Consensus Study on Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population

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Good morning. My name is Dr. Mary Gullatte, and I am the president of the Oncology Nursing Society (ONS). ONS is a professional association of more than 35,000 members committed to promoting excellence in oncology nursing and the transformation of cancer care. Since 1975, ONS has provided a professional community for oncology nurses, developed evidence-based education programs and treatment information, and advocated for patient care, all in an effort to improve quality of life and outcomes for patients with cancer and their families. It is an honor and privilege to share some opening comments with the IOM’s committee on Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population. Thank you for the opportunity to address the committee.

Cancer is primarily a disease of people older than 50, considering that advancing age may be the single most impactful risk factor for the development of most cancers (Howlader et al., 2012). Although overall cancer mortality has seen declines in recent years, the American Cancer Society estimates that more than 1.6 million new cancer cases will be diagnosed in 2012, with more than 577,000 deaths projected this year (Siegel, Naishadham & Jemal, 2012). The Centers for Disease Control and Prevention and the National Cancer Institute estimated that nearly 12 million cancer survivors
are living in the United States, and that number is growing (CDC, 2011). The vision of ONS is to transform cancer care through our mission of promoting excellence in oncology nursing and quality cancer care. As Baby Boomers age, they are at risk for health problems, including multiple comorbid conditions, that may affect their ability to tolerate cancer treatments and increase the rate of significant side effects (Extermann, 2007). The challenges for the aging population are related to mobility, diminished capacity, fixed or reduced incomes, comorbid health conditions, limited access to care, and potential decreases in the number and geographic availability of family caregivers over time (Ryan, Smith, Antonucci, & Jackson, 2011).

When patients attempt to access the complex healthcare system, they are often frustrated by long waits and lack of coordination of care by multiple consulting providers. Astute healthcare institutions are employing nurse navigators, nurse case managers, and transition managers to help all patients, but aging patients in particular.

Additionally, nurses, by profession and preparation, promote evidence-based practices and patient-centered care to enhance patient education, treatment, and survivorship. Nurses not only “do no harm” but also prevent harm. Maureen Bisognano, BSN, MSN, executive vice president and chief operating officer for the Institute for Healthcare Improvement, shared the following story during her October 19, 2009, participation in the Forum on the Future of Nursing:

She also noted that care is much more patient centered in other countries than in the United States. She described a friend’s account of her father’s experience after breaking a hip in England. “The day before he went home, a nurse-led squad arrived at the house … and went through the entire house with her mother. They installed a
grab bar in the shower, a [seat] on the toilet so he could get up and down. They handed the mother the pain medication and went over diet. They tacked down the rugs and talked about how to take care of his wound. That is patient-centered care, and the patient won’t be readmitted because the nurses are carrying that patient care from one setting to another. We need to figure out how to measure that (p.22).

Recognizing the crucial role of nurses in actively promoting positive outcomes for patients with cancer, ONS has made quality a pillar of our 2012–2016 strategic plan. In oncology, especially in the ambulatory setting, nurses serve as translators and navigators of care for patients and their families over the course of a disease trajectory that may fluctuate over many years. By coming to know patients’ values, their preferences for learning and decision making, and their knowledge level about their health and treatments, nurses are truly positioned to facilitate patient-centered, high-quality cancer care.

Quality care has many proposed definitions, including the excellent description from the 2001 IOM report, Crossing the Quality Chasm: “care that is consistently safe, timely, effective, efficient, equitable, and patient-centered” (p. 7). Inherent is an emphasis on consistent implementation of the best-available evidence for care proven to improve cancer outcomes. The integration of nursing perspective, gained through experience at the chair- and bedside, can provide valuable insights on how to best manage patients with complex physical and psychosocial needs.

Oncology nurses encounter daily barriers to providing evidence-based quality care to patients. A quality healthcare system might be described as one where dedicated health team members do not have to work around those barriers to achieve goals of care with resultant desired patient outcomes.
Rather, the best healthcare system creates a national environment where the culture, structure, and processes nurture excellence and evidence-based safeguards are in place to protect the clinician and patient from straying from the critical paths that work.

Patients with cancer, especially those over age 65, represent a growing population of individuals living with a chronic disease (which includes cancer) and are seen by multiple members of the healthcare team in a variety of settings. In our current, fragmented system, patients are at risk for redundant, uncoordinated, and ineffective care. The risk of medical errors and additional healthcare costs increases when tests and procedures are repeated because results are unavailable to all healthcare providers managing patients’ ongoing treatment. In addition, information from hospital admissions and treatments provided in other settings may not be readily available to primary or oncology care clinicians, severely limiting the ability to provide effective follow-up care and avoid unnecessary rehospitalization. In each of these examples, cancer survivors require long-term, coordinated care from multiple clinicians and community resources. The system often does not support the adequate education of patients and families as they are discharged. This critical intervention, provided by nurses, helps patients and their families to effectively manage their disease and can help to prevent readmissions and untoward events.

In 2009, the ONS Foundation began a multiyear project to develop and test national patient quality measures for the supportive care of patients with breast cancer. Although many examples of excellent care have been illustrated through the results of this project, significant challenges have been uncovered as well. Even within a single health system providing multidisciplinary breast cancer services, challenges exist in care coordination, collaboration, and communication. In many cases,
medical, radiation, and surgical oncology providers appear to view the type of care they provide as separate and sequential, rather than as part of an integrated treatment plan for patients. Further, testing thus far of a coordination of care quality measure indicates inconsistencies in interprovider communication, even as basic as sending copies of patient visit notes to referring physician practices. In many cases, data abstractors found it difficult to locate documentation of the intended or already provided treatments from the various oncology specialties, including the date that patients completed their overall treatment plans.

Quality measurement is an essential tool to improve the structures, processes, and linked outcomes across the healthcare system. Current hand-abstraction and data submission of measures, either from paper or electronic records, fall primarily to nurses and are time consuming and burdensome. The average time to collect eight measures for 30 patient cases in our first pilot test in 2010 was approximately eight hours. Combine this effort for one measure set with the growing opportunities and requirements for measurement, and it becomes clear that the current hand-collection model is unsustainable. Efforts to align electronic health records and other systems to allow real-time, automated data collection as a byproduct of care, rather than as an additional activity, can only enhance quality efforts. As these new systems emerge, it is also critical that measures that assess the full spectrum of care provided by all members of the team are included.

As you know, the IOM recommends inclusion of specific components for survivorship care plans (Hewitt & Ganz, 2007). These care plans are personalized documents provided by the treating oncology team, highlighting the diagnosis and treatment plan, potential late effects of treatment, and recommendations for ongoing care. Use of survivorship care plans is not yet standard practice across
oncology practices and institutions, and evidence regarding their effectiveness in practice is mixed; in addition, providers voice concerns about the time and effort required to create them (Campbell et al., 2011; Grunfeld et al., 2011; Hewitt, Bamundo, Day, & Harvey, 2007; Salz, Oeffinger, McCabe, Layne & Bach, 2012). Of benefit to patients and interprofessional oncology providers would be an integrated electronic health record or system that could automatically abstract and update such a care or treatment plan and that could be retrieved by patients and interprofessional providers anywhere, anytime through real-time Internet access. Such a system has unlimited potential to promote care coordination, safe medication prescribing, and risk assessment for clinical decision making.

Essential to the future of oncology nursing and to ensure desired outcomes of care is a continued focus on a healthcare pipeline of new nurses across all settings, including academia, research, and practice, to meet the ever-growing healthcare needs of an aging population. The strength of partnership between patients and the interprofessional healthcare team is the model for the future, and it is recognized that formal competencies and innovative, collaborative curricula are needed to ensure that the education of all future providers occurs with true patient-centeredness as a core perspective (Goldberg, Scott Koontz, Rogers, & Brickell, 2012). It is imperative that patients be true partners in their care to ensure compliance with health promotion and disease prevention strategies for the best outcomes.

Clearly, many challenges must be overcome to create the type of healthcare system the interprofessional team needs to coordinate and facilitate care and decision making in collaboration with patients and their families. Continued efforts to focus attention, and expert dialog such as this hearing, will serve to inform and drive purposeful improvements. ONS is pleased and honored to
sponsor this consensus study. We anticipate that the committee will develop recommendations for systems of the future that not only improve the quality of cancer care but also value the interprofessional healthcare team across the entire spectrum of care, as per the recent IOM report on *The Future of Nursing: Leading the Change, Advancing Health* (2011).

Thank you.


