

Patient Priorities Should Be Paramount When Measuring Quality in Cancer Care According to Panelists at NCCN Policy Summit

NCCN hosted a policy summit at the National Press Club in Washington, DC, addressing how to define, measure, and apply quality in cancer care. Speakers across the cancer care continuum shared perspectives on current quality measurement initiatives including the Oncology Care Model and the Merit-based Incentive Payment System (MIPS), and looked ahead to future trends in this area.

“A lot of effort has already gone toward measuring quality via various reporting programs in order to improve performance,” said Ronald S. Walters, MD, MBA, MHA, MS, Associate Head for the Institute for Cancer Care Innovation, The University of Texas MD Anderson Cancer Center, and Chair, NCCN Board of Directors. “However, there are still many opportunities to expand quality metrics in order to make them more relevant and meaningful for both providers and patients. Feasible and low-burden measures need to represent quality across the continuum of care, and be as coordinated and non-fragmented as possible. This summit gives us a chance to discuss the current status for quality measurement programs while also thinking about what we may need in the future.”

Speakers discussed how quality measurement can serve as a tool for improving patient outcomes.

“Measuring the quality of cancer care that we deliver is essential for understanding current performance and outcomes and identifying any gaps in care,” said Lawrence N. Shulman, MD, FACP, FASCO, Deputy Director for Clinical Services, Abramson Cancer Center at the University of Pennsylvania. “It’s naïve to assume that our cancer care is excellent without measuring it. We must be thoughtful in choosing measures that are relevant to meaningful quality and linked to patient outcomes. Measurements should be easily attainable without adding administrative burdens—ideally by extracting them from electronic health records or cancer registries, rather than by manual chart abstraction—and must be repeatedly measured with an approach geared toward continuous process improvement.”

Many panelists wanted to see patient preferences play a much larger role in defining quality cancer care, and called for an increased emphasis on patient reported outcomes.

“Cancer persists as the second leading cause of death in our nation. With complicated and costly treatment options to consider, aligning quality measures allows providers and clinicians to put patients and their priorities at the center of care,” said Shantanu Agrawal, MD, MPhil, President and CEO, National Quality Forum.

“We have to define exactly what we mean by outcomes and make sure to prioritize what is most important to patients, in a focused, aligned, and thoughtful way,” said Tracy Wong, MBA, Director, Quality and Value, Seattle Cancer Care Alliance. “Focusing on value has helped to elevate the measures that are important to patients—such as avoiding hospitalization—and shined a spotlight on financial toxicity. As patient-reported outcome measurement becomes part of routine care in oncology, new ways to characterize quality will emerge, with the patients’ voice at the center. Developing intuitive patient-facing tools should help with patient-level symptom reporting and group-level performance evaluation, without overburdening patients.”

“We need a unified, national quality reporting program with defined standards for patient-centered cancer care,” agreed Kashyap Patel, MD, Oncologist, Managing Partner, Carolina Blood and Cancer Care. “I would like to see

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“NCCN hosts summit on defining, measuring, and applying quality in an evolving health policy landscape and the implications for cancer care.”

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supported incentives for providers that implement patient-centered care through voluntary shared savings programs.”

Those with experience in implementing value-based models, such as the Oncology Care Model (OCM), shared insights into successes and opportunities for improvement.

“The OCM is multi-faceted and complex, and practice transformation takes time, but it is valuable and worth the investment,” said Diana Verrilli, MS, Senior Vice President of Strategy and Practice Solutions for McKesson and The US Oncology Network. “By participating in the OCM, community oncology practices are empowered to become leaders in this value-based world rather than be passive participants. There are 15 practices in The US Oncology Network participating in CMMI’s OCM, and we’ve witnessed an improved patient experience for Medicare beneficiaries as well as an increase in pathways and guidelines adherence. The ultimate goal is providing high-quality and high-value care to cancer patients, and this is a step in the right direction.”

Kerin Adelson, MD, Chief Quality Officer and Deputy Chief Medical Officer, Smilow Cancer Hospital, talked about the impact that OCM had at her institution. “We used program revenue to build infrastructure in order to reduce acute care utilization. This included opening an oncology urgent care center, launching a care management program, and implementing clinical pathways across our network. We developed dashboards to measure individual providers’ patterns of care and systematically shared the data with them. Claims data shows that we have reduced the number of emergency department visits, hospitalizations, and post-acute care use, while keeping those costs stable. However, our total cost of care claims data shows that for patients on systemic therapy, cost of care has increased overall. Future cost containment efforts will only succeed if efforts are also directed at curtailing the rising cost of pharmaceuticals.”

Other panelists concurred that OCM and others might not address the full picture, and noted that there are many challenges to improving quality measurement.

“Many of the current value-based payment models include measures of utilization, such as emergency department visits, which may not necessarily reflect poor quality,” said Nancy Keating, MD, MPH, Professor of Health Care Policy & Medicine, Harvard Medical School. “Patient experience is a key aspect of quality, but collecting that data is expensive and limited by patients who aren’t able to respond, are getting care from more than one practice, or who find new doctors after a poor experience. Outcome measures such as survival are also important, but adequate risk adjustment is challenging and survival is often influenced more by nonclinical factors, such as socioeconomic status, than by cancer treatment.”

However, the panelists were hopeful that advancing technology and data collection can play a role in improving quality measurement for cancer care going forward. Jacqueline Waldrop, MS, from Pfizer’s Global Medical Grants team, noted her interest in exploring how grant-supported quality improvement (QI) projects could provide insights into new metrics for quality in cancer care and potentially advance the conversation about quality-based payment structures. She described some examples of grant-funded QI projects where quality is being measured in innovative ways such as using a technology platform to track patient-reported outcomes, improving biomarker testing rates, appropriately using the biomarker information to inform treatment plans, and increasing patient referrals to clinical trials.

“Quality measurement is both critical and challenging in oncology, but real world data will increasingly help all of us as a community to better understand where we are succeeding and where there are still gaps,” said Gaurav Singal, MD, Chief Data Officer, Foundation Medicine. “As biomarkers and cancer care become more complex, I anticipate that these quality measures will rely not only

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on adherence to guidelines but also on the use of real world data to inform decision-making where randomized trial data aren't available or don't apply."

The summit began with an introduction from Wui-Jin Koh, MD, Chief Medical Officer, NCCN. The panels were moderated by Clifford Goodman, PhD, Senior Vice President of The Lewin Group, and also included Alan Balch, PhD, Chief Executive Officer, National Patient Advocate Foundation; Reena Duseja, MD, MS, Chief Medical Officer for Quality Measurement, Centers for Medicare and Medicaid Services (CMS); Bryan Loy, MD, MBA, Physician Lead – Oncology, Laboratory, and Personalized Medicine, Humana; Jim Martineau, MBA, Director, Product Management & Operations, Flatiron; Alexandra Chong, PhD, OCM Team Lead, Center for Medicare & Medicaid Innovation (CMMI). NCCN Senior Policy and Advocacy Director Alyssa Schatz, MSW, provided closing remarks.

NCCN will return to the National Press Club on December 11 to continue the conversation at the upcoming NCCN Patient Advocacy Summit: Delivering Value for Patients across the Oncology Ecosystem. That summit will further explore value-based care from the patient perspective, and examine ways to remove barriers to patient-centered care. Visit NCCN.org/policy for more information, and join the online conversation with the hashtag #NCCNPolicy.

International Collaboration to Improve Cancer Care in Sub-Saharan Africa Announces Management of Most Adult Cancers Covered by NCCN Harmonized Guidelines

A collaborative project from NCCN, the African Cancer Coalition (ACC), the American Cancer Society (ACS), and others to improve cancer outcomes in Sub-Saharan Africa has entered a new phase in Addis Ababa, Ethiopia. Oncologists from 11 African countries—along with the CEOs of ACS and NCCN—attended a meeting hosted by the Ethiopian Health Minister. Attendees helped finalize additional NCCN Harmonized Guidelines for Sub-Saharan Africa, bringing the total to 42 guidelines providing best practice cancer treatment recommendations for more than 86% of all adult cancer incidence in the region according to ACS.

There are an estimated 811,000 new cases of cancer and 527,000 deaths from cancer each year in Sub-Saharan Africa¹ and incidence is expected to double by 2040 to more than 1.6 million cases annually due to population growth and aging.² Cancer care in Africa is characterized by late presentation, limited access to treatment, and poor outcomes relative to other geographical regions.

"Cancer can be twice as lethal in Sub-Saharan Africa as it is in the United States," said Robert W. Carlson, MD, CEO, NCCN. "By providing free online access to the latest research and analysis, we can help local medical providers save more lives. More than 7,000 copies of the NCCN Harmonized Guidelines for Sub-Saharan Africa have been downloaded from the NCCN website, and many more via our mobile app."

"ACS is proud to be part of this critical step toward standardizing cancer care in Africa," said Gary Reedy, CEO, American Cancer Society. "The harmonization of 42 NCCN Guidelines is a tremendous accomplishment that would not have been possible without the collaboration of individuals and institutions committed to advancing cancer care in Africa."

The first NCCN Harmonized Guidelines for Sub-Saharan Africa debuted in November of 2017, during the biennial African Organisation for Research and Training in Cancer (AORTIC) conference in Kigali, Rwanda. In addition to

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New and improved mobile app and upcoming NCCN Global Academy event reflect the organization's efforts to increase worldwide access to NCCN resources.

covering various cancer types (such as breast, prostate, and cervical cancer), they also provide treatment recommendations for pain management, survivorship, smoking cessation, and other aspects of supportive care. The full list of current and upcoming guidelines can be found at [NCCN.org/harmonized](https://www.nccn.org/harmonized).

The medical recommendations have been officially endorsed in Ethiopia, Malawi, Nigeria, Tanzania, Uganda, and Zambia. Together, those countries are home to 43% of the population of Sub-Saharan Africa. With support from ACS, 121 cancer experts from 34 institutions in Africa have attended Coalition meetings, as well as representatives from 7 health ministries and 19 experts from NCCN and its Member Institutions.

“As African governments and specialists mount a response to the growing cancer epidemic, they identified the need for cancer treatment guidelines that reflect the most up-to-date clinical knowledge and provide flexibility for use across resource levels, from state-of-the-art cancer centers to basic community hospitals,” said Prof. Isaac F. Adewole, FAS, FRCOG, FSPSP, DSc, Immediate past Honorable Minister for Health, Nigeria. “Without these guidelines, it would not be possible to scale-up access to treatment to meet the needs of people with cancer.”

NCCN Harmonized Guidelines use color-coding to represent both the optimal care that low- and mid-resource countries aspire to provide and pragmatic approaches that provide effective treatment options for resource-constrained settings. They are based on the NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines), containing recommendations from interdisciplinary panels of experts from across the 28 leading academic cancer centers that comprise NCCN. NCCN Guidelines are the recognized standard for clinical policy in cancer care and are the most thorough and frequently updated clinical practice guidelines available in any area of medicine. They cover most types of cancer, plus supportive care, prevention, and genetic screening.

NCCN began including recommendations for pediatric cancers in May 2019. The Sub-Saharan Africa harmonization of the NCCN Guidelines for Pediatric Acute Lymphoblastic Leukemia (ALL) is set to publish in early 2020. The organization is also continuing to increase worldwide resources for pediatric cancers with the future publication of NCCN Guidelines for Pediatric B-Cell Lymphomas (including Burkitt Lymphoma, which has higher prevalence in Africa), Pediatric Wilms Tumor, and Pediatric Hodgkin Lymphoma.

Learn more at [NCCN.org/global](https://www.nccn.org/global), and join the conversation online with the hashtag #NCCNGlobal.

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