



## Quality Cancer Care

The Oncology Nursing Society's (ONS's) mission is to promote excellence in oncology nursing and quality cancer care. But what does quality cancer care really mean? For me, it means that the care I want my family to receive is delivered to all—the best care, nothing less. And yet that doesn't happen, at least not with everyone facing this diagnosis. Some still experience poorly controlled pain. Or have too many computed tomography scans. Or get referred to hospice just days before dying, if at all.

The first report addressing this topic, *Ensuring Quality Cancer Care*, was published by the Institute of Medicine (1999). The report defined quality cancer care as avoiding the over, under, misuse, or wrong care while providing patients “with appropriate services in a technically competent manner, with good communication, shared decision making, and cultural sensitivity” (p. 79). The report contained recommendations (see Figure 1) for ensuring quality cancer care. Since that report 14 years ago, others followed, focusing on different components of quality cancer care. So how are we doing?

We have seen progress in cancer care that includes declining death rates, a growing population of survivors, and enhanced quality of life for many of them. And yet we are far from delivering quality cancer care to everyone who needs it. We need evidence on what quality care is. And we need systems and processes to help us know about and consistently apply the evidence. We also need the skills and tools to use available resources to help us do that. We need to be able to practice to the full extent of our education and training so all of our patients can benefit from our expertise to be able to deliver this care (Institute of Medicine, 2011). As our healthcare system changes to meet the mandates of the Affordable Care Act, we need to drive the long overdue changes in how we deliver cancer care to make it better. The time is right

**Recommendation 1:** Ensure that patients undergoing procedures that are technically difficult to perform and have been associated with higher mortality in lower-volume settings receive care at facilities with extensive experience (i.e., high-volume facilities). Examples of such procedures include removal of all or part of the esophagus, surgery for pancreatic cancer, removal of pelvic organs, and complex chemotherapy regimens.

**Recommendation 2:** Use systematically developed guidelines based on the best available evidence for prevention, diagnosis, treatment, and palliative care.

**Recommendation 3:** Measure and monitor the quality of care using a core set of quality measures.

**Recommendation 4:** Ensure the following elements of quality care for each individual with cancer:

- That recommendations about initial cancer management, which are critical in determining long-term outcome, are made by experienced professionals
- An agreed-upon care plan that outlines goals of care
- Access to the full complement of resources necessary to implement the care plan
- Access to high-quality clinical trials
- Policies to ensure full disclosure of information about appropriate treatment options
- A mechanism to coordinate services
- Psychosocial support services and compassionate care.

**Recommendation 5:** Ensure quality of care at the end of life, in particular, the management of cancer-related pain and timely referral to palliative and hospice care.

**Recommendation 6:** Federal and private research sponsors and various health plans should invest in clinical trials to address questions about cancer care management.

**Recommendation 7:** A cancer data system is needed that can provide quality benchmarks for use by systems of care (e.g., hospitals, provider groups, managed care systems).

**Recommendation 8:** Public and private sponsors of cancer care research should support national studies of recently diagnosed individuals with cancer, using information sources with sufficient detail to assess patterns of cancer care and factors associated with the receipt of good care. Research sponsors should also support training for cancer care providers interested in health services research.

**Recommendation 9:** Services for the un- and underinsured need to be enhanced to ensure entry to, and equitable treatment within, the cancer care system.

**Recommendation 10:** Studies are needed to find out why specific segments of the population (e.g., members of certain racial or ethnic groups, older patients) do not receive appropriate cancer care. These studies should measure provider and individual knowledge, attitudes, and beliefs, as well as other potential barriers to access to care.

### FIGURE 1. Recommendations of the National Cancer Policy Board's Cancer Care System on Ensuring Quality Cancer Care

Note. From *Ensuring Quality Cancer Care* (p. 212), by M. Hewitt and J.V. Simone (Eds.), 1999, Washington, DC: National Academies Press. Copyright 1999 by National Cancer Policy Board, Institute of Medicine, and National Research Council. Reprinted with permission.

as a number of changes are aligning so that we can do just that.

One of the ONS pillars in its strategic plan is about quality. ONS “supports the development, dissemination, and evaluation of patient-centered interventions and their contribution to high-quality cancer care” (ONS, 2012, p. 3). To further

those aims, we decided that each column in this issue of the *Clinical Journal of Oncology Nursing (CJON)* would address some aspect of quality care. In addition, we will be launching a new column on Quality with Anne H. Gross, PhD, RN, NEA-BC, as associate editor in the June 2013 issue of *CJON*. We want to

keep this topic visible and help you think about quality cancer care in your own setting. We want to hear about the quality initiatives you have initiated or are part of to make cancer care better. And, as Mahatma Gandhi said, "You must be the change you wish to see in the world" (Quotations Page, 2013).

## References

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