Pursuing quality care in 2008

Everyone, it seems, is trying to define it and deliver it. So what exactly is quality care, and how do we ensure that every patient receives it? The dialogue takes place here.

The pursuit of quality care has evolved from a desirable goal to a practice imperative. Although quality care results in good clinical outcomes using efficient processes that produce a cost savings, delivering it is not always easy. That was the consensus of panelists—representing physicians, administrators, insurers, and other third parties—who discussed the need to offer quality care as well as the best ways to measure it.

Session moderator Dawn G. Holcombe, FACMPE, MBA, president of DGH Consulting and executive director of the Connecticut Oncology Association, posed the first question: "Why can't we just continue to say we are doing quality care without proving it?" David H. Henry, MD, clinical professor of medicine at the Pennsylvania Hospital in Philadelphia, responded, "I should be able to tell the payer I'm following guidelines, and I am keeping costs down, and this will make a dent in a huge national budget item, but it's not that simple. We fly around with our hair on fire, but we still need to show that we are abiding by the rules. It is not enough for us to answer that we are."

From the payer's side, Ranae A. Dahlberg, BNS, RN, director of clinical services for UnitedHealthcare's Oncology Line of Service, said physicians often believe they are practicing quality care when they are not. "In evaluating our Herceptin policy," she said, "we audited patient charts and found that 12% did not overexpress human epidermal growth factor receptor 2 (HER2). This led us to change the policy for reimbursement, and we continue to find 12% of patients ineligible. We also discovered that a large number of pathology reports are difficult to interpret. We think that Herceptin is too often prescribed due to unintentional errors. It has been similar with erythropoietin-stimulating agents. When we began to ask for hemoglobin or hematocrit levels for authorization, usage dropped 30%."

Also speaking from the insurer's point of view was Dave M. Johnson, MD, regional medical director of Premera Blue Cross in Spokane, Washington. He commented that the large variation in clinical approaches is not efficient and does not consistently deliver quality care.

"You would be surprised, but we have data showing great variation in how you practice oncology," said Dr. Johnson, who practiced medicine himself until 12 years ago. "Take the same cancer, and oncologists are treating it differently, all costing a different amount of money." Quality care initiatives aim to reduce variation, which inevitably streamlines care and reduces costs, he emphasized.

Bruce A. Cutter, MD, a medical oncologist and the director of Cancer Care Northwest in Spokane, agreed that consistency is tied to quality. "Quality and efficiency are two aspects of the same thing. Variation is the enemy of quality. We need to become operationally excellent like never before," he said. "This involves data-driven processes and systems improvement."

As an oncologist involved in the administrative side of his practice, Dr. Cutter has concluded that the current system is unsustainable, from the point of view of quality and cost. "There is a critical and crying need to change the compensation model to encourage and reward quality and provide incentives," he said. "The acute illness model for compensation does not work in chronic diseases like cancer. Change is inevitable, but it is a question of who will drive it and what it will look like. Physician leaders have an obligation to lead the change in a value-driven fashion."

Ms. Dahlberg, of UnitedHealthcare, summed up the essence: "We want to reward clinicians for the quality of their patient care and outcomes, and not just for *giving* care."

Getting started

To kick-start the process of demonstrating quality care, a convincing argument must be made and heard, the panelists said. "We are often too quick to go to the 'how.' We need to step back and ask 'what' and 'why.' If you jump into the process, you will lose support," advised Dr. Cutter, who spearheaded a comprehensive quality care plan for Cancer Care Northwest with Premera Blue Cross and Dr. Johnson.

"First, understand that quality is important and that there is variation in quality within your practice. I would maintain that the biggest barrier to getting started is the physician culture. Staff *can* buy into this, if they see it as doing the right thing," Dr. Cutter emphasized.

Components of his "Foundations of Quality" program included clinical metrics and measurement of patient satisfaction, clinical pathways for optimizing care and determining outcomes, and a pay-for-performance contractual relationship between clinicians and Premera. The program has been a success.

"The key aspect was that we developed this jointly with a third-party payer," Dr. Cutter emphasized. "This was unheard of."

In his position as regional medical director for Premera Blue Cross, Dr. Johnson has helped other physicians and administrators get started as well.

He advised community oncologists to simply "pick up the phone and get a conversation started. Tell your story." But understand that this is not going to happen in one meeting. At insurance companies, we work in bureaucracies. We have to sell concepts up the ladder, and this can take an excruciatingly long time. Physicians need to know that the mindset of the corporate world is totally different from theirs."

Trust one another

In initial conversations between providers and payers, the focus should be on delivering optimal care. "Money should come last in the discussion," said Ms. Holcombe. Otherwise, gaining trust becomes difficult when physicians want to talk about *getting* more money, whereas payers want to talk about *saving* money, she pointed out. Physicians need to feel that payers understand what it costs to deliver drugs and services. "We can only get to the discussion on saving money after recognizing what it costs doctors to deliver care," she emphasized. "Additionally, such discussions are most effective with groups of area physicians and an interested payer and under antitrust laws; groups of physicians can only approach such discussions in a collaborative manner if the intent is to focus on quality and optimal clinical care. Financial issues can only be an offshoot of clinically integrated initiatives and peripheral to the main discussion—not the focal point."

Dr. Cutter added, "There needs to be assurance that this is not a one-way street. If my group felt the whole reason for change is to enhance the profit of the payer at our expense, the conversation would go nowhere." In his collaboration with Premera, money was not discussed until the end of the development process. "But for this to happen, there had to be trust and collaboration up front."

From the payer's side, the key is "transparency," Dr. Johnson said. "If you look at the cost of cancer care, it is in drugs and radiotherapy. Surgical and hospitalization costs are low, and the cost of seeing patients is low, compared to everything else. But oncologists have gotten a bad rap," he told the audience. "There is a tidal wave of new drugs costing huge dollars. As long as you hold onto drugs without transparency, you are a target."

Dr. Johnson said his company would rather pay oncologists for the work that they do, than for the drugs that they use.

Improving processes

Once there is an agreement to move forward with a quality care initiative, the next challenge is to determine what should be measured and how to alter processes. "You need someone who knows how to start setting things up, what you should be measuring, how you should be improving processes," Dr. Johnson said. This should involve input from various angles. "I recommend that you think in terms of 'we,'" he added.

Money is saved when processes are improved, the panelists agreed, but this is challenging. Dr. Cutter advised using clinical pathways as surrogates to clinical metrics. On the clinical pathways form, physicians enter the relevant clinical information, such as disease stage and patient performance status, and the pathways are tracked on Excel spreadsheets. When oncologists are "not on the pathway," there is a physician-driven internal mechanism for improvement.

"The use of clinical pathways eliminates the need to look at every measure. If you have quality pathways, you just need to know if you are on or off the pathway," he explained.

Arriving at data that will help develop clinical metrics is another matter. "Claims data are good for some things but not all," said Dr. Cutter, but for this they are damn near worthless." Instead, he and his staff identified the appropriate ICD9 codes from the practice management system.

Dr. Johnson added that the metrics must be doable. In developing their quality care program, he and Dr. Cutter questioned every data point and tossed out those they considered "too tough."

Quality care from other third parties

Elan Rubinstein, PharmD, a management consultant and principal of EB Rubinstein Associates in Oak Park, California, discussed how specialty pharmacies intend to contribute to the quality care movement.

Panel members Dr. Rubinstein, Ms. Dahlberg, Dr. Cutter, Dr. Johnson, and Dr. Henry

"Insurers see specialty pharmacies as a way to achieve greater control, trackability, and accountability of certain dispensed prescription drugs. These include drugs that may be very expensive, in short supply, have specific storage, handling, preparation and/or administration requirements, can only be dispensed through manufacturer-restricted networks, present complex transactions, or require monitoring of compliance," he said. They believe their benefits will include greater implementation of their coverage policies, better medication therapy management, improved trackability (because specialty pharmacy uses the National Drug Code basis rather

than J codes), and greater accountability through interaction with the specialty pharmacy.

But specialty pharmacy has reason to be frustrated with regard to the quality care mandate, Dr. Rubinstein noted. Specialty pharmacy does not have comprehensive or immediate access to patient records housed in the physician's office, and the patient typically does not come to the pharmacy to receive drug therapy (although specialty pharmacy-affiliated infusion suites are emerging).

"This means there is limited information available to the specialty pharmacy for the purpose of measuring quality of care," Dr. Rubinstein said, "and there is a limit to what we can accomplish. We have to request information from physicians. We have little data to deal with. We can't tell whether our efforts to increase compliance have a return on investment in terms of health care utilization. So there are problems."

From a specialty pharmacy perspective, the quality of care challenge is to access the necessary patient information and prescriber interaction, to better understand the patient's medical condition, to address changes in the patient's circumstances, and to do all this efficiently and in a timely fashion, he said.

How can payers improve?

The discussion gave oncologists the chance to air ongoing concerns with payers. Speaking for community oncologists, Dr. Henry acknowledged, "We do need to get our house in order, but how do we know this is happening at the other end? For example, I am interested in the use of erythropoiesis-stimulating agents [ESAs]. I visited a local large payer to talk with the medical directors over lunch. Frankly, I was surprised at their lack of understanding of the field of anemia, even among doctors. How do we know the payers are getting the education they need to make the right decisions?" he asked.

Payer representatives on the panel responded that their protocols are largely developed by physicians. Ms. Dahlberg reported that the oncology line of service at UnitedHealthcare has an advisory board of 12 practicing oncologists. "We have challenges but we are trying to incorporate practicing physicians into our service. We run our potential issues and solutions and policy procedures by them. To develop our ESA policy, we asked for their input. But we recognize that not all physicians may have knowledge on this particular issue, and we do bring educational material to them."

Dr. Johnson said Premera has three physicians on its board of directors, and they oversee quality. Physicians on their Pharmacy and Therapeutics Committee develop the formulary. "We have think tanks," he said. "Physicians—outside doctors—are running things."

Dr. Henry also wondered why many treatment decisions require a 45-minute phone call to the payer, after which 24–72 hours must pass before he receives approval (or denial). "Where is this information going? Who is deciding? Why so long?" he asked.

Ms. Dahlberg responded for UnitedHealthcare. "Our turnaround time is even more than 72 hours, and we recognize this as a problem. We just announced that we will begin using the National Comprehensive Cancer Network compendium as a basis for claims editing and efficient processing. For each diagnosis that is a 1, 2A, or 2B recommendation, the patient is eligible for coverage under a standard contract," she said. "If the proposed drug is not in the compendium, the case goes to medical review. We believe this is a strong move that will help doctors understand when they do and do not need to call."

Negative effects?

Is it possible that "quality care" could also have some negative repercussions? Panelists said they worry about discontinuity of patient care and "cookie cutter medicine."

As an example, Dr. Rubinstein noted that there are now specialty pharmacy-affiliated infusion suites. When patients are referred there for chemotherapy, are their complete medical needs being met (as in the oncologist's office), or will they become victims of a discontinuity of care? "We are talking about quality, and this could make matters worse," he suggested.

Ms. Holcombe said she worries about the death of innovation in treatment. "With comparative efficacy, when the 'best' regimens are instituted, doctors will be encouraged to react in the same way to all patients and drugs. Today, oncologists have the freedom to treat patients as they wish and to consider the needs of the individual."

Dr. Rubinstein agreed. "When you tie quality to payment, it ends up being like a hammer: not flexible. From a payer's perspective, it's easy to implement. You pay providers X dollars if they meet X criteria for X percentage of patients. But with a hammer, providers must be concerned with practice economics, and they change how they make clinical decisions. I am concerned about physicians self-regulating to the point where they make decisions that are too conservative for individual patients."

A call for more collaboration

Healthy collaboration between all players is needed, the panelists acknowledged. Small practices need to team up with larger practices, everyone needs to share data, and feedback needs to become routine. One session attendee asked for more collaboration on a national level, which she hopes will reduce the burden of working with individual payers. "We need a task force to sit down with the Community Oncology Alliance and think outside the box," she said. "We know we need to do something. It's time to work out a model that will fit all the individual carriers. The time is now, and it is critical."