ORIGINAL ARTICLE

Perspectives of Quality Care in Cancer Treatment: A Review of the Literature

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Background: Approximately 1.7 million Americans are diagnosed with cancer annually. There is an increasing demand for high-quality cancer care; however, what constitutes quality care is not well defined. There remains a gap in our knowledge regarding the current perceptions of what defines quality care.

Objective: To review the current understanding and perspectives of key stakeholders regarding quality cancer care for adult patients with cancer who are receiving chemotherapy-based treatment regimens.

Methods: This systematic qualitative literature review involved a search of MEDLINE and PubMed databases for articles that were published between January 2009 and May 2013 using a predefined search strategy with specific Medical Subject Headings terms encompassing 3 core concepts—cancer, chemotherapy, and quality of healthcare. Articles were eligible to be included if they focused on adult cancers, discussed quality indicators of cancer care or quality of care in the article's body, discussed treating cancer with chemotherapy, were conducted in the United States and with US respondents, and reported data about cancer quality that were obtained directly from stakeholders (eg, patients, caregivers, providers, payers, other healthcare professionals). Thematic analyses were conducted to assess the perspectives and the intersection of quality care issues from each stakeholder group that was identified, including patients, providers, and thought leaders.

Results: The search strategy identified 542 articles that were reviewed for eligibility. Of these articles, 15 were eligible for inclusion in the study and reported perspectives from a total of 4934 participants. Patients with cancer, as well as providers, noted information needs, psychosocial support, responsibility for care, and coordination of care as important aspects of quality care. Providers also reported the importance of equity in cancer care and reimbursement concerns, whereas patients with cancer considered the timeliness of care an important factor. The perspectives of thought leaders focused on barriers to and facilitators of quality care.

Conclusion: Thematic elements related to cancer quality were relatively consistent between patients and providers; no additional information was found regarding payer perspectives. The perspectives of these groups are important to consider as quality initiatives are being developed.

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According to the American Cancer Society, more than 1.6 million people will receive a new diagnosis of cancer in 2013.[1] It is also estimated that there were almost 14 million cancer survivors (ie, any living person who has ever received a diagnosis of cancer) in the United States in 2012.[2] Although many aggressive forms of cancer still exist, individuals who receive a diagnosis of cancer today are less likely to die from their disease than in the past; the death rate from cancer has decreased by 20% since 1991.[1] However, the number of cancer diagnoses is increasing, and it is expected that there will be more than 18 million cancer survivors in the United States in the next decade.[2]

Representing a set of heterogeneous diseases, the term "cancer" refers to a diagnosis that is increasingly becoming a chronic condition. Patient care is shifting from a model that was focused on the immediate need to treat the tumor to a more holistic approach in the care of the patient to ensure both quantity and quality of life. The consideration of these needs begins before the active

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KEY POINTS

- With an increasing number of cancer diagnoses and the development of quality initiatives, there is a growing demand for high-quality cancer care.
- However, quality care is currently ill-defined, and a uniform understanding of what constitutes quality care is still lacking.
- This study sought to describe perspectives of various stakeholders about quality cancer care.
- Using search criteria that included cancer, chemotherapy, and quality healthcare, 15 articles published between January 2009 and May 2013 were eligible for inclusion, representing perspectives from a total of 4934 patients with cancer, providers, caregivers, and thought leaders.
- Information needs, psychosocial support, responsibility for care, and coordination of care were indicated by patients and providers as important components of quality cancer care.
- Providers also noted the importance of equity in cancer care and reimbursement concerns.
- Perspectives from thought leaders focused on barriers to and on facilitators of quality care.
- These themes can serve as a starting point for future initiatives designed to improve quality cancer care and help identify quality measures that are important to patients and providers.

treatment phase and continues after the transition to long-term survivorship.

This shift from acute cancer care to treating cancer as a chronic disease has corresponded with the more recent focus on quality cancer care; however, the relationship between these trends and general attitudes about cancer care is unclear.

A number of cancer quality–focused initiatives are ongoing to ensure and assess the quality of cancer care in the United States. These range from legal requirements, such as the Quality Reporting Program for Prospective Payment System–Exempt Cancer Hospitals (Patient Protection and Affordability Care Act, Section 2701 includes mandatory quality reporting requirements, and Section 3005 is specific to cancer hospitals),[3] to completely voluntary quality initiatives, such as the Quality Oncology Practice Initiative (QOPI) and its certification system,[4] and initiatives led by the Institute of Medicine, such as Improving the Quality of Cancer Care: Addressing the Challenges of an Aging Population (www.iom.edu/Activities/Quality/QualityCancerCareAging.aspx).

Cancer quality measures are being developed by many groups with different or overlapping goals. For example, the National Quality Forum (NQF) (www.quality forum.org) sets standards and recommends and endorses measures for quality performance in anticipation of the increase in pay-for-performance reimbursement systems. The Physician Quality Reporting System (PQRS), which is sponsored by the Centers for Medicare & Medicaid Services (www.cms.gov/PQRS), is focused on payment incentives and adjustments to enhance quality reporting measures.[3] Measures may be coendorsed by the NQF and the PQRS. The National Committee for Quality Assurance (www.ncqa.org) is a not-for-profit organization that is focused on care structure and the process of care delivery, and it offers a variety of accreditation and certification programs to ensure quality care.

The largest oncologist organization in the United States, the American Society of Clinical Oncology (ASCO), initiated the QOPI program to be a physician-led initiative that promotes improvement in cancer care by oncologists through self-assessment via specific retrospective chart review procedures.[4] The National Comprehensive Cancer Network (NCCN) collaborated with ASCO to develop a set of measures that are now being used in the QOPI program. The Community Oncology Alliance (www.communityoncology.org) is a nonprofit organization that is designed to protect the community oncology care delivery system in the United States, with the primary goal of ensuring patient access to quality cancer care.

Many other specialist organizations (eg, Society of Thoracic Surgeons, American Medical Association, College of American Pathologists) have measures that are focused on specific cancers that are not part of the larger disease site–specific measures that are already within the NQF and PQRS tools. As the measures are being developed, what is being measured will ultimately determine how quality is defined; hence the importance of efforts to develop the measures that will assess what is important to the key stakeholders in cancer care (ie, the patients, providers, and payers) cannot be understated.

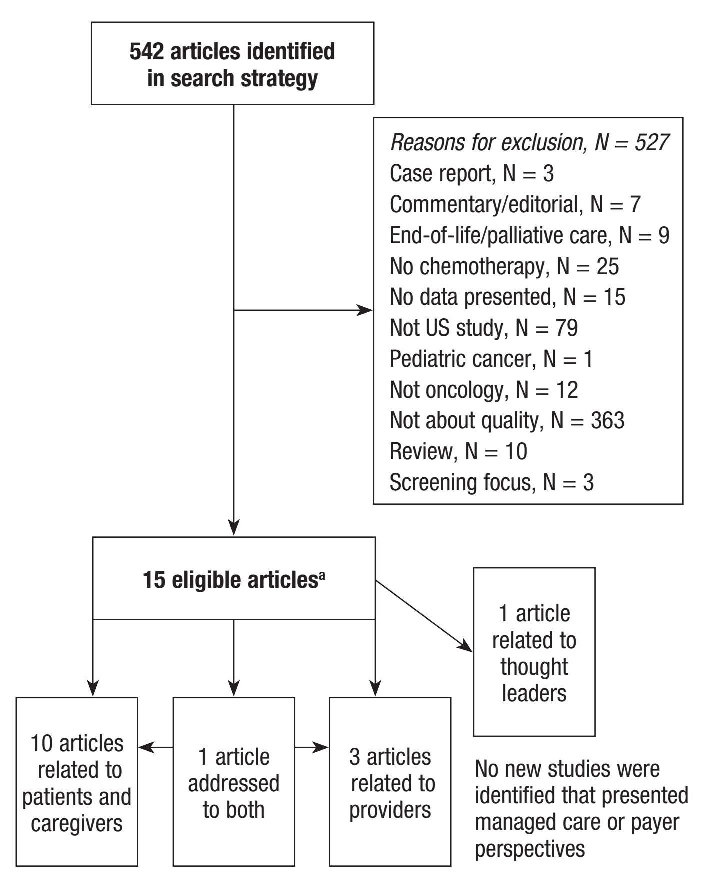
Patients, caregivers, providers, managed care organizations, payers, and other stakeholder groups have all communicated their interests in improving the quality of cancer care. However, what a patient defines as quality care may not always correspond with how the groups that are developing the key quality measures perceive as quality care. Improvement in quality care could have a very different inherent meaning across stakeholder groups, and discrepancies in values may not be reflected in the measures being created by the various groups. Therefore, it is important to understand the values of each stakeholder through their perceptions of quality in cancer care.

As measures are being developed, it will be important that the patient voice, as well as the voices of others, be adequately represented, or there will be a risk of focusing quality-of-care improvement efforts in such a way as to have no meaning to the recipient of that care.

A previous literature review was conducted by Eli Lilly and Company (Indianapolis, IN) and RTI Health Solutions (Research Triangle Park, NC) on perspectives of quality care in the published literature from 1996 through 2009.[5] The study identified 25 published articles that assessed perspectives of quality care. The authors reported the key promoters to quality that were identified by patients (eg, communication, trust, caring behavior and comfort, social and spiritual support), barriers to quality care that were identified by patients (eg, getting health information, lack of coordinated care, lack of psychosocial care, delays in care, billing issues), concerns of providers (eg, workload or administrative burden, lack of coordinated care, bureaucracy of managed care, lack of processes to support treatment guidelines), and the strategies being implemented by managed care to address cancer quality (eg, decision support tools, pathways, guidelines, and cost reduction strategies).[5]

Each of these perspectives provides insight as to how quality care is interpreted and defined. However, the payer–provider–patient landscape has been changing rapidly in recent years, and trends and perspectives are likely to have changed since 2009. Therefore, we repeated the search strategy in this present study to provide a more current overview of the state of the science related to perspectives on quality in cancer care from January 2009 through May 2013.

Figure 1 CONSORT Diagram



[a]References 6-20.

Methods

MEDLINE and PubMed databases were searched systematically for publications related to cancer that were published between January 2009 and May 2013. The PubMed Medical Subject Headings (MeSH) terms that were used in this study include "neoplasms/drug therapy," "cancer care facilities," and "oncology service, hospital." The MeSH terms that were used to capture studies on quality of care are "quality of health care," "quality assurance, health care," and "quality indicators, health care." Additional articles were obtained from the selected article bibliographies and from online searches informed by content from the selected articles.

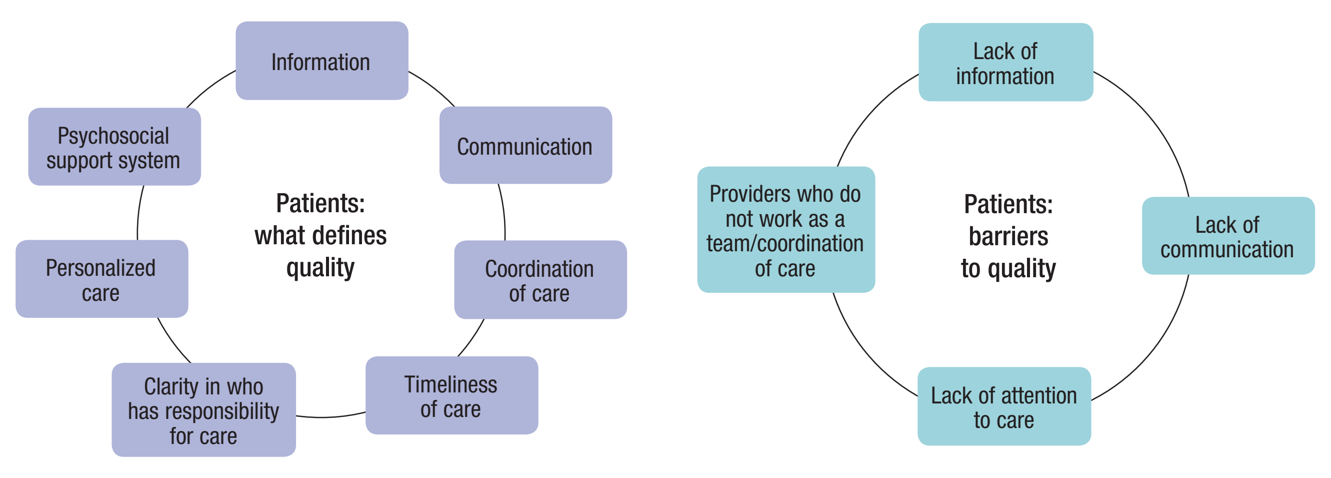
Each article obtained through the predefined MeSH terms search strategy and hand-searching method was reviewed for eligibility. Articles were eligible for inclusion if they met all the following criteria—(1) the article was focused on adult cancers, (2) quality indicators of cancer care or of quality of care were discussed in the article body, (3) the article discussed chemotherapy treatment for cancer, (4) the study was conducted in the United States and with US respondents, and (5) the article reported data about cancer quality that were obtained directly from various stakeholder groups (ie, patients, caregivers, providers, payers, other healthcare professionals).

An article was ineligible for inclusion if it did not present any perspectives on cancer quality care, if it focused on pediatric oncology, if it was not related to oncology or cancer, or if it did not include perspectives on the chemotherapy treatment period. To be consistent with the previous review by Colosia and colleagues,[5] studies were also deemed ineligible if they only addressed quality of survivorship, end-of-life care, supportive care, or hospice care for patients with cancer; if they only addressed quality of preventive or screening services for cancer prevention or early detection; if they addressed quality-of-care delivery methods; if the article had been included in that earlier review[5]; or if the article type was a review, editorial or letter to the editor, case report, news report, meeting summary report, or a commentary.

Table 1 Eligible Studies: 15 Publications, 4934 Participants

Study	Stakeholder group(s), N	Study design	Primary objective of study	Data source
Taplin et al, 2010[7]	Patients, 6	Retrospective	To understand process of care and quality perspectives	Interview
Dulko and Mooney, 2010[8]	Patients, 92	Cross-sectional	To understand patient perception of quality care	Survey
Scandrett et al, 2010[9]	Patients, 159	Pre-/post-design	To compare quality of care with or without intervention	Survey
Teno et al, 2009[10]	Patients, 206	Longitudinal	To measure quality-of-care concerns of patients	Survey
Roundtree et al, 2011[11]	Patients, 33	Retrospective	To describe perceptions about care	Focus group
Thind et al, 2010[12]	Patients, 924	Cross-sectional	To identify factors in satisfaction related to quality care	Survey
Lis et al, 2011[13]	Patients, 2018	Cross-sectional	To assess the relationship between quality and willingness to recommend	Survey
Tsianakas et al, 2012[14]	Patients, 95	Cross-sectional	To compare interviews to surveys to understand priorities for quality improvement	Survey/ interview
Bickell et al, 2012[15]	Patients, 374	Longitudinal	To describe perceptions of quality care	Survey
Landercasper et al, 2010[16]	Patients, 234	Retrospective	To assess relationship between timeliness and patient satisfaction	Survey
Wagner et al, 2010[17]	Patients/ caregivers, 39 Providers, 15	Retrospective	To assess barriers and facilitators to quality care	Focus group
Nelson, 2011[18]	Providers, 20	Longitudinal	To describe perceptions of staffing for quality care	Interview
Bunnell et al, 2013[19]	Providers, 74	Pre-/post-design	To measure changes in perceptions of quality care	Survey
Burg et al, 2010[20]	Providers, 622	Cross-sectional	To describe barriers to quality patient care	Survey
Aiello Bowles et al, 2008[6]	Thought leaders, 23	Cross-sectional	To assess barriers and facilitators to quality care	Interview

Figure 2 Patient Perspectives of Quality Cancer Care



Source: References 7-17.

The following data were extracted from each eligible article or abstract: type of study, sample size, study population demographics, disease site(s), and survey instruments or questionnaires that were administered. The thematic qualitative data extraction initially focused on the themes within the earlier review by Colosia and colleagues.[5] The articles were further culled for emerging themes that were not previously identified and were re-

Table 2 Content of Patient-Reported Cancer Quality Themes

Patient theme	Content
Information	**Defining:** help patients and families find reputable websites; navigators to help patients participate in decision-making; knowledge of how to manage side effects; care team helping patient to understand diagnosis; written information on what to expect during treatment, side effects, and what to do at home; knowing who to ask when there are questions **Barriers:** patients overwhelmed by amount of, complexity of, and conflicts in information; patient education provided after major decisions have been made; lack of awareness of what was going to happen, procedures not explained; not understanding test results; contradictory information; not knowing where to call after hours
Communication	**Defining:** high ratings of communication correspond to high ratings of quality care **Barriers:** inaccurate/contradictory information from interactions with providers; understandability of instructions or information given at diagnosis and during treatment decision-making
Coordination of care	**Defining:** find a “one-stop shopping” approach to cancer care; enhanced role of primary care provider during treatment; all providers working as a team **Barriers:** lack of teamwork among a variety of healthcare providers; disorganization between providers; lack of single source of information on treatment history, tests, and billing; primary care does not understand cancer and specialist is only familiar with cancer
Timeliness of care	**Defining:** patients getting a more rapid diagnosis and are more satisfied with care; timely care is in accordance with patient preferences, not just shorter time **Barriers:** problems with appointment systems or waiting times lead to missed appointments; takes too long to reach a provider when there is an urgent issue; delays during the diagnostic period increased distress; long wait times add to patient stress
Responsibility for care	Participatory decision-making associated with greater satisfaction; need to have clarity in who is responsible for which part of care; patients do not want to be left with the responsibility of making sure things are done correctly
Personalized care	Being cared for as a person rather than just as a patient; “whole person” approach to care; provider and staff knows you by name; high ratings of treatment by providers associated with willingness to recommend provider
Psychosocial support	Need for peer and professional psychosocial support for patients; need for emotional support from the healthcare provider; services need to be introduced earlier in the care plan; social support from family and friends
Lack of attention to care	Providers do not pay enough attention to the individual’s care; patients have insufficient amount of time with the provider; lack of attention during inpatient stay and lack of respect have an impact on recovery

Source: References 7-17.

lated to cancer care quality from each perspective. Finally, the qualitative analysis assessed the intersection of quality care issues from the various perspectives.

Results

The search strategy identified 542 articles that were reviewed for eligibility (**Figure 1**, page 323). Of these articles, 15 were eligible for inclusion and reported perspectives from patients, providers, caregivers, and thought leaders (**Table 1**, page 324).[6-20]

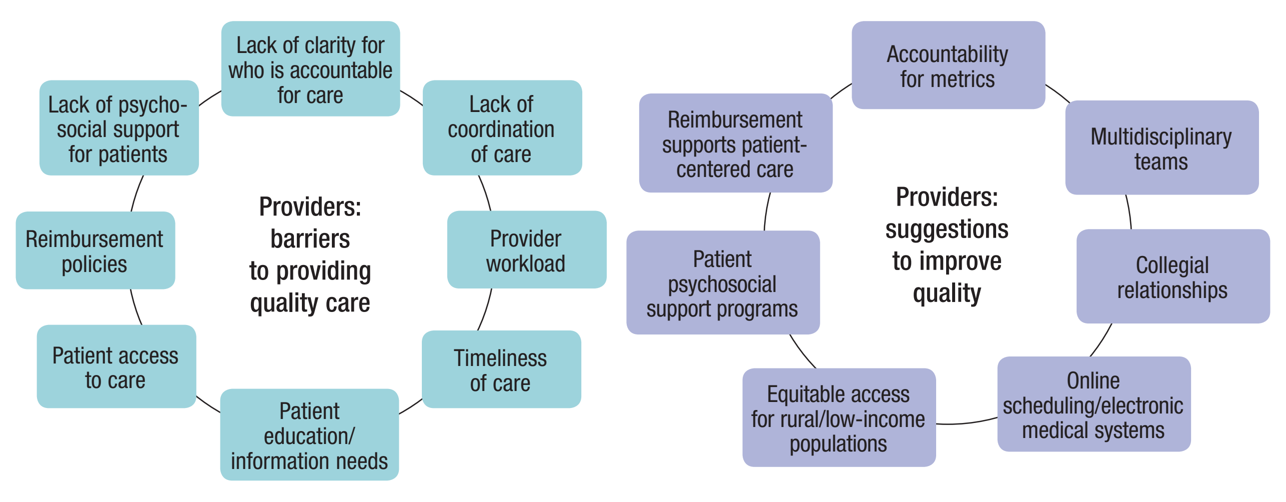
The primary reasons for article ineligibility included a lack of information on cancer quality (N = 363), data from outside of the United States (N = 79), and not focusing on quality of care during chemotherapy (N = 25).

Of the eligible articles, 10 articles focused solely on the perspectives of patients and caregivers[7-16]; 3 articles focused on the perspectives of providers[18-20]; and 1 article covered both perspectives.[17] One article presented the perspectives of thought leaders,[6] and no new articles were identified that presented the perspectives of managed care or of payers.

Patient Perspectives

Of the eligible articles, 11 included perspectives from 4180 patients with cancer and caregivers.[7-17] Of the 5 studies that reported age, the mean age of patients was

Figure 3 Provider Perspectives of Quality Cancer Care



Source: References 7-17.

55.7 years.[9,11,13,15] Five studies were limited to patients with breast cancer,[11,12,14-16] 5 studies included various tumor types (primarily breast, colon, lung, prostate, cervical, pancreatic, and hematologic malignancies),[7-10,13] and 1 study did not provide information on the tumor type of the patients who were included in the study.[17]

A number of key themes emerged related to the perspectives of patients with cancer regarding quality care (**Figure 2**, page 324). Examples of content from the eligible articles supporting these themes is provided in **Table 2** (page 325).[7-17] The themes defining quality care included information for patients, communication between patients and providers, coordination of care, timeliness of care, responsibility for care, personalized care, and psychosocial support. Three of these themes (ie, coordination of care, communication, and information) were also considered barriers to quality care if they were not met, along with the final theme of a lack of attention to care, which was a patient-reported barrier to healthcare quality.[7,9-11,14,17]

Provider Perspectives

Provider perspectives were obtained from 731 physicians, nurses, social workers, and clinic staff. Their perspectives included recommendations to improve quality, such as accountability for metrics of care, the use of multidisciplinary teams, collegial relationships among the provider team, electronic medical and scheduling systems, equitable access to care, patient psychosocial support programs, and reimbursement programs that support the use of patient-centered care (**Figure 3**).[17-20]

Providers noted that barriers to quality care included a lack of clarity regarding who is responsible for the patient's care, lack of coordination of care, provider workload, challenges with the timeliness of care, patient education and information needs, barriers to patient access to care, reimbursement policies, and the lack of psychosocial support programs (Figure 3). Examples of the content that was associated with these themes is summarized in **Table 3**.[17-20]

Thought Leader Perspectives

Perspectives were obtained from 23 thought leaders in one study.[6] The barriers to quality care noted in this study included a lack of standardization and a lack of adherence to guidelines, difficulty in scheduling appointments, patient out-of-pocket costs, reimbursement policies, a lack of documentation, a lack of teamwork and care coordination, low provider awareness of new research, patient anxiety, and a lack of patient awareness and education.[6] Some of the facilitators that were reported to improve quality care included real-world data, shared decision-making, interactive websites, electronic medical records and other information technology innovations, patient navigators and family or social support, outcomes-based performance measures, and risk-adjusted reimbursement policies.[6]

Discussion

This study has updated an earlier review of perspectives of quality care in cancer, because there have been more recent initiatives and mandates related to quality healthcare.[3] In the previous review, 25 sources were identified that reported perspectives of quality care over a 13-year period.[5] The current study identified an additional 15 articles that were published within the past 4 years (from 2009 to 2013), representing a much shorter

Table 3 Content of Provider-Reported Cancer Quality Themes

Provider theme	Content
Access to care	**Barrier:** racial, ethnic, socioeconomic, and geographic disparities; childcare/eldercare needs; low income and uninsured difficulties in accessing services; inadequate insurance **Recommendation:** use of telemedicine for rural care; increased linkages between cancer centers and safety net hospitals
Reimbursement policies	**Barrier:** no reward for services that provide information or supportive care; reimbursement discourages patient-centered care **Recommendation:** financial incentives/changes in reimbursement that encouraged patient-centered services
Lack of psychosocial support services for patients	**Barrier:** patients experience fear, anxiety, depression, and distress; lack of systematic assessment of or attention to psychosocial issues **Recommendation:** enhancing the quality of service provision by hiring more oncology social workers and educating them in cancer care; use of patient navigators to provide support
Accountability for care/ metrics of care	Lack of clarity in who guides patient care before and after therapy for cancer; integrated cancer care services will help support accountability; published performance measures
Coordination of care	Lack of coordination before and after treatment period; multidisciplinary care starts too late, after treatment is already initiated; no clear provider at time of arrival to oncology; difficulty communicating with off-site providers
Provider workload	Inadequate staffing leads to alteration, elimination, or delay in patient care and increases concerns about safety; nursing fills in for missing support services, thereby impacting quality care
Timeliness of care	Unclear accountability and inadequate staffing contributes to delays in care; care managers could facilitate this
Patient education/ information	Patient navigators to help them access information; care centers vary widely in emphasis and resources devoted to educating patients; key information provided after major decisions have already been made; provider time to answer patient questions and details needed by patient takes away provider's time for care of the patient
Multidisciplinary teams	Multidisciplinary teams can improve the timeliness of care; a barrier when multidisciplinary care begins after the initiation of treatment
Collegial relationships	Quality care improves when collegial relationships and good communication exist between nurses and physicians
Electronic systems	Electronic systems can improve the timeliness of care; electronic health records and patient portals could inform/connect patients to information and services; shared electronic health records can help coordinate care, facilitate provider communication, support multidisciplinary care planning, and improve safety; online appointment scheduling

Source: References 17-20.

period, which indicates an increasing interest in and focus on the topic of quality cancer care.

Some of the themes emerging from this update are consistent with the earlier review, such as patient information needs, the importance of social support, concerns with coordination of care, provider workload, reimbursement policies, and the need for improved patient interaction and communication with providers. However, new themes emerged in the new publications related to the perspectives of providers, such as accountability for care, the desire for multidisciplinary teams, and collegial relationships among providers to enhance quality care.

There were no perspectives identified in the eligible articles that addressed improved outcomes associated with quality care. However, the ultimate goal of quality cancer care should not only be the short-term improvements in processes, but rather improvements in patient outcomes, such as reduced toxicity resulting from supportive care, fewer hospitalizations as a result of improved healthcare delivery that can help to address concerns before they become serious or life-threatening.

Recent research has demonstrated that adherence to treatment guidelines, such as guidelines published by the NCCN, are associated with improved survival outcomes.[21,22] However, quality measures remain largely process-oriented, and there is an expressed need to include additional outcomes-oriented quality measures.[23] The relationship between process improvements and outcomes measures has yet to be fully demonstrated, but it may help to address this concern.

The common themes that emerge in this analysis in the 2 most researched stakeholder groups—patients and providers—suggest common perceptions of quality cancer care. Patients, their caregivers, and providers all express the need for better patient information, improvements in care coordination, and for multidisciplinary care that includes psychosocial support and the importance of timeliness of care. In addition, patients desire more personalized care, improved communication with providers, and additional clarity regarding who has responsibility for their care.

Overall, these findings suggest that there may be a need to develop improved initiatives that address patient–provider communication and information sharing, as well as initiatives to provide multidisciplinary care at the point of an initial diagnosis. However, there may also be barriers to these initiatives as noted by providers: their workload and their time are already restricted; there is inequitable access to care among patients (as a result of healthcare disparities, insurance issues, rural location, and out-of-pocket costs); and there is a need for appropriate reimbursement to support patient-centered care.

Limitations

Although the search strategy was designed to be comprehensive, it is possible that additional publications addressing the quality of cancer care were not identified. Although MEDLINE and PubMed databases were searched, there are other sources of information, such as meeting abstracts and organization reports, that were not explored as sources of information for this study.

The summaries and themes cannot necessarily be considered representative of the views of these stakeholder groups, because many of the studies identified in the literature were designed to explore specific concepts, which contributed to the themes that were chosen. There is always the risk of a subjective interpretation of common themes in a qualitative review of the literature.

Although the current study focused on quality care during chemotherapy, to be consistent with the methods of the earlier review,[5] there is a need to understand the quality cancer care perspectives in the survivorship community, which is not represented in this present article.

In addition, because 9 articles were identified that focused on end-of-life care and up to 25 other articles that dealt with other treatment or follow-up periods during survivorship, there may be sufficient information to evaluate the perspectives of cancer care for periods of cancer-related care beyond the chemotherapy treatment period. The full trajectory of care throughout the survivorship period is therefore recommended as a topic for future research.

Conclusion

The themes identified in this study may serve as a starting point for initiatives or programs that are designed to improve quality of cancer care and to identify measures associated with factors that are important to patients and to providers. Initiatives that focus on enhancing the quality of cancer care may need to consider the limitations and barriers to care noted in this article, especially regarding the patient–provider communication and information sharing, as well as the need for reimbursement to support patient-centered care. To increase the likelihood of success, such initiatives should include strategies to mitigate these barriers. Future studies are warranted to address the full range of quality care throughout the survivorship period and through end-of-life care, as well as to better understand payer perspectives. ■

Author Disclosure Statement

Dr Hess is an employee of Eli Lilly and Company. Dr Pohl is an employee of and a stockholder of Eli Lilly and Company.

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STAKEHOLDER PERSPECTIVE

Quality of Cancer Care: Emerging Definition and Measurements, but Reimbursement Lagging

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The article by Dr Hess and Dr Pohl in this issue of *American Health & Drug Benefits* examines quality care in cancer treatment. There has recently been much focus in the mainstream media on the quality of care that is delivered in the US healthcare system, specifically in hospitals. However, the challenges that organized medicine and the general public have with identifying, or even defining, quality are problematic.

POLICYMAKERS: In the past several years, the Centers for Medicare & Medicaid Services (CMS) has invested a great deal of effort in defining and measuring quality. Some of the parameters that CMS has examined include the frequency of rehospitalization within 30 days postdischarge, hospital-acquired infections, adverse events, surgical errors, and mortality. These data have mostly been aggregated by the Agency for Healthcare Research and Quality and by CMS, and have been widely reported and used to rate hospitals.

In recent months, publications and organizations such as *Consumer Reports*, *US News & World Report*, The Leapfrog Group, and others have used some of these data to formulate their own rating systems for quality. Transparency and the dissemination of this information can only help patients and payers identify which organizations are committed to improving the care they deliver to patients. Nevertheless, few, if any, of these analyses measure value, because they fail to impute the cost of care, which can vary from one hospital to another by several-fold.

Quality care in the treatment of patients with cancer can be even more difficult to define and measure. The American Society of Clinical Oncology has invested tremendous effort in creating the Quality Oncology Practice Initiative, and CMS has created a similar program in its Physician Quality Reporting System. Although neither program has been widely adopted, both represent important efforts toward measuring and improving care quality.

PROVIDERS/PATIENTS: Dr Hess and Dr Pohl review cross-sectional retrospective and longitudinal studies measuring quality in cancer care from the perspectives of patients, physicians, and other stakeholders, but payer studies are lacking. The authors should be commended for their important and timely contribution to this discussion. However, their research is focused on quality that is associated with chemotherapy; in reality, only a subset of patients with cancer receive chemotherapy, and additional studies are needed to assess the full spectrum of cancer care, including survivorship, end-of-life care, supportive care, radiation, and hospice care.

Recently, Halpern and colleagues examined quality parameters in patients with cancer at community hospitals, based on 5 National Quality Forum–approved quality-of-care measures for patients with breast or colon cancer.[1] They found that quality improvements were related to hospitals' participation in the National Cancer Institute Community Cancer Centers Program compared with nonparticipating hospitals.[1]

The Affordable Care Act has made a tremendous financial investment in defining, measuring, and improving the quality of care for patients with cancer and other chronic diseases. The expectation is that this investment and increasing focus by researchers will better define quality and help to improve the care that patients with cancer receive in the outpatient setting and at US hospitals.

PAYERS: New ongoing initiatives highlight the importance of quality of care for patients and for providers. Quality measures are being introduced into the clinical setting, but few payers are willing to reimburse providers in any significant manner for improvement in quality or outcomes. Payers need to look more closely at quality and outcomes and reassess quality measures as important components of reimbursement.

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1. Halpern T, Spain P, Holden DJ, et al. Association of increases in quality of care with the NCI Community Cancer Center Program (NCCCP) pilot. *J Clin Oncol*. 2012;30(suppl):Abstract 6046.