The Rossy Cancer Network: A philanthropy-driven quality program

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The McGill Academic Health Network (MAHN) in Montreal, Quebec, provides cancer services at the McGill University Health Centre (MUHC), Jewish General Hospital (JGH) and St. Mary’s Hospital Center (SMHC), and represents one of the largest service providers in Canada, caring for roughly 11,500 new cancer patients in 2012. The institutions are internationally recognized, with strong research leadership and excellent health science and medical education.

But while important common clinical initiatives have been forged between the hospitals, organizational boundaries have prevented these institutions from fully benefiting from their combined critical mass. The funding, governance, leadership and care delivery structures have favoured more independent approaches to cancer care delivery. Yet, it was well understood that cancer patients frequently cross hospital boundaries for a variety of reasons, including discrete clinical services more easily available at one or another hospital. This migration between institutions occurs in an uncoordinated fashion that makes movement of patient identifiers and their medical files difficult to track. The lack of common processes of care, access to patient data and a standardized approach to quality improvement were important concerns for the organizations involved, and represented major opportunities for transforming cancer care in this academic network.

Under the principle that the unique strengths and independent governance of the institutions would be preserved, leaders at McGill University and the 3 teaching hospitals met in early 2011 to explore opportunities to create a united platform for cancer care delivery and quality improvement. With generous financial support from the Larry and Cookie Rossy Family Foundation, a letter of intent was signed, paving the way for the creation and launch of the Rossy Cancer Network (RCN) in March 2012.

The RCN represents a shared commitment among our institutions to improving the quality of cancer care for patients. It also has a 10-year goal of becoming a world-class comprehensive cancer network with outcomes equivalent to or better than those of leading cancer networks and centres around the world. The donation would not be used to directly fund patient care; instead, it would be used to support quality improvement infrastructure and the many activities necessary to achieve best in class, quality cancer care.

ESTABLISHING THE PRECONDITIONS FOR HIGH-QUALITY CANCER CARE

The scholarly literature shows that a few factors consistently drive better cancer care and outcomes. Among them are:

- a specific statement of goals for improvement, with a plan for reaching these goals
- public reporting of results with a clear link to improvement plans that become part of the strategy
- strong (practising) clinician and organizational leadership of efforts aligned to improvement goals
- ability to access evidence and tools to support improvement
- support for training and use of improvement skills
- timely access to data

These preconditions were identified prior to the decision to establish the RCN, and came to represent the constituting framework for our network. The next sections of this paper describe the rationale for and importance of these preconditions to high-quality cancer care, and how the RCN responded to them during its inception year.

A SPECIFIC STATEMENT OF GOALS WITH A PLAN FOR REACHING THEM

It has been shown that high-performing health systems and organizations that are capable of sustained quality improvement are also ones that are able to establish a clear and explicit strategy, make strong linkages between quality improvement initiatives and the strategy, and establish clear accountability for execution. For example, Cancer Care Ontario (CCO) regularly refreshes their 4-year Ontario Cancer Plan, which sets the comprehensive strategy for action for Ontario’s cancer system, with annual updates that publicly report progress against measurable targets for each stated goal. The Institute for Healthcare Improvement’s 100,000 Lives Campaign is another example of the successful use of goal statements with a tight linkage to tactics to improve healthcare. Over the 18-month period ending in 2006, the campaign was able to exceed its target of saving 100,000 lives; moreover, it helped
Inspire a legion of healthcare providers to create a quality improvement culture and sustain their efforts beyond the lifespan of the campaign.

The organizations that make up the RCN developed a detailed work plan laying out specific steps to be taken towards clear, measurable targets on the road to our long-term strategic goal. This commitment was matched by the foundation’s pledge to provide funding support to the initiative over 10 years, subject to the achievement of critical milestones and demonstrable improvements in patient outcomes along the way.

PUBLIC REPORTING OF RESULTS WITH A FOCUS ON IMPROVEMENT

Numerous studies have shown that public comparative reporting drives improvements.

Reporting of cardiac surgery outcomes in New York State and California prompted surgeons to rethink how they care for certain groups of patients, particularly those who are at high risk.11 Within the first three years of public reporting, 27 surgeons who had low volumes and high-risk-adjusted mortality rates ceased performing cardiac surgery in New York State, and more than one-third of the state's cardiologists indicated that the data had affected their referral patterns.7 In terms of its impact on outcomes, the public reporting effort in New York State and the improvement efforts it engendered were associated with a 41% reduction in risk-adjusted cardiac bypass surgery mortality.6

In Canada, a cardiac report card by the Institute for Clinical Evaluative Sciences for treatment of patients with heart attack prompted over half of clinicians surveyed to launch one or more quality initiatives at their hospital.8

While public reporting may not have much dramatic effect on patient behaviour, it has been shown to motivate healthcare administrators to make necessary changes to improve care.10 Examples of administrative responses to publicly reported information include improvements in recruitment practices, performance monitoring and investments in quality improvement.11 Such information has also been used to restrict the privileges of lower-quality clinicians12 and improve followup care and patient education.13 Moreover, these types of changes have been shown to be much more significant when performance reports are made public, rather than only provided on a private/confidential basis.14

Early on in the formation of the RCN, an Indicators and Outcomes team was established, with a mandate to develop a set of performance indicators that could be tracked across the 3 hospital sites of the RCN. The indicator selection process involved a large number of clinicians across the 3 hospitals, starting initially with the breast cancer groups, then prostate, colorectal and lung cancer groups. In time, this process can expand to include less common cancer sites.

In addition to these clinical indicators, the initial measurement efforts of the RCN included a strong emphasis on the patient experience. Historically, each of the 3 hospitals measured the patient experience using different survey instruments. Accordingly, the results were neither comparable across the RCN nor could they be benchmarked against other centres. A Patient Experience team was formed that included patient representation from the 3 hospitals in the network, and a decision was made to invest in and adopt the standard Ambulatory Oncology Patient Satisfaction Survey (AOPSS) across the 3 hospital sites for ambulatory care. The new AOPSS survey was rolled out in June 2012. For the inpatient experience, the widely used Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey was chosen. These choices were driven by the imperative to benchmark performance and the 10-year goal of demonstrating outcomes on the international stage. Some projects previously initiated at the 3 hospitals (i.e. distress screening) are now the focus of a more coordinated approach.

STRONG (PRACTISING) CLINICIAN LEADERSHIP ALIGNED TO GOALS

Strong peer and administrative accountability for clinical decision making based on evidence (clinical governance) has been demonstrated to be an important ingredient for continuously improving the quality of patient care.15,16 The importance of clinical governance has been highlighted through the United Kingdom’s National Health System reform.17,18 In Ontario, CCO has established physician-led structures, both formal and informal, to champion quality improvement.9

Engagement of the large and historically distinct communities of clinicians across the McGill hospitals remains a work in progress. Senior clinical leaders were actively involved in developmental stages of the RCN, both as key members of the executive body shaping the initial approach to work and as team leads on 4 critical streams of developmental activities: establishing performance indicators, integrating oncology patient information across the network, harmonizing patient experience surveys, and implementing synoptic cancer pathology reporting. The latter stream is essential, as unlike free text, standardized synoptic reporting is the modern standard to ensure complete and standardized diagnostic, prognostic and staging data for cancer patients.

As we enter year 2 of RCN operation, we are recruiting a clinical initiatives champion who will work with disease site groups across the 3 hospitals to advance the transfer of ideas and promote consistency of disease site management for cancer patients. In March 2012, the RCN hosted the inaugural leadership conference, where approximately 150 oncology and institutional leaders across the network assembled to discuss the shared vision for excellence in cancer care, and to engage in workshops to shape critical aspects of the RCN.

ABILITY TO ACCESS EVIDENCE AND TOOLS TO SUPPORT IMPROVEMENT

Successful improvement efforts like the 100,000 Lives Campaign demonstrate that for improvement goals to be effective, they need to cascade to the front lines of care in the form of evidence-based tools and technical know-how to enable effective and widespread implementation. In cancer care, evidence-based guideline development and dissemination programs have become a staple.19,20 Tumour/disease site groups organized usually by organ system, but also involving
different aspects along the continuum of cancer care (e.g., palliative care), are often the building blocks of improvement programs. They can take responsibility for establishing and disseminating clinical guidelines, reviewing performance information, identifying quality gaps and setting improvement priorities and targets.

The RCN, having devoted its earliest activities toward infrastructure development for measuring quality of care, subsequently turned its attention to assisting tumour/disease site groups to examine and improve the quality of their own service delivery at the clinical level. At the time, a variety of tumour/disease site groups were already well established within and across the hospitals and doing good work. However, there was a need for greater consistency and reliability of care as well as leveraging of knowledge and resources across the network. As an initial step, the RCN is in the process of establishing a competitive tumour/disease site group funding pool to provide dedicated resources to accelerate collaborative tumour/disease site group quality initiatives across institutions, toward common standards of care within the network.

**SUPPORT FOR TRAINING AND USE OF SKILLS**

The experience of quality improvement in other industries, such as manufacturing, has shown that front-line workers need to be equipped with the necessary skills and training to execute improvement goals. Investment in training and building capacity for improvement among healthcare workers has proved key to sustaining improvement efforts among leading healthcare systems around the world. This is most apparent in Jönköping County, Sweden, where structures such as the Qulturum have been established to ensure ongoing learning and support for staff and leaders through action-based quality improvement training. In the course of the next 2 years, the RCN will explore how best to support specialized training for quality improvement among the staff of the RCN.

**TIMELY ACCESS TO DATA**

Empirical evidence on the importance of clinical information systems for efficient, effective care is extensive. CCO has made very significant capital investments to enhance the utility of its data stores, piggybacking on its lead role in designing and deploying a province-wide wait times information system that was well supported by the Ontario government. CCO has focused efforts on developing an extensive business intelligence system to allow timely data access for providers and planners. Data collection and information system development efforts have led to a significant increase in population stage capture, from 30% in 2005 to the current rate of more than 90% for major cancers and 80% for all cancers.

An information technology (IT) readiness assessment was an early step in the RCN, with particular emphasis on the capacity to support a sustained focus on improving cancer care outcomes. The assessment identified a number of challenges including: a need for common definitions; barriers to sharing of common patient data across the hospitals; differences in data capturing across the institutions and within various sectors within the same institution; and little cross-institution coordination of IT initiatives that impact oncology.

An ambitious initiative was launched to integrate oncology information more effectively across the network, and a team was put in place to implement the changes. Among the top priorities were: the development of a common patient identifier to support the identification of cancer patients across the hospitals, regardless of where among the 3 hospitals they enter the network; standardization of data terminology and nomenclature for oncology across institutions; implementation of explicit consent for cancer patients across all institutions at induction or presentation; integration of oncology patient data across all hospitals — standardized on common oncology data interfaces; and integration of pathology data, diagnostics and patient results information.

Given the importance to clinical decisions of having complete and consistent reporting of pathology stage data, the RCN established a team, led by the head of pathology at SMHC, to implement common standardized synoptic pathology reporting based on the College of American Pathologists (CAP) synoptic protocols, with a commitment to solve inter-hospital IT-related obstacles and implement the protocols initially for the 4 commonest cancers by mid-2013. An expansion to other tumour sites will follow.

**LOOKING AHEAD**

The RCN was born at a turbulent time, when staff and institutional leaders were heavily preoccupied with the day-to-day challenges of trying to maintain service delivery under heavy fiscal pressures. This is not a project aimed at a cohesive and comprehensive cancer jurisdiction like Ontario; rather, its explicit goal is to transform the McGill hospital sector within the overall Quebec cancer care enterprise. It is hoped that the eventual lessons will transform the McGill network of hospitals. It is also hoped that the eventual lessons might be adapted and adopted by other hospitals within Quebec. So the task is formidable in a challenging and novel context.

Establishing a world-class cancer network requires a long-term strategic focus. The emphasis during RCN’s formative period was on establishing the preconditions necessary for high-quality cancer care. Whether these preconditions are actually sufficient remains to be seen. The change process is complex. It is difficult to fully lay out a comprehensive change program in advance; unanticipated events are often encountered. The time and resources needed to bring about the desired change are in short supply and in constant competition with pre-existing priorities. Despite these uncertainties and obstacles, there is much optimism among the senior executive and oncology and informatics staff, led by the McGill work stream leaders on this paper, who have reached out to many front-line staff. We all share the ambition to be among the best. The promise of philanthropic support over 10 years, combined with the implementation of best practices seen in other high-performing health systems, suggest that significant improvements in cancer outcomes are within reach.

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References