team, a value-based care manager, and a quality improvement coordinator. Like Clearview Cancer Institute, Ellis's Washington-based practice relies on MEOS fees and other commercial, value-based care models whose funds can be allocated to non-reimbursable staff positions.

QI in Action

To broadly address QI efforts, including staff involved in the initiatives, each practice has a distinct approach to internal quality issues. At Clearview Cancer Institute, a QI issue can get greater traction if the presenting issue is similarly perceived by multiple clinical staff. For instance, if the issue is provider related, the physician will take it to the board of physicians to determine whether it is worth investigating and addressing. "We'll have everybody from our imaging center, lab, front desk, clinical staff, vitals, medical assistants, nurses, and physicians involved in the decision, but it depends on the project," Rainey shares, adding, "Reimbursement is not always tied to these efforts, so we work in a different way to try to achieve buy-in from key stakeholders." A group of advanced practice providers, nurses, and a representative from the quality department confirm the research and present it to the practice's board of physicians, which can help find a solution.

At Northwest Medical Specialties, Ellis approaches QI efforts by holding monthly quality committee meetings with six to seven key staff to address emerging issues. The meeting lasts an hour, and the time is focused on defining root causes and strategizing the direction of the solution, after which staff will have breakout sessions to determine how to bring about an improvement. "We want the right people to be involved," says Ellis. "I don't want to make all the decisions because I'm not the one who, at the end of the day, is going to be delivering that care to patients."

In both instances, Rainey and Ellis stress the importance of involving physicians who can advocate for and move issues forward. Ellis specifically identifies Sibel Blau, MD, medical oncologist and medical director at Northwest Medical Specialties, as a "partner in crime and physician champion of all things." Rainey equally stresses the significance of involving a physician champion, particularly when researching and implementing new pilot programs.

Quality improvement touches multiple disciplines (e.g., physicians, nurses, social workers) and teams (e.g., IT, administration). Interdisciplinary and inter-departmental collaborations are key to successful QI intervention and implementation, as noted by both interviewees, and open dialogue is a key part of the process. "As quality professionals, we must be very open about communicating what we need from different departments to make an idea work, [especially] when the end goal is to improve outcomes for our patients and to benefit the clinic," Rainey says.

In a successful inter-departmental scenario, the QI department can be the solid center of a well-oiled wheel, a resource other disciplines and departments can rely on to run a thriving, efficient program or practice. Nevertheless, some departments may be better at utilizing the QI department than others, at times necessitating QI officers to interject unsolicited intervention due to an occurrence or trend picked up in the data.

Ellis illustrated this by sharing an example of using tablets (e.g., iPads) at the front desk to administer a self-reported depres-

sion scale at Northwest Medical Specialties. Over the span of several years, it was noted that more and more patients struggled with or failed to complete the self-assessment questionnaire. To address the problem, it was crucial for staff from different disciplines to work as a team to bring about a different solution. "We had our value-based care manager, patient access specialists, nursing manager, and social workers involved in the conversation, because it's [the solution is] going to touch several hands to make its way to the final product."

Using data analysis and working as a team, the practice determined that technology was the key barrier in this instance, and changes were made to address patient needs. The assessment was switched to the back office, where medical assistants administer the questionnaire while rooming patients. "We now complete the distress and depression screening in the EHR [electronic health record]," Ellis says. "It's a note template in our EHR, and we are having huge success, even though we struggled for five years to get a really solid process in place."

Data collection and analysis are central elements of successful implementation in quality improvement. Clearview Cancer Institute under Anne Marie Rainey and Northwest Medical Specialties under Amy Ellis both rely heavily on plan-do-study-act cycles (a four-stage, problem-solving model used for improving a process or carrying out change) because it is simple, efficient, and cost-effective. "We have looked into other tools, like Lean Six Sigma," shares Rainey. "But those require a significant monetary investment that's not feasible for us." Ellis concurs, adding, "There are fishbone diagrams to understand a root cause, but I'm not using fishbone diagrams weekly."

Rainey and Ellis both endorse the use of dashboard data. Ellis additionally utilizes annual Hutchinson Institute for Cancer Outcomes Research reports[3] through the Fred Hutchinson Cancer Center in Washington, and Rainey shared that Clearview Cancer Institute has recently added Microsoft Power BI[4] to report data more frequently to stakeholders.

How Can the Association of Community Cancer Centers Support QI?

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for multidisciplinary cancer care teams, offering a wide range of education projects that could be considered quality or process improvement initiatives. But how can ACCC ensure that the right person at its busy member practices and programs receive this information? Ellis and Rainey provided invaluable input to help answer this question.

Ellis suggests possible modifications to the current ACCC website layout to make it easier for quality improvement staff to navigate educational resources without getting overwhelmed by the plethora of information available on the website. "I want the page to speak to them," Ellis says. "It would be helpful if there was an easy menu for care teams, the in-the-trenches team members, with a specific bulleted hub for them to access resources."

Chair of the ACCC Education Committee, Rainey agreed with Ellis's suggestion, adding, "Anytime I see education that's available for free and [that] can benefit someone in our clinic, I'm automatically sending it on to the next person."

Rainey frequently participates in ACCC-led educational programs, as does Ellis, who also an ACCC board member. Because of their existing relationship with ACCC, Ellis and Rainey encourage participation in experiential education programs by staff at their respective oncology practices.

To reach oncology professionals unfamiliar with ACCC educational programming, Rainey suggests being more forthright with self-promotion. "If I'm looking at a specific program, testimonials [from other oncology professionals] would sway my decision to give it a listen."

But not all cancer programs or practices are interested in participating in pilot or value-based programs. The misconception, according to Ellis, is not realizing that there are resources across the board but instead focusing on, "How will that benefit us and our practice?" Ellis suggests marketing materials outline the target audience, highlight key takeaways, and identify benefits to participating. "It could be beneficial to point out resources that can be shared with staff as they're trying to learn about oncology topics because we are constantly challenged to find oncology-experienced team members."

Closing Thoughts

The overall aim of quality improvement in healthcare is to deliver high-quality care to patients through a well-managed, high-functioning system aimed at improving the overall quality of life in the general population. By providing appropriate resources and skills needed to overcome barriers, a systematic and coordinated approach is necessary to bring about measurable improvement. "The system is by no means perfect," confides Ellis. "If you want to fix something in healthcare, there has to be resources, including financial resources, to support those changes."

The potential to create successful healthcare delivery services is a reward onto itself, particularly for those working in the field of quality improvement. Though the work can be painstaking and time consuming, juggling multiple disciplines and departments while managing daily challenges, the work itself is unique in that it can contribute to improving quality of life for patients. Rainey puts it succinctly: "We have an opportunity to make someone's day better and potentially make the outcomes of their health better by some of the projects that we work on. That's what keeps me going every day."

References

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