

For a **WEB EXTRA** with an interactive graphic of results from this study, see [dartmed.dartmouth.edu/f09/we03](http://dartmed.dartmouth.edu/f09/we03).



A suspected whooping cough outbreak at DHMC was a false alarm. But the event had an upside in a finding that 88%-94% of vaccinated employees showed a booster response within just two weeks.

## Are NCI centers the cream of the crop?

For decades, U.S. cancer centers have worked hard to attain and maintain National Cancer Institute (NCI) designation. But is there a measurable difference in the care patients get at the nation's 65 NCI-designated centers? Or is the designation merely window-dressing?

Until recently, no one knew for sure. But two recent studies, including one led by DMS researcher Tracy Onega, Ph.D., have finally shed light on the question.

The first study looked only at postsurgical mortality and showed short-term benefit to getting care at an NCI center.

**Care:** The DMS study, published in *Medical Care Research and Review*, was the first to look at both surgical and nonsurgical mortality. The researchers identified 211,048 Medicare patients who had cancers of the lung, breast, colon/rectum, or prostate diagnosed between 1998 and 2002. Then they compared mortality for 15,377 who got care at one of 15 NCI cancer centers to mortality for 195,671 who got care at non-NCI facilities. They reported on mortality one year and three years after diagnosis.

Mortality at one year was on average 25% lower in the NCI group than in the non-NCI group. And it was lower regard-

less of cancer type or stage at diagnosis. In fact, NCI patients with late-stage cancers had especially low relative mortality. Even NCI patients with three or more comorbidities (other health problems, such as congestive heart failure or diabetes) had 26% lower mortality at one year.

**Outcomes:** Just 7.3% of patients in the study got care at NCI centers. That means if all the patients had gone to NCI centers, there would have been over 4,000 fewer deaths at one year and over 2,000 fewer at three years. "This estimate, if extended to the entire population of cancer patients in the United States," the authors wrote, "could have major implications on cancer outcomes."

A surprising finding was that patients who had more primary-care visits than specialist visits in the six months prior to diagnosis had 22% to 28% higher mortality, compared to those who had predominantly specialist visits. The reason for this anomaly is unknown, Onega says.

**Effect:** The study had some limitations, including the fact that none of the 15 NCI-designated centers are in the southeastern U.S., so there's the possibility of a geographic bias. Even so, Onega believes the evidence is convincing that NCI centers offer an advantage. "When you look specifically at the people with high comorbidities who went to cancer centers versus those who didn't, the ones who went . . . did better," she says. "It's nice to see that even when you slice and dice and try to control and adjust for differences in the patient population . . . it still looks like the effect is there."

Next up is to find out why. The team suspects that high patient volumes, guideline-based treatments, and multidisciplinary care teams are possible reasons. "This is the first step," says Onega, "the 30,000-foot view." **MATTHEW C. WIENCKE**

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### Let's talk about it

As talking heads nationwide argued about "death panels," a Dartmouth study showed that, when all treatment options have been exhausted, patients feel better if they talk about end-of-life issues. Patients with advanced cancer who got palliative counseling reported a higher quality of life and better mood than patients who did not. "Comprehensive, high-quality cancer care includes interdisciplinary attention to improving physical, psychological, social, spiritual, and existential concerns for the patient and his or her family," wrote Marie Bakitas, D.N.Sc., *et al.* in the *Journal of the American Medical Association*.



### Vary important research

There are huge variations in the amount of health care provided per capita in different parts of the country, as DMS research has shown for years. But perhaps, critics have argued, those differences are the result of patient preference. According to a new paper by DMS and Dartmouth College experts, that's not the case. There are big variations in the intensity of care patients prefer, but those variations exist across the country. So, they argued in *Health Affairs*, "more of the variation in use is the consequence of health-care system characteristics than it is of patients' preference."



Dartmouth's Norris Cotton Cancer Center has been an NCI-designated cancer center since 1978.