

A call for action: leadership is needed now on quality, safety, and pay for performance in community oncology

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Community oncologists are caught up in a vortex of increasing and often conflicting demands: Health plans, government payers and regulators, employers, and consumers all want us to more fully articulate the value of our care. The time to speak out and show leadership is now.

Over the past 20 years, community oncologists have been quietly elevating the quality of cancer care across the country, broadening access and improving affordability in large cities and towns and in small rural communities. Our work with more than 80% of American cancer patients and 60% of the patients taking part in clinical trials has resulted in significant improvements in survival rates, lengthened times to disease progression, improved quality of life, and improved end-of-life care.

This success has received little fanfare as small groups of cancer professionals have dealt with the cancer burden and met local cultural needs. But we now need to discuss this success more vigorously in order to educate the many healthcare stakeholders about the value of our accomplishments. Only in this way can we preserve community cancer care and ensure its continued evolution to meet increasing demands, even as we remain high touch *and* high tech.

Newer treatments, an aging population, cancer patients living longer—all of these factors have increased the costs of cancer care. Public attention is focused on ensuring that the money spent on treating this increasingly chronic disease achieves the best outcomes for patients while minimizing their suffering. The delivery of high-quality care is now widely recognized as the best way to ensure value for the healthcare dollars spent. Employers, consumers, and governmental organizations—including the largest payer for healthcare services, the Centers for Medicare & Medicaid Services (CMS)—all agree on this point.

However, if we are to continue helping our patients benefit from the best that medicine has to offer, community oncologists must step forward

to actively champion the development of quality standards and programs. These programs must be integrated into the network of community cancer clinics, which remain the most cost effective, responsive, and compassionate venues for the care of Americans with cancer.

Although it's a daunting task just to keep current with the increasing amounts of data on new therapies for cancer and blood diseases, it's not enough. A number of community oncologists have

KEY POINTS

Community oncologists have elevated the quality of cancer care in this country.

We need to communicate that success and educate healthcare stakeholders in order to continue meeting demand.

The need to show leadership is urgent because of changes in Medicare.

When we let middlemen take charge, quality suffers and patients lose.

An action plan is in place; the time to get involved is now.

also taken on the vital task of developing standards to help payers and consumers better evaluate the care they receive. Although many cancer professionals have contributed to these efforts to date, we need a much broader base of professionals to get involved—those who care for pa-

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tients daily and can best articulate the many elements of quality clinical care.

Why the urgency now? Since the enactment in 2003 of the Medicare Modernization Act (MMA), we're facing twin threats: inadequate payments for the cancer therapies we give and inadequate payments for the complex services cancer patients need. And now, various managed care organizations, as well as private payers, are adopting the MMA price structure, at various rates across the country. It's an unbalanced and ineffective system. To correct these imbalances, we need to establish appropriate delivery standards and pay for performance reimbursement plans.

We've watched helplessly as these IPAs have swung a wrecking ball at the comprehensive and affordable care we offer.

Those who practice community oncology need to implement measurable methodologies and standards. We must also ensure that the additional costs of implementation, infrastructure, technology, and outcomes measurements for these programs are covered *in addition to the normal medical care costs traditionally covered by payers*. When excellence is encouraged, quality programs can once again align the best interests of patients, society, payers, and cancer care professionals in which all stakeholders win.

How did we get here?

You only have to open the newspaper to find out what the "outside world" thinks of our profession. An article in the *Los Angeles Times* on January 31, 2005, made this quite clear to me when I read the comments of influential Congressman Pete Stark (D-California). He observed that consumers don't know how to evaluate

quality cancer care, and he believes that we have no standard approaches to that care:

"Health care isn't like buying a Chevrolet. You can go to *Consumer Reports* and read about the new Malibu, but if I asked you to describe a regimen of chemotherapy for someone who has colon cancer, you'd be out of gas.... We are talking about highly technical services that 99% of the public doesn't even know how to spell the names of. Secondly, there is no uniformity within the medical community as to what services ought to be used. It's a 'by guess and by gosh' sort of practice."

Disturbingly, these perceptions are far from what we know and see in practice every day. Mr. Stark's remarks are a dash of cold water. We need to do a *much* better job of communicating the rationale and comprehensive nature of community cancer care. But first, we must have in place the ability to document and track outcomes of that care so we can describe our success—in lay language—and gain support for that care.

What is quality care?

My definition of quality care comes from my reading of the National Committee for Quality Assurance (NCQA) materials: Essentially, it's the right care at the right time to maximize disease prevention, control, and quality of life. The 1998 President's Advisory Commission on Consumer Protection and Quality in the Health Care Industry recommended that national objectives for improving healthcare quality focus on "common and/or costly conditions, areas where wide variability in practice exists, and areas where improvements have the greatest impact on reducing morbidity and mortality and improving functional capacity."

This group also reported that although most Americans receive high-quality care, too many patients receive substandard care. The Committee

identified four major areas that quality programs should address:

1. underuse,
2. overuse,
3. variations in use of services, and
4. errors.

Reducing variation was also recommended in NCQA's 2003 report on quality, which noted "Unwarranted variation in medical practice is costly and deadly.... Worse, 57,000 lives are lost annually because physicians aren't using evidence-based medicine to guide their care."

Do quality standards improve the quality of care?

Based on the notion that performance improves when you identify and measure it, NCQA developed the Health Plan Employer Data and Information Set (HEDIS). The HEDIS measures help employers and consumers gauge how well a health plan cares for its members. Two of the seven key HEDIS points apply to cancer: advising smokers to quit and encouraging breast cancer screening. In yearly reports, NCQA has shown continued improvements in the percentage of health plans that comply with the measures. But at the same time, NCQA continues to find significant quality gaps where care is less than optimal, which leads to increased disease burden and excess healthcare costs.

At the 2004 annual meeting of the American Society of Clinical Oncology, Dr. Jane Weeks reported on data from Medicare records showing that 30% of Americans with Medicare and stage III colorectal cancer do not receive the adjuvant chemotherapy that can reduce morbidity and mortality. The result: 2,000 unnecessary deaths annually. The fix: according to NCQA, in order to enhance quality, it will take expanded performance measurement, better care coordination, and broadened accountability throughout the healthcare system. An equally important component is pay for performance—the simple idea

that hospitals and physicians who deliver excellent prevention and care for chronic illness should be rewarded.

When quality doesn't count: the California experience

As a practicing oncologist in southern California for the past 15 years, I've watched in dismay as a mismanaged care system developed through a delegated health plan model. Here's how it works: Health plans that sell policy coverage to employers or consumers delegate delivery of that care to independent physician associations (IPAs). The IPAs are paid fixed dollars for their members' care regardless of the number of cancer patients, their diagnoses, stage, or complex medical needs. Patients are free to sign up and then move to different IPAs throughout the year under their health plan's same policy. But there is no mechanism to make any adjustments in the dollars paid to the IPA that patients transfer into or out of. As a result, the system punishes IPAs with specialists whose reputations for quality attract high-risk patients or those with cancer or other high-cost diseases. It has become a significant threat to cancer care, about which patients and employers are not informed.

As cancer budgets have increased, several health plans in California (PacifiCare, Blue Shield, Aetna, and Cigna, but not Blue Cross or Health Net) have incentivized a number of local IPAs serving members in Riverside, San Bernardino, and Los Angeles counties to accept full risk, not only for the professional components of cancer care but also for the unpredictable and continuously rising costs of chemotherapy, biologic therapy, radiotherapy, and supportive care. This, despite the fact that these IPAs have little or no control over the entry of patients into their fixed payment medical groups.

The IPAs are middlemen who stand between the health plans and the caregivers, often taking 8%–13%

of the premium dollar for their "management services." But the IPAs are not held accountable for the outcomes of their members with cancer or for the quality of cancer care that is delivered. In fact, in my recent experience, the health plans that delegate the cost of cancer therapy to IPAs, as well as the IPAs themselves, have refused to meet and review the comprehensive data sets that practices like ours can provide. For example, we have put electronic medical record-keeping into place, conducted comprehensive symptom assessment programs, and run clinical trials, all of which can prove that what the health plans unfairly and incorrectly label "overuse and excess costs" are actually the costs associated with treating large numbers of cancer patients who got the evidence-based care they needed.

Southern California IPAs, like many such plans, are increasingly run for the health of the bottom line rather than the health of patients. Cancer moneys allocated to IPAs from health plans that delegate chemotherapy, biologic therapy, and other cancer treatment risks are seen as fair game for diversion into primary care bonuses and management profit margins. The IPAs then force their oncology providers to accept that risk for cancer care with the advice that they manage care within the fixed budget, regardless of the population's needs. It would be difficult to imagine a less principled arrangement. Patients are not informed, nor is there any lay oversight of these conflicting underlying contracts. Yet not only is this legal in California, we are seeing more and more IPAs adopt what, for them, are profitable contract deals.

For 15 years, legions of "medical directors," responsible primarily for the financial performance of their IPAs, have repeated to me the same four messages:

1. "You know too much." (Because our patients' up-to-date care includes

expensive new drugs and supportive care.)

2. "Your patients live too long." (Because we give them effective cancer therapies, manage symptoms, and relieve suffering.)

3. "Sick patients transfer into our IPA to get to your group for care. That increases our costs without any associated increase in payments from the health plans."

4. "We don't want flagship hospitals or flagship medical specialty groups in our organization because sick patients will crawl from far and near to get coverage from our group."

These medically unsound, unethical, and bald-faced risk-shifting arrangements from health plans to intermediaries to providers point out yet another critical reason why community oncology professionals must embrace and lead the quality oncology movement. When health plans are not held accountable for the outcomes of the care delivered, the goal of care becomes minimizing costs and maximizing profits. Because cancer has been perceived as too complex for accountability standards, the field has been ripe for unscrupulous business people to siphon premium dollars from cancer care into profits.

We've watched helplessly as these IPAs have swung a wrecking ball at the comprehensive and affordable care we offer. They reward minimalist medicine, forcing consumers to accept low quality cancer care, file time-consuming appeals, or transfer out of the IPA to see the best doctors. Whichever option the consumer takes, the benefits flow to the money men. Without accountability for the longer-term outcomes and patient satisfaction, quality cancer care is not valued, and those of us who provide it are terminated for excellence. It's a perversion of pay for performance: For us, P4P means "*persecuted* for performance." Were quality outcomes valued, health plans would hire the best oncology groups, rather

On the Web

LUCKILY, MANY COLLEAGUES and professionals have been thinking and working in the field of quality for years and have developed a wealth of ideas and materials we can draw from to document and enhance quality cancer care in our communities. What follows is a sampling:

Agency for Health Care Research and Quality (www.ahrq.gov)

Under its slogan "Advancing excellence in health care," this lead government agency on quality of care research (formerly known as the Agency for Health Care) has taken on the task of coordinating all federal quality improvement efforts and health services research. One of its stated goals: Build the evidence base for what works and doesn't work in healthcare.

American Society of Clinical Oncology (www.asco.org)

On this Website you'll find information on the Quality Oncology Practice Initiative (QOPI). One goal of this program is to provide tools for practitioners to implement "best practices." In an effort to provide comparative data regarding best practices, QOPI has developed a set of evidence- and consensus-based measures.

Centers for Medicare & Medicaid Services (www.cms.hhs.gov)

The quality-of-life demonstration project is an excellent start to furthering quality care. This project of the Centers for Medicare & Medicaid Services assesses the chemotherapy side effects of fatigue, nausea/vomiting, and pain. An expanded project for 2006 is in the planning phase, as are plans for pay-for-performance pilot programs.

Community Oncology Alliance (www.communityoncology.org)

The Community Oncology Alliance serves as a focused voice for community cancer clinics that provide the majority of care for cancer patients. This group is directly involved in national political process to effect appropriate payment reforms and to promote initiatives that enhance the quality, affordability, and accessibility of cancer care, the hallmarks of cancer treatment delivered in the community setting.

National Business Group on Health (www.wbgh.org)

This organization of large employers who purchase the bulk of healthcare for working Americans is committed to supporting the use of quality oncology programs. Its goal is to identify practices of excellence for its members.

National Committee for Quality Assurance (www.ncqa.org)

This independent, non-profit organization already has committees and groups working on quality oncology measures, with the goal of developing standards that practices can implement and measure themselves against and that health plans would then be evaluated on. Its goal has been to move forward with oncology standards by 2007.

National Quality Forum (www.qualityforum.org)

This organization was created to develop and implement a national strategy for healthcare quality measurement and reporting. It provides research on data for use in evidence-based guideline development. Look for reports later this year on end-of-life issues, pain management, treatment of small-cell lung and breast cancers, and others.

Evidence-based oncology guideline groups

These groups also regularly publish evidence-based cancer guidelines:

- International Oncology Network (www.iononline.com)
- National Comprehensive Cancer Network (www.nccn.org)
- National Oncology Alliance (www.noainc.org)

than those who do the least and drive the most patients from their network.

Where we go from here

Our challenge now is to rethink our practices, to embrace our traditional commitment to quality, and to articulate and document it so that consumers and payers can realize value for their healthcare dollars. Oncology professionals must then negotiate appropriate payments for quality oncology care. To that end, the Community Oncology Alliance (COA)

has formulated a plan of action. I chair its national committee on quality, safety, and pay for performance. This committee helps practices evaluate and implement programs in six major areas that affect the quality of cancer care we deliver daily:

1. Practice procedures

- a. Staffing: personnel training and credentials
- b. Evidence-based guidelines: review, adoption, updating, and implementing as available

c. Documentation: paper, templates, Pixis/Lynx, EMR solutions

d. Data collection: analysis and use for performance improvements

e. Comprehensive diagnosis and staging of all patients, treatment tracking by line of therapy, and performance status

f. Documenting goals of therapy

g. Safety guidelines adoption: implementation of and compliance with NIOSH and USP safety standards for staff and patients to ensure that chemotherapy is delivered safely.

2. Treatment of cancer and associated blood diseases

- a. Documenting the rationale for, standardizing the delivery of, and measuring the outcomes of cancer treatment for breast, colorectal, prostate, lung, lymphoma, ovarian cancer, and other malignancies
- b. Compliance with evidence-based guidelines
- c. Compliance with standardized chemotherapy protocols
- d. Outcomes and cost analysis
- e. Consent process for treatments
- f. Patient education

3. Management of symptoms and side effects

Throughout her career, Jimmie Holland, MD, has championed the use of these measures as quality indicators. She has worked tirelessly to develop and promote the tools that help oncology professionals recognize and measure distress so that it could be treated as part of a standard oncology care plan. Dr. Holland's NCCN-adopted, paper-based oncology distress thermometer tool assesses patients' physical, social, spiritual, and psychological distress.

Her efforts inspired the AIM Higher program, so named for the assessment, information, and management of such symptoms as anemia, neutropenia, nausea/vomiting, diarrhea/constipation, and depression/anxiety. AIM Higher is a national project involving 18 community practices, led by Supportive Oncology Services and The West Clinic in Memphis. In the program, patients use mobile computer tablets to communicate simply and quickly with their providers at each visit about psychosocial issues. Plans are under way to incorporate the tablets into electronic medical record systems by the end of this year to further enhance the documentation of these symptoms so that providers can easily and systematically address them.

4. Clinical trials

We need defined approaches in order to offer appropriate patients the chance to take part in clinical trials. Among the issues to address:

- a. Referral to sites where trials are available
- b. On-site trials with technology tools and specialized staffing or networking to improve access
- c. The ability to measure patient choices for trial participation, track eligibility, accrue patients, deliver complex trial care, and track outcomes

5. Risk assessment, prevention, and follow-up care

We need to define our approaches to risk assessment:

- a. Three-generation family history
- b. Policies for genetic risk education, counseling, testing, and informed consent

We need to define prevention programs or guidelines:

- a. Patients at high risk for breast and other cancers
- b. General risk reduction advice: diet, exercise, screening

We need follow-up care that includes the following:

- a. Giving patients copies of their records, dictations, or treatment summaries, as medical records are purged after 10 years
- b. Patient guidelines for health maintenance, cancer screening, and prevention. Our patients look to us for advice on: (1) diet, exercise, and use of statins for reducing elevated LDL-cholesterol levels; (2) specific screening recommendations for prostate, breast, colon, lung, skin, and other cancers; (3) minimizing sun exposure; and (4) smoking cessation and avoidance.

6. End-of-life care

As society and payers weigh in on the value of end-of-life care, we urgently need to gain patients' perspectives on the choices they and their families face when treatment has run its course or the focus should be

on minimizing symptoms. No area seems more in need of tools for better documentation. In developing quality programs in this area, we need to hope that barriers to earlier palliative and hospice care can be removed so that we can better incorporate those modalities into earlier phases of our treatment plans. By documenting the extent of appropriate care and the many discussions of patient options, appropriate payments can be established to cover the important, but time-intensive, coordination of care and the complex treatment plans needed to improve treatment at the end of life.

The time to act is now

In recent talks with COA members, Dr. Peter Bach—a senior adviser to Medicare on the quality of cancer care—said that *we need not wait* for the perfect program or final standards to be developed before taking steps to ensure that quality care is delivered at the highest level possible at each practice site. He encouraged groups to work together in supporting quality standards as the benchmark against which Medicare will develop newer payment methodologies. He assured us that he intends to work with all stakeholders to encourage and pay for appropriate quality care for Medicare recipients.

By working together, we can maximize our extensive experience and administrative talents and avoid having to reinvent the same wheel as we innovate and implement quality care programs in our practices. In leading this movement, we will get back into the clinic with renewed vigor and with the tools and payments we need to deliver comprehensive, high-quality cancer care that is accessible, affordable, efficient, and compassionate.

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