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Highlights of the ACCC Fall Leadership conference

This year's Fall Leadership Conference, "Oncology Economics VIII: Quality, Technology and Reimbursement—The Challenges of the '90s," in La Jolla, CA, drew a record number of attendees (275). This report contains highlights of key sessions and speakers.

NTRA Conducts Clinical Indicator Study

A 1991 study by the National Tumor Registrars Association (NTRA) of clinical indicators for breast cancer found that there may be significant problems in the collection and availability of the oncology data the Joint Commission (JCAHO) will soon be requiring from all hospitals. April Fritz, President of the NTRA, presented results of the study at the ACCC Fall Leadership Conference. A total of 373 hospitals participated in the NTRA study, submitting data on five breast cancer clinical indicators for more than 5,800 cancer cases. According to Fritz, the study revealed that:

- In more than 90 percent of the applicable cases analyzed, there was documentation that patients received estrogen receptor and progesterone receptor (ERA/PRA) testing at the time of diagnosis. An additional 6.7 percent indicated that ERA/PRA testing was not done or there was no documentation of such testing in the medical record (2.1 percent).
- The most significant problem in many medical records was the absence of clinical staging by a physician prior to the first course of treatment. In nearly 60 percent of the aggregate cases, there was either no AJCC clinical staging prior to treatment (48 percent) or there was no documentation that staging was done by the managing physician (10.9 percent).
- Of the 1,957 cases that were documented as node positive stage II breast cancer, about 20 percent were either not evaluated for adjuvant therapy (9 percent) or there was no documentation that a referral was made to medical oncology (11.9 percent).
- A referral to radiation therapy for additional treatment of lymph nodes following minimal surgery was documented for more than two-thirds of the 1,822 applicable cases. However, almost 30 percent of the applicable cases were either not evaluated or lacked documentation of a referral to radiation therapy.
- Only 51 percent of the aggregate cases received a referral to rehabilitation, social services, or a psychosocial support group. There was no documentation of such a referral in more than 25 percent of the cases studied, and an additional one-fifth clearly were not referred for psychosocial/ support services.

Fritz noted that the lack of documentation of referrals to medical oncology for adjuvant therapy may be due to "the trend of outpatient consultation and treatment by medical oncologists." Nevertheless, she warned that even if some of the treatment to be documented by clinical indicators is lacking, because the treatment was received in the outpatient department, "JCAHO will still hold the hospital responsible for collecting that data." She strongly advised hospitals to monitor the clinical indicators currently being field tested by the JCAHO using the Commission on Cancer's guidelines for patient care evaluation (PCE) studies.

Assessing New Technologies

With so many new cancer technologies, cancer programs that are interested in adopting these new technologies need to ask very specific questions, according to Robert O. Dillman, MD, Medical Director, Hoag Cancer Center, Newport Beach, CA.

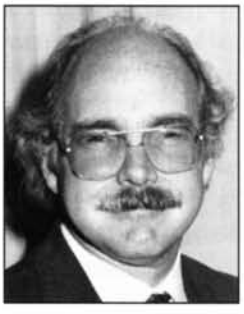
For instance, Dillman asked, "How well can you assess the technology in question? What are your resources? How progressive/conservative is the hospital's administration and the medical staff? What are the competing priorities within the institution? Who will use the technology and who will be the gatekeepers? How quickly will the technology change? And how do you assess cost/benefit of the technology?"

Robert Dillman, M.D.

"All of these issues will be viewed differently at each institution," Dillman acknowledged, "but they need to be asked." But the bottom-line, and a "technology dilemma," according to Dillman, is "having the appropriate data to estimate the risk and cost benefit" of a new technology.

Negotiating techniques

Open communication is the key to effective joint venture negotiations between hospitals and physicians, according to panelists who presented various case studies at the ACCC Fall Leadership Conference. "You must keep in mind the needs of potential partners and keep issues that affect market share, finances, the program, and politics in the forefront," said Lloyd K. Everson, M.D., Medical Director, The Indiana Regional Cancer Center, Indianapolis. "It is very important that the goals, vision, and strategy for a joint venture are identical or at least congruent," he said. "If they are not, economics and politics will disrupt your efforts."



Lloyd Everson, M.D.

Christine Michaud

Christine Michaud, Vice President for Ancillary Services, Multi-Care Health System, Tacoma, WA, said that their use of outside consultants "made for an easier and smoother [negotiation] process. When one of Multi-Care's hospitals first sought to contract with private practice oncologists, discussions were held between the administrator and the physicians, through local attorneys representing the two parties, and between the hospital's in-house attorney and the physicians' private attorney. But Michaud said, "We finally resorted to outside consultants." The hospital hired "a business person who provided reimbursement management of the physicians' and hospital's revenue stream, and a physician consultant," Michaud explained. "It was helpful to have a physician consultant, because the oncologists identified with him and felt represented despite the fact that he was hired by the hospital."

"Consultants from outside locations have no vested interest and provide a totally unbiased sounding board" in negotiations, concurred Robert L. White, M.D., Director of Medical Education and Research for Radiation Oncology, The Cancer Institute, Washington, DC. "They facilitate more open communication and allow communication to flow," White said.

Michael Boo

A lack of such open communication forced a hospital in the Health One Corporation, Minneapolis, MN, to renegotiate a proposed joint venture several times, according to Michael Boo, Vice President for Business Development. "We wanted to develop, in conjunction with independent physicians, a chemotherapy center at one of our hospitals. The problem was that we were not sharing our goals and objectives. We wanted the physicians to commit to the hospital's programs and for the new center to be under the hospital's name," Boo explained. However, "the physicians came from three different groups representing six different medical oncologists. Some of these physicians wanted to work closely with our hospital, but others were closely tied to another hospital. We didn't focus on the fact that [the physicians] didn't want to be overwhelmed by our hospital."

Ultimately, after several renegotiations, "we ended up with [a model] wherein the physicians own the chemotherapy center and sell its services to the hospital," Boo said. "The hospital had to give up some control," he acknowledged, "but we came to the conclusion that physicians can be involved proactively in the development of programs in the community." And, he says, "the hospital now enjoys a better quality service on campus that is convenient to the physicians' patients. We also developed a better relationship that we will be able to build on in the future."

MD payment reform

Although the final rules for a resource-based relative value scale of payment under Medicare had not yet been released by the Health Care Financing Administration (HCFA), panelists at a session on physician payment reform had a number of concerns about the impact of the new system on both physicians and cancer programs.

A. Collier Smyth, M.D.

Prospective payment reform is the "last chance for fee-for-service medicine in the United States," contended A. Collier Smyth, M.D., President of the New England Clinical Oncology Society. "If physician payment reform fails, I think the Health Care Financing Administration (HCFA) will have to go to coordinated care," Smyth predicted.

Robert T. Clarke, MHA, Chief Executive Officer, Memorial Medical Center, Springfield, IL, pointed out that "for the first time, hospitals will be at risk for the practice patterns of physicians in outpatient departments. And, noting that the "physician component for outpatient services will be as high as 40 to 50 percent by the end of this decade," Clarke predicted that RBRVS will "accelerate physicians' interest in competing with hospital outpatient services."

Robert Clarke

Clarke also predicted that hospitals will begin to shift the use of their assets to the most profitable areas of health care. "For instance, if a hospital's beds are full, and cardiology brings in more dollars than oncology, the hospital is likely to let the more profitable service encroach on other services."

Moreover, hospitals will have to deal with Ambulatory Patient Groups (APGs)—the outpatient equivalent of DRGs—within the next couple of years. "There is significant bundling in the proposed APGs for both diagnostic and treatment procedures and significant averaging of costs," said Lisa Ogorzalek, Ambulatory Services Manager, Johns Hopkins Oncology Center, Baltimore, MD. "We will need both inpatient and outpatient data," she warned. For instance, "Are hospital fees paying for hospital services? The time is now to take a serious look at your practice setting and where the costs and revenues are coming from."

James L. Wade, III, M.D., Director of Medical Oncology, Decatur (IL) Memorial Hospital, pointed out that under RBRVS, physicians will lose their ability to bill for technical codes in outpatient settings. Therefore, Wade urged "physicians and administrators to have a very open dialogue regarding the impact of RBRVS on practice sites. Administrators need to think of strategies to keep oncologists in the outpatient setting by recouping some of the loss from technical charges under RBRVS."

Surgical oncologists will experience significant reductions in revenues from Medicare patients, according to Irvin D. Fleming, Associate Professor of Surgical Oncology, University of Tennessee, Memphis. In a study comparing the 1990 Medicare Fee Schedule and the proposed National Fee Schedule for Tennessee, Fleming and a colleague found that there

Irvin Fleming, M.D.

will be drastic reductions in fees for common cancer diagnoses and procedures. For instance, the fee for a breast biopsy will be reduced by 38 percent; a modified radical mastectomy by 30 percent, a partial colectomy by 36 percent; and a staging laparotomy by 42 percent.

"The fees vary tremendously by what type of practice you have and what procedures you do," Fleming said. Nevertheless, he is already seeing a "shifting of Medicare patients to tertiary centers, general medicine physicians opting out of hospital settings, and specialty groups refusing to accept new Medicare patients even on an outpatient basis."

Clarke believes that "we are obligated to work on a strategy to increase the value of the health care dollar. We must come up with ideas on how the system can be changed to free up dollars and to increase the quality of care."

Einhorn honored for excellence in clinical research

he ACCC honored Lawrence H. Einhorn, M.D., Distinguished Professor of Hematology/Oncology, Indiana University School of Medicine, Indianapolis, for his outstanding contributions to clinical research.

In his acceptance address, Einhorn pointed out the need for cancer care providers to continue to be proactive in the 1990s. "The 1970s and 1980s were a kinder and gentler time for patients and the practice of medicine. As we approach the 1990s, we find that we have lost control of our own destinies and the control of patient treatment," he contended.

And although Einhorn believes that "diagnostic and therapeutic improvements will continue," he also said, "it is tragic to look at the variety of innovative ideas that are being thwarted by bureaucracy and red tape. It is only by continuing to be proactive that "we can once again control our own destiny and patient treatment." ■

EXHIBIT 6

General Medical Center

Estimate of Pre/Post-STP Potential Additional Contribution to Margin for Selected Oncology Procedures

Procedure	No. Disc.	Pre-STP Profit/Loss	Post-STP Profit/Loss	Potential Additional Contribution
Abdominal Hysterectomy	204	$183,013	$242,549	$58,536
Vaginal Hysterectomy	41	$46,599	$66,495	$19,896
Mastectomy	59	$5,890	$40,836	$34,946
Abdominal/Perineal Resection	17	$27,835	$59,132	$31,297
Colon Resection	96	$8,011	$449,002	$440,991
Breast Biopsy *	163	$1,216	$22,062	$20,846
Needle Localization*	3	$221	$407	$186
TOTAL	583	$272,785	$880,483	$607,698

**Outpatient*

Clinical Pathways

(Continued from page 28)

improved communication among disciplines. Participants have a better understanding of how the hospital system works, and they derived a sense of empowerment and team participation from their efforts to problem solve. All of these process outcomes contribute to long-term bonding between the hospital and the medical staff, and to a common understanding of the need for conservative financial management in an environment of continually decreasing resources.

Even the problems that the subcommittees were not able to solve, and which were brought to the attention of BMC's administration, resulted in a significant list of recommendations regarding opportunities and strategies for changing hospital systems. These recommendations are currently being considered for implementation.

The subcommittee meetings provided a unique opportunity for key caregivers involved in oncology to openly discuss the problems and frustrations that they encountered on a daily basis. The long-term, positive effects of sharing a successful, task-oriented experience are expected to be of continuing benefit to the oncology program at BMC.

An additional byproduct of the CP/STP process at BMC has been in the area of quality review and quality assurance. By establishing STPs, caregivers acknowledge what is accepted to be high-quality care. Either this level of care is provided to the patient or the reasons for not providing it are documented on variance reports compiled by the nursing staff. The ongoing monitoring of STP compliance is performed by a committee composed of key participants in the process and provides an excellent form of quality review, reinforcing the normative influence of the STPs.

In addition, using the charge/cost model, which includes overhead costs in its calculations, allows all participants in the process to understand the true costs of providing oncology care. Charge/cost models are now being developed to segregate resource consumption for each day of a targeted patient's expected length of stay. Utilization review personnel will be able to match the expected norm with actual resource consumption on a daily basis. As a result, interactions with the physicians responsible for resource consumption can occur in real time instead of retrospectively.

In conclusion, the success of the STP process can be translated into expected decreased costs, enhanced quality of care, improved communication, and better positioning of the hospital in today's cost- and quality-conscious environment. ■

Note: *Inquiries about the CP/STP process at BMC should be addressed to*

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