Udine
14 Ottobre 2013
ore 8.30

Palazzo della Regione
Sala Auditorium
Via Sabbadini, 31 Udine

AZIENDA OSPEDALIERO UNIVERSITARIA Santa Maria della Misericordia di Udine

REGIONE AUTONOMA FRIULI VENEZIA GIULIA

Seminario

GIORNATA REGIONALE DELLA SICUREZZA E QUALITÀ DELLE CURE

Presentazione

La giornata si propone di fare il punto sullo stato della arte dei programmi per la sicurezza e qualità delle cure del SSR. Allo stesso tempo è occasione per condividere e diffondere le pratiche di eccellenza esistenti tra tutti gli operatori. Partendo dallo stato dell'arte infine si potranno abbozzare gli obiettivi futuri da raggiungere.

Iscrizioni

La scheda di iscrizione è scaricabile dal sito http://www.ospedaleudine.it -> Didattica e Formazione-> Formazione-> Modulo iscrizione

La scheda, compilata in ogni sua parte e sottoscritta, va inviata a mezzo posta o fax alla Funzione di Staff Formazione, P.le S. Maria della Misericordia n. 11, 33100 UDINE tel. 0432 554 245 fax 0432 554 381 e-mail: formazione@aoud.sanita.fvg.it

Programma

8.30 Iscrizione dei partecipanti
8.45 Saluti
9.00 Introduzione ai lavori
Adriano MARCOLONGO - DCSISPS
Moderatore:
Alessandrino FANZUTTO - DCSISPS
9.15 Sicurezza e qualità delle cure in Italia
Alessandro GHIRARDINI - Ministero della Salute
9.45 I programmi per Sicurezza in Regione FVG
Silvio BRUSAFERRO - Università degli Studi di Udine - AOU Udine
10.15 La sicurezza del sangue ed emoderivati
Vincenzo DE ANGELIS - AOU UD
10.30 La sicurezza nei trapianti
Roberto PERESSUTTI - Centro Regionale Trapianti
10.45 La gestione centralizzata del contenzioso
Antonella BULFONE - DCSISPS
Mario MARIANI - Dipartimento Servizi Condivisi
11.00 Coffe break
11.15 I programmi per la qualità delle cure nella regione FVG
Vandamaria FORCELLA - DCSISPS
Anna Paola AGNOLETTO - DCSISPS
11.45 L'Accreditamento fra pari dei servizi di alcologia del FVG
Francesco PIANI - ASS 4
Gianni CANZIAN - ASS 4
12.00 L'Accreditamento all'Eccellenza
- degli ospedali:
Nicola DELLI QUADRI - AOSMA - Pordenone
- del territorio:
Maurizio ANDREATTI - ASS 5
- professionale:
Gianpiero FASOLA - AOU Udine
12.45 Conclusioni e prospettive
Maria Sandra TELESCA - Assessore Regionale alla Salute, Integrazione socio-sanitaria e politiche sociali

13.00 Lunch

14.00 Best Practices delle Aziende
Moderatore:
Silvio BRUSAFERRO - Università degli Studi di Udine - AOU UD
Vandamaria FORCELLA - DCSISPS
Anna Paola AGNOLETTO - DCSISPS
Percorsi diagnostico terapeutici nel cardiopatico cronico complesso
Andrea DI LENARDA - ASS 1
Gestione di un out break di infezione ospedaliera da Acinetobacter baumannii: efficacia delle misure organizzative
Camilla NEGRI - ASS 2
Lo screening dell'MRSA nell'artoprotesi
Marta POLONIA - ASS 3
Cultura e clima della sicurezza del paziente: indagine conoscitiva dell'ASS 4 Medio Friuli
Simonetta DEGANO - ASS 4
15.00 Prevenzione della violenza a danno degli operatori: l'esperienza dell'Ass 5 Bassa Friulana
Luciano STRIZZOLO - ASS 5
Il fenomeno della sottonotifica delle sospette malattie professionali quale elemento critico di Sanità Pubblica: analisi, metodologia e risultati preliminari del piano di miglioramento in un reparto di chirurgia specialistica
Barbara MIGLIETTA - ASS 6
Il cruscotto direzionale in funzione del miglioramento della comunicazione dei risultati assistenziali
Ilario GUARDINI, Maura MESAGLIO - AOU Udine
Adozione di una "do not crush list" nella gestione della terapia dei pazienti con difficoltà deglutorie
Ketty PARENZAN, Alfredo PERULLI - AOU Trieste
16.00 La gestione in sicurezza del sistema POCT in AOSMA
Michele CHITTARO - AOSMA
Sicurezza ed empowerment: quale rapporto
Ivana TRUCCOLO - IRCCS CRO
Creazione di un Manuale di Gestione del Sangue, revisione modulistica trasfusionale, realizzazione di un corso in sei edizioni "Il percorso della richiesta trasfusionale"
Paolo CESSELLI - Casa di Cura San Giorgio Pordenone
L'impatto della pianificazione infermieristica sulla sicurezza del paziente
Maja TENZE - Casa di Cura Pineta del Carso Trieste
17.00 Discussione
17.30 Fine lavori e consegna Attestati

INVITO

Info e crediti

L'evento è accreditato per tutte le professioni sanitarie ed ha ottenuto 5 crediti ECM

La partecipazione è gratuita e si accettano iscrizioni fino ad esaurimento dei posti disponibili (300)

Segreteria organizzativa

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Udine, 14 ottobre 2013

L'accreditamento all'Eccellenza professionale

Gianpiero Fasola

Dipartimento di Oncologia
Azienda Ospedaliero Universitaria
Udine

America's cancer care crisis

The publication of a new report from the US Institute of Medicine (IOM) on Sept 10 paints a stark picture about the current and future demands on the country's cancer service provision. America currently has 14 million cancer survivors, 4% of its population, with 1·6 million new cancer cases diagnosed every year. That figure is anticipated to reach 2·3 million by 2030 as the country grapples with an increasingly elderly population, a burgeoning obesity epidemic, plateauing of a reduction in tobacco use, and spiralling costs in the provision of cancer care. More worrying still, the report describes the US health system as fragmented and ill-prepared to deal with the current inequities in cancer services, especially the need to reach out to ethnic minorities and elderly people.

Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis builds on a 1999 IOM report, which called for an improvement in the quality of US cancer care. Back then, although engaging parts of the oncology community at the time of its publication, the sad reality, acknowledged by authors of the new report, is that it failed to bring about substantive change in the way that US cancer services have been delivered since the turn of the millennium.

The new report, while acknowledging recent progress in cancer services—such as increased screening, better diagnosis, more precise surgery, and the potential of targeted molecular therapy—also clearly population". Six areas are highlighted as being crucial to the implementation of this framework: effective engagement and communication with patients; an adequately trained, resourced, and coordinated workforce; evidence-based cancer care, including the use of data from trials enrolling older patients with cancer; an improved learning and information technology approach to cancer care, including the future use of key metrics to assess the quality of care; translating new evidence into clinical practice, including the public dissemination of performance-related practice; and the creation of cancer care that is accessible and affordable, in which clinicians are rewarded on the quality, rather than purely the quantity, of care provided.

Laudable though this future vision of US cancer care is, there are very real concerns about how the principled aspirations of the report can translate into a change in the delivery of cancer services for patients. Although some recommendations—such as improved communication between clinicians and patients—can start today, other aspects of the report are inextricably linked to the complexity and fragmentation of a changing US health system, with its dizzying complexity of insurance plans, which may or may not cover an individual's access to cancer care. Meanwhile, 47 million uninsured Americans currently have no certainty of being able to access cancer services at all. Hope rests, of course,

in affiliation with BulletinHEALTHCARE

CANCER IN THE NEWS

For the members of: ASCO

Cancer in the News is a daily digest of news selected from print, broadcast and online sources by the editors of Bulletin Healthcare

Customized Briefing for Gianpiero Fasola **Wednesday, September 11, 2013**

IOM Report Says US Facing Crisis In Cancer Care.

According to the AP (9/11, Neergaard), a new report from the Institute of Medicine contends that "the U.S. is facing a crisis in how to deliver cancer care, as the baby boomers reach their tumor-prone years and doctors have a hard time keeping up with complex new treatments." The IOM's "recommendations are: more research to tease out how to best treat different patients; new strategies to help doctors keep up with that evidence; and development of tools to help communicate the choices to patients so they understand what really may happen to them."

On its website, NBC News (9/11, Fox, 6.68M) reports that American Society of Clinical Oncology President Dr. Clifford Hudis said in regard to access to high-quality cancer care, "The truth is, not everybody can travel," but "we have a golden opportunity now that we are in the age of bioinformatics." NBC News adds, "Electronic communications can help doctors connect to one another and share expertise, and it needs to happen more often, Hudis and the panel agree."

Reuters (9/11, Begley) reports that some groups, including ASCO, have developed guidelines for the treatment of most cancers. However, according to the IOM, many clinicians do not adhere to these guidelines. Dr. Hudis is quoted as saying that "every person with cancer should receive state-of-the-art, high-quality and compassionate care."

Long Island (NY) Newsday (9/11, Ricks, 1.32M) reports that the IOM report also points to the challenge of rising costs of cancer treatment and care. Costs are "rising faster than in any other medical sector, jumping to $125 billion in 2010 from $72 billion in 2004."

HealthDay (9/11, Preidt, 2K) reports that "a shift toward patient-centered, evidence-based care" is needed, "the IOM report said."

According to MedPage Today (9/11, Pittman, 185K), "The report authors...called on the National Cancer Institute, the Agency for Healthcare Research and Quality, the Patient-Centered Outcomes Research Institute, and other research funders to evaluate the role of standard and novel interventions and technologies used in cancer care."

CQ (9/11, Reichard, Subscription Publication, 530) reports on the IOM report and also reports that yesterday, "cancer patients, survivors and caregivers blanketed Capitol Hill...to urge lawmakers not to cut cancer research and prevention programs." The sequester has led to cuts in "cancer research funding at the National Institutes of Health by about $250 million, according to network press materials." Additionally, "the sequester...means 32,000 fewer breast and cervical cancer screenings for low-income women with limited access to medical services...said" the American Cancer Society Cancer Action Network.

IOM Recommendations to Address Concerns and Meet Goals

Provide patients and their families with understandable information about cancer prognosis, treatment benefits and harms, palliative care, psychosocial support, and costs
Provide patients with end-of-life care that meets their needs, values, and preferences
Ensure coordinated and comprehensive patient-centered care
Ensure that all individuals caring for cancer patients have appropriate core competencies
Expand the breadth of data collected in cancer research for older adults and patients with multiple comorbid conditions
Expand the depth of data collected in cancer research through a common set of data elements that capture patient-reported outcomes, relevant patient characteristics, and health behaviors
Develop a quality healthcare information technology system for cancer that enables real-time analysis of data from cancer patients in a variety of care settings
Develop a national quality reporting program for cancer care as part of a learning healthcare system
Implement a national strategy to reduce disparities in access to cancer care for underserved populations by leveraging community interventions
Improve the affordability of cancer care by leveraging existing efforts to reform payment and eliminate waste

VOLUME 22 · NUMBER 15 · AUGUST 1 2004

JOURNAL OF CLINICAL ONCOLOGY | COMMENTS AND CONTROVERSIES

Developing a System to Assess the Quality of Cancer Care: ASCO's National Initiative on Cancer Care Quality

Eric C. Schneider and Arnold M. Epstein, *Department of Health Policy Management, Harvard School of Public Health, Harvard University; and the Section on Health Policy, Division of General Medicine, Brigham and Women's Hospital, Boston, MA*

Jennifer L. Malin and Katherine L. Kahn, *Department of Medicine, University of California, Los Angeles, Los Angeles; and Rand Corporation, Santa Monica, CA*

Ezekiel J. Emanuel, *Department of Clinical Bioethics, Warren G. Magnuson Clinical Center, National Institutes of Health, Bethesda, MD*

The quality of care for cancer has been questioned in recent years.[1-7] In a 1999 report, the Institute of Medicine (IOM) concluded that many patients with cancer did not receive state-of-the-art care.[8] The IOM committee recommended a number of steps including the creation of a quality monitoring system capable of regularly reporting on the quality of care for patients with cancer.

Oncologists might find the IOM recommendation surprising. Efforts to monitor the care and outcomes of oncology patients date back at least to 1922, when the American College of Surgeons (ACS) founded its Commission on Cancer—a group specifically tasked with standardizing and improving the quality of cancer care.[9] The Commission's National Cancer Data Base (NCDB) has provided useful data about the epidemiology of cancer and treatment patterns.[10] Furthermore, oncology trials have led the way in assessment of patient outcomes such as health status and quality of life; the results from these trials have improved treatments, survival, and the quality of life for many patients with cancer.

Nevertheless, research on the quality of care throughout at least the last decade has demonstrated that increases in the *knowledge of* treatments with proven efficacy do not translate directly to the *optimal delivery* of such treatments to patients.[11-16] Accumulating evidence suggests that "underuse" and "overuse" of care may occur for patients with cancer.[17-19] Also, compared with the outcomes of patients in clinical trials, the outcomes of treatment for the general population of patients with cancer may be less favorable.[20]

In the last few decades, the methods used to measure the quality of care have advanced.[21] However, until recently, few programs have attempted to use these methods to measure and improve the quality of care for large populations of patients with cancer on an ongoing basis.[22] Despite its appeal, the development of a national monitoring system is likely to be a highly complex undertaking with substantial implications for clinicians, patients, institutional leaders, policy makers, and other stakeholders. In this manuscript, we describe a recent effort, the National Initiative on Cancer Care Quality (NICCQ) promoted by the American Society of Clinical Oncology (ASCO), to develop a prototype for a national system that could monitor the quality of cancer care. We discuss the goals, key features, practical challenges, and key decisions that lie ahead if this program is to be expanded.

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Santa Maria della Misericordia di Udine

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Table 3. Quality of Care Measures for Breast Cancer and Colorectal Cancer: Examples of Proposed Measures

Quality Measure Denominator (patients eligible for measure)	Quality Measure Numerator (eligible patients who received the indicated care)
Breast cancer	
IF a patient has a new diagnosis of stage I, II, or III breast cancer and meets all of the following criteria: (1) age < 70 years, (2) tumor size > 1 cm, (3) no evidence of metastatic disease, (4) no patient refusal of axillary sampling, and (5) no documentation in the record that axillary lymph node sampling would not change treatment	THEN the patient should have axillary lymph node sampling (either sentinel lymph node biopsy or lymph node dissection)
IF a patient is newly diagnosed with stage III breast cancer	THEN the patient should undergo a bone scan within 12 weeks before or after pathologic diagnosis of breast cancer
IF a patient newly diagnosed with stage I, II, or III breast cancer meets all of the following criteria: (1) estrogen receptor or progesterone receptor–positive tumor, (2) tumor size ≥ 1 cm or involved axillary lymph nodes	THEN the patient should receive tamoxifen 20 mg/day for 5 years*
IF a patient with a diagnosis of stage I, II, or III breast cancer has breast conserving surgery and the patient does not refuse radiation therapy	THEN the patient should receive local radiotherapy of 45 to 50.4 Gy to the chest wall
Colorectal cancer	
IF a patient has resection of a malignant tumor of the rectum and there is < 1cm of margin that is free of tumor cells	THEN the patient should be informed of the potential for an increased risk of recurrence AND should receive adjuvant chemotherapy and radiation*
IF a patient receives a diverting colostomy	THEN the patient should receive enterostomy care and management instructions prior to discharge or receive a home-health care follow-up*
IF the patient had resection and adjuvant therapy for stage II or stage III colon or rectal cancer	THEN the patient should be counseled about the need to have first degree relatives undergo colorectal cancer screening*

*Potential patient survey indicators.

Education and debate

Integrated care pathways

Harry Campbell, Rona Hotchkiss, Nicola Bradshaw, Mary Porteous

Integrated care pathways are structured multidisciplinary care plans which detail essential steps in the care of patients with a specific clinical problem. They have been proposed as a way of encouraging the translation of national guidelines into local protocols and their subsequent application to clinical practice. They are also a means of improving systematic collection and abstraction of clinical data for audit and of promoting change in practice. The degree to which they succeed in realising this potential for improving patient care is still uncertain, but enough evidence exists in their favour to justify more widespread evaluation of their impact. Here we describe integrated care pathways, show how to create and use them, and review the evidence of their effectiveness.

Summary points

Integrated care pathways are care plans that detail the essential steps in the care of patients with a specific clinical problem and describe the expected progress of the patient

They exist for over 45 conditions or procedures, and national users' groups exist to give advice and support in their use

They aim to facilitate the introduction into clinical practice of clinical guidelines and systematic, continuing audit into clinical practice: they can provide a link between the establishment of clinical guidelines and their use

They help in communication with patients by giving them access to a clearly written summary of their expected care plan and progress over time.

Despite the sound principles which underlie integrated care pathways, few evaluations have been done of the cost of developing and implementing them and their effectiveness in changing practice and improving outcomes

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PDTA = strumento di Governo clinico per..

- Affrontare problemi e inefficienze legati alla variabilità
- Testare e/o implementare l'adesione alle Linee Guida
- Imparare a misurare risultati ed esiti
- Rendere sistematica l'autovalutazione
- Determinare i "costi di produzione" per patologia
- Fare emergere i costi evitabili

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QUALITA'

- **Clinico professionale**
- **Gestionale organizzativa**
- **Relazionale**

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INDICATORI DI QUALITA'

Definizione: *'elementi misurabili di performance per cui esiste evidenza o consenso che possano essere utilizzati per testare la qualità del servizio offerto'*

Grimshaw JM. *Lancet* 1993

validità: letteratura, linee guida, consenso di professionisti

- attendibilità: esito confrontabile nel tempo e con altre realtà
- significatività: stima della qualità clinica ed organizzativa del percorso
- misurabilità: recuperabilità al basale e nel tempo

Campbell SM. *BMJ,* 2003

University Hospital of Udine, Department of Oncology, Italy | ESMO - Windows Internet Explorer

http://www.esmo.org/Patients/Designated-Centres-of-Integrated-Oncology-and-Palliative-Care/University-Hospital-of-Udine-Department-of-Oncology-Italy

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- Surveys
- Resources for Patients
- Patient Seminars
- Useful Links to Patient Support Websites
- Cancer Patient Working Group

Related content

ESMO Guidelines about Supportive care

University Hospital of Udine, Department of Oncology

ESMO Designated Centre of Integrated Oncology and Palliative Care

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Web	**University Hospital of Udine**

History

The Oncology Unit of Udine, was instituted in the late 1950's and is one of the oldest in Italy, possibly in Europe. In 2004 the Department of Medical Oncology was born from the merger of two pre-existing units: the Oncology Unit of the Regional Hospital Santa Maria della Misericordia and the Oncology Unit of the University of Udine. Four years later the two hospital structures were unified. A few months after the merger, in 2008, the Palliative Care Unit, sited close to the Oncology Ward, was opened.

Profile

Cancer centres which provide comprehensive services in supportive and palliative care as part of their routine care can apply to receive the ESMO recognition as an "ESMO Designated Centre of Integrated Oncology and Palliative Care".

The centres receiving the certification will be entitled to:

- Use the subtitle, 'ESMO Designated Centre in the Integration of Oncology and Palliative Care'
- Use the ESMO logo in accordance to the ESMO Logo Policy (marketing/advertising related to the centre itself. No advertising of specific events)
- Be eligible to receive fellows in palliative medicine supported by ESMO grants
- The ESMO designation is valid for three years and the centres can reapply

Programme objectives

- Promote the integration of palliative care services into the existing national cancer care guidelines
- Encourage palliative care education and training for medical oncologists as well as other healthcare professionals
- Expand the cooperation between ESMO and other existing professional medical associations and organisations worldwide in supporting and sustaining palliative care development

Application criteria and process

Applications will remain anonymous during the review process undertaken by the Palliative Care Working Group. Any oncology department or cancer centre can apply. Size is not important; to be eligible what matters are the quality and the extent of the integration of services.

The criteria for accreditation, based on recommendation from the World Health Organization (WHO) guidelines on the provision of palliative care for patients with cancer, have been recently revised to make the process of application easier and clearer than ever before. The criteria reflect the issues of integration (items 1-2), credentialing (Items 3-4), service provision (items 5-11), research (item 12) and education (item 13). The complete list is included in the **application form (/content/download/8440/172528/file/ESMO Designated Centres Application Form.pdf)**.

ESMO

Designated Centers of Integrated Oncology and Palliative Care

Eligibility Criteria Checklist

1. The center is a cancer center or oncology department which provides closely integrated oncology and palliative care clinical services.

2. The center is committed to a philosophy of continuity of care and non-abandonment.

3. The center incorporates expert medical and nursing care in the evaluation and relief of pain and other physical symptoms.

4. The center incorporates expert care in the evaluation and relief of psychological and existential distress.

5. The center provides routine patient assessment of physical and psychological symptoms and social support and has an infrastructure that responds with appropriate interventions in a timely manner.

6. The center provides emergency care of inadequately relieved physical and psychological symptoms.

7. The center provides facilities and expert care for in patient symptom stabilization.

8. The center incorporates programmatic support of family members.

9. The center provides high level home care with expert back-up and coordination of home care with primary cancer clinicians.

10. The center provides respite care for ambulatory patients for patients unable to cope at home or in cases of family fatigue.

11. The center provides facilities and expert care for inpatient end of life care and is committed to providing adequate relief of suffering for dying patients.

12. The center participates in basic or clinical research related to palliative care and the quality of life of cancer patients and their families.

13. The center is involved in clinician education to improve the integration of oncology and palliative care.

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History

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Profile

The Medical Oncology Department lays in a building on its own. There are three levels: on the level 0 or ground floor there is the Day Hospital, on the level 2 or second floor the Visiting Rooms for out-patients visits and on level 3 or third floor both the Oncology Ward and the Palliative Care Unit.

The Day Hospital is made by five rooms, one with six armchairs and twelve beds are disposed in the other four rooms. The Oncology Ward is reserved to patients that must undertake chemotherapy or radiotherapy treatments but also supportive care; the Palliative Care Unit is reserved to those patients with advanced disease candidated to best supportive care. The Oncology Ward is made of 8 rooms with 20 beds, 2 beds in 2 separated rooms are kept for isolation; the Palliative Care Unit is made of 6 beds both in single and double-rooms. In each area there is a separated Nursing Staff: 20 between Nurses and Health Care Assistants work in the Day Hospital and 33 between Nurses and Health Care Assistants work on the both the Oncology Ward and the Palliative Care Unit. However, the Nursing and Medical Team devoted to the Palliative Care Unit has been further instructed on palliative care.

The Medical Staff is composed of 18 Medical Oncology Consultants and 17 Trainee in Medical Oncology.

There are also three Psychologists working in our Department, two devoted to the in- and out-patients and one to the patients on the ward. Finally, everyday there are a Welfare Worker, a Physiotherapist, a Dietologist and a Spiritual Assistant working in the Oncology Ward and Palliative Care Unit.

Each patient starting a chemotherapy treatment gets a brochure/leaflet describing the principal treatment side effects and how to manage them, together with the useful phone numbers in case of emergencies. As a result of the collaboration with voluntary associations, two more guides are provided to patients, with all the informations about services, facilities and assistances reserved to cancer patients both in hospital and local areas. Moreover, in our Department there is a Visiting Room dedicated to unplanned visits, most of them related to treatment side effects or disease complications. This service is covered everyday by a Trainee in Medical Oncology and a Medical Oncology Consultant.

Specialities

In our department the Medical Oncology Consultants and all Trainees in Medical Oncology are subdivided in groups, each dedicated to the main cancer diseases: Breast, Gastro-Intestinal (GI) , Thoracic and Genitourinary (GU) group. Recently, also the Head & Neck (H&N) the Central Nervous System (CNS) and the Skin & Melanoma group have been activated. As clinical research is one of the main interest and objects of our Department, our Institute is a recruiting center for several national and international, sponsored and spontaneous clinical trials (about 38 clinical trial are currently ongoing). Both clinical and research meeting are regularly planned in our institution: the weekly MDTs for subspecialties; meetings to discuss clinical cases twice a week, management meeting once a week, once a month research group meeting and a weekly Journal Club. Seminars and Meetings are periodically organized in our institution, also in collaboration with other cancer centers.

Palliative and supportive care

Palliative Care Unit is made by 6 beds and 4 rooms, provided with sofa beds for relatives. Spaces are organized in order to offer both to patients and caregivers a comfortable place, allowing the patient's relatives to stay all day and night with the patients in privacy. A Medical Oncology Consultant and a Trainee in Medical Oncology visit the patients during the daily ward round; a Trainee in Medical Oncology is present and a Consultant is on call at home during the night. Psychosocial problems are identified by meeting the patient and his family. Doctors Nurses and Welfare Worker usually attend these meetings. Moreover, the Welfare Worker helps to find the best continuing care at home, being in contact with the community team. Our Psychologist offers psychological support to care givers during all the phases of disease and during the grief. Finally, a great help comes from volunteers, being affiliated to voluntary associations. A written document (called "Carta dei servizi") provides all information for supporting patients at home.

ESMO

Designated Centers of Integrated Oncology and Palliative Care

Department of Oncology,
University Hospital of Udine

Udine, Italy

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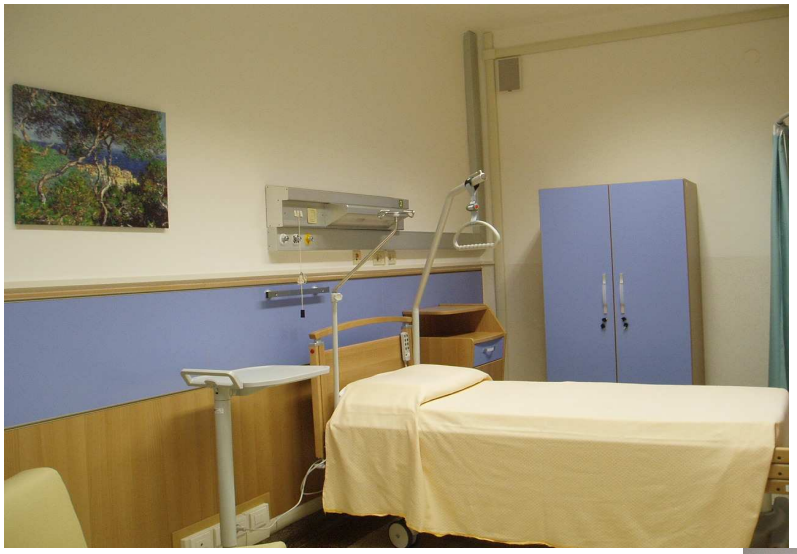
for the period 2012 - 2014

on the occasion of The ECCO – ESMO – ESTRO Multidisciplinary Cancer Congress
Stockholm, Sweden
23 – 27 September 2011

David Kerr
ESMO President

Nathan Cherny
Chair, ESMO Palliative Care Working Group

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DIRETTA DAL DOTT. ***GIANPIERO FASOLA***

HA OTTENUTO

L'ACCREDITAMENTO ALL'ECCELLENZA

DIMOSTRANDO DI APPLICARE, NELL'ESPLETAMENTO DELLE ATTIVITA'
DI DIAGNOSI E CURA DEI TUMORI, PROCEDURE DI ELEVATA QUALITA'.

Il Presidente del CIPOMO
dott. *Giorgio CRUCIANI*

Udine, 22 Marzo 2007

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Caratteristiche generali dell'accreditamento fra pari

- E' un percorso volontario
- Prevede procedure formalizzate e condivise fra tutti gli OPERATORI che vengono aggiornate continuamente ("accreditamento all'eccellenza")
- E' gestito da professionisti che valutano professionisti ("fra pari" o "peer-review")
- Non conferisce attestazioni con valore giuridico

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OBIETTIVI

- cambiare l'organizzazione del lavoro, passando dal lavorare per "ordini di servizio" o per "consuetudine" al lavorare per "procedure condivise fra gli operatori"
- creare nuovi standard di procedure che tutti, all'interno del team, seguono
- migliorare l'organizzazione del lavoro
- ridurre il rischio clinico

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LO STRUMENTO

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TIPOLOGIA DEI CRITERI

- Generali
- Specifici
- Obbligatori
- Facoltativi
- Distinti per aree
  - degenza ordinaria
  - day hospital
  - ambulatorio

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CAMPI DI APPLICAZIONE

- Linee di gestione dell'organizzazione
- Organizzazione per il paziente
- Risorse umane
- Procedure
- Documentazione e sistema informatico
- Valutazione e miglioramento della Qualità
- Strutture
- Attrezzature e dotazioni


18/12/2012 11:23

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CRITERI OBBLIGATORI
Criteri Generali

1. Linee di Gestione dell'Organizzazione

Criterio 1. La U.O. adotta uno o più documenti formali, **(NOTA: redatti secondo le istruzioni del criterio 4.2)** Aziendali, Dipartimentali o di U.O. che specificano :

1. la "mission"
2. gli obiettivi
3. le strategie complessive, cioè gli ambiti prioritari di azione e le principali attività per raggiungere gli obiettivi generali
4. articolazioni delle attività dell'U.O.C.

Punteggio	Livello di evidenza
5	**Sono presenti uno o più documenti che specificano tutti gli elementi richiesti**
3	**Sono presenti solo alcuni documenti.**
0	Non **esiste alcun documento**

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CRITERI OBBLIGATORI
Criteri Generali

1. Linee di Gestione dell'Organizzazione

Criterio 4. Gli obiettivi selezionati autonomamente dalla U.O. sono formulati con il contributo documentato delle diverse componenti professionali della U.O. o del Dipartimento (NOTA: per documentare l'evidenza delle informazioni, delle condivisioni, e così via, è sufficiente un verbale di riunione contenente i nominativi dei presenti)

2. L'organizzazione per il paziente

Criterio 1. Vi devono essere uno o più documenti (Carta dei Servizi, Cartella infermieristica, e così via) che definiscono:

1. i programmi e le azioni per identificare i bisogni e le aspettative dei pazienti e le necessità mediche ed infermieristiche del paziente, identificate nella valutazione iniziale, conferendo priorità ai bisogni di cura più urgenti ed importanti;

2. le procedure di accesso e di prenotazione delle prestazioni ambulatoriali, ed in particolare i criteri per la definizione delle liste di attesa, differenziati per tipologia di problemi e di attività, approvati dalla Direzione Medica della struttura;

3. le modalità di coinvolgimento delle associazioni dei pazienti e del volontariato

4. le modalità di coinvolgimento dei pazienti e dei familiari nelle decisioni e nei piani di cura ovvero la definizione di un "protocollo di comunicazione in base al processo di cura del paziente

Punteggio	Livello di evidenza
5	Tutti gli elementi descritti sono chiaramente definiti
3	Più del 50% degli elementi descritti sono chiaramente definiti
0	Meno del 50% degli elementi descritti sono chiaramente definiti

3. Risorse umane

Criterio 1. E' documentato che tutto il personale della U.O. sia a conoscenza dell'esistenza degli obiettivi, e che, a scadenze determinate, venga aggiornato sul grado di applicazione dei programmi e di raggiungimento degli obiettivi.

Criterio 4. E' indicato l'organigramma della U.O. con le rispettive funzioni; sono indicate le varie articolazioni ed ambiti di attività della U.O., sono definiti i compiti per ciascun operatore o per ciascun gruppo (ad esempio, quali siano i compiti del personale di ciascun turno); sono definiti i meccanismi di sostituzione dei responsabili dei vari settori in caso di assenza.

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5. Documentazione e sistema informativo

Criterio 2. Nelle U.O. che posseggono degenza ordinaria o day-hospital, devono esistere ed essere applicate disposizioni per la compilazione della cartella clinica, del diario clinico e della cartella infermieristica; le disposizioni riguardano le modalità di compilazione e chi ha la responsabilità di compilare le varie parti della cartella, e quando; deve essere definito ed identificabile chi compila, chi prescrive, chi esegue, chi somministra.
Per tutti, deve essere inoltre definito chi ha la responsabilità di raccogliere il consenso informato e in quale momento; il consenso informato per tutte le procedure o situazioni che ne richiedono l'adozione deve essere contenuto nella cartella, o comunque nella documentazione sanitaria ambulatoriale.

Criterio 6. Esiste un Documento della Sicurezza relativo alla protezione dei dati personali che disciplina la gestione delle password del sistema informatico (validità, scadenza, etc)

6. Valutazione e miglioramento

Criterio 2. A livello aziendale ed in ogni U.O. o Dipartimento è nominato un responsabile del coordinamento delle attività di valutazione e promozione della qualità. **(NOTA: evidenza della delibera o di una lettera formale d'incarico)**

Criterio 7. Vi è registrazione sistematica degli errori ed incidenti e documentazione delle azioni intraprese per risolverli, possibilmente utilizzando, per uniformità, le schede fornite dal Ministero della Salute.

Criterio 10. In ogni U.O. è nominato un Referente per il Risk Management in ambito oncologico. **(NOTA: vedi nota del criterio precedente)**

Criterio 11. In ogni U.O. è stata intrapresa almeno una azione (operativa o formativa; esempio: la compilazione delle schede di "near miss) per la gestione del rischio clinico

Criterio 3. Sono disponibili procedure o protocolli scritti inerenti la gestione delle principali attività organizzative ed assistenziali svolte dalla U.O. di Oncologia:

1. Accoglienza e gestione del paziente
2. Programmazione delle procedure di ricovero (ove esistente) e delle liste d'attesa
3. Procedure per la dimissione (per chi dispone di degenza ordinaria)
4. Modalità di raccolta e conservazione del consenso informato del paziente
5. Procedure per prenotazione ed accesso alle prestazioni ambulatoriali, e per il ritiro dei referti
6. Modalità di preparazione,somministrazione e smaltimento dei farmaci antiblastici
7. Modalità operative dell'Unità Farmaci Antitumorali (UFA)
8. Manutenzione ordinaria, periodica e straordinaria dell'UFA
9. Gestioni di errori ed incidenti e loro registrazione
10. Prevenzione di infortuni sul lavoro dei dipendenti
11. Gestione di lamentele dei pazienti e loro suggerimenti (ndr 22/04/2010)
12. Rapporti con altri servizi ed U.O. aziendali (consulenze, richiesta esami ordinari ed urgenti, ecc.)

Criterio 4. Sono disponibili procedure o protocolli scritti inerenti la gestione delle principali attività cliniche svolte dalla U.O. di Oncologia:

1. Modalità per usufruire delle prestazioni di psico-oncologia
2. Gestione delle infezioni in pazienti immunocompromessi
3. Gestione di cateteri venosi centrali (CVC), port a cath, nutrizione parenterale totale
4. Gestione dello stravaso, sia a livello clinico che ambientale
5. Identificazione e gestione organizzativa delle più frequenti emergenze oncologiche
6. Rilevazione del dolore nei pazienti degenti (ove esista la degenza ordinaria)
7. Gestione della terapia del dolore
8. Gestione di attività di supporto socio-assistenziali (assistenza sociale)
9. Gestione del paziente sottoposto a trattamenti terapeutici combinati e integrati
10. Gestione del paziente in follow up
11. Gestione di attività scientifica e di ricerca clinica


18/12/2012 12:45

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Evoluzione del percorso CIPOMO

2006, edizione n. 1

- 10 criteri obbligatori
- 25 criteri facoltativi (numero minimo) a discrezione assoluta
- Valutatori solo medici

2013, edizione n. 26

- 27 criteri obbligatori
- 18 criteri facoltativi (numero minimo) ma almeno 2 criteri per ciascuna sezione
- Pre-visita e introduzione del valutatore-consulente
- Valutatori anche Infermieri e Pazienti
- Nuovi criteri sulla sostenibilità (Green Oncology)
- Eliminazione o riscrittura di criteri non utili o poco chiari

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I partner "storici"…..

SIQuAS
Società Italiana per la Qualità dell'Assistenza Sanitaria

AMOS

Associazione per il Management e la qualità nelle Organizzazioni per la Salute-onlus

ORTHO BIOTECH
UNA DIVISIONE JANSSEN-CILAG S.p.A.

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… e quelli "nuovi"…

AIIO

Associazione Italiana Infermieri di Oncologia

BiancoAirone pazienti onlus

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FORMAZIONE

- **Corsi formativi per i Primari**
  - **suddivisi per aree geografiche,**
  - **stesso programma**
  - **stessi docenti**
- **Corso formativo per i valutatori**

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Santa Maria della Misericordia di Udine

In totale : 18 visite

1. Benevento
2. Biella
3. Cosenza
4. Castelfranco Veneto
5. Udine
6. Asti
7. Potenza
8. Verbania
9. Trieste
10. Macerata
11. Roma San Filippo Neri
12. Belluno
13. Montecchio Maggiore
14. Legnago
15. Saronno
16. Aosta
17. Torino
18. Pavia

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AGGIORNAMENTI

- La pre-visita
- Nuovi criteri (etica, sostenibilità → Green Oncology)
- Aumento dei criteri obbligatori (27)
- Il manuale è aggiornato dopo ciascuna visita
  - edizione numero 26
- Partner nel programma di accreditamento regionale della Regione Piemonte

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PROGETTI PER IL FUTURO

- visite di controllo periodico
- Reti Oncologiche Regionali

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AUTOVALUTAZIONE

CIPOMO ha chiesto una valutazione alle SOC accreditate, utilizzando il Net Promoter Score: le risposte pervenute separatamente dai Primari e dai Coordinatori Infermieristici esprimono un punteggio ed un gradimento pari a 98.6%

The NEW ENGLAND JOURNAL of MEDICINE

SOUNDING BOARD

Bending the Cost Curve in Cancer Care

Thomas J. Smith, M.D., and Bruce E. Hillner, M.D.

Annual direct costs for cancer care are projected to rise — from $104 billion in 2006[1] to over $173 billion in 2020 and beyond.[2] This increase has been driven by a dramatic rise in both the cost of therapy[3] and the extent of care.[4] In the United States, the sales of anticancer drugs are now second only to those of drugs for heart disease, and 70% of these sales come from products introduced in the past 10 years. Most new molecules are priced at $5,000 per month or more,[5] and in many cases the cost-effectiveness ratios far exceed commonly accepted thresholds.[6] This trend is not sustainable.[7,8]

We must find ways to reduce the costs of everyday care to allow more people and advances to be covered without bankrupting the health care system. Brody recently challenged each medical specialty to identify at least the top five tests or treatments for which costs could be substantially reduced without depriving any patient of meaningful benefit.[9] Medical oncologists directly or indirectly control or influence the majority of cancer care costs, including the use and choice of drugs, the types of supportive care, the frequency of imaging, and the number and extent of hospitalizations. Here, we respond to Brody's challenge by suggesting five changes in medical oncologists' behavior (Table 1) and five changes in their attitudes and practice (Table 2) that will bend the cancer-cost curve downward. We recognize that these changes will cause discomfort and adjustments, since all of them will inevitably result in dissatisfaction for important constituents such as patients, physicians, or payers. Unless otherwise stated, our recommendations are restricted to the care of patients with incurable solid tumors and not those with curable cancers.

CHANGING ONCOLOGISTS' BEHAVIOR

TARGETING SURVEILLANCE TESTING OR IMAGING

The American Society of Clinical Oncology (ASCO)[10] and National Comprehensive Cancer Network (NCCN)[11] guidelines agree that there is no benefit to surveillance testing with serum tumor markers or imaging for most cancers, including those of the pancreas, ovary,[12] or lung,[13] yet these tests are commonly used in many settings. In breast cancer, randomized studies showed that scheduled (not symptom-guided) imaging does not detect curable recurrences or alter survival. Twenty years ago, the estimated cost of wasted medical resources in the United States for patients with breast cancer was $1 billion per year.[14] The common exception is colon cancer, for which some patients do benefit from scheduled carcinoembryonic antigen testing and computed tomography.[15]

Changing practice will not be easy. Patients want reassurance that things will be "caught early," and it can be troubling to both patients and doctors to confront the realization that detecting liver metastasis when the lesion measures 1 cm rather than 2 cm does not alter the prognosis. Many practices earn ancillary income from ordering laboratory and imaging tests. Advocates for testing who believe that modern advances in treatment justify routine testing should attempt to confirm this contention by means of randomized trials or prospective studies, just as for other innovations.

Besides lowering costs, targeting testing has other benefits. Switching to a new norm of less testing and better survivorship counseling could reduce patient anxiety.[16] To increase the use of effective testing strategies, we envision a multipronged social-marketing approach that would include printed guidelines distributed at office visits[17] and support from advocacy groups, professional societies, and insurers. We suggest that ASCO add recommendations regarding surveillance testing to its Quality Oncology Practice Initiative (QOPI).[18]

SEQUENTIAL MONOTHERAPY VERSUS COMBINAT THERAPY

This is another area in which the ASCO NCCN guidelines agree. Using advanced bre

Reducing the Cost of Cancer Care: How to Bend the Curve Downward

By Thomas J. Smith, MD, Bruce E. Hillner, MD, and Ronan J. Kelly, MD, MBA

Overview: Health care and cancer care costs are rising unsustainably such that insurance costs have doubled in 10 years. Oncologists find themselves both victims of high costs and the cause of high-cost care by what we do and what we do not do. We previously outlined five ways that oncologists could personally bend the cost curve downward and five societal attitudes that would require change to lower costs. Here, we present some practical ways to reduce costs while maintaining or improving quality, including: 1) evidence-based surveillance after curative therapy; 2) reduced use of white cell stimulating factors (filgrastim and pegfilgrastim); 3) better integration of palliative care into usual oncology care; and 4) use of evidence-based, cost-conscious clinical pathways that allow appropriate care and lead to equal or better outcomes at one-third lower cost.

THE RISING cost of cancer care is unsustainable. Medical care costs more in the United States than anywhere else in the world, as shown in Fig. 1. The impact of this rising cost is felt throughout the health care system, from patients and families to insurers and the government. The high cost of medical care is a concern for manufacturers who must build that cost into their goods. We illustrate some of the impact in human terms in Sidebar 1.

Cancer doctors often think we are the victims of the rising cost of cancer care, when we are both victims and causal agents. In fact, we are responsible for what we do and what we do not do, and the consequences of that action or inaction. We order the tests and prescribe the chemotherapy and supportive care drugs, and make the decisions to continue chemotherapy, involve palliative care or hospice early, have discussions about goals of care and advance directives—or not. In our review[4] we explored five changes in oncologist behavior that would bend the cost curve (Sidebar 2), and five attitudes that needed to change for this to happen (Sidebar 3).

Here, we want to think about recognizing the coming problems, and propose some concrete solutions. First, the world is changing from fee-for-service to bundled payments to take away the incentive to administer more profitable chemotherapy. We have never maintained that oncologists administer chemotherapy just to make money. Interestingly, patients in countries like Sweden and Portugal, where oncologists do not make money giving chemotherapy, still receive chemotherapy near the end of life.[7] However, there is no way to generate an income of nearly $400,000/year from cognitive services alone, and there is an inherent conflict of interest when we must choose between chemotherapy that gives us little profit compared with major profit. Second, more people will be uninsured or have less coverage with higher copays and deductibles, and shift between plans as insurance becomes more portable. Third, value is missing in some of our spending, if we define value as quality/cost. Finally, all of us have to realize that change is risky and disruptive, with major implications for our salaries and ability to support an enterprise.

We propose practical ways to improve health, quality of care, and value. First, we propose redesign of the National Comprehensive Cancer Network (NCCN) and other pathways to incorporate cost and value. Second, we propose an audit of current patterns of care for under- and overuse. We can help improve electronic medical record (EMR) prompts that promote best practices. Finally, we want to redesign NCCN and other pathways to incorporate palliative care early and concurrently to provide the best care at a cost we can afford.

This is part of a major national effort to restrain costs while maintaining quality. The American Board of Internal Medicine is promoting "Choose Wisely" to have each specialty find at least five ways to reduce costs[8] has been endorsed by at least eight major organizations (http://choosingwisely.org/wp-content/uploads/2011/12/about_choosingwisely.pdf). Accountable care organizations and medical homes are part of all new health care legislation and attempts to restrain costs while maintaining quality.[9] The American College of Physicians has recognized the inherent tension between doing all that one can for an individual patient compared with careful use of societal resources: "Physicians have a responsibility to practice effective and efficient health care and to use health care resources responsibly. Parsimonious care that utilizes the most efficient means to effectively diagnose a condition and treat a patient respects the need to use resources wisely and to help ensure that resources are equitably available.... Physicians' considered judgments should reflect the best available evidence including data on the cost-effectiveness of different clinical approaches."[10]

Some Specific Examples of Actions Under Oncologist Control

Target Surveillance Tests or Imaging to Those Situations Where a Benefit Has Been Shown

This one should be easy. There are no data suggesting better medical outcomes for patients with breast or ovary cancer treated with curative intent who are followed by other than routine exams. For breast cancer, two large European studies showed that routine follow-up compared with more intense schedules of scans gave equal outcomes and equal quality of life. There are no data that suggest early identification of metastatic breast cancer leads to better outcomes. In one small study, carcinoembryonic antigen (CEA) could detect breast cancer recurrence, but early

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Authors' disclosures of potential conflicts of interest are found at the end of this article.
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The Lancet Oncology Commission

Lancet Oncol 2011; 12: 933–80
See Comment pages 923–32

Delivering affordable cancer care in high-income countries

Richard Sullivan, Jeffrey Peppercorn, Karol Sikora, John Zalcberg, Neal J Meropol, Eitan Amir, David Khayat, Peter Boyle, Philippe Autier, Ian F Tannock, Tito Fojo, Jim Siderov, Steve Williamson, Silvia Camporesi, J Gordon McVie, Arnie D Purushotham, Peter Naredi, Alexander Eggermont, Murray F Brennan, Michael L Steinberg, Mark De Ridder, Susan A McCloskey, Dirk Verellen, Terence Roberts, Guy Storme, Rodney J Hicks, Peter J Ell, Bradford R Hirsch, David P Carbone, Kevin A Schulman, Paul Catchpole, David Taylor, Jan Geissler, Nancy G Brinker, David Meltzer, David Kerr, Matti Aapro

Kings Health Partners, King's College, Integrated Cancer Centre, Guy's Hospital Campus, London, UK (Prof R Sullivan MD); Duke Cancer Institute, Duke University Medical Center, Durham, NC, USA (Prof J Peppercorn MD); CancerPartnersUK, London, UK (Prof K Sikora FRCP); Peter MacCallum Cancer Centre, University of Melbourne, Melbourne, VIC, Australia (Prof J Zalcberg FRACP); University Hospitals Seidman Cancer Center, Case Comprehensive Cancer Center, Case Western Reserve University, Cleveland, OH, USA (Prof N J Meropol MD); Division of Medical Oncology and Hematology, Princess Margaret Hospital and University of Toronto, Toronto, ON, Canada (E Amir MBChB, Prof I F Tannock MD); Hôpital Pitié-Salpêtrière, Paris, France (D Khayat MD); International Prevention Research Institute, Lyon, France (Prof P Boyle PhD, P Autier PhD); Medical Oncology Branch, Center for Cancer Research, National Cancer Institute, Bethesda, MD, USA (T Fojo MD); Cancer College London and King's Health Partners Integrated Cancer Centre, London, UK (Prof A D Purushotham MD); Department of Surgery, Umeå University, Umeå, Sweden (Prof P Naredi MD); Institut Gustave Roussy, Paris, France

The burden of cancer is growing, and the disease is becoming a major economic expenditure for all developed countries. In 2008, the worldwide cost of cancer due to premature death and disability (not including direct medical costs) was estimated to be US$895 billion. This is not simply due to an increase in absolute numbers, but also the rate of increase of expenditure on cancer. What are the drivers and solutions to the so-called cancer-cost curve in developed countries? How are we going to afford to deliver high quality and equitable care? Here, expert opinion from health-care professionals, policy makers, and cancer survivors has been gathered to address the barriers and solutions to delivering affordable cancer care. Although many of the drivers and themes are specific to a particular field—eg, the huge development costs for cancer medicines—there is strong concordance running through each contribution. Several drivers of cost, such as over-use, rapid expansion, and shortening life cycles of cancer lack of evidence-based sociopolitical debate, and a declining degree of fairness for all patients with cancer. Urgent solutions range from re-engineering of the macroeconomic basis of cancer costs (eg, value-based approaches to bend the cost curve and allow cost-saving technologies), greater education of policy makers, and an informed and transparent regulatory system. A radical shift in cancer policy is also required. Political toleration of unfairness in access to affordable cancer treatment is unacceptable. The cancer profession and industry should take responsibility and not accept a substandard evidence base and an ethos of very small benefit at whatever cost; rather, we need delivery of fair prices and real value from new technologies.

www.medscape.com

Cancer Drug Costs: Oncologists Must Be 'Part of the Solution'

Zosia Chustecka | Sep 06, 2013

The extremely high prices being charged for new cancer drugs in the United States, and all the factors contributing to these high prices, are discussed again, but this time, oncologists are urged into action.

"As oncologists advocating for our patients, we have a responsibility to better understand these issues, explain them and their implications to our patients, and work with our professional societies and other stakeholders to be part of the solution," writes David Pfister, MD, from the Memorial Sloan-Kettering Cancer Center in New York City, in an editorial published online September 3 in the *Journal of Clinical Oncology*.

He was commenting on "the challenge to the status quo on cancer drug pricing" that was issued by Hagop Kantarjian, MD, from the University of Texas M.D. Anderson Cancer Center in Houston, and colleagues in an essay published online on May 6 in the *Journal of Clinical Oncology*.

That status quo sets drug prices arbitrarily without regard to the real value of a drug, write Dr. Kantarjian and colleagues.

They suggests that, instead, the initial price of a new cancer drug should be set according to a value-based system, which would take into account several parameters: the benefit in overall or progression-free survival, improvement in quality of life, and the reduction of adverse effects and/or cost when compared with existing therapies.

In their detailed review, Dr. Kantarjian and colleagues discuss the many factors that contribute to the extremely high prices of cancer drugs in the United States, which can be 2 to 4 times the price charged for the same drugs in other countries. They also make the point that even within the United States, cancer patients undergoing the same treatment are charged differently according to which medical insurance system they are in, and some end up paying substantial amounts for cancer drugs, especially the new oral agents, out of their own pockets. These high costs are causing many patients with cancer to abandon treatment because they cannot afford it, they note, pointing out that medical debt is now the most common cause of personal bankruptcy in the United States.

Some of these points have already been made in a recent article in *Blood* by Dr. Kantarjian and colleagues, which was widely reported in the lay press and created such a buzz that politicians were spurred into action.

In this latest essay, Dr. Kantarjian and colleagues outline a potential solution, which they believe would result in a *justum pretium*, a "just price" where the price reflects worth.

Waste Not, Want Not: Promoting Efficient Use of Health Care Resources

The pressure to control health care costs in the United States is at an all-time high. In the governmental sector, Medicare and Medicaid consume approximately one quarter of the federal budget and are growing more rapidly than revenues; the commercial sector is no different (1). Despite these exceptional levels of health care spending, Americans do not live any longer or better than their counterparts in other industrialized countries (2). Indeed, many experts believe that a significant proportion (as much as 30%) of the excess health care spending in the United States generates little or no health benefit. These facts and the growing urgency of calls to reduce the federal budget deficit have energized efforts to reform health care delivery and increase the value of health care (that is, reduce spending, increase quality, or both).

A leading strategy for improving the value of U.S. health care is to create incentives for providers to eliminate at least $500 billion worth of wasteful spending that accrues annually (3). Provisions of the Patient Protection and Affordable Care Act of 2010 support the use of novel payment methods that blend global payment (such as population-based global budgets) or bundled payments (such as episode-based payments) with pay-for-performance incentives. However, it is unclear how effectively these reforms will increase the value of health care (4).

One main challenge facing those interested in better aligning payment incentives with high-value care is the degree to which physicians (and other health care providers) have the knowledge and tools to prioritize health care services (including supporting services, such as care coordination) according to value. Payment arrangements based on global budgets or bundles assume that physicians can act as good "agents" (a term from the health economics literature) to identify and deliver high-value services (5). Although the path to improving care quality continues to advance rapidly, the road to lowering costs by eliminating waste without stinting on needed care is fraught with obstacles (6). Even where physicians are able to estimate the degree to which a recommended treatment or diagnostic intervention may clinically benefit their patients, they know notoriously little about the cost or cost-effectiveness of their recommendations to their patients or the health system in which they work (7, 8). Furthermore, what may benefit an individual or society may be at odds with what may be advantageous for the providing organization, so physicians must negotiate the complexities of the existing payment system (9). In summary, even if physicians wanted to respond to incentives to reduce waste, they probably lack the essential information, tools, and infrastructure to do so.

Confusion about the best approach to controlling cost while improving value is not restricted to rank-and-file physicians. In this issue, Hussey and colleagues (10) systematically review the limited evidence available on the relationship between health care costs and quality. They identified only 56 U.S. studies that have empirically investigated the relationship between care quality and costs. Among these studies, definitions of "costs" are heterogeneous, as are levels of analysis. In addition to methodological concerns, Hussey and colleagues (10) found that the available data suggest no clear relationship between cost and quality. This result could be attributed to problems of measurement, underlying differences among the patients, practices, other units of analysis studied, or fundamentally suboptimal patterns of care—or perhaps all of the above. These results are a stark reminder of how little researchers and caregivers know about the optimal allocation of scarce health care resources to achieve the best health outcomes.

Ultimately, the success of payment reforms that shift financial accountability for health care spending to providers requires that all parties have better information on the value of medical care inputs and systems so that they can effectively deploy scarce resources. Physicians need it to set priorities, provider organizations need it to build supporting infrastructure, and payers need it to monitor the outcomes of contracting and adjust incentive arrangements. For example, 1 consequence of not having better information on value is highlighted by Weeks and colleagues in this issue (11). In particular, they note that although incentives for overuse (for example, "induced" demand) are partially abated by moving from fee-for-service to bundled payment, the potential for overidentification of bundles remains as long as there is no clear standard for appropriateness. This is only 1 example, however. Although no payment system is without side effects, better information about costs and benefits of care could vastly improve the outcomes of these nascent efforts to transform care delivery by means of payment reform.

The bottom line is that we need detailed and timely data to make medical, operational, and policy decisions that affect the clinical and fiscal health of our nation. Stakeholders can take many important steps now to improve the prospects that providers can respond to new payment models in ways that increase value. First, physicians need to begin having some understanding of the costs of the services they provide and their potential relationship to care quality. This can be achieved if provider organizations are more transparent about the cost and price of the services they deliver and if physicians become more active about acquiring this information. Second, those who fund research should routinely support studies that aim to eval-

Cost Effectiveness of Evidence-Based Treatment Guidelines for the Treatment of Non–Small-Cell Lung Cancer in the Community Setting

By Marcus A. Neubauer, MD, J. Russell Hoverman, MD, Michael Kolodziej, MD, Lonny Reisman, MD, Stephen K. Gruschkus, PhD, MPH, Susan Hoang, PharmD, Albert A. Alva, MEd, Marilyn McArthur, MS, Michael Forsyth, RPh, Todd Rothermel, and Roy A. Beveridge, MD

Abstract

Purpose: The goal of this study was to evaluate the cost-effectiveness of Level I Pathways, a program designed to ensure the delivery of evidence-based care, among patients with non–small-cell lung cancer (NSCLC) treated in the outpatient community setting.

Patients and Methods: We included patients with NSCLC initiating a chemotherapy regimen between July 1, 2006, and December 31, 2007, at eight practices in the US Oncology network. Patients were characterized with respect to age, sex, stage, performance status, and line of therapy and were classified by whether they were treated according to Level I Pathways guidelines. Twelve-month cost of care and overall survival were compared between patients treated on Pathway and off Pathway. A net monetary benefit approach and corresponding cost-effectiveness acceptability curves were used to evaluate the cost-effectiveness of Level I Pathways.

Results: Overall, outpatient costs were 35% lower for on-Pathway versus off-Pathway patients (average 12-month cost, $18,042 *v* $27,737, respectively). Costs remained significantly less for patients treated on Pathway versus off Pathway in the adjuvant and first-line settings, whereas no difference in overall cost was observed in patients in the second-line setting. No difference in overall survival was observed overall or by line of therapy. In the net monetary benefit analysis, after adjusting for potential confounders, we found that treating patients on Pathway was cost effective across a plausible range of willingness-to-pay thresholds.

Conclusions: Results of this study suggest that treating patients according to evidence-based guidelines is a cost-effective strategy for delivering care to those with NSCLC.

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Documenting the Benefits and Cost Savings of a Large Multistate Cancer Pathway Program From a Payer's Perspective

By Eugene D. Kreys, PharmD, BCPS, and Jim M. Koeller, RPh, MS

University of Texas at Austin, Austin; and University of Texas Health Science Center at San Antonio, San Antonio, TX

Purpose: Clinical pathways are viewed as valuable practice tools leading to presumed cost savings. CareFirst BlueCross

Results: Forty-six sites representing 4,713 patients met inclusion criteria. The unadjusted site compliance rate for chemotherapy decreased from $2,502 to $1,064 ($P = .004$). Compared with projected cost increases, pathways resulted in $10.3 million in savings by participant sites ($7.0 million from drugs and $3.3 million from hospitalizations) or $30.9 million when extrapolated to the entire health plan.

Conclusion: Broadly implemented clinical pathways can achieve reasonable physician compliance, resulting in substantial cost savings.

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Original Contribution

Closing the Quality Loop: Facilitating Improvement in Oncology Practice Through Timely Access to Clinical Performance Indicators

By John Srigley, MD, Sara Lankshear, PhD, James Brierley, MD, Thomas McGowan, MD, Dimitrios Divaris, MD, Marta Yurcan, MHSc, Robin Rossi, MPH, Tim Yardley, Mary Jane King, MPH, Jillian Ross, MBA, Jonathan Irish, MD, Robin McLeod, MD, and Carol Sawka, MD

Cancer Care Ontario; University Health Network; Mount Sinai Hospital; University of Toronto, Toronto; Trillium Health Partners, Mississauga; Grand River Hospital, Kitchener; and McMaster University, Hamilton, Ontario, Canada

Purpose: Health care organizations and professionals are being called on to develop clear and transparent measures of quality and to demonstrate the application of the data to performance improvement at the system and provider levels.

Materials and Methods: Ca
ated a pathology reporting projec
of cancer pathology by standar

This population-base
provement project involved more than 400 Ontario
and more than 100 hospitals.

pathologists and more than 100 hospitals. Clinically relevant quality indicators that used the newly available data were developed and shared. Synoptic pathology data were electronically captured at the point of report development and used to automate the timely generation of clinical performance indicators that support quality improvement in surgical oncology. These reports provided comparison data at the organizational, regional, and population levels.

Results: Monthly quality indicator reports are generated and

Since the launch of the project, colorectal lymph node retrieval rates have increased from 76% to 87%, and pT2 prostatectomy margin positivity rates have decreased from 37% to 21%.

Conclusion: High-quality, complete cancer pathology reports are important not only for contemporary oncological practice, but also for secondary users of pathology information including tumor registries, health planners, epidemiologists, and others involved in quality-improvement activities and research.

Niente tagli automatici, interveniamo con equilibrio: la ricetta di Howard Brody

The NEW ENGLAND JOURNAL of MEDICINE

Perspective

From an Ethics of Rationing to an Ethics of Waste Avoidance

Howard Brody, M.D., Ph.D.

N Engl J Med 2012; 366:1949-1951 | May 24, 2012

"Se si evitassero tutti i test diagnostici e tutti gli interventi che non portano alcun beneficio agli ammalati si potrebbe dare a tutti ciò di cui hanno bisogno"

"Ci sono tanti interventi che non portano a nulla e insieme rappresentano il 30% delle spese"

"Quello che non serve può far male"

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The NEW ENGLAND JOURNAL of MEDICINE

REVIEW ARTICLE

GLOBAL HEALTH

Governance Challenges in Global Health

Julio Frenk, M.D., M.P.H., Ph.D., and Suerie Moon, M.P.A., Ph.D.

A robust response to this complex picture requires improved governance of health systems

The notion of governance goes beyond the formal mechanisms of government and refers to the totality of ways in which a society organizes and collectively manages its affairs.

N ENGL J MED 368;10 NEJM.ORG MARCH 7, 2013

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GRAZIE PER L'ATTENZIONE!