Quality Care, Outcome, Cost... A Complex Balance for Hospitals

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In recent years, various configurations of pay for performance (P4P) have appeared—most often in primary care settings. The diverse and often complex nature of cancer care has made P4P applications for oncology far less straightforward.

But this situation is about to change. To date, oncology-specific P4P structures have yet to be determined, but P4P for oncology is undoubtedly headed our way. What might an "ideal" oncology P4P program look like? In our view it would include cancer care of the highest clinical quality that is delivered in an efficient, accessible, timely, comprehensive, patient-centric manner. Ideally, such an oncology P4P program would reward those who provide care that is multidisciplinary, longitudinally well coordinated across all treatment environments, and delivered in a positive, pleasant, and supportive environment.

Implemented effectively, P4P can be an important force for improving cancer care in the U.S. But ongoing dialogue—and a great deal of it—is key to ensuring P4P evolves into a viable system that appropriately reflects the relationship between evidence-based patient outcomes and the quality of care provided, in balance with cost-containment objectives.

Two looming questions remain: How will P4P metrics in oncology be determined and by whom?

P4P and Hospital-based Cancer Centers

Because many hospital-based cancer centers offer many of the components of high-quality care listed above, these programs may be excellent arenas for early implementation of P4P. Hospital-based cancer programs typically offer:

- Medical records maintained at the highest hospital standards.
- A full range of patient services including, for example, screening and diagnostic imaging, chemotherapy, radiation therapy, and pathology.
- Access to a range of patient and family education, complementary therapies, and patient survivorship and rehabilitation services.

In addition, hospital cancer centers can implement comprehensive quality assurance programs that measure and manage the full range of patient care services provided; the timeliness of access to care (including after-hours); the clinical quality of care; the quality of patient service; and longitudinal coordination of care—both internally and with other care providers.

Complexities of Cancer Care

The diagnosis and treatment of cancer is complex—so too are efforts to develop and implement oncology specific P4P programs.

Consider the following examples from the primary care setting. In the primary care setting, guidelines clearly state that all women should have a Pap smear and all individuals 65 years or older should be immunized for pneumonia. Once the Pap test is performed or the immunization is given, the care guideline is fulfilled. Equally straightforward are relatively unambiguous cases, such as strep throat. Essentially, one form of treatment exists, unless the patient is allergic to penicillin, and the care guideline is met by prescribing penicillin for 10 days.

Cancer does not fit this simple model. Instead of a single disease with one specific treatment, cancer comprises from 130 to 150 diseases, with varying causes and treatments. As a result, every cancer patient's care is different. Cancer treatment is based on a series of approaches that may be specific to the cancer diagnosis, but also tailored to the individual patient. For example, some treatment approaches may be appropriate for a patient with normal cardiac function, but inappropriate—and even dangerous—for a patient with congestive heart failure. Case in point: a lung cancer patient whose cancer impacts the right lung and has spread to the bone. Even at this level of specificity, there is no one single treatment option; rather, providers may consider eight or nine treatments—with some being better tolerated by the patient than others.

As another example, six months of chemotherapy is

the "standard of care" for a patient with colon cancer that has spread to the lymph nodes and whose tumor is removed. However, a patient who has liver disease or is on dialysis and cannot tolerate chemotherapy will require a different course of treatment.

When a patient enters the cancer center, the doctor does not yet know the care pathway because it depends on a range of factors, including the results of tests, radiology, surgical options, and chemotherapy, as well as other aspects of the patient's physical condition. Only a few diseases in oncology have absolute pathways for care, and P4P indicators will need to take these distinctions into consideration.

The "Changing" Face of Cancer

Patient management guidelines that are developed from evidence-based patient outcomes are vital to quality care for cancer patients. At the same time, with cancer treatment in particular, providers are always learning new information. The vast majority of oncologists are acutely aware that it's not what they already know, but *what they learn next* that enables them to provide the most effective and up-to-date treatments. Care standards should be updated on an ongoing basis to help ensure that oncologists transform the latest discoveries and insights in cancer management into improved patient care.

P4P opponents and skeptics fear that performance measures could potentially become so rigid as to result in inappropriate therapies, or that P4P standards will "morph into a clinical cookbook" and restrict clinical judgment.[1] As discussed above, "knowing how" to treat cancer according to an appropriate clinical guideline does not take into account the idiosyncrasies in the overall clinical condition of an individual patient. Thus, guideline-recommended-therapies may not automatically apply to a given patient.

Physician Buy-In

Although evidence-based standards are important, they are only a small part of the practice of medicine. Ultimately, the successful P4P system will also reward the "human" qualities of physicians that patients continue to seek.[1] For this reason, we believe that the right vision and supporting structure will enhance not only physician buy-in to P4P, but also the delivery of quality cancer care that is as comprehensive as it is compassionate.

Obviously for any P4P application to succeed, physician support is essential. Yet, understandably, physicians accustomed to traditional payment arrangements have mixed reactions to P4P. In 2005, when the Center for Studying Health System Change examined 12 nationally representative communities, positive responses to P4P were found most often in larger physician groups. In contrast, in markets dominated by small physician practices where quality-related payments were virtually non-existent, P4P met with skepticism. Only two of the communities—Orange County, California, and Boston, Massachusetts—had thriving physician P4P programs. Yet, in both, physicians still voiced concerns related to "the burden of reporting" and an overall perception that "P4P means a little more money and a lot more work."

Characteristics of "Quality" Care

High-quality cancer care may not always result in desirable patient outcomes. The best we can do is to ensure that each cancer patient is on a specific path that will lead to the most appropriate treatment. The treatment path, however,

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is only part of a complex "quality" equation that encompasses patient satisfaction and the overall ambiance of the care. For example, if a patient is experiencing excessive nausea with chemotherapy—even though treated according to an appropriate care guideline—the patient is not receiving the highest quality of care. In such cases, providers should consider going outside the guideline to prescribe the appropriate medication to relieve the nausea.

Effective symptom management—including the managing of cancer pain, fatigue, depression and anxiety—is an extremely important component of quality clinical cancer care. Everyone cared for in a hospital-based cancer center should have access to social workers, dietitians and psychological and/or psychiatric services.

In addition, the standard of care is reduced if overcrowding at a cancer center results in a four-hour wait to register for chemotherapy. And, while pristine facilities are admirable, if the right patient cannot get to the right procedure and the right professionals at the right time, quality of care suffers. In our opinion, personal support and user-friendliness are absolutely essential to the continuum of quality cancer care and must be at the heart of any oncology P4P program. Ultimately, kindness, compassion, comfort, and convenience are the salient characteristics of care that ensure patients come in (and come back) to receive the care they need.

Community cancer centers should also seek to ensure that all patients receive appropriate palliative and end-of-life care. This care should be delivered in the environment of the patient's choice and be well coordinated among the cancer center, inpatient hospital, home, and hospice care providers. Lastly, currently millions of cancer survivors suffer from a myriad of physical, social and psychological issues—many of which remain unresolved. Ensuring that cancer survivors, as well as their family members and caregivers, receive effective services and are equipped with the necessary skills to navigate through the various stages of survivorship should also be included in future cancer care standards.

EMR's Role in P4P

An effective oncology specific P4P program will rely heavily on four key documentation issues:

1. Information about each patient's diagnosis and disease stage
2. The active treatment plan each patient received, including how it conformed (or did not conform) to accepted national clinical practice guidelines
3. Patient performance status and major co-morbidities that affected active treatment delivery decisions
4. Important patient outcomes, such as information about the appropriateness and effectiveness of supportive care, symptom management, palliative and end-of-life care services.

In the paper-chart world, obtaining this documentation is usually extremely difficult, resource intensive, and costly. EMR adoption, on the other hand, allows key clinical quality indicator data to be routinely entered into the electronic system, and the resource costs associated with retrieval, aggregation, analysis, and reporting of these clinical quality indicators will be greatly decreased.

A Proposed 'Phase 1' P4P Program for Hospital-based Cancer Programs

Based on the available literature, cancer quality of care definition and measurement efforts reviewed above, we suggest the following components for an early ("Phase 1") hospital cancer P4P program:

1. ***Accreditation***—The program has ACOS CoC accreditation appropriate to its program classification and separate accreditation for any specialty programs (e.g., breast cancer).
2. ***Chart Information***—All patients should have cancer diagnosis and staging information entered in their chart prior to the beginning of the center's first active treatment regimen (excluding emergency patient treatment).
3. ***Multidisciplinary Care***—A high percentage of newly diagnosed (analytic) center cases should be presented to a multidisciplinary team prior to the initiation of the patient's first treatment regimen. Case presentation to the multidisciplinary team is particularly useful for unusual cases and/or for cases where the initial active treatment plan is outside the boundaries of accepted national clinical practice guidelines.
4. ***Safety Processes***—The program must have in place robust safety processes for medication (with special emphasis on chemotherapy safety) and for radiation therapy.
5. ***Quality Indicator Dashboard***—A "cross-cutting" Quality Indicator Dashboard (as suggested by the Oncology Roundtable[1,2]) must be utilized to measure at least one quality indicator in each of the major Dashboard categories (e.g., patient communication, diagnosis, multidisciplinary care, outcomes, pain control, palliative care, and symptom management).

Oncology P4P Metrics

In "Does Pay-for-Performance Improve the Quality of Patient Care," a systematic review of 17 original studies published over a 25-year period (categorized according to incentive level and type of quality measure rewarded), the authors assessed the effect of explicit financial incentives for improved performance on measures of healthcare

Quality Initiatives—Basis for P4P

One challenge to implementing P4P in oncology is defining "quality" in cancer care. Many prominent organizations have been actively involved in defining cancer care quality standards, which could serve as the basis for P4P programs. While some of these quality standards are specific to the hospital cancer program or office-based/freestanding environment, many are applicable across the provider spectrum. Most clinical standards focus on the process of care (i.e., the appropriateness of care) rather than on patient outcomes.

Some of the organizations spearheading efforts to develop quality care initiatives include the following:

■ ***The American College of Surgeons Commission on Cancer (ACOS CoC).*** These hospital cancer program standards are outlined in *Cancer Program Standards 2004: Revised Edition*, which was released in March 2006. Implementation of these standards was required of all CoC-approved cancer programs beginning Jan. 1, 2006. These standards are also available online at: *www.facs.org/cancer/coc/cocprogramstandards.pdf.*

■ ***The American Society of Clinical Oncology (ASCO).*** This group has developed clinical practice guidelines based on expert recommendations on the best practices in diagnosing and managing a variety of different diseases. ASCO's guidelines also include useful tools to streamline treatment at the point of care.

ASCO has also undertaken additional quality initiatives, including the National Initiative on Cancer Care Quality, the Quality Oncology Practice Initiative, and the development of a chemotherapy treatment summary. While these efforts have focused on the office-based practice environment, most of these initiatives are also applicable to the hospital cancer center environment.

Visit *www.asco.org* for more information.

■ ***The Association of Community Cancer Centers (ACCC).*** ACCC's *Cancer Program Guidelines* are not standards; however, this resource tool assists cancer programs in developing and/or maintaining a comprehensive interdisciplinary program reflecting the optimal components for a cancer program. ACCC's guidelines are available online at *www.accc-cancer.org/PUBS/pubs_cpguidelines.asp.*

■ ***The Centers for Medicare & Medicaid Services (CMS).*** Both the Agency for Health Research and Quality[1] and the National Quality Forum[2, 3] have been involved in the development of oncology quality of care standards that are being used by CMS in its oncology P4P initiatives.

In 2005, CMS initiated an oncology P4P demonstration project focusing on the office practice environment, and, in 2006, CMS ran a second, extensively revised oncology demonstration project that, in essence, involved pay for reporting. A transitional, voluntary Medicare P4P quality reporting program is underway this year. Medicare physicians who participate in this program will receive a bonus payment for reporting on certain quality measures. And, CMS has already announced its intention to implement a more widely based oncology P4P program in the near future.

■ ***The National Comprehensive Cancer Network (NCCN).*** This organization has developed clinical practice guidelines that cover more than 97 percent of all cancers. *The NCCN Clinical Practice Guidelines in Oncology* address cancer detection, risk assessment and reduction, and supportive care areas such as nausea and vomiting, distress management, cancer-related fatigue, and cancer pain management. These guidelines can be accessed online at *www.nccn.org/professionals/physician_gls/default.asp.*

■ ***The Oncology Nursing Society (ONS).*** This group has also created clinical practice guidelines related to diagnosis, treatment, supportive care, symptom management, and palliative/end-of-life care for cancer patients. Visit *www.ons.org* for information on ONS resources.

References

[1]U.S. Department of Health and Human Services Agency for Health Research and Quality. *Evidence Report/Technology Assessment # 61: Management of Cancer Symptoms: Pain, Depression, and Fatigue.* AHRQ Pub. No. 02-E031, July, 2002.
[2]The National Quality Forum. *National Voluntary Consensus Standards for Symptom Management and End-of-Life Care in Cancer Patients*; 2006.
[3]The National Quality Forum. *National Voluntary Consensus Standards for Diagnosis and Treatment of Breast & Colon Cancer*; 2006 (Under active review; not finally approved as of Jan. 9, 2007).

quality. The article notes that "the best process-of-care measures are those for which evidence shows that better performance leads to better outcomes."[2] Also, that "process-of-care measures may be more sensitive to quality differences than are measures of outcomes, because a poor outcome does not necessarily occur every time there is a quality problem."[2]

These findings are especially profound when comparing oncology to other specialties. In cardiology, for example, hospital inpatient mortality rates are published for 30-day, six-month and one-year survival rates following coronary bypass surgery. But outcomes are different in cancer care. If a tumor shrinks even though the patient does not survive for five years, the outcome is not necessarily a bad one. Conversely, in cardiac surgery, if 20 percent of patients die in the first 30 days, something is wrong.

The study also suggests that incentives could be based on a combination of a process-of-care measure (such as documenting smoking cessation advice) and an outcome of interest (like tobacco quit rates). This approach could avoid

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basing incentives solely on outcomes that may be relatively rare, difficult to achieve, or somewhat beyond the control of the provider and, thus, "capitalize on the advantages and complementary nature of both types of quality-of-care measures."[2]

Who Should Develop P4P Metrics?

We believe a general national oncology P4P program could be developed—ideally through the collaborative efforts of a consortium of stakeholders that collectively ensure a balanced voice. Providers from both hospital and freestanding office environments should be engaged in the process. Input from professional and provider organizations is also essential. These organizations and many others have either already developed—or are in the process of developing—quality metrics for oncology that could serve as a foundation for P4P programs. Equally vital is participation from payers, employers, cancer survivors' organizations, CMS (which has already applied standards to the hospital environment that are working effectively for those specific settings), and those organizations that have worked with CMS in developing and implementing P4P programs.

Given the many quality standards and measurement systems already in place, P4P dialogues should focus on unifying multiple participants and achieving balance. For example, numerous P4P programs organized by multiple payers and applied to individual providers could easily overwhelm providers' quality management efforts and reporting resources, and ultimately be counterproductive. Another concern is that some payers' P4P programs may focus too heavily on cost containment, rather than on maintaining the delicate balance between quality improvements and cost containment objectives. Above all, as noted by John H. Armstrong, MD, Secretary of the American Medical Association (AMA), "The primary goal of any pay-for-performance program must be to promote quality patient care."

The Future of P4P in Oncology

Moving forward, we should remain mindful that P4P can uphold the vision of ongoing quality improvement in patient care and in patient satisfaction. To ensure this vision, oncology P4P programs should be introduced in phases, initially focusing on a small number of quality measures for key cancer services, affording providers optimal opportunity to adapt. Once success is achieved in initial phases, additional measures can be added incrementally, while remaining vigilant that providers' quality management resources are not overloaded.

Ultimately, P4P programs should become an effective means for further enhancing the quality of care provided by U.S. cancer care providers, improving patient outcomes, fostering stronger physician-patient relationships, and containing costs for the long-term benefit of the U.S. healthcare system—and the people who rely on it.

P4P Preparedness: The Aptium Oncology Approach

The multidisciplinary team approach for treating cancer patients is integral to Aptium Oncology's network of hospital-based outpatient cancer centers. Each Aptium-managed center brings together a group of cancer specialist physicians, oncology nurses, and other clinicians who collaborate and deliver core clinical services in a central location. This broad offering of services includes access to clinical trials and affords each patient the benefit of a group of physicians—many minds—working together, educating each other on the latest treatment developments. Elements of high-quality outpatient cancer care central to the Aptium model include:

- Extended infusion center hours of operation (ideally 24/7) to ensure continuity of patient care and reduce after-hours visits to alternative care providers (including the hospital ER) for urgent or emergency care.
- Coordinated provision of patient information, care planning, and care delivery for all cancer center patients across all cancer care provider environments (cancer center, hospital inpatient, office-based/community centers, home and hospice care providers) throughout all disease stages.
- A high level of patient and family education materials and services including formally designated Patient Resource Centers.
- Ongoing patient satisfaction measurement benchmarked against a national database.

Aptium's network of cancer centers share clinical, technical, and administrative resources and best practices. This sharing accelerates learning curves and allows for timely implementation of process improvements and new programs. Together, these factors enable the establishment and demonstration of positive patient-care parameters, and, at the same time, help ensure readiness for P4P.

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