AT THE CROSSROADS

What Your Oncology Practice Can Do *Today*

In simple terms, all potential pay for performance (P4P) programs or quality measures boil down to proving the "value" of the care or services provided to, in turn, justify the "cost" of providing the services. This concept is difficult for oncology practices to grasp because so much of the cancer care process has been *intuitively* quality and value driven, but rarely *objectively* justified.

Undeniably, the costs of healthcare are rising. While consumers still expect access to all levels of healthcare, the question of "cost" versus received "benefit" is being broached by employers, payers, and even patients. This debate will likely intensify in the coming years, fueling public and private choices for treatment and providers.

In this "cost of care" debate, payers are positioning themselves as stewards of the employers' and employees' premiums. In the past, payers were reluctant to draw many lines regarding treatment choices or access to treatments, especially in oncology. Now, the healthcare community is seeing an increasing rush toward consumer directed health plans, which place a greater responsibility on the patient for care choices and treatment costs. This movement, in turn, is making patients more aware of the costs of choices, and more willing to decline care or treatments based on perceived "value" vs. "costs."

The Value Message of Oncology Care

Very few oncologists believe they provide poor quality of care. Yet, if a payer asked your oncology practice today to "prove" that your physicians provide good quality care, or offered your practice contractual changes that forced physicians into a defensive position of "proving" that a certain level of reimbursement is essential to allow your practice to continue to operate, could your practice compile the necessary documentation? Few practices could.

Most payers, in the absence of hard data from practices, tend to believe that there may well be a need to manage oncology in order to ensure effective, efficient care the first time. At the same time, many healthcare organizations believe they can justify an investment in disease management of oncology, formulary, and even payer guideline and treatment recommendations for care.

A former medical director for a major payer described his willingness to pay a third party for disease management of oncology patients in active treatment. (Unfortunately, few oncologists are actually running these third-party disease management programs.) Some of the services he expected this third party to perform included:

- Inbound and outbound communications with patients regarding their symptoms
- Education and counseling of patients regarding their role in their own care.

These third-party disease management programs are also expected to provide a myriad of other services—all of which are already an essential part of the routine oncology care provided in private practices across the country.

So why then are payers willing to pay another entity to provide these services? The answer is simple: these third-party vendors track their interactions, document the results and outcomes of their interventions, and quantify the resultant savings from "effective care management." In other words, these third party entities can fully document to payers exactly what services they are performing and establish a return on investment for those services. The take home message is that oncology practices need to develop that same mindset.

Oncology practices can prepare for the "value" and "proof" environment by building their own quality profile and vision for quality. First steps include:

- Developing practice standards
- Assessing your practice's current situation
- Educating staff about P4P and what it will mean for the future of the practice
- Participating in P4P and quality care demonstration projects
- Developing a system for collecting, measuring, and assigning value to quality care data—a Quality Care Portfolio.

Turn to page 29 for an eight item P4P "To Do" list for oncology practices.

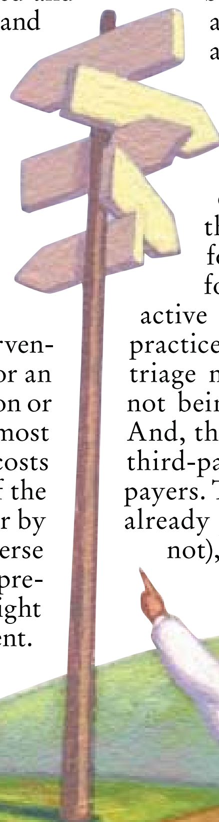
See the Invisible

You have probably heard some variation of the saying: "Only those who can see the invisible can do the impossible." Much of the quality measures that practices will want to track are part of their normal day, but "invisible" in the traditional mindset. For a practice to adapt and survive in a P4P and "quality" focused world, those "invisible" quality measures need to become "visible." Let's look at one simple, but common example involving triage care management. Most practices are likely to use a variation of this scenario: When a call comes in from a patient, the nurse or physician talks with the patient, assesses the situation, and makes a "treat, advise, or handle" decision, and then goes on to the next task. The call and/or discussion may or may not be

by Dawn Holcombe

entered into the chart. Today, the "management of calls" is accepted as another unreimbursed part of the normal practice routine.

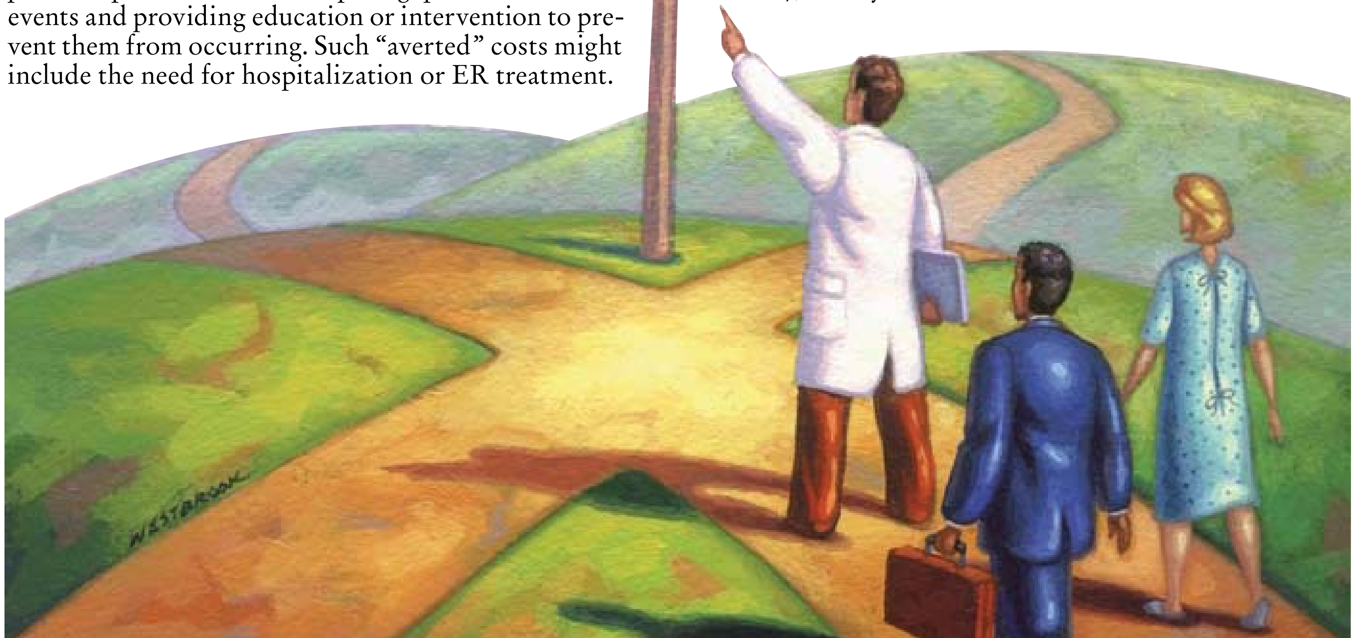
For a patient under active treatment, "seeing the invisible" requires that practices see this type of call and discussion as a measurable event. Either the patient was unprepared and sought advice, or the patient was prepared and sought advice and/or care. Using years of experience and knowledge of the patient's current treatment regimen and history of care (documented and undocumented), the practice professional assessed the situation, and made a determination of future action. That "future action" may have been sufficiently handled by communication over the phone; or the call may have led to a request to see the patient in the practice; or advised the patient to seek immediate medical treatment in the hospital or ER.



Each of these actions has a financial component: the time for the triage, counseling and intervention; the time and resources used in the practice for an unscheduled visit; and the cost of the hospitalization or ER treatment. For payers, however, perhaps the most important financial component is the *averted* costs that the call precluded by effective management of the patient and his or her symptoms during the call, or by practice professionals anticipating potential adverse events and providing education or intervention to prevent them from occurring. Such "averted" costs might include the need for hospitalization or ER treatment.

Documenting and evaluating the volume, purpose, disposition, and effectiveness of something as simple as the inbound and outbound phone calls in a practice, not only provides information for its Quality Care Portfolio, it allows the practice to embark on a continuous quality improvement process. For example, if a number of calls are for nausea management, a deeper analysis could reveal that anti-emetics guidelines and resources are not being used effectively by patients, which has financial and quantifiable effects on the practice.

Practices that perform such analyses and improve their triage management programs can easily establish the economic "value" of these actions to payers. If, for example, the costs for an ER visit were $300 and hospitalizations for the most common side effects for patients in active treatment ranged from $13,000 to $25,000, a practice can easily assign an economic value to a solid triage management program. Currently practices are not being paid for these triage management services. And, these are precisely the type of services that some third-party organizations are already shopping out to payers. Take home message: Practices cannot prove they already provide this service (whether it is done well or not), if they do not measure it.



ILLUSTRATION/ERIC WESTBROOK

Where Does a Busy Practice Start?

Unless payers are banging on your door today, you have some time to prepare and move into the quality measurement and assessment mode. Physicians run small businesses. They would not waste precious resources on activities, staff, or services that do not make a contribution to effective oncology care and management. As mentioned above, a good starting place for practices is to first perform an internal assessment and look for gaps in quality care. The next step is to look at those services deemed so essential that they are provided even in the face of no reimbursement.

These analyses need not be lengthy. Tracking activity for one or two weeks could provide valuable information, especially when annualized. Start with a component that has an obvious impact on the value or cost of care. Then, ask and answer questions to reveal the "invisible." Practices can begin by looking at the following areas:

- Pharmacy facilities (drug inventory, acquisition, and handling costs).
- Oncology treatment planning.
- Consistent and mapped end-of-life discussions.
- Pharmacoeconomic analyses on regimens, treatments, and/or choices for palliative care vs. treatment.
- Fully informed patient consent (an essential component of consumer-directed healthcare).
- Calls to and from patients and families, identifying what is asked, what adverse consequences were avoided, and any trends.
- Unplanned patient visits—again identifying what is asked, what adverse consequences were avoided, and any trends.
- Patient education, support, counseling, symptom management (analysis should include outbound and inbound counts, results, and outcomes).
- Patient compliance with treatment regimens.
- Rate of ER visits and hospitalizations, including the purpose and/or cause. This information should then be analyzed for trends and to improve patient management.
- Variation from quality care standards and the reasons for these variations.
- Rate of clinical trial accruals and the percent of clinical trials offered.
- Compliance with lab testing prior to use of certain drugs (HER2, hematocrit levels, etc.).
- Patient compliance with oral prescriptions.
- Utilization of imaging, diagnostics, and hospitalization.
- Use of growth factors, standards, and lab work.

The Future of Cancer Care

Today, most cancer care is delivered in independent physician offices; however, the future reveals a world where measurement, outcomes, and continuous validation and proof of quality care are likely to become the norm. Unless independent oncology practices quickly develop an infrastructure for evidence-based medicine, we may see an evolution away from private offices into hospital- or corporate-owned cancer centers strategically placed around the country.

Obviously, continuous quality measurements and operational standards will be difficult to achieve without some technology infrastructure; however, practices can begin by seeing the "invisible," and then measuring, documenting, analyzing, and improving daily care. These steps will help you tomorrow in your payer negotiations related to changing fee schedules, and in a few months when specific P4P programs are unveiled for oncology. No matter the timeline, the future is in your hands and will depend

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Pay for Performance: A Timeline of Milestone Events

2001... The Institute of Medicine (IOM) releases a report "Crossing the Quality Chasm," which calls for fundamental healthcare system reform.[1] This landmark report clearly identifies deficiencies and problems with the U.S. healthcare system, including sub-optimal healthcare quality, compromised patient safety, and significant waste of dollars and resources within the system. One of the key principles stemming from this IOM report is the concept that doctor and hospital performance data should be transparent, standardized, objective, and evidence-based.

2001-2003... The Centers for Medicare & Medicaid Services (CMS) rapidly embraces the challenge to ensure quality care for its beneficiaries—starting with the launch of an initiative with the National Committee for Quality Assurance (NCQA), the AMA Physician Consortium for Performance Improvement, the National Quality Forum (NQF), and other programs to develop quality measures for the ambulatory care setting. Now numbering more than 30, these measures cover several specialties and have become national standards for public and private quality programs. (Detailed information on these measures is available at *www.ncqa.org*.)

2004-2005... In 2005, CMS issues a Medicare *Quality Improvement Roadmap,* which outlines a direction which, in concept, few find hard to support. The Roadmap's basic premise is to shift from the current payment system that pays for what was done "to" a patient (rewarding high volume and possibly poor care due to misalignment of incentives) to a future payment system that would pay for what treatment does "for" a patient (rewarding good care by aligning incentives toward that goal). The Roadmap's vision is simple: *The right care for every person every time.* (For more on the CMS Quality Improvement Roadmap go to: *www.cms.hhs.gov/center/quality.asp.*)

In support of this vision, CMS develops several pilot projects, predominantly in primary care and internal medicine. These quality projects, including the Premier Hospital Quality Incentive Demonstration, which involves acute care hospitals, and the Physician Group Practice Demonstration, which involves 10 large

P4P "To Do" List

STEP 1: ***Set the standard.*** Develop a quality mission statement and focus for the entire practice. Every action, every word of every person in the practice should be cognizant of that quality standard.

STEP 2: ***Assess your current position.*** An ideal first step for practices is a self assessment. What is your practice doing now? What quality care data already exists? What is missing?

STEP 3: ***Participate in ASCO's Quality Oncology Practice Initiative (QOPI) project.*** This project also involves a self-assessment that is completed twice a year using chart review and reporting. QOPI benchmarks provide a launching pad for practices not sure where to begin in either proving existing quality or fixing gaps in quality care. Details can be found at *www.asco.org/qopi.*

STEP 4: ***Standardize, measure, document.*** Identify where variation exists and how it can be reduced. Know what your practice can quantifiably measure and what your practice and payers can learn from the information. Beyond documentation ("proof"), most payers will want your practice to be able to place a "value" on the services you provide to your cancer patients.

STEP 5: ***Prepare a Quality Care Portfolio.*** Start a profile of your practice that proves the value of the quality you provide. Be sure to identify both the cost and value of the care you provide. This portfolio will be an important tool during payer negotiations and can be used as a springboard for demonstration projects.

STEP 6: ***Identify and educate key employers in your region.*** Many payer policies are really driven by employer demands and expectations. Educating employers brings an awareness of oncology issues and quality further upstream.

STEP 7: ***Establish a local presence regarding "quality" and leverage networking affiliations.*** Data is useless in a vacuum. No single practice will generate all the data it needs, or be able to survive, without collaborating with other practices into larger quality units. The guiding factor can be clinical integration and does not necessarily require financial or operational integration. Common clinical and operating processes are not anti-competitive and actually serve the greater good by being pro-quality for the market. State associations or regional and/or national networks of private physician practices collectively embracing evidence-based medicine and common approaches to quality care could provide the impetus to keeping community, rather than corporate-owned cancer centers, the locus of cancer care.

STEP 8: ***Make educated business decisions about payer programs and fee schedules.*** Know your own breakeven points, and use your "Quality Care Portfolio" to validate your care in negotiations.

PHOTOGRAPH/PHOTODISC

multispecialty group practices across the country, start to yield significant results. (For more on the design and progress of these demonstration projects go to: *www.cms.hhs.gov/DemoProjectsEvalRpts/MD/list.asp* and *www.qualitynet.org*.)

2006-2007... The Tax Relief and Health Care Act, enacted in December 2006, includes a transitional, voluntary Medicare P4P reporting program slated to begin July 1, 2007. Physicians who opt to participate in this voluntary program will report on certain quality measures to receive a bonus of up to 1.5 percent of their total Medicare payment during the reporting period of July to December 2007. The P4P program will use clinical measures that are to be determined by April 2007. The bonus payment will made as a lump sum payment after the reporting period ends.

Recently, CMS announced the 2007 launch of a new pay-for-performance project for solo and small-sized physician practices in Alaska, California, Massachusetts, and Utah.[2]

Oncologists Weigh In on P4P

In April and May of 2006, Oncology Therapeutics Network (OTN) conducted an online survey of community-based oncologists. The topic: pay for performance initiatives. The OTN survey used a random sample of physicians from the Supportive Oncology Services database. In brief, here's what the survey respondents had to say.

- 94 percent believe P4P initiatives will help improve the overall outcomes of cancer patients
- 81 percent believe P4P initiatives will become a reality in oncology
- 80 percent believe they will participate in a P4P initiative within the next 12 months
- 80 percent stated they would adopt the use of evidence-based standardized treatment guidelines as a part of P4P initiatives
- 70 percent believe regimen standardization will help control treatment costs, improve patient outcomes, increase practice efficiencies, and lead to the availability of better outcomes data
- 65 percent agree that standardized P4P initiatives, with performance measures that can be quantified, are one of the better ways to provide quality care in oncology.

A "History" of Pay for Performance

Headlines in the managed care and general press are touting new initiatives in pay for performance (P4P) and quality reporting. While some quickly fizzle out, most of these initiatives are laying essential groundwork to revamp the healthcare payment system. The role of P4P is two-fold: to improve the quality of care and to help contain the cost of care.

Government and private payers are concerned that escalating healthcare costs coupled with projected increasing demands for healthcare services will mean there will not be enough dollars to continue to fund the healthcare needs of the country. Today's payers also believe that precious dollars, resources, and lives are being "wasted" due to inefficiencies in the current healthcare system. For these reasons, programs that reward quality, efficiency, and choosing the "right" care the first time are seen as the only way to equitably balance the funding versus the need, and to eliminate unnecessary waste of our precious healthcare resources.

Meanwhile, in the private sector, initiatives focused on quality and pay-for-performance have mushroomed, driven by regional and national business and healthcare coalitions, such as the Leapfrog Group, Bridges to Excellence, and the California Integrated Healthcare Initiative. Private payers are building physician performance reporting programs, performance programs, or limiting payment subject to performance of specific measures and actions.

Enter Oncology

To date, P4P has not dramatically altered how cancer care is delivered; however, that situation is rapidly changing. The recurring frustrations and funding challenges related to the Medicare payment formulas for physicians, and the transitional nature of the ongoing modifications of Medicare reimbursement for oncology, are leading to a crescendo of efforts to tie reimbursement of physicians to some indication of quality, as early as this year. Private payers tend to mimic Medicare payment policy in varying degrees. Therefore, it is likely that within one year of a Medicare P4P program that clearly ties some portion of oncology revenue to some reporting process of quality measures, oncology practices could find a significant percentage of their private payers requiring participation in a wide variety of programs in order to receive some portion of their current reimbursement. Take home message: practices need to recognize this reality *now* and take steps to prepare for survival in this new P4P and Quality Reporting environment.

For medical specialties, such as oncology, that have not yet been affected by the pilot P4P and quality reporting programs of the last few years, the biggest challenge is that P4P programs (in both the public and private sectors) have a steep learning curve on the execution and management end. Each year, the sophistication of the measures and outcomes expectations grows exponentially. Practices that have not yet begun to consider these quality measures and reporting issues may face significant financial risk—if the programs in their region begin to unroll and the impact of payment policy changes go into effect faster than these uninitiated practices are able to get up to speed and respond.

Lessons Learned and Implications

As the P4P and quality reporting trends gather momentum and a myriad of federal and private sector programs are developed, it's possible to outline some "lessons learned" and also consider the implications of a rapidly escalating learning curve for oncology practices that are on the cusp of integration into programs that measure, benchmark, or otherwise shape care and treatment.

The Federal Sector. Evolving government programs have experimented with various methods of data reporting, all focused on measures linked to quality in hospital and primary care settings and chronic care and disease management. These programs usually involve a slow implementation, looking at utilization questions in successive phases. While well-intended these programs are not always designed with consideration for the operational realities of a busy private practice. Often a federal program will begin by offering pay for reporting, and then evolve into a pay-for-performance mode.

The Private Sector. Private payer P4P programs are usually different from government efforts. For example, these P4P programs tend to:

1. Be more oriented to utilization measures
2. Focus on specific episodes of care
3. Possibly integrate some component of pharmacy management and/or integration.

Private payer P4P programs may give a nod to quality—but only when there is a specific measurable fiscal impact—and can be executed in a faster time frame than federal programs. Additionally, these P4P programs can jump into punitive processes that restrict access to payment unless reporting/performance measures are fulfilled, rather than developing a system of reward upon execution.

on your practice's ability to build your own Quality Care Portfolio—outlining both costs and value for payers.

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