Delivering High-Quality Cancer Care:
Then, Now, and in the Future

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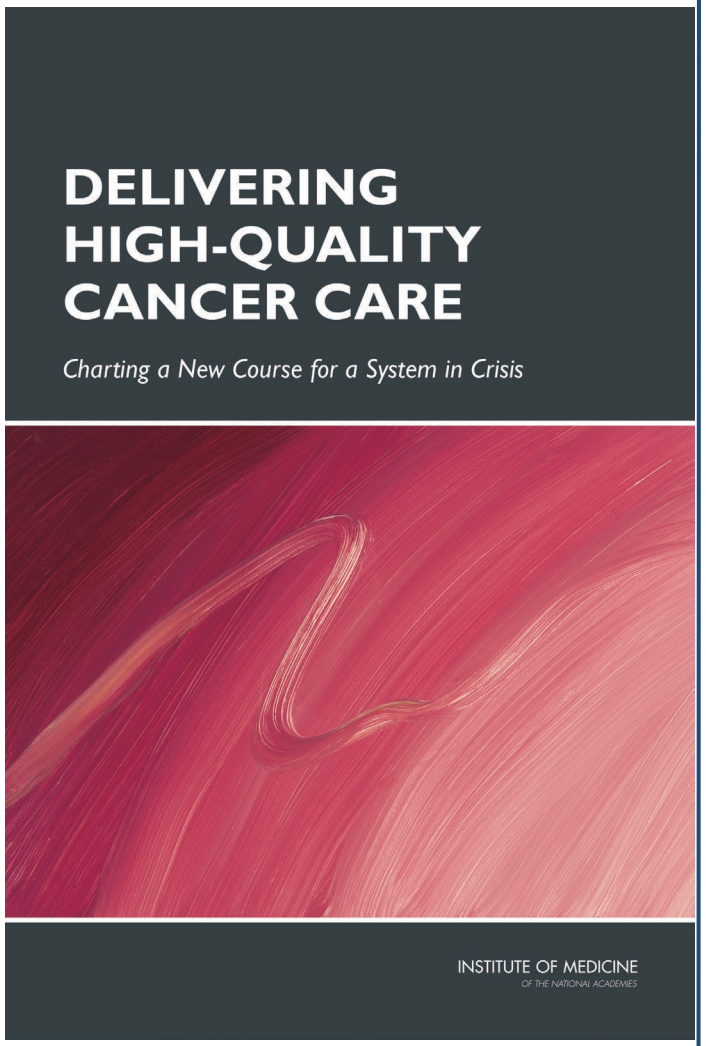
National Cancer Policy Forum - October 5, 2023

Assessing and Advancing Progress in the
Delivery of High-Quality Cancer Care: A Workshop



- September 10, 2013…..
- "Cancer care is often not as patient-centered, accessible, coordinated, or evidence-based as it could be."
- Report concludes that the cancer care system is in crisis
- **Makes 10 bold recommendations for delivering high-quality cancer care**
- What did patients and committee members say? See study video segment.

Study Charge

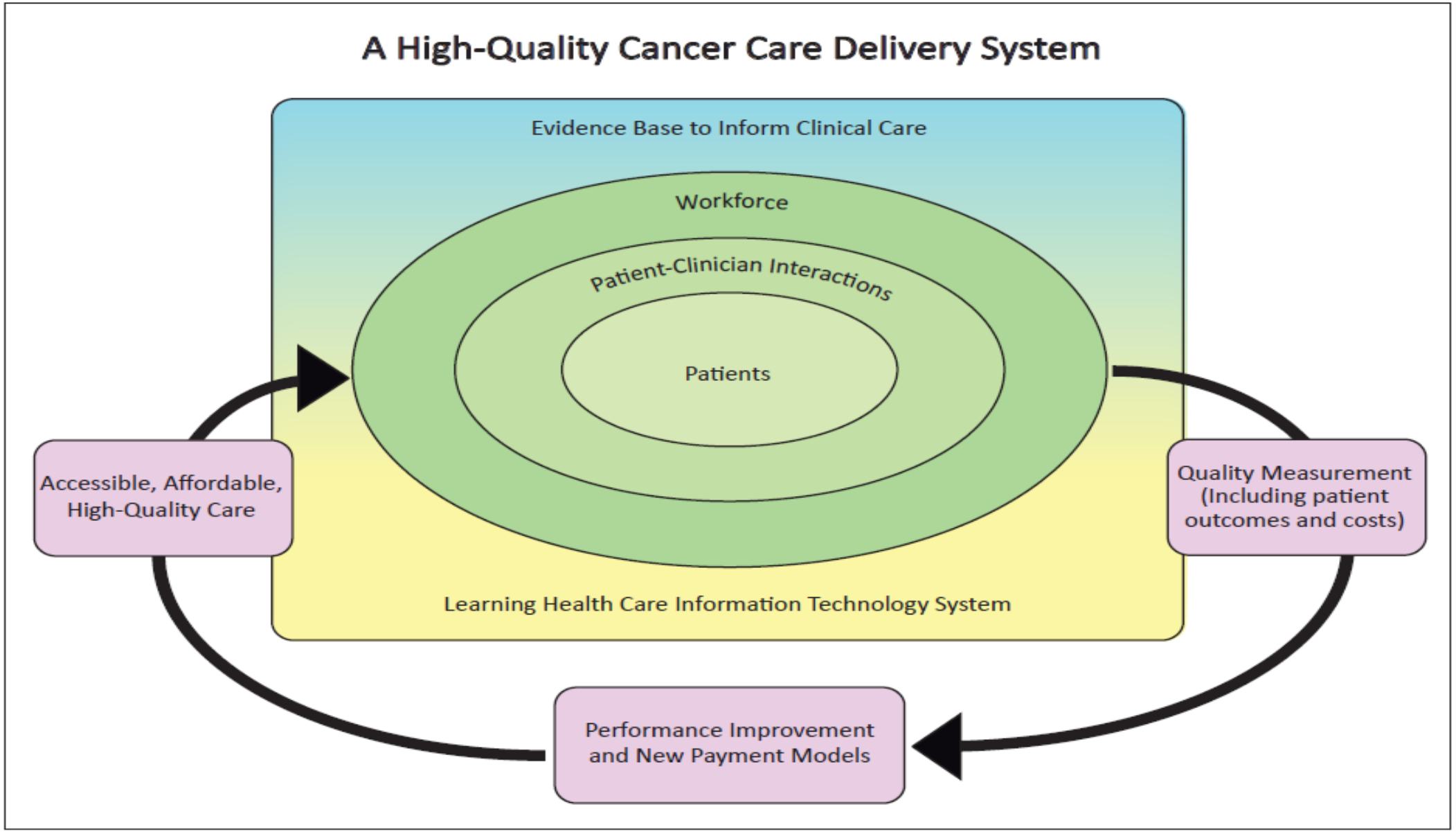
- **The IOM committee will examine opportunities for and challenges to the delivery of high-quality cancer and formulate recommendations for improvement.**
- Specific issues reviewed:
  - Coordination and organization of care
  - Outcomes reporting and quality metrics
  - Growing need for survivorship care, palliative care, and family care giving
  - Complexity and cost of care
  - Payment reform and new models of care
  - Disparities and access to high-quality cancer care

Trends Amplifying the Crisis Noted in 2013

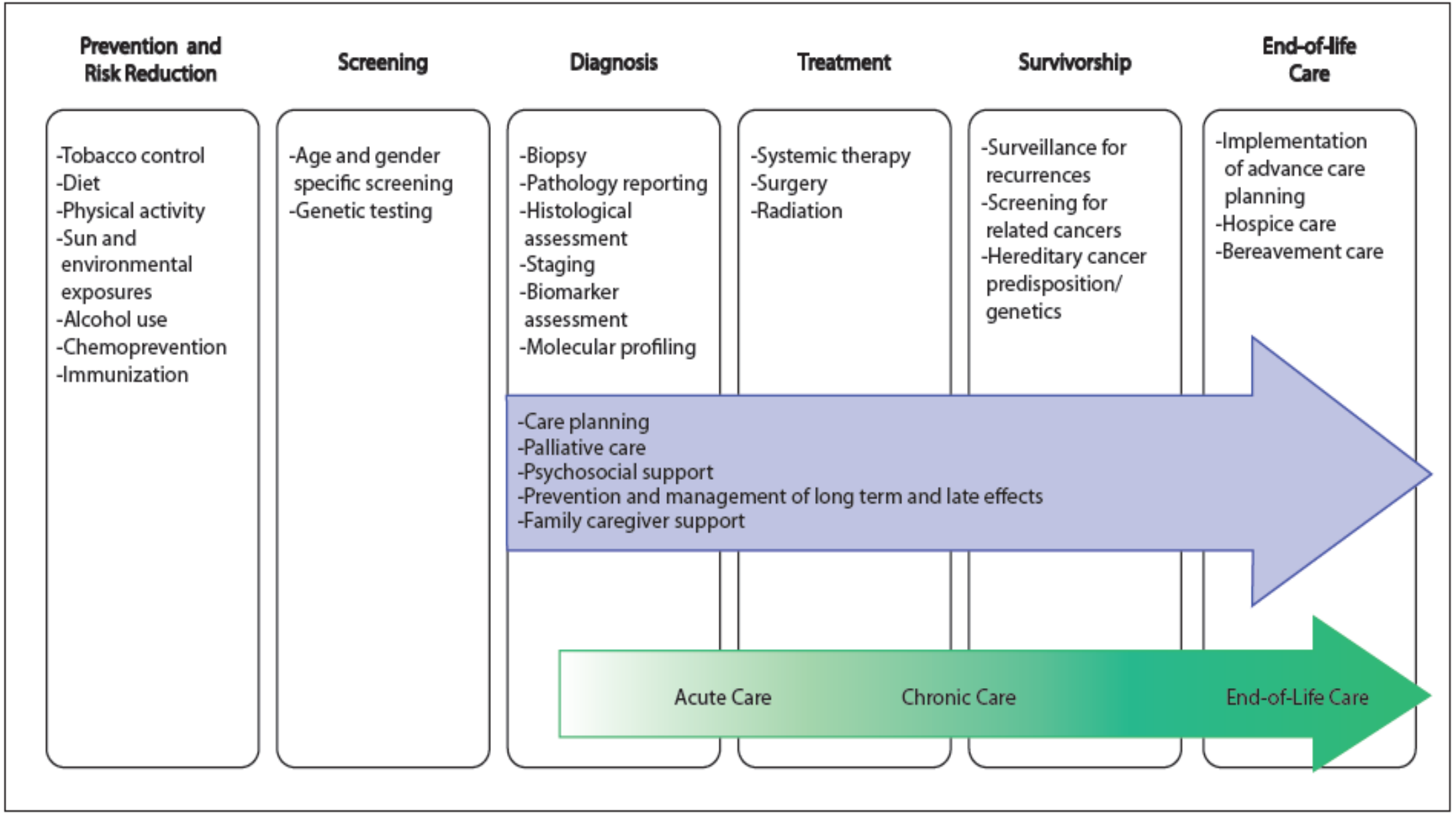
- The aging population:
  - 30% ⇧ in cancer survivors by 2022
  - 45% ⇧ in cancer incidence by 2030
- Workforce shortages
- Reliance on family caregivers and direct care workers
- Rising cost of cancer care:
  - $72 billion in 2004 ⟹ $125 billion in 2010
  - $173 billion anticipated by 2020 (39% ⇧)
- Complexity of cancer care
- Limitations in the tools for improving quality

Conceptual Framework for the Report

1. Engaged Patients
2. Adequately staffed, trained, and coordinated workforce
3. Evidence-based cancer care
4. A learning health care IT system for cancer
5. Translation of evidence into clinical practice, quality measurement, and performance improvement.
6. Accessible, affordable cancer care


A High-Quality Cancer Care Delivery System
Evidence Base to Inform Clinical Care
Workforce
Patient-Clinician Interactions
Patients
Learning Health Care Information Technology System
Accessible, Affordable, High-Quality Care
Quality Measurement (Including patient outcomes and costs)
Performance Improvement and New Payment Models

Cancer Care Continuum



Specific Goals, Recommendations, and Stakeholder Responses

Engaged Patients

- **GOAL 1**
- The cancer care team should provide patients and their families with understandable information on:
  - Cancer prognosis
  - Treatment benefits and harms
  - Palliative care
  - Psychosocial support
  - Estimates of the total and out-of-pocket costs of care.

- **GOAL 2**
- In the setting of advanced cancer, the cancer care team should provide patients with **end-of-life care consistent with their needs, values, and preferences.**

Recommendations 1 and 2

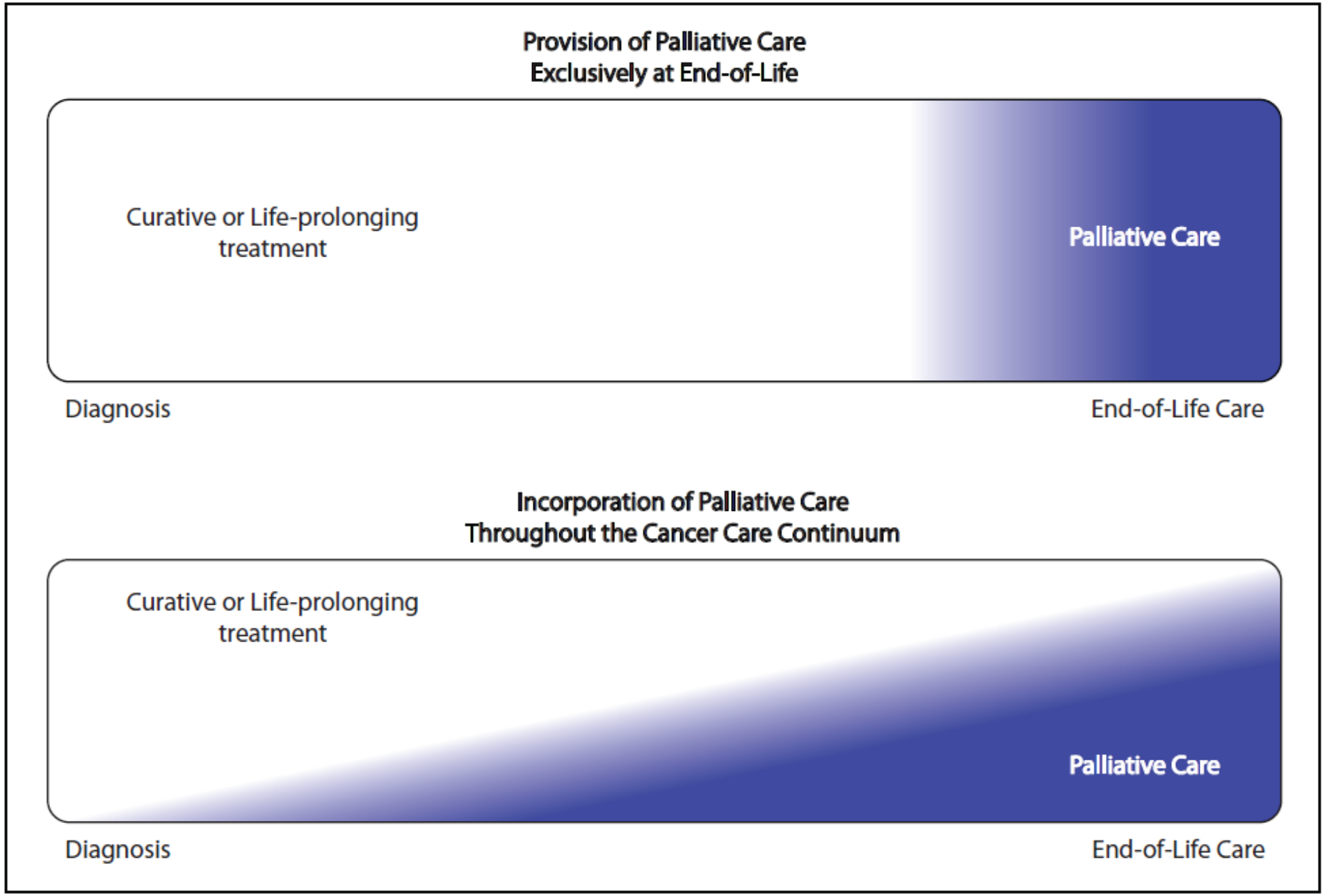
- The federal government and others should **improve the development and dissemination** of this critical information, using decision aids when possible.
- Professional educational programs should **train clinicians in communication**.
- The **cancer care team** should:
  - **Communicate and personalize** this information for their patients.
  - Collaborate with their patients to **develop care plans**.
- CMS and others should design, implement, and evaluate **innovative payment models**.

- Professional educational programs should **train clinicians in end-of-life communication**.
- The cancer care team should **revisit** and **implement** their patients' **advance care plans**.
- Cancer care teams should provide patients with advanced cancer:
  - **Palliative care**
  - **Psychosocial support**
  - **Timely referral to hospice for end-of-life care**.
- CMS and others should design, implement, and evaluate **innovative payment models**.

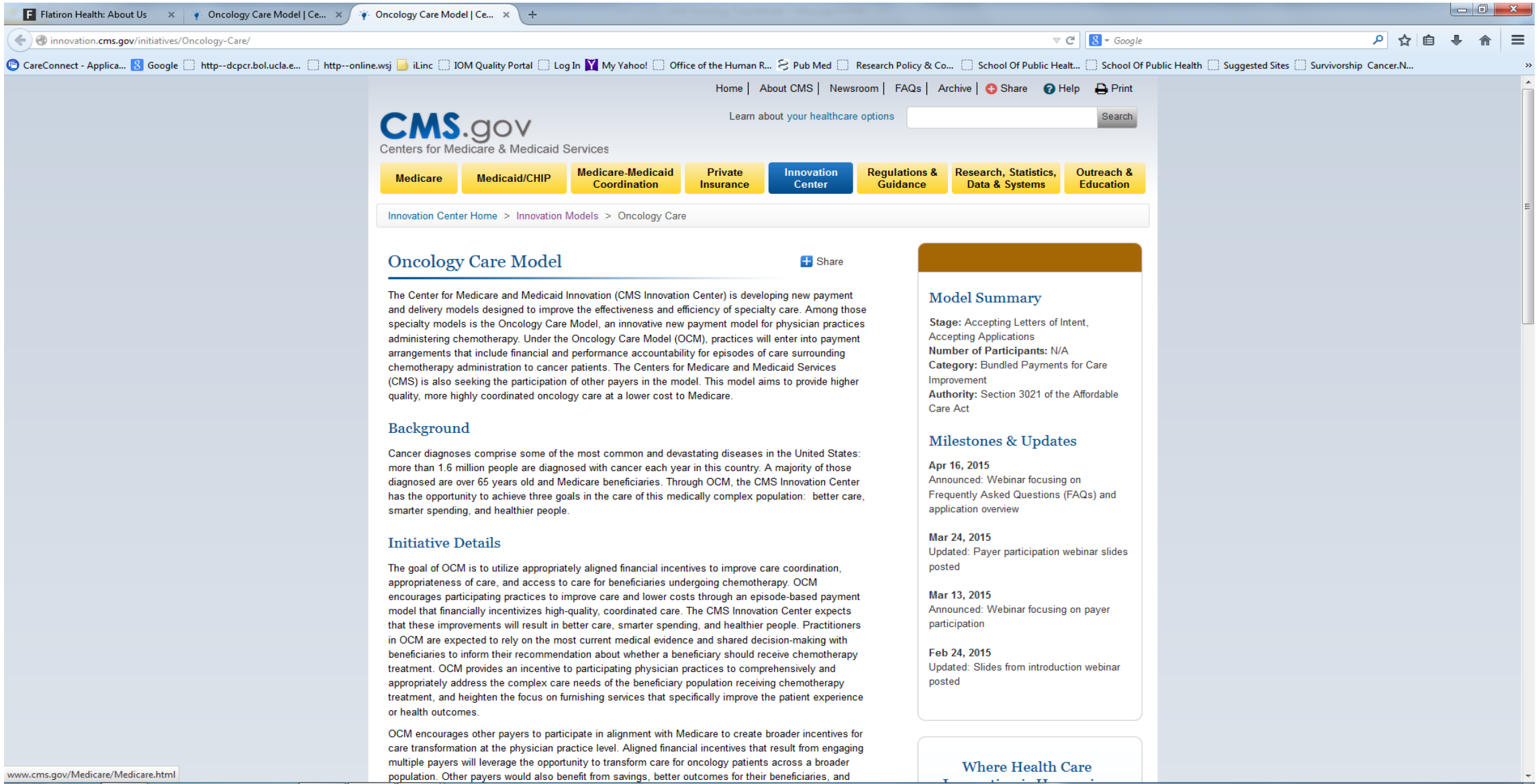
Information in a Cancer Care Plan

- Patient information
- Diagnosis
- Prognosis
- Treatment goals
- Initial plan for treatment and duration
- Expected response to treatment
- Treatment benefits and harms
- Information on quality of life and a patient's likely experience with treatment
- Who is responsible for care
- Advance care plans
- Costs of cancer treatment
- A plan for addressing psychosocial health
- Survivorship plan

Incorporation of palliative care across the care continuum



CMS Responds to IOM Report



Episode of Care Payment for High-Quality Cancer Care

- Starts with chemotherapy administration (including oral meds)
- Covers 6 months of prospective care
- $160/beneficiary additional payments to provide high-quality cancer care
- Joined by multiple private payers as well
- Bundled payments were considered the future for many types of chronic specialty care

http://innovation.cms.gov/initiatives/Oncology-Care/.

"All the News That's Fit to Print"

The New York Times

VOL. CLXIV . . . No. 56,922 THURSDAY, JULY 9, 2015

Medicare Plans to Pay Doctors For Counseling on End of Life

By PAM BELLUCK

Medicare, the federal program that insures 55 million older and disabled Americans, announced plans on Wednesday to reimburse doctors for conversations with patients about whether and how they would want to be kept alive if they became too sick to speak for themselves.

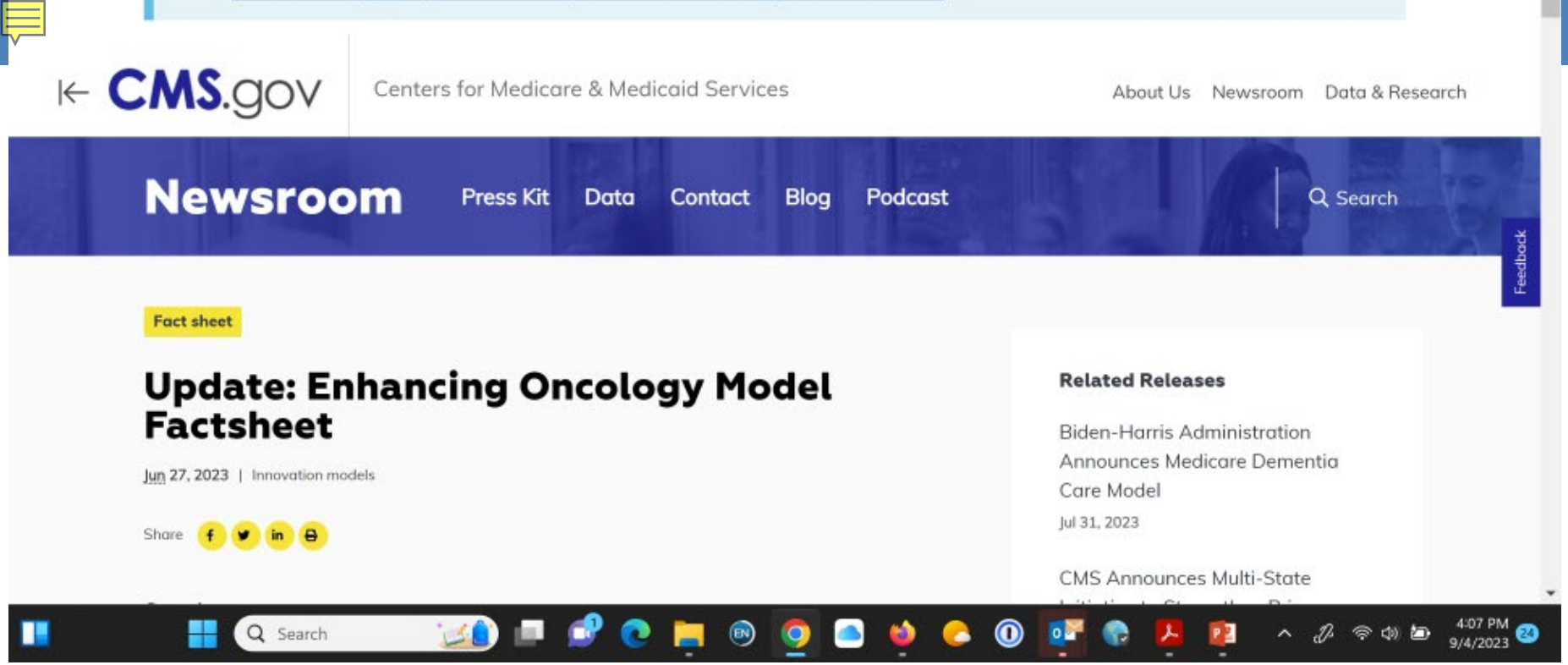
The proposal would settle a debate that raged before the passage of the Affordable Care Act, when Sarah Palin labeled a similar plan as tantamount to setting up "death panels" that could cut off care for the sick. The new plan is expected to be approved and to take effect in January, although it will be open to public comment for 60 days.

Medicare's plan comes as many patients, families and

how they die — whether that means trying every possible medical option to stay alive or discontinuing life support for those who do not want to be sustained by ventilators and feeding tubes.

"We think that today's proposal supports individuals and families who wish to have the opportunity to discuss advance care planning with their physician and care team," said Dr. Patrick Conway, the chief medical officer for the Centers for Medicare and Medicaid, which administers Medicare. "We think those discussions are an important part of patient- and family-centered care."

Dr. Conway said a final decision on the proposal would be



The model is national in scope. As of June 27, 2023, EOM participants consist of 67 oncology physician group practices. Across the 67 oncology physician group practice participants, there are over 600 sites of care representing approximately 37 states nationally and over 3,000 unique practitioners. Approximately 15% of EOM participants' sites of care are located in a rural/small town/micropolitan areas, with a little over half of EOM participants having previously participated in the Oncology Care Model (OCM).

An Adequately Staffed, Trained, and Coordinated Workforce

- **GOAL 3**
- Members of the cancer care team **should coordinate with each other** and **with primary/geriatrics** and **specialist care teams** to implement patients' care plans and deliver comprehensive, efficient, and patient-centered care.

- **GOAL 4**
- All individuals caring for cancer patients should have **appropriate core competencies**.

Recommendations 3 and 4

- Federal and state legislative and regulatory bodies **should eliminate reimbursement and scope-of-practice barriers** to team-based care.
- Academic institutions and professional societies should develop **interprofessional education programs**.
- Congress should fund the **National Workforce Commission.**
- Professional organizations should **define cancer core competencies**.
- Cancer care delivery organizations should **require** cancer care teams to have **cancer core competencies**.
- Organizations responsible for accreditation, certification, and training of **nononcology clinicians** should promote the development of relevant cancer core competencies.
- HHS and others should fund demonstration projects to train **family caregivers and direct care workers**.

Limited Responses to these Recommendations

- Some improvements in scope of practice
- Increased recognition of need for inter-professional training
- Greater incorporation of advanced practice providers
- Workforce commission was never funded and appointments expired in 2019

WORKFORCE COMMISSION

By Peter I. Buerhaus and Sheldon M. Retchin

DOI: 10.1377/hlthaff.2013.0385
HEALTH AFFAIRS 32,
NO. 11 (2013): 2021–2024

ANALYSIS & COMMENTARY

The Dormant National Health Care Workforce Commission Needs Congressional Funding To Fulfill Its Promise

ABSTRACT Congress established the National Health Care Workforce Commission under section 5101 of the Affordable Care Act to provide data on the health care workforce and policy advice to both Congress and the administration. Although members of the Workforce Commission were appointed September 30, 2010, Congress has been unable to appropriate the $3 million requested by the administration to fund the commission. Consequently, the commission has never met and is not operational. As a new era of insurance coverage, care delivery, and payment reforms unfolds, the commission is needed to recommend policies that would help the nation achieve the goals of increased access to high-quality care and better preparation, configuration, and distribution of the nation's health workforce. In a climate where fiscal policy is dominated by spending on health care, the commission can also stimulate innovations aimed at reducing the cost of health care and achieving greater value and transparency.

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Sheldon M. Retchin is the senior vice president for health sciences at Virginia Commonwealth University, in Richmond, and vice chair of the National Health Care Workforce Commission.

Evidence-Based Cancer Care

- **GOAL 5**
- Expand the **breadth of data** collected on cancer interventions for **older adults** and individuals with **multiple comorbid conditions**.

- **GOAL 6**
- Expand the **depth of data** available for assessing interventions.

Recommendations 5 and 6

- The federal government and other funders should require researchers to **include a plan to study a population that mirrors the age distribution and health risk profile** of patients with the disease.

- Congress should amend patent law to **provide patent extensions of up to six months** for companies that conduct clinical trials of new cancer treatments in **older adults or patients with multiple comorbidities**.

- NCI and others should build on ongoing efforts to develop a **common set of data elements** that captures **patient-reported outcomes**, **relevant patient characteristics**, and **health behaviors** that researchers should collect from RCTs and observational studies.

NCI DIRECTOR'S REPORT

Moonshot and HHS agencies to develop standards for data interoperability

By Matthew Bin Han Ong

The Office of the Secretary of Health and Human Services is coordinating a health informatics initiative—as part of the Cancer Moonshot—to set common data standards that could be used across key federal health agencies, including NCI, NIH, and FDA.

The Cancer Letter, 9-8-23

A Learning Health Care IT System for Cancer

- **GOAL 7**
- Develop an ethically sound **learning health care IT system for cancer** that enables real-time analysis of data from cancer patients in a variety of care settings.

- **Recommendation**
- Professional organizations should design and implement the necessary **digital infrastructure and analytics**.

- HHS should **support the development and integration** of this system.

- CMS and other payers should **create incentives for clinicians to participate** in this system, as it develops.

Sadly, this has not been realized.

Quality Measurement

- **GOAL 8**
- Develop a **national quality reporting program** for cancer care as part of a learning health care system.

- **Recommendation**
- HHS should work with professional societies to:
  - Create and implement a formal **long-term strategy** for publicly reporting quality measures.
  - Prioritize, fund, and direct the **development of meaningful quality measures**.
  - Implement a coordinated, transparent **reporting infrastructure.**

Quality Measurement in Cancer Care: A Review and Endorsement of High-Impact Measures and Concepts

Thomas A. D'Amico, MD[a]; Lindsey A.M. Bandini, MPH[b]; Alan Balch, PhD[c]; Al B. Benson III, MD[d]; Stephen B. Edge, MD[e]; C. Lyn Fitzgerald, MJ[b]; Robert J. Green, MD[f]; Wui-Jin Koh, MD[b]; Michael Kolodziej, MD[g]; Shaji Kumar, MD[h]; Neal J. Meropol, MD[f]; James L. Mohler, MD[e]; David Pfister, MD[i]; Ronald S. Walters, MD, MBA, MHA, MS[i]; and Robert W. Carlson, MD[b]

Table 1. Quality Measures Selected by the NCCN Quality and Outcomes Committee

Disease	Measurement Stream	Measure	Similar Measures
Breast	Evidence-based concordance measure	Patients with M0 disease, and ≥4 involved axillary lymph nodes, receive breast/chest wall plus regional lymph irradiation as part of their treatment	CoC[10]
Breast	Evidence-based concordance measure	Tumor markers are not performed during the period of follow-up surveillance for those who have completed breast cancer treatment with curative intent	Choosing Wisely,[11] QOPI (62c1 & 62c2)[12]
Colorectal	Evidence-based concordance measure	For patients with resected pathologic stage II and III colorectal cancer in surveillance, carcinoembryonic antigen is performed at least every 6 months for 5 years	QOPI (66)[12]
Colorectal	Evidence-based concordance measure	Patients with rectal cancer are staged with a CT scan of chest, abdomen, and pelvis and pelvic MRI with contrast or endorectal ultrasound before surgery	QOPI (78)[12]
Cross-cancer	Evidence-based concordance measure	Proportion admitted to the intensive care unit in the last 30 days of life	QOPI (49icu),[12] MIPS (455),[13] PCHQR (EOL-ICU),[14] NQF (0213)[15]
Cross-cancer	Evidence-based concordance measure	Performance status documented prior to initiating chemotherapy regimen	QOPI (13aa)[12]
Cross-cancer	Patient experience measure	Patients are offered smoking cessation counseling if current smoker	QOPI (22aa),[12] MIPS (226),[16] NQF (0028)[17]
Cross-cancer	Treatment team	Proportion receiving chemotherapy in the last 14 days of life	QOPI (48),[12] MIPS (453),[18] PCHQR (EOL-Chemo),[14] NQF (0210)[19]
Cross-cancer	Treatment team	Chemotherapy given within 30 days of end of life	Oncology Medical Home (15)[20]
Cross-cancer	Treatment team	Cancer stage documented	QOPI (2),[12] NQF (0386)[21]
Cross-cancer	Treatment team	Proportion dying from cancer in an acute care setting	NQF (0214)[22]
Lung	Evidence-based concordance measure	Palliative care consult is offered to patients with metastatic non–small cell lung cancer within 8 weeks of diagnosis	QOPI (43),[12] NQF (0215)[23]
Prostate	Evidence-based concordance measure	Patients in the high-risk or very high-risk prostate cancer groups, who receive radiation therapy, receive ADT	QOPI (117),[12] OCM (OCM-7),[24] PCHQR (PCH-17),[15] NQF (0390)[25]
Prostate	Patient experience measure	All patients treated with surgery or radiation for localized prostate cancer should be assessed for urinary incontinence and erectile dysfunction with tools, such as the UCLA Prostate Cancer Index questions and the Sexual Health Inventory for Men	MD Anderson (CMS 5656 and 5657)[26,27]
Prostate	Treatment team	Prostate-specific antigen has been measured in the last 12 months to monitor disease recurrence in patients with prostate cancer	NQF (0625)[28]

Table 2. Quality Measure Concepts for Development

Disease	Measurement Stream	Measure Concept
Breast	Evidence-based concordance measure	Cardiac function is assessed before starting and at least every 4 months during trastuzumab therapy
Colorectal	Evidence-based concordance measure	Adjuvant chemotherapy is not administered for patients with pathologic stage 1 colorectal cancer
Colorectal	Evidence-based concordance measure	PET scan is not performed for patients with locoregional colorectal cancer
Colorectal	Evidence-based concordance measure	Patients with colon cancer are staged with CT scan of chest, abdomen, and pelvis before surgery
Prostate	Evidence-based concordance measure	Patients with newly diagnosed prostate cancer have a risk group assigned
Prostate	Evidence-based concordance measure	Patients in the very low-risk and low-risk prostate cancer groups do not receive androgen deprivation therapy
Prostate	Treatment team	Patients with localized prostate cancer have a multidisciplinary evaluation or conference (including urology, radiation oncology, pathology) before making a treatment decision

J Natl Compr Canc Netw 2020;18(3):250–259
doi: 10.6004/jnccn.2020.7536

Accessible, Affordable Cancer Care

- **GOAL 9**
- Reduce **disparities in access** to cancer care for **vulnerable and underserved** populations.

- **GOAL 10**
- Improve the **affordability** of cancer care by leveraging existing efforts to **reform payment and eliminate waste**.

Vulnerable and underserved populations include, but are not limited to:

- Racial and ethnic minorities
- Older adults
- Individuals living in rural and urban underserved areas
- Uninsured and underinsured individuals
- Populations of lower socioeconomic status

Recommendations 9 and 10

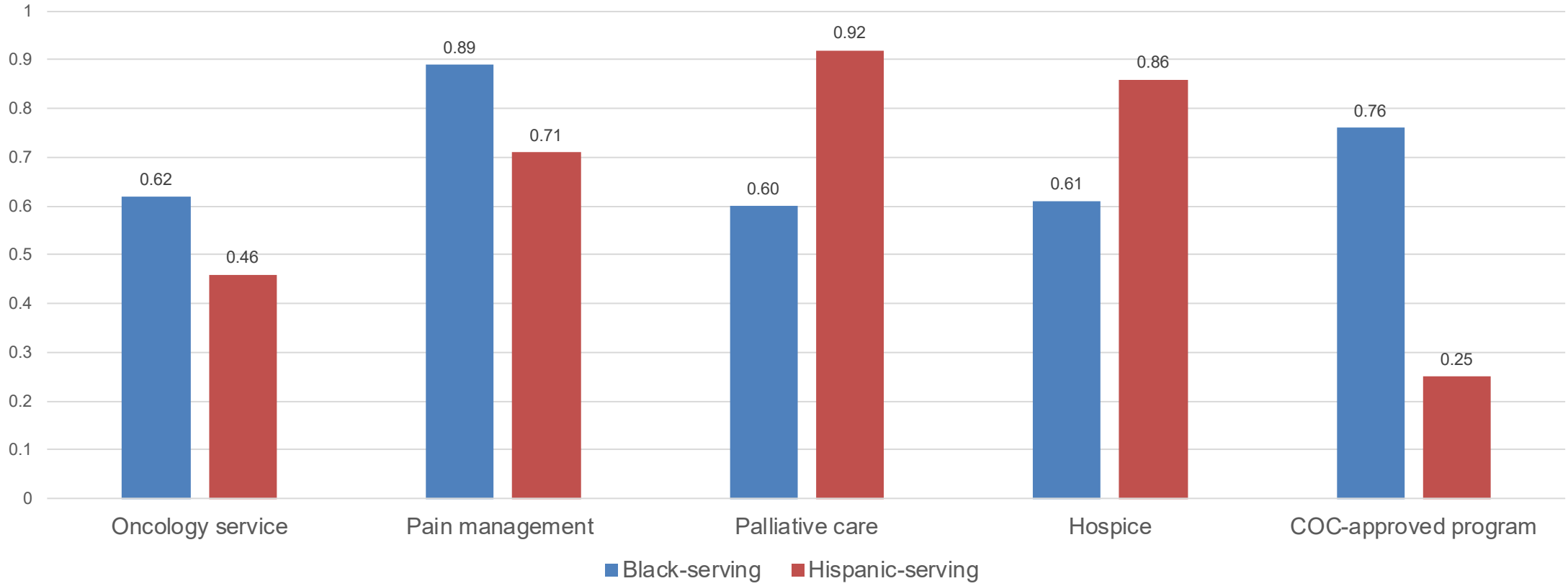
HHS should:

- Develop a **national strategy** that leverages existing efforts.
- Support the **development of innovative** programs.
- Identify and disseminate **effective** community interventions.
- Provide **ongoing support** to **successful** existing community interventions.

- Professional societies should identify and disseminate practices that are **unnecessary or where the harm may outweigh the benefits**.
- CMS and others should **develop payment policies** that reflect professional societies' findings.
- CMS and others should design and evaluate **new payment models**.
- If new payment models demonstrate increased quality and affordability, CMS and others should **rapidly transition** from fee-for-service reimbursements to **new payment models**.

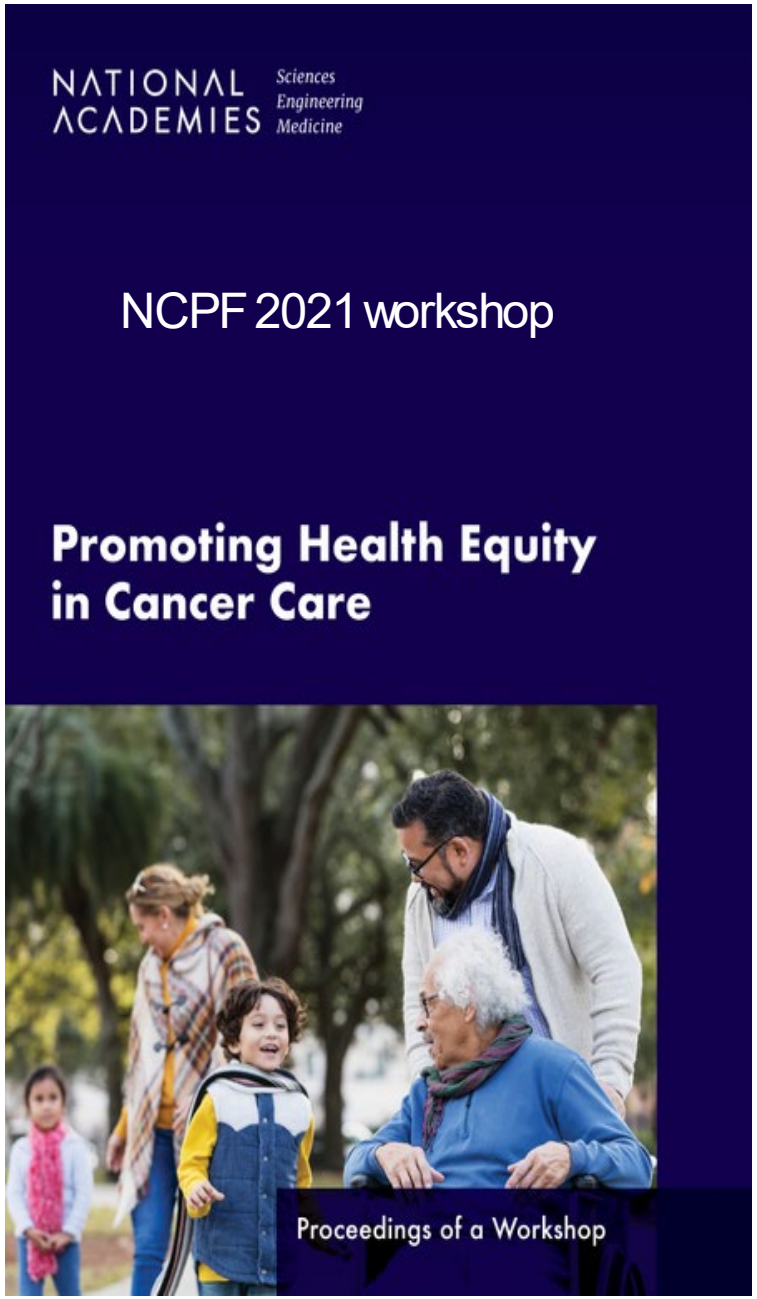
Availability of Core Cancer Services in Minority Serving Hospitals

*Odds ratios relative to other U.S. Hospitals



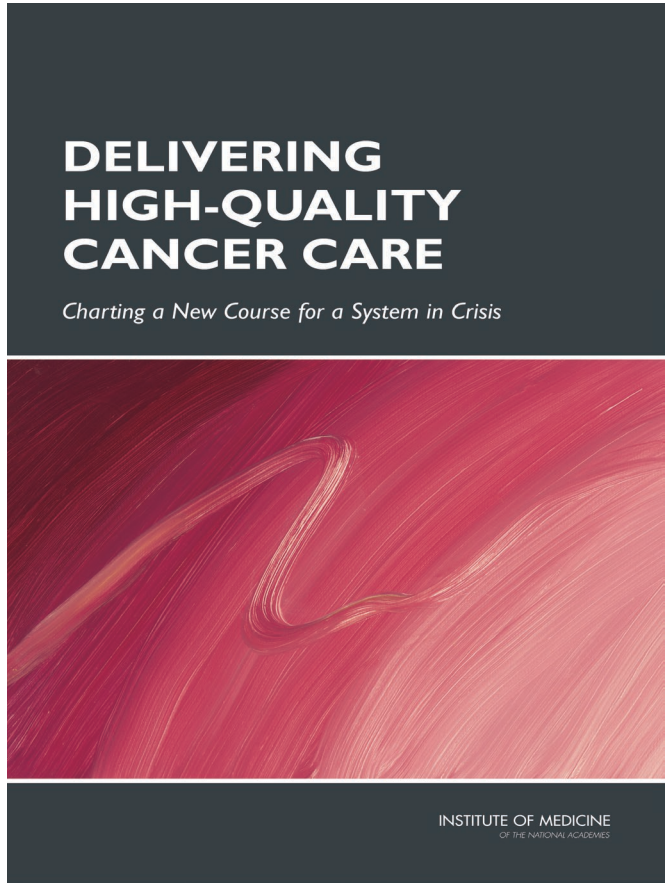
*Odds ratios are adjusted for hospital bed size and rural location. All differences for Black- and Hispanic-serving (combined) and other hospitals are statistically significant

Source: G. Himmelstein & P. Ganz, unpublished data



- 1. Establishing clear organizational definitions of health disparities and health equity.
- 2. Explicitly identifying the disparities to be addressed, actions to be taken, and metrics of success.
- 3. Systematically collecting standardized sociodemographic data during cancer care and cancer research.
- 4. Engaging the community as valued partners.
- 5. Establishing multisectoral collaborations to address SDOH and end structural racism.
- 6. Structuring cancer care to better facilitate access to high-quality care for all patients.
- 7. Developing and testing interventions that will reduce or eliminate health disparities.
- 8. Sustaining health equity as a priority area for action.

Report Conclusions



- **All participants and stakeholders** must reevaluate their current roles and responsibilities in cancer care and **work together** to develop a higher quality cancer care delivery system.
- By working toward this shared goal, the cancer care community can **improve the quality of life and outcomes** for people facing a cancer a diagnosis.

- How did we do in achieving the goals of the 2013 report and what new challenges do we face?
  - The presentations and discussion in this session will begin the conversation.
  - Subsequent sessions will elaborate on continuing challenges in the delivery of high-quality care, along with some proposed solutions.