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GUEST EDITORIAL

The State of Quality Indicators in Surgical Oncology

SANDRA L. WONG, MD, MS, FACS*
Division of Surgical Oncology/Department of Surgery, University of Michigan, Ann Arbor, Michigan

Ask any clinician . . . there isn't a soul who would disagree. Quality in health care is important. It would also be difficult to find many who would disagree that there is much room for improvement in terms of cancer care quality. The Institute of Medicine's ''Ensuring Quality Cancer Care'' highlighted a dearth of information on the quality of cancer care and recommended the development of better measures of the quality of cancer care for use by consumers, providers, and payers [1]. In response to this report, many healthcare stakeholders have worked to develop clinical care guidelines based on evidence-based medicine. However, the question remains: Will widespread implementation of these guidelines assure better care for cancer patients?

Recent efforts have focused on the development of quality indicators, which measure processes of care. Quality indicators can be used as proxies to assess the quality of care being provided to patients. Findings of variations across providers may represent areas for improvement. Ideally, problems can be flagged and addressed since quality indicators help care providers better understand and improve performance. Physicians and hospitals would use the measurement-feedback loop to help identify areas for improvement in attempts to continually improve performance.

Surgeons may be familiar with quality indictors developed by the Surgical Care Improvement Project (SCIP), which include consensus standards for hospital care which are specific to perioperative processes of care. The National Surgical Quality Improvement Program (NSQIP) has also developed surgery specific measures, evaluating a multitude of patients' pre-operative risk factors and post-operative outcomes. SCIP measures include the appropriate administration of antibiotics and use of venous thromboembolism prophylaxis in the perioperative period. The Centers for Medicare and Medicaid Services (CMS) has been paying hospitals for reporting compliance with certain SCIP quality measures. In addition to giving hospitals a financial incentive to report the quality of their services, this hospital reporting program provides feedback to hospitals and consumers (patients).

Specific cancer care measures have been developed by the American Society of Clinical Oncology (ASCO) through the Quality Oncology Performance Initiative (QOPI). QOPI employs a mechanism for improving cancer care through measurement, feedback and improvement tools for medical oncology practices on a voluntary basis. Practicing oncologists and quality experts developed over 70 quality measures which were derived from clinical guidelines or published standards. While QOPI has focused on outpatient practices, both ASCO and the National Comprehensive Cancer Network (NCCN) have developed immensely popular clinical care guidelines. Not only have clinicians relied on these guidelines, CMS has used them as a basis for the Medicare Quality in Cancer Care Demonstration Project (2006), which reimbursed physicians for reporting on evidence-based practices.

In 2007, leading cancer organizations such as ASCO, the NCCN, and the American College of Surgeons Commission on Cancer (ACS-CoC), jointly developed five quality measures for breast and colon cancer (Table I). Development of the measures was based on evidence from a host of patient-level studies supporting improved patient outcomes if said measures were met. Recognizing that cancer treatment is an interdisciplinary practice, these quality measures were meant to be applied and measured at the hospital level. Endorsed by the National Quality Forum (NQF), these represented the first set of nationally recognized hospital-based performance measures specific to the quality of breast and colorectal cancer care.

In general, quality indicators have been popular, and they have been heralded as a means to help physicians and hospitals assure quality care. CMS has already paid hospitals and physicians for reporting results. Not surprising, there is also increasing interest on the part of third-party payers to incorporate adherence to quality indicators into their pay-for-performance initiatives. However, there has been some controversy as to the effectiveness of these measures, since adherence to them at the hospital level may not necessarily be associated with improved patient outcomes. For example, the number of lymph nodes that hospitals examine following colectomy for colon cancer is not associated with staging, use of adjuvant chemotherapy, or patient survival even though examining more than 12 nodes seems to portend a better prognosis for any given patient [2].

Learning what factors affect hospital/physician performance and patient outcomes is important. What may be more important is how

TABLE I. NQF-Endorsed Quality Measures Developed by ASCO, NCCN, and ACS-CoC

1. Radiation therapy is administered within 1 year (365 days) of diagnosis for women under age 70 receiving breast conserving surgery for breast cancer
2. Combination chemotherapy is considered or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1c, or Stage II or III hormone receptor negative breast cancer
3. Tamoxifen *or* third generation aromatase inhibitor is considered or administered within 1 year (365 days) of diagnosis for women with AJCC T1c or Stage II or III hormone receptor positive breast cancer
4. Adjuvant chemotherapy is considered or administered within 4 months (120 days) of diagnosis for patients under the age of 80 with AJCC Stage III (lymph node positive) colon cancer
5. At least 12 regional lymph nodes are removed and pathologically examined for resected colon cancer

*Correspondence to: Sandra L. Wong, MD, MS, FACS, Division of Surgical Oncology/Department of Surgery, University of Michigan, Ann Arbor, MI 48109-0932. Fax: 734-647-9647. E-mail: wongsl@umich.edu

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those things are related. The current state of quality indicators in surgical oncology represents well-intentioned efforts. However, implementation and enforcement of quality measures require a commitment of resources. If policy moves ahead of science, there is valid concern that efforts may actually detract from other things that might be more effective in improving quality of care. Effective quality indicators must be measurable, actionable, and shown to be associated with optimal outcomes.

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