Official Nudge Toward Patient-Centric Oncology Practices

By Eric T. Rosenthal

Oncology is ever more patient-centric, and the American College of Surgeons Commission on Cancer (CoC) is setting standards to that end.

The organization, which has been accrediting oncology clinics since 1933, has expanded its focus beyond oncology and treatment standards to include several complementary supportive-care programs designed to enhance a patient’s cancer experience. These new standards include risk assessment and genetic counseling, palliative care services, the patient navigation process, psychosocial distress screening, and survivorship care. For accreditation, institutions must enforce the standards by 2015.

The CoC accredits about one-quarter of all institutions offering cancer care in the United States, but those 1,500 centers treat some 70% of all newly diagnosed patients, according to the commission.

Although a hospital’s decision to apply for accreditation is voluntary, the CoC seal of approval connotes quality cancer care, said Stephen B. Edge, M.D., CoC chair and Alfiero Foundation endowed chair in breast oncology and professor of surgery and oncology at Roswell Park Cancer Institute in New York.

Modernizing Oncology

According to Daniel P. McKellar, M.D., chair of the CoC accreditation committee and medical director at Wayne HealthCare in Greenville, Ohio, the new standards were in part prompted by certain Institute of Medicine reports that had criticized oncology care. The CoC considers the standards part of modern oncology.

“It’s not an easy thing to address the entire continuum of care, but we wanted to make sure that the new standards had a direct patient benefit, and we invited certain advocacy and patient organizations to join us so that all perspectives would be included,” McKellar said.

He said that the CoC is the main organization in the country with any power to make cancer centers make changes in cancer care, and although the new programs do not have to be implemented until 2015, the educational process has already begun.

“This is a tremendous open door to educate health care professionals, and an opportunity for patients to get every component of care since the commission will be looking over the shoulders of cancer programs,” McKellar said.

Noting that the CoC accredits institutions, not individuals, and that private practices deliver much of cancer care, he added:

• Meeting all CoC standards and specified thresholds on quality improvement measures
• Maintaining a database of cancer cases treated at the facility that must be submitted annually to CoC’s National Cancer Database
• Performing internal quality improvement assessments
• Undergoing an external assessment every 3 years
• Performing annual prevention and screening activities designed to meet specific community needs
• Ensuring that all processes are in place to meet all the needs of cancer patients
• Diagnosing and treating cancer according to national guidelines

The largest cancer data repository in the world, CoC’s National Cancer Database “has evolved from just being a repository for retrospective analysis to a prospective mechanism for evaluation, monitoring, and tracking of quality,” Edge said.

Through a now-voluntary Rapid Quality Reporting System, hospitals enter data about every patient and then transmit them to the College of Surgeons headquarters in Chicago, which tracks whether patients’ care is meeting the standards.

“Then the clock is ticking by diagnosis and if, for instance, it doesn’t state that a certain patient has started chemotherapy by a certain time, then an alert goes out saying that certain measures may not have taken place,” Edge said.

Noting that the CoC accredits institutions, not individuals, and that private practices deliver much of cancer care, he added.
that CoC-accredited hospitals can oversee community oncologists with hospital privileges, thus extending the reach of the standards.

**Views Afield**
Jimmie C. Holland, M.D., Wayne E. Chapman chair in psychiatric oncology at Memorial Sloan–Kettering Cancer Center in New York, was a member of the Institute of Medicine committee that wrote the 2007 consensus report, *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*.

The CoC standards for psychosocial distress are an amazingly helpful nudge, said Holland, who is founding president of both the American Psychosocial Oncology Society and the International Psycho-Oncology Society and is generally regarded as the founder of psycho-oncology.

“Nobody ever before has come to someone like me and asked, ‘What do we have to do to make sure we don’t lose our accreditation?’ So instilling a little fear, the stick, is going to be helpful to us because when there is no stick and there is no reimbursement to speak of, it is hard to get anyone to move, so I think this is going to be a helpful thing,” she said.

Holland added that the new standards incorporate three points: (1) distress screening as the standard of care for oncology patients; (2) development and implementation of a process to integrate and monitor on-site psychosocial distress screening and referral; and (3) consistency with the National Comprehensive Cancer Network guidelines that distress should be recognized, monitored, documented, and treated promptly in all stages of disease.

Otis W. Brawley, M.D., chief medical and scientific officer and executive vice president of the American Cancer Society, as well as author (with Paul Goldberg) of *How We Do Harm: A Doctor Breaks Ranks about Being Sick in America* (St. Martin’s Press, 2012), said that the American Cancer Society supports the new standards, especially the inclusion of patient navigation and supportive care.

“We need to think about the patient experience as the patient is being treated. So frequently we have just thought about what is good treatment and not about what is good care. And this is an effort that tried to look at care, which includes treatment, but also supportive services,” Brawley said.

He added that the standards may help patients overcome obstacles to getting complete care.

“I’m avoiding using the phrase ‘being more compliant,’” he continued, “since [we should not be] blaming patients for the fact that they were unable to get complete treatment—when the reality is, sometimes there are a lot of social issues that are beyond the patients’ control that prevent them from getting complete treatment.”

© The Author 2012. Published by Oxford University Press. All rights reserved. For Permissions, please e-mail: journals.permissions@oup.com. DOI: 10.1093/jnci/djs366

---

**C-Path: Updating the Art of Pathology**

By Mike Martin

A n 84-year-old scoring technique pathologists use to diagnose and stage breast cancer is getting a 21st-century update from a computer model called Computational Pathologist (C-Path), which uses digital imagery and computer software to analyze more than 6,000 cell and tissue features faster and in more depth than the pathologist’s eye peering through a microscope.

“It would not replace human pathologists, but there are things a computer can do easier than a human,” said radiation oncologist Frances Wong, M.D., chief physician for the Fraser Valley (British Columbia) Cancer Centres. Wong did not participate in C-Path’s development, but she reviewed a study about it from research teams at Stanford, Harvard, the University of British Columbia (UBC), and the Academic Medical Center in Amsterdam.

According to a study in the November 2011 *Science Translational Medicine*, C-path generated prognostic scores that were “strongly associated with overall survival” in 576 patients from the Netherlands Cancer Institute (NKI) and Vancouver General Hospital (VGH).

The best histological predictors of patient survival are not from the carcinoma itself, but from adjacent stromal connective tissue. Women with worse breast cancer outcomes tended to have inflammatory and epithelial cells in distinct, thin cords infiltrating the stroma.

Oncology surgeon Paul Dale, M.D., chief of surgical oncology at Ellis Fischel Cancer Center in Columbia, Mo., said the latter finding was absolutely fascinating.

“This is a stand-alone result in its own right, and one of the more interesting research concepts to emerge from a recent paper,” explained Dale. “There have been reports about the importance of lymphocytes scattered in stroma around tumors, but nothing definitive that connects stromal observations with prognosis.”