Review of IOM Reports: Policy and Quality of Care

Ya-Chen Tina Shih, PhD
Associate Professor, Department of Medicine
Director, Program in the Economics of Cancer
University of Chicago
Cancer in Elderly People: Workshop Proceedings

- Workshop presented to the IOM National Cancer Policy Forum in October 2006
- Identified clinical, psychosocial, and policy issues and challenges in caring for elderly cancer patients
Cancer in the Elderly: Special Considerations

- Limited clinical evidence on how older patients respond to new therapies due to under-representation of elderly people in clinical trials.
- Complexity in managing this population due to comorbidity and functional status as a result of aging.
- Care coordination among primary care providers and cancer specialists.
- Transition among multiple sites (home, hospital, nursing home, or hospice) at the end of life, underutilization of hospice and palliative care.
- Oncology workforce.
Policy Recommendations:

• Increase elderly people’s participation of clinical trials
• Establish standards and guidelines for family care and the quality of family care
• Change in reimbursement policy to allow concurrent hospice and active treatment
• Increase workforce training in geriatric oncology
• Impact of Medicare Modernization Act and Part D on quality of care needs to be evaluated
Ensuring Quality Cancer Care Through the Oncology Workforce: Sustaining Care in the 21st Century: Workshop Summary

• Workshop presented to the IOM National Cancer Policy Forum in October 2008

• Discussed current state of demand and supply of health care workforce relevant to the entire spectrum of cancer care

• Workforce shortage is a quality of care issue
Oncology Workforce: Demand and Supply

**Demand curve**

- aging of the American population
- increasing complexity of cancer care driven by fast pace of medical advances
- treatment success creates a large number of cancer survivors
- patient empowerment among baby boomers

**Supply curve**

- Aging workforce heading into retirement
- Limited number of training programs and faculty
- Rising insurance premium for malpractice lawsuits disincentivizes general surgeons
- Different attitude toward medical practice in younger cohorts of physicians

**Shortage**

- time
Oncology Workforce: Current State

• Physicians
  ● High insurance premiums for malpractice lawsuits contributes to the increasing lack of general surgeons
  ● Underserved communities more susceptible to shortage than wealthy communities

• Oncologists
  ● Aging of current workforce (over 50% of currently practicing oncologists are age 50 and over)
  ● Few oncology fellowship programs have plans to increase the number of training slots
  ● Decreasing number of students in internal medicine, and increasing subspecialization
  ● A steady increase of radiation oncologists, but still might not meet the increasing demand
Oncology Workforce: Current State

• Nurses
  ● Shortage in nursing faculty contributes to shortage of nurses
  ● Temporary (but not sustainable) relief of nursing shortage from recession
  ● Oncology nurses
    ● 50% reduction in the number of nursing schools with oncology specialty in the past 5 years

• Allied health care workforce
  ● Shortage of laboratory and radiology technicians may be worse than the shortage of physicians and nurses
  ● Inadequate number of allied health care education programs
  ● Other Oncology Health Care Workers
    ● Shortage in public health workers, social workers, pharmacists, cancer registrars, laboratory workers and technicians were also noted
Proposed Solutions

• A systems-over-silos approach of oncology care
• New models of care
  ● Improve efficiency (e.g., HIT)
  ● Team-based model that integrates and expands the role of physician assists and nurse practitioners
  ● New model of survivorship care to bolster the use of primary care physicians or nonphysician health care workers
  ● More use of palliative and hospice care
  ● Family care giving, could facilitate or hinder patient care
  ● Medical homes

• Recruitment and retention
• Education and trainings
• Research support
Policy Recommendations

• Payment reforms
  ● To provide incentive for team-based care models
  ● To cover appropriate monitoring and support for the physical, social, and emotional effects
  ● Less strict criterion on the type of care allowed in hospices
  ● Pay-for-performance

• Less stringent requirements for Medicare’s reimbursement of residencies and fellowships
  ● recent legislation efforts to promote cancer workshop had not been successful

• Capacity-building (not discussed at the meeting)
Assessing and Improving Value in Cancer Care: Workshop Summary

- Workshop presented to the IOM National Cancer Policy Forum in October 2009
- To seek agreement in understanding and assessing value and provide policy tools to improve value in cancer care
<table>
<thead>
<tr>
<th>Attributes of Value</th>
<th>Metrics of Value</th>
<th>Pertinent Stakeholder Perspectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outcome Attributes</td>
<td>Economic Metrics</td>
<td>Patient perspective, including families or other social supports</td>
</tr>
<tr>
<td>Survival—duration of life</td>
<td>Cost per QALY</td>
<td>Physician or clinician perspective</td>
</tr>
<tr>
<td>Quality of life</td>
<td>Equity Metrics</td>
<td>Health insurer perspective—public and private</td>
</tr>
<tr>
<td>Adverse events</td>
<td>Variation in care</td>
<td>Pharmaceutical manufacturer perspective</td>
</tr>
<tr>
<td>Time to progression</td>
<td>Financial hardship</td>
<td>Societal perspective—the public at large</td>
</tr>
<tr>
<td>Tumor response</td>
<td>Workforce or service shortages</td>
<td></td>
</tr>
<tr>
<td>Cause Attributes</td>
<td>Access to insurance and appropriate services</td>
<td></td>
</tr>
<tr>
<td>Access to care</td>
<td>Disparities in care</td>
<td></td>
</tr>
<tr>
<td>Quality of care</td>
<td>Innovation Metrics</td>
<td></td>
</tr>
<tr>
<td>Communication</td>
<td>Willingness to pay for cancer treatment research</td>
<td></td>
</tr>
<tr>
<td>Social equity</td>
<td>FDA new drug applications</td>
<td></td>
</tr>
<tr>
<td>Patient-Centered Attributes</td>
<td>Generic treatments</td>
<td></td>
</tr>
<tr>
<td>Compassion and respect</td>
<td>Biosimilars</td>
<td></td>
</tr>
<tr>
<td>Opportunity for treatment benefit</td>
<td>Care Metrics</td>
<td></td>
</tr>
<tr>
<td>Choice</td>
<td>Quality of clinician-patient communication</td>
<td></td>
</tr>
<tr>
<td>Hope</td>
<td>Coordination of care</td>
<td></td>
</tr>
</tbody>
</table>

Value in Oncology Care

• Definition:
  ● Patient-physician communication creates a framework to define what is valuable in cancer care
  ● Patients: value of hope, but also value in eliminating “false hope” early on
  ● FDA: value = benefit to the patient
  ● Pharmaceutical companies: “value-based” pricing accounts for numerous factors
  ● Insurers: value cannot be determined solely based on evidence from clinical trials

• Expensive treatment ≠ high value

• High value care ≠ cost saving
Policy Recommendations

• Payment reforms
  ● Policy remedies for patients with advanced cancer to access hospice care
  ● Reimbursement realigned to cover patient management, psychosocial, and palliative care services necessary for high-quality care
  ● To cover last-chance therapies only in clinical trials or for registry patients so as to provide more evidence of effectiveness
  ● Pay-for-performance
  ● Value-based insurance design
  ● Coverage with evidence development (CED)

• Authorize CMS to negotiate drug prices
• Transform the comparative effectiveness program into a cost-effectiveness program
• Post information in NCI or ACS website to reduce unrealistic expectation for cancer treatment benefits
Summary

• Payment reforms
• End-of-life care
• New models of oncology care
• Oncology workforce
• Patient-physician communications
• Value / Quality is multi-dimensional
• Unique health care need in population subgroups