PRESIDENT'S MESSAGE

Cancer Quality—GP³?

BY BECKY L. DEKAY, MBA

It is so interesting to see the word "quality" becoming a mantra for so many groups—federal and state governments, and payers, providers, and patients (GP³). The quest for "quality" has been around for a long time. What is different today is the increased emphasis on quality in *cancer care*.

Quality measures for acute myocardial infarction, congestive heart failure, and total hip replacement have been in existence since the late 80s, early 90s. While patients with those conditions are unique—many with co-morbidities—the treatment and outcome for these patient populations are very similar and predictable for at least the proverbial 80 percent of cases.

In contrast, cancer providers treat more than 100 diseases in various stages and with varying tumor markers, differing genetic structure, and individual tolerances for many toxic drugs. Choosing the appropriate quality measures for this patient population has proven to be a daunting task. Even more formidable is how to communicate quality to the stakeholders who want to understand what "quality" cancer care really means.

In June, I attended ACCC's Institute for the Future of Oncology in Chicago. Two topics were on the agenda: "Organizational Leadership" and "Communicating Quality." Stakeholders held lively discussions around both topics, which will lead to white papers you'll hear more about later, but I found it very interesting how the topic of quality in cancer care bubbled to the top during the discussion of "Organizational Leadership." This experience illustrates perfectly how quality cannot be separated from other discussions. In fact, quality should take a central role, along with the patient, in any discussions related to cancer care.

I'd like to highlight two recent articles I read that touch on quality in very different ways. First was an article published online July 8, 2014, from the *Journal of Oncology Practice*, "Changing Physician Incentives for Affordable, Quality Cancer Care: Results of an Episode Payment Model." Among much interesting information about the study itself, this statement stood out to me: "Multiple quality measures were monitored, and none of them provided an early signal that quality of care was different than controls." (Quality measures monitored included ER and hospitalization rates, average drug cost per episode, survival rates, and many others.)

The second was a perspective in *The ASCO Post*, published June 25, 2004, titled "Sharing 50 Years of Christmas: A Quality Metric?" The author points out that clear-cut metrics, such as mortality, morbidity, hospital length of stay, and readmissions are closely monitored and hospitals and providers fall somewhere along the quality spectrum. He speaks of a 68-year old woman who was referred to him with biopsy-proven liver metastasis from primary colon cancer. After consultation with his patient, who had lost her husband of 49 years a few months earlier, and her daughter, a nurse by profession, they agreed upon a right hepatectomy. Surgery was uneventful but the patient suffered marked pulmonary problems post-surgery due to her history of smoking. The problems were reversible and easily treatable, but after a few days the patient and daughter decided to withdraw all active interventions. She was transitioned to comfort care and passed away surrounded by her family.

The author stated the patient's providers felt that they satisfied all of the quality metrics—appropriate assessment, uneventful surgery, appropriate post-operative care, site-of-service transition, and respect for the family wishes. His point: the person sitting at a remote computer assessing the quality of care objectively may believe this mortality was negative since the metric is "yes" or "no." To the patient and her daughter, the fact that the patient would spend the 50th Christmas with her husband was a much better metric of "quality" than mortality.

These two articles exemplify the wide chasm that exists when trying to capture quality in cancer care; what is important to the many stakeholders, including GP³. It is not too late to join in this important conversation at the ACCC 31st National Oncology Conference, October 8-10, in San Diego. Add your voice to the collective! OI

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