Ensuring Quality Cancer Care:
A Follow Up Report of the Institute of Medicine’s 10 Recommendations for Improving the Quality of Cancer Care

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Ensuring Quality Cancer Care

• MD Anderson created the Institute for Cancer Care Excellence in 2008 to study value-based cancer care
• The 1999 IOM report was a key document as we established this institute to study cancer care delivery
• We revisited the report in 2011 to see what progress had been made and what further work needed to be done
• We used internal faculty to expedite the review of the 10 recommendations
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A Follow-Up Review of the Institute of Medicine’s 10 Recommendations for Improving the Quality of Cancer Care in America

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Responding to growing concerns regarding the safety, quality, and efficacy of cancer care in the United States, the Institute of Medicine (IOM) of the National Academy of Sciences commissioned a comprehensive review of cancer care delivery in the US health care system in the late 1990s. The National Cancer Policy Board (NCPB), a 20-member board with broad representation, performed this review. In its review, the NCPB focused on the state of cancer care delivery at that time, its shortcomings, and ways to measure and improve the quality of cancer care. The NCPB described an ideal cancer care system in which patients would have equitable access to coordinated, guideline-based care and novel therapies throughout the course of their disease. In 1999, the IOM published the results of this review in its influential report, \textit{Ensuring Quality Cancer Care}. The report outlined 10 recommendations, which, when implemented, would: 1) improve the quality of cancer care, 2) increase the current understanding of quality cancer care, and 3) reduce or eliminate access barriers to quality cancer care. Despite the fervor generated by this report, there are lingering doubts regarding the safety and quality of cancer care in the United States today. Increased awareness of medical errors and barriers to quality care, coupled with escalating health care costs, has prompted national efforts to reform the health care system. These efforts by health care providers and policymakers should bridge the gap between the ideal state described in \textit{Ensuring Quality Cancer Care} and the current state of cancer care in the United States. \textit{Cancer} 2012;118:2571-82. © 2011 American Cancer Society.

\textbf{KEYWORDS:} oncology service, hospital, quality of health care, benchmarking, guideline adherence, medically uninsured, palliative care, comparative effectiveness research.

Recommendations 1-5

• Original report described large gap in delivery of quality care with poor survival and quality of life for patients not receiving evidence-based care

• First 5 recommendations describe optimal care practices to narrow the gap
Recommendation 1

Ensure that patients undergoing procedures that are technically difficult to perform and have been associated with higher mortality in lower volume settings receive care at facilities with extensive experience

- Variable success – sufficient capacity for only ½ of potential cases
- Increased capacity at high volume centers is needed
- Lower volume high quality programs do exist
- Mechanisms needed for matching patients with centers with best outcomes, regardless of program size
Recommendation 2

*Use systematically developed guidelines based on the best available evidence for prevention, diagnosis, treatment, and palliative care.*

• Most cancer care is structured around disease- and stage-specific guidelines, including over 135 guidelines co-developed by NCCN

• Guidelines incorporated into CMS’ PQRS program as a basis for incentive payments and in ASCO’s QOPI program

• Concordance has been variable owing to: voluntary physician participation, unproven relationship between use and long-term outcomes, effects of prior treatment and co-morbidities, and patient preference

• Concordance will increase with better EHR systems for public reporting and pay for performance
Recommendation 3

Measure and monitor the quality of care using a core set of quality measures.

• NQF has endorsed over 150 cancer-related measures, including measures developed by ASCO and NCCN
• Core measures not yet defined
• ACA mandated PPS-exempt centers to report on outcomes, process, structure, efficiency, costs, and patient perceptions of care by 2014
• Preliminary 5 measures are: 3 cancer-specific process measures and 2 cross-cutting outcomes measures
• NQF and CMS have accelerated the measure endorsement process
Recommendation 4

Ensure the following elements of quality care for each individual with cancer; 1) that recommendations about initial cancer management, which are critical in determining long-term outcome, are made by experienced professionals; 2) an agreed-upon care plan that outlines goals of care; 3) access to the full complement of resources necessary to implement the care plan; 4) access to high-quality clinical trials; 5) policies to ensure full disclosure of information about appropriate treatment options; 6) a mechanism to coordinate services; and 7) psychosocial support services and compassionate care.

• We see better use of multidisciplinary planning, greater payment for clinical trials, and improved patient education materials
• Care coordination, access, informed decision making, supportive care, and clinical trial access are continuing problems for US healthcare
Recommendation 5

Ensure quality of care at the end of life, in particular, the management of cancer-related pain and timely referral to palliative and hospice care.

• Proven benefit of early palliative care referral in survival and symptom control

• More centers provide palliative services but delayed access

• Barriers include perception of diminished hope, belief that care must happen in series rather than in parallel, under-resourcing of these services and poor patient understanding

• Improvement strategies include provider and patient education, increased MLP roles, and direct insurer to patient EOL benefits
Recommendations 6-8

• The IOM report attributed the gaps outlined above to lack of research evaluating cancer care delivery
• Recommendations 6-8 address how such research could be supported
Recommendation 6

Federal and private research sponsors such as the National Cancer Institute, the Agency for Health Care Policy and Research, and various health plans should invest in clinical trials to address questions about cancer care management.

• Few trials devoted to care delivery models due to inherent heterogeneity of the population

• Informed consent a problem

• Carefully designed observational studies may answer some delivery questions
Recommendation 7

A cancer data system is needed that can provide quality benchmarks for use by systems of care (such as hospitals, provider groups, and managed care systems).

• Some large system EHRs capture necessary data fields
• Progress slow since benchmarking requires measures with definitions and systems of data collection
• No standard reporting system for all cancer providers
• Need stronger mandate for EHRs to capture and report oncology-specific data elements and guideline concordance
Recommendation 8

Public and private sponsors of cancer care research should support national studies of recently diagnosed individuals with cancer, using information sources with sufficient detail to assess patterns of cancer care and factors associated with the receipt of good care. Research sponsors should also support training for cancer care providers interested in health services research.

• The ARRA directed $1.1 billion to comparative effectiveness research, accelerating interest
• IOM CER report highlighted cancer in its top 100 priorities
• Cancer well represented in ARRA expenditures
• Trained HSR investigators in cancer remains an issue (8 career development awards from NCI)
Recommendations 9-10

• Cancer survival improving, and more patients living longer with cancer; however, certain populations have higher mortality rates
• Recommendations 9 and 10 address the barriers facing some Americans in receiving quality cancer care
Recommendation 9

Services for the un- and underinsured should be enhanced to ensure entry to, and equitable treatment within, the cancer care system.

• Access and coverage have worsened since 1999 report due to growth in uninsured and underinsured
• ACA partially addresses uninsured
• Some programs direct screening to underserved – this is a critical leverage point
• Much needs to be done as cancer care costs escalate
Recommendation 10

Studies are needed to find out why specific segments of the population (eg, members of certain racial or ethnic groups, older patients) do not receive appropriate cancer care. These studies should measure provider and individual knowledge, attitudes, and beliefs, as well as other potential barriers to access to care.

• Many studies describe the ongoing inequities and the etiology
• NCI centers have partially addressed issue with programs to reduce health disparities through research, education and outreach
• Now that the factors are understood more needs to be done to correct the inequities
Conclusions

• Report came at beginning of IOM’s landmark work on quality and safety, raising awareness

• Clear that much still needs to be done and some issues were addressed by the ARRA and ACA

• Major problems with our data systems and integration of quality concepts into cancer care delivery

• Major problems remain with respect to equitable access
Some Additional Considerations

• We must consider that biomarkers and other new detection techniques may uncover more early stage disease in elderly patients
  § How will they be managed and treated?
  § Which ones will progress and which ones will not?
• Age is the major risk factor for cancer – why?
• What is the difference between chronologic age and biologic age? Who is really at risk?
• We must consider effect of age on treatment toxicity
• Rapid advances in science need more rapid translation to care of our population
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