Editorial

Nursing Homes and Cancer Care

The article in this issue by Clement, Bradley, and Lin (2009, “Organizational Characteristics and Cancer Care for Nursing Home Residents”) provides a timely reminder of an often forgotten issue: the elderly frequently do not receive appropriate cancer treatment, and the elderly in nursing homes are particularly at risk for poor quality cancer care. There is considerable empirical evidence to support the first observation (see Supplement to *Cancer* published December 2008: “Cancer and Aging: Challenges and Opportunities across the Cancer Control Continuum”), and there has been increased attention recently to the second.

Clement et al. do a particularly good job of drawing our attention to the intersection of the literatures on the dimensions of high-quality cancer care and measuring quality of care in nursing homes; that particular intersection set is not well populated. They should also be commended for focusing on long-stay nursing home residents who are diagnosed with cancer *after* nursing home admission. This group of residents is particularly problematic due to both advanced age and location. They are at higher risk of delayed or misdiagnosis; they are more likely to suffer from preexisting comorbidities, which complicate cancer management planning; and nursing homes are care settings where there are few if any incentives to provide high-quality cancer care. This commentary will review some of the key issues raised by a dual focus on cancer care in the nursing home setting. Three issues are particularly important: (1) cancer is increasingly prevalent among nursing home residents; (2) standard measures of nursing home quality of care do not provide much information on cancer treatment quality; and (3) standard measures of quality cancer care are not easily adapted to the nursing home setting.

CANCER AMONG NURSING HOME RESIDENTS

Approximately 60 percent of all cancer diagnoses occur among the elderly (age 65 and older; Johnson et al. 2005), and nearly 9 percent of all nursing home residents have a cancer diagnosis (Bradley et al. 2008). Many research-

ers have called for increased attention to posttreatment care patterns for older cancer survivors, but most of that research has focused on community-dwelling elderly (e.g., Bellizi et al. 2008). Although it is expected that nursing home admission often follows major cancer treatment for elderly patients in decline, we know little about the diagnosis and treatment and/or palliative care of cancer among nursing home elderly, for either previously diagnosed patients, or newly diagnosed cases.

The nursing home is a common site of death for the elderly with cancer (Weitzen et al. 2003; Johnson et al. 2005). The proportion of cancer patients dying in nursing homes increased from 13.2 percent to 16.8 percent between 1986 and 1997 (Johnson et al. 2005). Whether that proportion has continued to increase is an empirical question. Only Clement et al.'s work (using data on dually eligible Michigan nursing home residents) has focused on residents who have been diagnosed with cancer while residing within nursing homes. These investigators found that 25 percent of these elderly residents were diagnosed at the time of death or within 1 month before death, and that pain medication was quite variable (40 percent received no pain medication). Little can be done in 1 month or less in pain management, palliative care, or hospice care (Teno et al. 2001b); indeed, in Clement's sample few patients were receiving hospice care. Given the "graying" of the U.S. population, and a concomitant increase in cancer diagnoses among the elderly and the oldest old, we need more studies of cancer care within nursing homes, especially studies that focus on those diagnosed after nursing home admission.

NURSING HOME QUALITY OF CARE

Studies of nursing home quality of care and the development of reliable and valid indicators of care quality have proliferated in recent years (see work by Mor et al. 2003; Mor 2004). Using indicators from the Online Survey Certification and Reporting (OSCAR) database and the Minimum Data Set (MDS), nursing home performance (and differences across nursing homes in care quality) have been studied using a wide range of quality measures, including clinical measures of physical and cognitive functioning (such as pressure ulcer occurrence and stage, decline in activities of daily living, and pain), inspection deficiencies, financial viability, and inadequate staffing. Studies of pain management within nursing homes (Bernabie et al. 1998; Clement et al. this issue) have used the MDS measure of whether the resident received pain medication. Pain management is an important aspect of cancer care, and this

research has led to policy and management changes in pain management within hospices. However, other aspects of cancer care within the nursing home setting have been difficult to conceptualize and measure. For example, appropriate end-of-life care requires consultation with the family and consideration of patient and family wishes; this is not captured by the MDS or OSCAR data (Teno et al. 2001a).

Clement et al. also found differences in pain management related to the percentage of residents of the nursing home funded by Medicaid; specifically the higher the proportion of Medicaid-covered residents, the less likely cancer patients were to receive any pain medication. This finding reminds us that we should also consider the recent spate of literature on disparities in nursing home care quality across racial/ethnic groups (Smith et al. 2007). Nursing homes remain relatively segregated, and nursing home care can be described as a tiered system in which nonwhites are concentrated in homes of marginal quality care (Mor et al. 2004). The implications of disparate quality of cancer and pain management within nursing homes need to be more fully examined.

CANCER CARE QUALITY

High-quality cancer care is usually defined and measured assuming care is delivered in hospital-based cancer programs and outpatient treatment facilities. The emphasis in contemporary cancer care is on multimodal treatment organized and delivered by a multidisciplinary treatment team (Wright et al. 2007). Although the ideal is to ensure multidisciplinary care that is coordinated throughout the cancer care continuum (from screening through end-of-life care; Zapka et al. 2003), the reality is that most specialty physicians and cancer care facilities tend to emphasize the active treatment stages of care more than they do survivorship, palliation, or end-of-life care. This can be seen in the recommendations of the Commission on Cancer (CoC) of the American College of Surgeons for defining standards of care and encouraging hospital cancer programs to collect standardized data on cancer care quality. The CoC has developed the Rapid Quality Reporting System (RQRS) to facilitate quality improvement and evidence-based care at the local level: the community-based hospital. The RQRS allows Web-based reporting of care provided to breast and colon cancer patients, emphasizing a core set of performance and outcome measures. These measures focus on “timely and appropriate” recommendations, offering and administration of radiation therapy, chemotherapy, tamoxifen, or aromatase inhibitor (for breast cancer at stage II or III),

adjuvant chemotherapy, examination for resected colon cancer, and removal and examination of selected lymph nodes (see <http://www.facs.org/cancer/ncdb/rqrs0509.pdf>). Follow-up care and survivorship issues are nowhere on this list, and it is hard to imagine either the treatments or measures following an elderly patient into the nursing home setting.

Another hallmark of high-quality cancer care is the availability of clinical trials and the recommendation of physicians to patients that they enroll in appropriate trials. However, most older adults with cancer (even ambulatory patients) are routinely excluded from clinical trials due to comorbid conditions (Bellizi et al. 2008). Clearly not all cancer patients in nursing homes would opt for clinical trials if offered, but they do not appear to have this option.

BEYOND PAIN MANAGEMENT

Research on nursing home quality of care and research on cancer quality of care have each developed as separate literatures, usually without reference to one another. The work by Clement et al. underscores how troublesome this is, and how little we know about the nursing home setting as the place where many older adults complete their cancer journey, and where others begin this journey, often without palliative treatments or pain management that could ease their burden. The pain management literature has provided an initial bridge between these two worlds; however, much remains to be done. More widespread use of treatment models for older cancer patients that emphasize multidisciplinary coordination (Oeffinger and McCabe 2006; Terret et al. 2007) by oncologists and geriatricians, with a focus on nutrition, cognitive and physical functioning, and mental health would help broaden our approach to the study of cancer care within nursing homes. Lastly, the further development and diffusion of measurement tools that capture patient and family preferences and a wider array of posttreatment care options would improve our ability to benchmark and measure improvement in care delivery for this special population (Miller et al. 2004).

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REFERENCES

- American College of Surgeons, Commission on Cancer. 2009. *Cancer Program Standards: Revised Edition Manual* [accessed on October 8, 2009]. Available at <http://www.facs.org/cancer/ncdb/rqrs0509.pdf>

- Bellizi, K. M., K. M. Mustian, O. G. Palesh, and M. Diefenbach. 2008. "Cancer Survivorship and Aging: Moving the Science Forward." *Cancer* 113 (12): 3530–9.
- Berg, K., V. Mor, J. Morris, K. M. Murphy, T. Moore, and Y. Harris. 2002. "Identification and Evaluation of Existing Nursing Homes Quality Indicators." *Health Care Financial Review* 23: 19–36.
- Bernabie, R., G. Gambassi, K. Lapane, F. Landi, C. Gatsonis, R. Dunlop, L. Lipsitz, K. Steel, and V. Mor. 1998. "Management of Pain in Elderly Patients with Cancer." *Journal of the American Medical Association* 279 (23): 1887–82.
- Bradley, C. J., J. P. Clement, and C. Lin. 2008. "Absence of Cancer Diagnosis and Treatment in Elderly Medicaid-Insured Nursing Homes Residents." *Journal of the National Cancer Institute* 100 (1): 21–31.
- Clement, J. P., C. J. Bradley, and C. Lin. 2009. "Organizational Characteristics and Cancer Care for Nursing Home Residents." *Health Services Research*. doi: 10.1111/j.1475-6773.2009.01024.
- Johnson, V. M. P., J. M. Teno, M. Bourbonniere, and V. Mor. 2005. "Palliative Care Needs of Cancer Patients in U.S. Nursing Homes." *Journal of Palliative Medicine* 8 (2): 273–9.
- Miller, S. C., J. M. Teno, and V. Mor. 2004. "Hospice and Palliative Care in Nursing Homes." *Clinics in Geriatric Medicine* 20 (4): 717–34.
- Mor, V. 2004. "A Comprehensive Clinical Assessment Tool to Inform Policy and Practice: Applications of the Minimum Data Set." *Medical Care* 42: 11150–9.
- Mor, V., J. Angelelli, D. Gifford, J. Morris, and T. Moore. 2003. "Benchmarking and Quality in Residential and Nursing Homes: Lessons from the U.S." *International Journal of Geriatric Psychiatry* 18: 258–166.
- Mor, V., J. Zinn, J. Angelelli, J. Teno, and S. C. Millar. 2004. "Driven to Tiers: Socioeconomic and Racial Disparities in the Quality of Nursing Home Care." *Milbank Quarterly* 82: 227–56.
- Oeffinger, K. C., and M. S. McCabe. 2006. "Models for Delivering Survivorship Care." *Journal of Clinical Oncology* 24 (5): 5117–24.
- Smith, D. B., Z. Feng, M. L. Fennell, J. S. Zinn, and V. Mor. 2007. "Separate and Unequal: Racial Segregation and Disparities in Quality across U.S. Nursing Homes." *Health Affairs (Millwood)* 26: 1448–58.
- Teno, J. M., V. A. Casey, L. C. Welch, and S. Edgman. 2001a. "Patient-Focused, Family-Centered End-of-Life Medical Care Views of the Guidelines and Bereaved Family Members." *Journal of Pain and Symptom Management* 22 (3): 738–51.
- Teno, J. M., S. Weitzen, M. L. Fennell, and V. Mor. 2001b. "Dying Trajectory in the Last Year of Life: Does Cancer Trajectory Fit Other Diseases?" *Journal of Palliative Medicine* 4 (4): 451–2.
- Terret, C., G. B. Zulian, and A. Naiem. 2007. "Multidisciplinary Approach to the Geriatric Oncology Patient." *Journal of Clinical Oncology* 25: 1876–81.
- Weitzen, S., J. M. Teno, M. Fennell, and V. Mor. 2003. "Factors Associated with Site of Death: A National Study of Where People Die." *Medical Care* 41 (2): 323–35.

- Wright, F. C., C. DiVito, B. Langer, and A. Hunter. 2007. "The Expert Panel on Multidisciplinary Cancer Conference Standards." *European Journal of Cancer* 43: 1002–10.
- Zapka, J. G., S. H. Taplin, L. I. Solberg, and M. M. Manos. 2003. "A Framework for Improving the Quality of Cancer Care: The Case of Breast and Cervical Cancer Screening." *Cancer Epidemiology, Biomarkers and Prevention* 12 (1): 4–13.