There is wide variation in cancer care in the United States that results in variation in outcomes including cancer recurrence and survival. Coordination of cancer care and oversight through collection of information on who is treated and how they are treated is a key element in improving cancer care. However, this is made difficult in the US because cancer care is largely provided in community settings outside large academic medical centers. Indeed, with the exception of surgical treatment, most cancer care is provided in the ambulatory setting through physicians whose medical practice is independent of any hospital or coordinated health care system.

The only organization in the US that accredits cancer care coordination and quality evaluation at the community level is the Commission on Cancer (CoC) of the American College of Surgeons (ACoS). The cancer program of the ACoS began in the 1920s and was formalized into the current accreditation program in the 1950s. The program has grown to now include preservation of over 1,500 cancer programs that in aggregate provide cancer treatment to over 75% of all Americans with cancer. Most of these programs are community hospitals, though the program also includes most major academic medical centers and NCI designated comprehensive cancer centers.

The accredited program is coordinated by an oversight "Cancer Committee" that includes leadership from specialists of all oncology disciplines as well as nursing, data management, and other related oncology fields. The cancer program must meet CoC accreditation standards for the structure of the program, coordination of care both within and outside the hospital, and for data reporting through the cancer registry system. Importantly, the cancer program is responsible for assuring that patients treated within their program receive appropriate, guideline concordant treatment even though that care may be administered outside the hospital.

A key component of accreditation is that the cancer program must maintain a registry of every patient who has any service provided by the cancer program. The registry must obtain all diagnostic, staging and subsequent treatment information on each such patient regardless of
where they receive treatment. In addition, the registry is responsible for annual follow-up to record both disease and vital status. The cancer program must submit the entire cancer registry data set to the CoC where is aggregated with data from the other cancer programs into a single large database termed the National Cancer Data Base (NCDB). The NCDB therefore collects information on over 1 million new cancer patients annually and has follow-up information on over 20 million cancer patients treated in the United States since 1989.

The CoC uses the NCDB to assist cancer programs and quality management and quality improvement. Most notably, quality measures for cancer care have been defined for application through the cancer registry program that are reported to the program on an annual basis. In addition, the NCDB has developed a rapid case ascertainment system that allows real-time identification of new cancer patients and tracking of their care to ensure that they receive appropriate care in a timely fashion. This program, called the Rapid Quality Reporting System, is being implemented nationwide in 2011. It is the first such nationwide disease tracking program in the United States.

This talk will review the organization of the CoC accreditation program, the recently revised cancer program accreditation standards, and the quality tools that have been developed to assure that cancer programs meet quality standards and have tools to assure continuous quality improvement.

Reference:

The mission of the Organisation of European Cancer Institutes (OECI) is to bring together the cancer research and care institutions in the Europe, in order to create a critical mass of expertise and competence.

In recent years the treatment of cancer has developed into a multidisciplinary approach supported by technical facilities in various services. Moreover, in Comprehensive Cancer Centres (CCCs), a close cooperation with various research groups and disciplines is a condition to perform successful translational research. As the organisation of a CCC is an important ingredient for optimal performance, there is a critical need for quality assurance of the Centres.

The OECI launched the Accreditation Programme in order to fulfil these goals. The programme is based upon the OECI standards for cancer care. The standards are translated in two questionnaires, a qualitative and a quantitative. Both are integrated in an electronic tool (e-tool) for self-assessment. An OECI peer review is a systematic and independent site visit to determine whether on a level of quality and the coherent results, activities correspond with the planned measures. A scoring system is included in the qualitative questionnaire.

The developments in accreditation have urged the OECI to develop and implement an additional system in which European cancer institutes can also be designated. Such a system creates a platform in which harmonisation and benchmarking of cancer activities will be possible on an international scale. By making an effort to gain a designation status, the cancer centre will be stimulated to disseminate knowledge and to form coalitions with other similar institutes in Europe.

The key word in the designation of European cancer institutes is the level of comprehensiveness of both professional infrastructure and performance. Four different types of cancer institutes/organizations are distinguished: Cancer Unit, Clinical Cancer Centre, Cancer Research Centre and Comprehensive Cancer Centre. The type of cancer organization indicates the comprehensiveness of the services and the degree of specialisation.
DEVELOPMENT OF TAIWAN’S NATIONWIDE ACCREDITATION PROGRAM ON CANCER CARE QUALITY

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Cancer has been the number one killer in Taiwan since 1982. In 2003 Taiwan passed the Cancer Control Act. Accordingly, the Bureau of Health Promotion (BHP) of Taiwan’s Department of Health (DOH) has implemented various measures to further enhance the quality of cancer prevention and treatment. An important component of the government’s integrated efforts in this area is the accreditation of cancer care programs.

In 2005 the BHP commissioned the National Health Research Institutes, to develop an accreditation system for cancer diagnosis and treatment quality. The following year, after conducting a thorough literature review, visiting world’s leading institutes, and consulting with the nationwide key opinion leaders in cancer care, a draft of approval standards was proposed using those of the American College of Surgeons’ Commission on Cancer as a template. A voluntary pilot survey of 10 hospitals was conducted to validate the standards and survey process. The accreditation program on cancer care quality was officially launched in 2008. Hospitals that make 500 or more new diagnoses of cancer are required to participate. The accreditation process evaluates 6 areas, including cancer committee leadership, cancer registry and data management, clinical management, cancer screening and early detection program, quality improvement, and clinical trial information.

During the first three-year cycle (2008–2010) 42 hospitals underwent the required accreditation survey, resulting in approximately 81% of all newly diagnosed cancer patients being treated in approved cancer programs. The results of accreditation evaluations are also posted online for public reference. The impact of the accreditation on the cancer care system operation and quality improvement has currently been evaluated through several projects funded by BHP. The standards and measure elements have been revised and launched in 2011. The accreditation report of each hospital will also be coupled into the official hospital accreditation report since 2011.
Substantial progress has been made in cancer in the last decade, particularly since the publication of the NHS Cancer Plan in 2000. However, major challenges remain and in January 2011 Improving Outcomes: A Strategy for Cancer was published.

The strategy acknowledges the importance of comprehensive information about cancer services being available to individual members of the public, cancer patients and their carers, healthcare professionals and commissioners.

The Manual for Cancer Services has been drawn up to incorporate the recommendations contained within NICE improving outcomes guidance and other national guidance including new guidelines and quality standards published by NICE.

The Manual for Cancer Services is used by the NCPR Programme as part of the assessment of cancer services and to provide a ready specification for the commissioning of cancer services within a given locality. It identifies the characteristics of a service that are likely to have a significant impact on health outcomes.

The NCPR Programme aims to improve care for people with cancer and their families by:

- ensuring services are as safe as possible;
- improving the quality and effectiveness of care;
- improving the patient and carer experience;
- undertaking independent, fair reviews of services;
- providing development and learning for all involved;
- encouraging the dissemination of good practice.

The outcomes of the NCPR Programme are:

- confirmation of the quality of cancer services;
- speedy identification of major shortcomings in the quality of cancer services where they occur, so that rectification can take place;
- published reports that provide accessible public information about the quality of cancer services;
- timely information for local commissioning as well as for specialised commissioners in the designation of cancer services;
- validated information which is available to other stakeholders.

This will outline the National Cancer Peer Review methodology and the outcomes of the programme.
PERCEPTIONS OF HOSPITAL STAFF WITH REGARD TO THE “ACCREDITATION PROGRAM ON CANCER CARE QUALITY” IN TAIWAN

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Background
This study investigated hospital staff’s perceptions of the potential benefits of the “Accreditation Program on Cancer Care Quality” which was officially launched by the Bureau of Health Promotion (BHP) and the National Health Research Institute in 2008.

Methods
Structured questionnaires were completed by 325 managing and 1204 staff members of 41 hospitals that participated in the Accreditation Program on Cancer Care Quality. The five-level Likert item questionnaires describe how the accreditation system affected the health care system in the following six domains, such as hospital staff professional ability, healthcare quality, healthcare administration, the benefits of participation the program, the barriers of promoting the accreditation and area of the program desired improvement. T-test was applied to analyze the perception difference between the managing and staff members.

Results
Results indicated that managing members had more positive perceptions of the potential benefits of the “Accreditation Program” rather than staff members, particularly in the issues of establishment of medical care process and structure, peer review process for continuous quality improvement, setting up multidisciplinary teams and resources relocation for promote cancer care quality ($P < 0.05$). Staff members had more strong perceptions of considered the barriers and desired improvement of the accreditation program ($P < 0.05$). Both managing and staff members had expectation on heavy paper work preparation and inconsistent consensus of surveyors to be improved.

Conclusions
Respondents agreed that this program could enhance the improvement of quality of cancer care. But the issues that the accreditation program needs to be improved include cumbersome document preparation and the current accreditation standards can not actually represent the care quality are more be concerned. Revised the standard systematically and more efficient surveyor training could be apply as major plan for improvement of this accreditation program by BHP and NHRI in the future.
IMPLEMENTING A CANCER CENTER IN A LARGE-SCALE GENERAL HOSPITAL:
PERSPECTIVES FROM PATIENT CARE AND QUALITY CONTROL

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Background
Most cancer patients in Taiwan are treated in general hospitals in which multi-discipline integration and quality control of cancer care are important tasks. This report presents the experiences from Chang Gung Memorial Hospital (CGMH) in setting up a Cancer Center providing “patient-centered” service and quality control programs through the integration in software and hardware.

Methods
CGMH-LinKou treated more than 8000 new cancer patients annually. It set up a Cancer Center in January 2004, and opened a new building to provide “one-stop” service in February 2007. Many systems were implemented to achieve the goal of providing best treatment outcome and process for cancer patients.

Results
To provide the best treatment process, this building has a complete set-up including wards for chemotherapy (C/T) and BMT, outpatient C/T room, combined outpatient clinics, Dept. of Radiotherapy, Molecular Diagnostics Laboratory for Cancer, Clinical Trial Center and Resource Center for Cancer Patients. The major members of cancer team have same service time in the combined outpatient clinics. The case manager, cancer dietitian, psychologist, social worker and volunteers provide holistic care to patients who can feel the concern and warmth from our team and are not alone in a large-scale general hospital.

To obtain the best treatment outcome, we have set up 19 teams based on the tumor location. Treatment guidelines are set up after full discussion, on which the team member will follow. We are the first hospital in Taiwan (probably in the world) to require physicians to fill in a “cancer treatment planning sheet” before they conduct major treatment like surgery, chemotherapy or radiotherapy to patients. This sheet is set to weekly team conference for discussion and review. We have set up quality indicators for each team and performed regular monitoring, feedback and improvement process. We also made remarkable efforts in the issues like C/T safety, quality control and education, and obtained great achievements.

Conclusions
Lack of integration and patient-centered care could be the potential weakness for cancer treatment in a large-scale general hospital. Through the well-designed system, we demonstrated that a large-scale general hospital can provide the same or even better quality service as hospitals specialized for cancer treatment.
FROM MEASUREMENT TO IMPROVEMENT IN CANCER QUALITY

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Linking Cancer Quality Measurement to Improved Care

Background
Great progress has been made in measuring cancer care quality in the past decade. This progress must now be matched with advances in linking those quality indicators to improved outcomes and sustainably disseminating best clinical and quality improvement practices.

Methods
We review the common quality metrics in cancer and their likely relationship to improved mortality and morbidity. US delivery system approaches to linking measures with quality improvement approaches are described. We present case examples of successful intertwining of measurement and improvement approaches in integrated delivery systems.

Results
Opportunities for disseminating successful quality improvement approaches take advantage of emerging information technology resources to foster collaborative approaches across institutional barriers. Among the most promising, examples of which are described in detail in this presentation, are those that activate managers and practitioners to contribute innovative ideas through “crowd sourcing” and electronic co-development “toolkits.” Explicitly linking this approach with expertly derived quality indicators merges industrial engineering and health services research paradigms, yielding potentially more effective quality improvement programs.

Discussion
Innovation often springs from interactions between experts with diverse settings and backgrounds. The struggle to improve cancer care can benefit from a structured information technology that fosters such connections.
In England over 250,000 are diagnosed with cancer every year, around 130,000 die from the disease and currently, about 1.8 million people are living with and beyond a cancer diagnosis. Despite improvements in survival, mortality and service quality, outcomes remain poor when compared with the best in Europe. To achieve cancer survival rates that match the European average, 5,000 lives need to be saved each year; to achieve the best 10,000 lives. To respond to this challenge those involved in delivering cancer services in England need to:

- reduce the incidence of ‘preventable’ cancers
- improve access to screening
- achieve earlier diagnosis of cancer, diagnosis at a later stage is generally agreed to be the most important reason for the lower survival rates
- ensure all patients have access to the best possible treatment and experience.

To demonstrate whether outcomes can be improved the Cancer Reform Strategy (2007) and Improving Outcomes Strategy for Cancer (2011) identified better information and stronger commissioning as two key drivers to achieve the goal that cancer services in England should be amongst the best in the world.

The National Cancer Intelligence Network and the National Cancer Action Team have a range of products to enable local services, commissioners and patients understand services and how these can affect service quality, and subsequent outcomes. These products cover the ‘burden’ of cancer within primary care through to understanding the services offered by secondary and tertiary care and ‘what makes a good service’ by bringing qualitative and quantitative data together from multiple sources such as incidence, mortality, screening, waiting times, inpatient activity, treatment and patient experience surveys within single tools.
CORE MEASURES DEVELOPMENT AND ITS APPLICATION FOR HOSPITALS IN TAIWAN: AN EXAMPLE FROM BREAST CANCER AND COLORECTAL CANCER

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Purpose
The purpose of the study was to develop organization-based core performance measures (CPMs) for breast cancer and colorectal cancer patients treated in hospitals that participated in cancer quality improvement programmes in Taiwan and apply these measures to compare hospital performance.

Method
CPMs were developed in three stages that included a preparation, a consensus building stage, and two stages of stakeholder feedback. Three criteria, seven and four sub-criteria were applied in the development process for breast and colorectal cancer, separately. Indicators listed in a Delphi questionnaire were based on a literature search, indicators developed by relevant institutions and discussion by authors. Each indicator needed to meet inclusion criteria as a final indicator. Evidence-based guidelines, expert opinions from panel group, 27 hospitals and empirical data were all applied to develop and revise the core measures. The study sample for colorectal cancer originated from 2004 data in the Taiwan Cancer Database, a national cancer data registry. Eighteen hospitals and 5585 newly diagnosed colorectal cancer patients were enrolled in this study. We used indicator-based and case-based approaches to examine adherences simultaneously.

Result
Fifteen and seventeen 28 indicators were selected and modified after the three stages for breast cancer and colorectal cancer, separately. There were two pre-treatment indicators for screening and diagnosis, nine treatment-related indicators, and four monitoring-related indicators for breast cancer. The final core measure set of colorectal cancer included seventeen indicators (1 pre-treatment, 11 treatment-related and 5 monitoring-related). There were data available for ten indicators in colorectal cancer. Indicator-based adherence possesses more meaningful application than case-based adherence for hospital comparisons. Mean adherence was 85.8% (79.8% to 91%) for indicator-based and 82.8% (77.6% to 88.9%) for case-based approaches. Hospitals performed well (>90%) for five out of eleven indicators. Still, the performance across hospitals varied for many indicators. The best and poorest system performance in colorectal cancer was reflected in indicators T5-negative surgical margin (99.3%, 97.2% - 100.0%) and T7-lymph nodes harvest more than twelve (62.7%, 27.6% - 92.2%), both of which related to surgical specimens.

Conclusions
In this nationwide study, quality of colorectal cancer care still shows room for improvement. These preliminary results indicate that core measures for cancer can be developed systematically and applied for internal quality improvement. Our experience can be extended to other cancer sites and adapted to link with pay for performance or certification program in cancer care.

*Keywords:* organization-based measures, core performance measures, breast cancer, colorectal cancer, case-based measure.
THE NATIONAL ACCREDITATION PROGRAM FOR BREAST CENTERS:
THE ROAD TO QUALITY IMPROVEMENT

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The prevalence of breast disease in the U.S. has created an opportunity for the medical establishment to open breast centers to serve their patients with efficient, multidisciplinary evaluation and management. These centers have rapidly proliferated over the past three decades but no national organization had taken the initiative to see what was going on inside until the American College of Surgeons (ACS) mobilized representatives from all the appropriate national organizations/societies dealing with breast disease. In 2006 the National Accreditation Program for Breast Centers (NAPBC) Board of Directors was organized, consisting of 32 members from 16 national groups.

The NAPBC is dedicated to the improvement of the quality of care and monitoring of outcomes of patients with diseases of the breast. This mission is pursued through standard-setting, scientific validation, and patient and professional education.

The NAPBC Board defined 17 essential components of evaluation and management every patient with breast disease should receive. In order to broaden the accessibility of patients to centers without compromising any step in the continuum, accredited centers may provide services on site or refer to nearby locales for services they may not have, such as genetic counseling. Likewise, the Board defined 27 evidence and consensus-based standards that accredited centers had to meet.

NAPBC accreditation is granted only to those centers that have voluntarily committed to provide the best in breast cancer diagnosis and treatment and are able to comply with established NAPBC standards. Each center must undergo a rigorous evaluation and review of its performance and compliance with the NAPBC standards. To maintain accreditation, centers must undergo an on-site review every three years. In order to be scheduled for survey, each center must complete an electronic survey application record (SAR).

As of late August, 2011, the NAPBC had accredited 350 centers in 42 states. By the end of year 2011 that number should reach nearly 400. Fifteen hundred breast centers in the U.S. have requested information about the NAPBC.

The NAPBC has received inquiries from 20 countries outside the U.S. An international committee has been formed to explore options.
QUALITY OF CANCER CARE IN THE U.S.:
WHAT DO WE KNOW AND WHERE SHOULD WE FOCUS OUR
FUTURE EFFORTS?

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Background
Since the Institute of Medicine called attention to the quality of cancer care in their 1999 report “Ensuring the Quality of Cancer Care”, a number of efforts have been undertaken to evaluate and improve the quality of cancer care in the U.S. What have we learned and how should this inform future efforts to improve the quality of cancer care?

Methods
This presentation will review the methods and results of a number of U.S. efforts to evaluate the quality of cancer care, including the American Society of Clinical Oncology’s National Initiative for Cancer Care Quality (NICCQ) and Quality Oncology Practice Initiative (QOPI), and the Veteran Health Administration’s (VHA) Special Study of Lung Cancer Care.

Results
Using rigorous approaches to data collection and quality measurement specification, many aspects of the quality of cancer care are much better than early studies suggested. Patient refusals and contraindications to cancer treatment are important factors in rates of adherence to recommended surgery, radiation therapy and chemotherapy. Wide variation in the quality of symptom management and end-of-life care persists and future efforts should focus on improving these important aspects of cancer care.

Conclusions
Based upon the results of recent programs to evaluate the quality of cancer care, future quality improvement efforts should focus on ensuring that care is patient-centered and address those aspects of care that have the most impact on quality of life.
QUALITY MEASURES OF BREAST CANCER CARE IN TAIWAN

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Background
Since 2001, under the guideness and support of Bureau of Health Promotion (BHP), cancer registry data from several major hospitals was collected. Cancer registry review was published annually. The experts from Taiwan Cooperative Oncology Group (TCOG) and major cancer centers noted the lack of information of the quality of cancer care. They recommended the development of better measures on the quality of cancer care. After throughout discussion, several measures were established in breast cancer of Taiwan. In these two years, BPH tried to apply these measures to the cancer registry data in 2007-2009 and contracted with The Breast Cancer Society of Taiwan (BCST) for this purpose. BCST was asked to work with experts to develop consensus standards for measuring the quality of breast cancer care from national cancer registry.

Methods
The BCST developed and implements quality measures in a wide variety of medical conditions. A set of 12 measures related to quality of diagnosis, operation, radiotherapy, hormonal and chemotherapy were chosen from previous experts' recommended measures. Every measure should be able to be calculated form our 95 fields cancer registry data. After several internal revisions, all these measures were released publically in the meeting held by BHP. Each hospital-specific data containing the 12 measures was compared with average standard and illustrated in a radar chart. The measures of 2009 were also compared with 2007-2008. The changes also showed in the radar chart. All the difference greater than 4% were further analyzed.

Results
From 2007 to 2009, 20772 breast cancer registries were included in this study. Among these measures, the indication of chemotherapy, hormonal therapy, and pathologic report showed good consensus. On the other hand, the indication for radiotherapy, conserving surgery, and sentinel lymph nodes (SLN) sampling showed little consensus. As compared the data of 2009 with 2007-2008, we found a greater improvement in the portion of pre-op diagnosis, radiotherapy for more than 4 positive nodes, and SLN sampling (>4% improvement).

Conclusions
We can easily understand the quality of cancer care in each hospital and the temporal change by using the measures developed from Taiwan breast cancer registry. Also, BPH can use these data to control costs, monitor effectiveness and outcomes of health care guide health policy, and promote informed decision making in an easy way.
QUALITY ANALYSIS OF DEFINITIVE TREATMENT FOR STAGE I-III COLORECTAL CANCER PATIENTS IN TAIWAN

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Background
In recent years, colorectal cancers have emerged with the highest rates of occurrence amongst all cancers in Taiwan. Early detection of colorectal cancer will not only increase the likelihood of cure, but also decrease medical expenses. This study aims to analyze treatment quality of stages I-III colorectal cancers in Taiwan and elicit areas for improvement.

Patients and Methods
This study extracts its data for colorectal cancers between the years of 2007 to 2008 from the Cancer Registry, which is maintained by the Bureau of Health Promotion. There were 9139 cases of colon cancer and 6834 cases of rectal cancer included.

Results
After initial diagnoses, 96.3% of patients with colon cancer were able to receive surgery within six weeks. Pathological reports showed that lymph node counts exceeding twelve occurred in only 69.2% of the patients. As for rectal cancer, 96.5% of patients were able to receive definite treatment within six weeks. Surprisingly, only 76.3% of those patients’ medical records clearly documented the clinical stage. Multiple regression analysis elicited strong relations between adherence rate and number of patients in treatment. However, older age and male gender formed weak relations to adherence rate.

Conclusion
It can be concluded that the percentage of patients with pathological reports indicating more than twelve lymph nodes, along with clear initial diagnoses indication of rectal cancer clinical stage, are the two foremost areas requiring improvement. Furthermore, it can also be concluded that patients with a 100% adherence rate yield a better 18-months survival rate.
Practice guidelines for cancer care are useful in defining the best treatment standards and to help patients and physicians in making appropriate treatment decisions. In addition, practice guidelines may provide standards for quality measurement and for quality improvement. However, developing and maintaining comprehensive and up-to-date practice guidelines is a difficult and expensive ongoing task. In the United States, the only organization that has met this challenge is the National Comprehensive Cancer Network (NCCN).

The NCCN is an organization of 21 of the National Cancer Institute designated comprehensive cancer centers. One of the primary missions of the NCCN is to establish and maintain practice guidelines for the purpose of defining best standards of cancer care, measuring cancer care, and assisting in quality improvement. The NCCN practice guidelines include virtually all cancer types and stages. First developed in 1996, they are updated at least annually using an evidence-based system that incorporates expert consensus where high-level evidence is not available. These guidelines have been accepted as defining the standard of cancer treatment in the US and have been adapted to support cancer practice around the world including Japan, China, the Middle East, and South America.

As part of the guideline program, the NCCN maintains a detailed outcomes database that includes information on all cancer patients treated at its member institutions in breast cancer, colon and rectal cancer, lung cancer, and non-Hodgkin’s lymphoma. These databases are used extensively for health services and patterns of care research as well as for quality monitoring and improvement at the participating centers. For the purpose of quality improvement, the outcomes database provides an assessment of whether the treatment of each patient was in concordance with the applicable NCCN guideline. These data are used for quality improvement that each cancer center. The NCCN Guideline program is expanding to integration with electronic medical record systems to provide real-time decision support and quality evaluation.

This talk will address the programs of the NCCN in developing practice guidelines and in the use of practice guidelines for quality measurement and cancer treatment decision support.
References:
Access to all NCCN Clinical Practice Guidelines:  www.nccn.org