Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

An Interview with ACCC President Robert Clarke, M.H.A.

To cite this article: (1992) An Interview with ACCC President Robert Clarke, M.H.A., Oncology Issues, 7:2, 20-24, DOI: 10.1080/10463356.1992.11905058

To link to this article: https://doi.org/10.1080/10463356.1992.11905058

An Interview With ACCC President Robert Clarke, M.H.A.

The ACCC's President for 1992-1993, Robert Clarke, has served as the Chief Executive Officer of Memorial Medical Center, Springfield, IL, since 1983. He has also served as the Treasurer for ACCC, in addition to many other leadership positions in the organization. In this interview, Mr. Clarke discusses his goals and priorities for the ACCC during his Presidency.

You've been actively involved in the ACCC for a number of years. Why are you, a CEO, attracted to an Association whose focus is cancer care?
Over time, I became involved because cancer care has been the second most frequent cause for hospital services and will become number one. If you're going to stay attuned to where the dollars are being spent, where the research opportunities are, how things are being done effectively, and who's on the cutting edge, you have to meet the people who know cancer care. Early on, in the mid-1970s, I found those people in the ACCC. They're the founders of ACCC and they're the active members of ACCC. Having the opportunity to interact with them has had significant advantages for our institution's cancer program.

How will your background and experience in management shape your leadership of the Association?
The expertise I bring to the Association is management. Although we are doing well in that regard, we can always do better. My focus will be trying to make the ACCC a more effective organization in terms of the organizational structure and procedures involved in decisionmaking. Take, for example, the recent strategic planning process. We set up a process to solicit input and we produced a product. Heretofore, the ideas were all there, but they needed to be on paper so that we can constantly challenge ourselves and say, "Are these the areas of emphasis that we want to work on?" If our strategic planning document doesn't identify the things that we are doing, we need to ask ourselves if we are getting off track or if we should modify the strategic plan. At the very least, you need to reconcile why the two are different. A strategic plan is a road map that suggests where you're trying to head.

As for clinical discussions, I don't always fully understand the issues. To me, effective management isn't what you know, it's knowing what you don't know. I'll be highly dependent on the clinical skills of those within the organization who manage cancer programs and deliver clinical services directly to patients. With so many talented persons within ACCC who are able and willing to help, I look forward with confidence to the year ahead.

ACCC touts its multidisciplinary nature and the fact that it's the only organization to address issues of concern to all members of the cancer care team. In truth, can one organization effectively represent the varied perspectives and concerns of so many disciplines?
Yes, but it's not easy. The incentives government has put in place aren't designed to encourage the providers of health care to work together cooperatively. And as long as the incentives created in the system tend to drive people apart, it won't be easy to recognize the common interests. For example, a hospital is at financial risk for a physician's patterns of care, but it can't control physicians' choices. If we allow those forces to become a dominant part of our thinking process, we are going to be ineffective in dealing with government, payers, and other parties who are trying to interfere with health care delivery. We will be much more influential working together.

If we really believe that the multidisciplinary nature of our organization is important, the decisionmaking processes by which we arrive at conclusions have to be multidisciplinary in nature. We have to look at what role the SIGs should play, for example, in policy development. Or should they play a role at all? Should we have a required board composition that assures participation by people from different disciplines? In the past, we've done that by choice, not by mandate. It's not in the bylaws.

I'm not sure we will end up legislating board composition, but we should consider it. We know the constituencies have different points of view on some matters, and it's absolutely essential that they know they have a process by which they are going to be heard before decisions are reached. If they feel disenfranchised instead of a party to the process, then they may abandon the organization.

What is the role of ACCC in comparison to professional societies such as ONS, ASCO, and ACoS?
Each of those organizations represents a professional discipline in and of itself, whereas we have already identified the key strength of ACCC as the only forum in which all the disciplines interact. All of our disciplines are a critical part of cancer care. The patient is totally dependent on all of us. Working on those components separately is needed, but somewhere along the line the cancer team that delivers care has to interact. They interact in the hospital every day on a clinical basis. But when do they have a chance to step back and interact with other multidisciplinary teams from other cancer programs? That's what the ACCC provides.

There have been concerns expressed by some members that ACCC predominantly focuses on issues that impact physicians, perhaps to the detriment of the other cancer specialists we represent. Does the ACCC need to develop a more equitable and balanced approach to the issues affecting different sectors of our membership?
We have to remember that the organization

was started by physicians, so it's not surprising that a predominant number of voting members are physicians. The largest number of elected leaders on our board are physicians, and physician issues get a lot of attention. But I've also seen the physicians in leadership positions support the fact that a multidisciplinary structure is critical.

There has been considerable effort in the past year or two to try to ensure that the needs of the other disciplines are more effectively met. That's evident, for example, in the content of our annual and fall programs. As APGs are introduced, our attention will naturally shift to the concerns they raise. When the issues we've been focusing on appear to be directed more toward one of our disciplines than another, it's partly a matter of timing. Some of the constituents felt that too much time was spent on the impact of RBRVS on physicians vs. hospital-based cancer programs. It's an issue that we are going to have to be aware of.

There's also been discussion about the emphasis we're putting on the Collaborative Research Group (CRG), which is a physician-driven effort, and whether we should have our attention directed more toward other goals and objectives in the strategic plan. ACCC state chapters have also raised questions, because they are single disciplines. The structure of chapters has related, in part, to national physician politics. That's why state chapters have been comprised of physicians. But now the organization is setting up some regional administrator chapters. So I think that issue will be addressed to everyone's satisfaction.

Ultimately, ACCC's mission is patient advocacy; to ensure access to high-quality cancer care. But in view of its economic-focused initiatives of late, is there a danger of the ACCC being viewed first and foremost by the public as an advocate for the providers of cancer care rather than the patients?

The public is losing confidence in health care providers. They don't think we are trying to be part of the solution; that we aren't recognizing there are other societal needs for the dollars that we are spending. I'm active in the Illinois Hospital Association. More and more of my colleagues are bringing that issue up. They want to be part of a solution that recognizes limited economic resources.

ACCC's consistent focus needs to be the removal of obstacles to quality cancer care on behalf of the patients we serve. If we can maintain that focus, we will maintain our credibility

That means we need to start making recommendations about how more "bang can be gotten for the buck," and how more value can be delivered for the same or less money. Health professionals don't want to make those choices. We're accustomed to getting everything and anything we want in health care, and we feel obligated to meet patient demands. It's hard to change direction. But as new technologies emerge which cost over $100,000 and help only a few, is that where the money ought to be spent? Or should we improve access to less costly technologies that can be applied to many people for the same dollars? We're going to have to make those value judgments.

Oregon is trying to do that; to rate how important different services are and how valuable they are, and they've been finding it to be a difficult process. ACCC's consistent focus needs to be the removal of obstacles to quality cancer care on behalf of the patients we serve. If we can maintain that focus, we will maintain our credibility.

What do you see as ACCC's role in that process?

It's a very complex, costly undertaking that requires significant databases. I'm not sure we have the information or the resources to do it ourselves. I think it's more likely, as we state in our strategic plan, that our role will be to identify and keep track of the groups that are trying to do it; to be familiar with their methodologies and to have ACCC members participate in their activities in a positive, constructive way. To date, we've identified a few groups and we know there are others. The American Hospital Association publishes a technology advisory paper and it has a technology assessment group. Blue Cross has a similar group and so does the Health Care Financing Administration and the Agency for Health Care Policy and Research. We need to pay attention to what they're telling people about cancer care and we need to be participants in the process.

ACCC has experienced rapid growth in its membership over the past few years. What organizational changes/issues does such rapid growth raise?

Communication and participation. The larger a group is, the harder it is to communicate effectively. Our plans to improve communications are in our goals and objectives, such as publishing excerpts from board meetings. It also reminds us that we have organizations representative of an entire range of skills. We have the advanced, cutting edge groups and we have the new programs that are seeking help from us to get organized. We need to maintain a high level of involvement by all of those programs.

Recent membership surveys have shown that some members perceive the ACCC's leadership as an "exclusive" group; a "good old boys" network that precludes participation by newer members with fresh ideas. How would you respond to that view?

It's necessary to have some continuity, but when I go into a board meeting now, I don't know everyone, and I'm an old face in ACCC. The strategic planning committee was a mix of new people and some experienced people. You have to understand the historical perspective and you need continuity, but you also need new thinking. Next year we plan to continue that pattern of trying to intermingle the

old faces with the new. I think we need to identify our future leadership and cultivate it so we aren't suddenly searching for leadership. There are many bright stars rising up in the organization, and people like me will phase out in a year or two and they'll be the leaders.

Since its inception, ACCC has maintained loose criteria for membership by institutions; criteria that allow programs ranging from fledgling cancer programs to highly sophisticated academic centers to participate in the organization. With such a policy, do we run the risk of accepting institutions that engage in unorthodox cancer treatments? What is your view of ACCC's current membership policy?
It's basically sound but, on the other hand, we can't afford to allow organizations that are being unscientific or unethical in their practices to identify with us. It implies to the general public that we're some type of accrediting or certifying agency if they use their affiliation with us to suggest that they are quality programs.

Even though we aren't an accrediting body, that's the public's perception if someone puts our name on their wall as a kind of stamp of good housekeeping. Therefore, I think we have an obligation and a direct interest in ensuring that we don't have unethical, unscientific, or unproven practices being promulgated or practiced by our members, or members that don't recognize their obligation to the public. We should make sure we have our facts right, but if they are engaging in such practices or aren't open to patients regardless of payor status, they should be terminated from membership by the board. Historically, this hasn't been a problem for ACCC. However, we need to be more vigilant than ever to ensure that it doesn't become a problem.

In the past, you served as Treasurer for ACCC. What is your opinion of ACCC's current and future financial position?
We found ourselves in a deficit spiral a few years back. Lloyd Everson and Dave King solved that problem by setting up an incentive- and performance-based management contract with ELM to ensure that ACCC's budgetary objectives are met. Whether we make budget is now a significant factor in appraising ELM's performance, which in turn affects the compensation level for ELM, just as it would for a CEO or any other officer.

The future looks great. Our budget is now more than $1.5 million a year. This year we're going to end up right on target and that means we're going to have additional reserves put away [two percent per year]. I don't see any reason why we won't be even stronger at the end of next year.

You have strong feelings about new activities and initiatives that ACCC should be involved in. From your perspective as a CEO, what are your views on the future of outpatient cancer care?
Patient care is moving to the least institutionalized setting possible, as a result of new technology, patient preference, and the cost factor, which may be the predominant factor. As long as government pays for about half of the U.S. health care bill, it is going to reimburse providers at payment rates that demand efficient, effective care. Whatever the site of care our members are using, be it the home, a physician's office, a freestanding center, an outpatient center, or in the hospital, it's going to have to be efficiently provided or the reimbursement is simply not going to be adequate.

What impact do you think APGs will have?
I have a few predictions regarding APGs. The decentralization of patient care has further fragmented the provider system to the point where it's harder than ever for government to control it. I think a system like APGs, which lumps services and fees together into a single payment source that providers must decide how to distribute, is government's effort to deal with this fragmentation of provider sites and provider ownership. It won't surprise me if APGs are the first step in the evolution of the health care system toward an all inclusive franchised health care delivery system.

In other words, a system in which, in order to receive any reimbursement for patient care, there are entities which have to provide a defined list of services, including public health, education, long-term and skilled care, outpatient care, prevention, and acute care. Unless a provider has a formalized relationship with one of those franchised, licensed systems, they will not be able to access third-party payment. It will be a type of public utility approach. I'm not advocating such an approach, because I see some problems with it, but I do think that's where we're heading. APGs are a move in that direction.

What about the future of clinical research?
I don't think the dollars for clinical research will ever totally disappear; they'll slow down and increase in cycles. Everyone knows there is always opportunity for improving man's health status and general enjoyment of life, and I think it's human nature to want to know what those opportunities are. No matter what happens temporarily to research funding, dollars will always be found somewhere, because research is essential. But I think research may shift a little to where people are trying to uncover the most cost-effective and preventive technologies as opposed to add-on technology.

How about prevention?
I think that's where the dollars are headed. It's a lot less expensive, and a lot better for the patient, to prevent illness in the first place than to treat it after the fact. Money will be poured into that versus, for example, an expensive technology like bone marrow transplantation. Society can't afford it.

Adequate reimbursement for cancer care?
It will remain a major issue. We need to argue for reimbursement practices that ensure quality cancer care for our patients, but we should simultaneously be part of identifying ways to conserve resources, which we haven't done. It doesn't bother me to promote the case for off-label drug use to my Congressman. I can argue that patients who are receiving less effective care are going to be more costly to treat than if they get the drugs of choice. In that case, maybe the economic issue can be dealt with effectively.

On the other hand, if ACCC isn't an advocate for more reimbursement, who will be? If we give up that role, no-one else will take up the banner, whereas there will be plenty of people trying to figure out what advances to stop paying for. I think the best knowledge base of effective therapies is within our Association.

Hospital/physician relations?
Our health care system will move in a direction where it is absolutely mandatory that we develop sound relationships. Right

(Continued on page 24)

Clark

(Continued from page 22)

now the reimbursement system has us all at odds—doctors are paid fee for service, hospitals at fixed DRG payments—but Congress is beginning to recognize that this creates a problem, and that unless all of the elements in health care work together, problems don't get solved. That's why we are going to end up with a franchised system approach. I think physician fee for service practice will end. Again, I'm not advocating that, but we're moving in that direction.

Product line management?
It is the approach to take because it's a management structure that takes care of patients with common needs. It enhances the ability to assign and delegate authority to the personnel who are best aware of the patients' needs, and it empowers them to do their job effectively on behalf of the patients. Traditional divisions and departments don't track patient care. If you have a product line structure, you can track all aspects of the care given to cancer patients instead of components of it. I think it's a sound, quality system that is consistent with high quality care, but it sounds too ruthlessly businesslike. There should be some better term for it.

Q: If, at the end of your tenure as ACCC President, there was only one accomplishment that you could point to, what would you want it to be?
I'd like to end the year with all of the constituencies feeling comfortable that our processes give due consideration to their points of view and that the organization is structured in a way that their voice means something; that we're not insensitive to any member, no matter how long or short a time they've been with us or what they have to say. I believe that if you give people an opportunity to say what is on their minds, and they know that it's been fairly considered, even if it isn't adopted, they'll live with it. But if they think they aren't heard, and that they have no ability to get involved, you'll have problems.

This is the year to reinforce the multidisciplinary nature of the organization and to make sure that everyone thinks we're balanced in our programming and in our approach. Electing a non-physician as President again is at least one evidence that the Association is prepared to do that. ■

CLASSIFIED