Evolution of a Community-Based Regional Program of Excellence in Cancer Care

An Interview with Randall A. Oyer, M.D.
Oncology Program Director, Cancer Care

INTRODUCTION

Across the United States, the incidence and prevalence of cancer continue to increase. According to the American Cancer Society, about 1.44 million new cancers cases were identified in 2007, representing an 18% increase over 2000. Reasons for the increase are complex and include population growth, changing demographics, and lifestyle factors. In conjunction with this dismal trend, significant advances in cancer diagnosis, treatment, and prevention have been achieved. Cancer mortality rates are decreasing, and the five-year survival rate for all cancers diagnosed between 1996 and 2002 is 66%, up from 51% in the mid-1970s. Factors that have fueled this improvement include progress in diagnosing certain cancers at earlier stages, innovations in targeted therapies, and greater understanding of the molecular and genetic basis of cancer. The increasing numbers of new cancer cases and cancer survivors translates into growing utilization of cancer services at both the national and local levels.

As the predominant health care system in Lancaster County, PA, Lancaster General Hospital (LGH) provides a broad range of services in both inpatient and ambulatory settings. Cancer Care is a high profile, multidisciplinary initiative of LGH that has evolved over the years to provide a comprehensive array of diagnostic, treatment and support services. Recently, the leadership of Cancer Care undertook a critical review of the service and embarked on a comprehensive program of quality improvement based in part on national benchmarks of cancer care excellence and the unique needs of the local population. In this interview, Randy Oyer, MD, Oncology Program Director, discusses the program currently underway to establish Cancer Care as the premier regional cancer care provider.

JLGH: What was the impetus for the revision of the Cancer Care model of care?

Dr. Oyer: Cancer Care is responsible for the care and treatment of over 2000 cancer patients per year. With new medical and administrative leadership in place in mid-2006, LGH took a fresh look at developing a roadmap for the future, building on some strong program components already in place.

JLGH: What is the reason for the focus on community-based cancer care?

Dr. Oyer: The majority of cancer care in the United States is delivered in the outpatient setting, and the utilization of community-based cancer programs is expected to increase in the coming years. The National Cancer Institute (NCI) has determined that about 85% of cancer patients in the United States are diagnosed at hospitals in or near the communities in which they live. The other 15% are diagnosed at NCI-designated Cancer Centers, a network of academic research institutions located in largely urban areas across the country. Many patients are not treated at the major cancer centers because of the distance from their homes, or for other personal or economic reasons. After decades of developing and building NCI-designated Cancer Centers across the country, the focus has shifted to the enhancement of existing community-based programs.

JLGH: How is NCI supporting the development of community-based cancer programs?

Dr. Oyer: In 2007 the NCI launched a three-year pilot program, the NCI Community Cancer Centers Program (NCCCP). NCCCP is a proposed national network of community cancer centers that will expand cancer research and deliver advanced cancer care to greater numbers of Americans in their own communities. The primary goals of the program are to expand access to clinical trials, reduce cancer healthcare disparities, provide greater access to blood and tissue samples for research, and explore the utility of a national database of electronic medical records. The NCCCP shares many of the same goals as other NCI community cancer programs, including increasing access to clinical trials among underserved populations and reducing health disparities. NCI has selected 16 community hospitals in 14 states to

participate in the pilot program. Although Cancer Care is not a part of the NCCCP program, we share many of the same goals.

JLGH: What other benchmarks are being incorporated into the Cancer Care remodeling program?

Dr. Oyer: The American College of Surgeons (ACOS) has been playing a key role in developing national standards in cancer care. Historically, ACOS has been the major accrediting body for cancer care programs. Over time, there has been an effort by ACOS to develop clear metrics for cancer care providers and make them available to the public. The EQUIP, or Electronic Quality Improvement Packet program, has been initiated by ACOS on a voluntary data submission basis with the intent of providing the information obtained to the public. There is a harmonization of cancer care criteria among different organizations, including the American Society of Clinical Oncology, the Agency for Healthcare Research and Quality, the National Quality Foundation, and others. We are incorporating criteria from all of these benchmarks into our remodeling program.

JLGH: What is the primary mission of the Cancer Care remodeling program?

Dr. Oyer: Our primary mission is to reduce the burden of suffering due to cancer in the communities we serve. To achieve this objective, cancer care must consist of a multidisciplinary integration of scientific advances and personalized care. The multidisciplinary approach incorporates multiple specialists and ancillary services for cancer prevention, diagnosis, treatment, and support. The multidisciplinary team combines genetic, molecular, and clinical expertise to provide targeted therapies, subject to peer review in compliance with established guidelines and protocols. For personalized care, our goal is to develop our professional staff to promote better understanding of our patients and their families and to find ways to meet and exceed their expectations along a continuum of diagnosis, treatment, surveillance, and support. Our providers will reference standardized care pathways customized to individual patient needs and preferences.

JLGH: What are some of Cancer Care's strategies for achieving these goals?

Dr. Oyer: One of our strategies is to create a functional, state-of-the-art cancer center that facilitates synergy among clinicians in the delivery of care. We also intend to develop a network of regional programs and providers. Other plans include investing in technology acquisitions, strengthening clinical and research partnerships and affiliations with other cancer centers, and promoting cancer prevention, awareness, and wellness in the community we serve through education, screenings, and support programs. By developing an experience-based multidisciplinary model of care, we can improve the health outcomes and quality of life for patients and their families in our service area.

JLGH: What has been done to identify the unique needs of the local population?

Dr. Oyer: We recently commissioned an analysis of the cancer health status of the residents of Lancaster County by epidemiologists from Drexel University. They examined cancer incidence rates by tumor type for the period 1999–2004, and mortality rates for 2000–2005, as available. The data have been extensively analyzed to provide an understanding of the cancer health status of the region we serve. We learned, for example, that overall morbidity and mortality rates due to cancer are lower in Lancaster County than in the Commonwealth of Pennsylvania. Mortality rates for breast and prostate cancers in Lancaster County compare favorably with statewide averages. The number of county residents suffering from breast or lung cancers also compares favorably with state data. The incidence rates of melanoma, thyroid and prostate cancers in our area exceed state averages. Melanoma survival in Lancaster County is comparable to state averages, whereas mortality rates from uterine cancer, leukemia, and colorectal cancer exceed state averages. Among adjacent counties, Lancaster County has the highest overall county-wide cancer mortality rate.

JLGH: How do these findings impact Cancer Care's strategic plans?

Dr. Oyer: We determined that the cancer types in greatest need of intervention are colorectal cancer and melanoma. These two cancers have been selected as the focus of our community outreach projects over the next two years. Let's address colorectal cancer first. We know that the state of Pennsylvania is in the lowest tertile nationwide for colorectal cancer screening, whether by stool occult blood testing, sigmoidoscopy, or colonoscopy. Our goal is to diagnose colorectal cancer early and thereby decrease the mortality rate. With this goal in

mind we are developing a Lancaster County colorectal cancer screening program in conjunction with community outreach. Our gastroenterologists, bowel surgeons, pathologists, information specialists, and others are in the process of developing this program. In addition to intensified screening, the program will include public education on approaches to lowering the colorectal cancer risk, including dietary modification, fiber intake, weight management, and exercise.

Melanoma is a major educational challenge. Our incidence of melanoma exceeds the state average, perhaps due in part to the high rate of sun exposure associated with farming and other outdoor occupations characteristic of our county. The goal of our melanoma community outreach project is early detection and education to reduce the extent of sun exposure by using sunscreens, covering up exposed skin, and avoiding sun exposure during the strongest hours of the day.

JLGH: How do these programs integrate with other aspects of the strategic plan?

Dr. Oyer: To meaningfully decrease the burden of cancer for individuals, their families, and their communities, you have to prevent it as well as treat it. The current belief is that about 40% of cancers are preventable. Interventions with a significant potential for cancer prevention include smoking cessation, healthy weight management, and colorectal cancer screening.

We have an active and engaged cancer committee that comprises all of the medical specialists likely to interact with cancer patients as well as supportive personnel from nursing, social work, chaplaincy, nutrition, physical therapy, research, data management, administration, and other areas. Our goal is to ensure that everybody is at the table, understanding the mission, integrating the pieces, and providing insight into practical ways to accomplish our objectives. There is a lot of communication, interaction, synergy, and cross-fertilization of ideas. Each of our site-specific cancer programs, which are breast, colorectal, lung, and genitourinary, has an individual steering committee with specific performance improvement and quality assurance objectives.

JLGH: What efforts are being directed towards cancer risk evaluation?

Dr. Oyer: We developed a genetic cancer risk evaluation program in conjunction with our academic partner, the University of Pennsylvania. Since the program began in November 2007, over 100 patients have been evaluated for breast or ovarian cancer risk. We plan to add genetic colorectal cancer risk evaluation in the spring of 2009. The program has three basic components; the construction and review of the family pedigree, a consent and educational visit with the patient to discuss what genetic testing might or might not reveal and the potential ramifications of the findings, and a then a third visit at which time the results of genetic testing are disclosed to the patient and a follow-up plan for treatment or surveillance is outlined. The program is provided free of charge as a community service. The only cost is for the genetic testing, which is performed by an outside commercial lab.

JLGH: What are some other recent accomplishments of the remodeling initiative?

Dr. Oyer: In addition to the genetics program, we have developed a standardized process for enrolling patients in clinical trials. Our goal is to make sure that patients for whom standard treatments are unsatisfactory or ineffective have access to clinical trials that assess the latest treatments. We are a member of the Penn Cancer Network which has been a productive relationship. We have also implemented revised procedures for scheduling outpatient chemotherapy and developed a comprehensive depression assessment and management program. Other accomplishments include the formation of multidisciplinary brain, gynecology, sarcoma, and gastrointestinal tumor boards, and the adoption of some newer technologies such as hepatic tumor embolization. Technology is a dynamic area of cancer care and an ongoing focus of our remodeling program.

JLGH: How are the needs of cancer survivors being addressed?

Dr. Oyer: Cancer survivorship is a distinct aspect of cancer care. There are about 10 million cancer survivors in the United States and thousands in Lancaster County. Cancer survivors report that many areas of their lives are altered following cancer treatment, including employment issues, exercise and weight management, cognitive functioning, spirituality, anxiety and fear of cancer recurrence, relationships, and financial issues. Comprehensive multidisciplinary support is needed to provide optimal survivorship care and empower survivors in redefining their lives post-treatment. Such care is best

provided through personal contact with a familiar health-care system. In the absence of well-established standard procedures, we develop individualized survivorship plans based upon early studies with suggestions for guidelines and evidence-based studies as they become available. Our membership in the University of Pennsylvania Cancer Network provides an opportunity to develop our survivorship program through participation in the Living Well After Cancer program at the Abramson Cancer Center's LIVESTRONG Survivorship Center of Excellence.

JLGH: What distinguishes Cancer Care from other models or providers?

Dr. Oyer: As noted earlier, our primary mission is to decrease the suffering due to cancer in the population we serve. Achieving this goal requires the prevention of cancer when possible, early detection so that patients can have a greater chance of cure and lower burden of treatment, providing up to date treatment options with supportive therapies and access to clinical trials, and supportive care to help patients as they emerge from the pain and burden of cancer treatment. This is not the typical approach of many cancer programs in which the emphasis is placed on finding the newest treatments for cancer. We strive to provide a comprehensive program of care, delivered through a multidisciplinary model, to best serve the needs of our patients.

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