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Oncology Managed Care/ Physician Groups

While federal agencies and major oncology societies develop guidelines related to oncology practice, health maintenance organizations, insurance companies, and a number of formal groups that offer oncology services are also busy with guideline activities. Their goal is to decrease variations in oncology care and at the same time curtail overutilization of services, thereby decreasing costs. Here is a look at where three major oncology groups stand on the development of cancer treatment guidelines.

SalickNet, based in Los Angeles, Calif., is a subsidiary of Salick Health Care. SalickNet specializes in developing managed care systems for people with catastrophic illness. Its primary focus is cancer. SalickNet serves almost 200,000 lives, providing a full range of services.

SalickNet completed its first treatment guidelines in 1994, soon after it began providing cancer services. The company has completed 11 guidelines, including autologous bone marrow transplantation (in lymphoma, myeloma, leukemia, and breast cancer), colorectal cancer, febrile neutropenia, site of care for chemotherapy, and use of such cancer drugs as colony-stimulating factors, erythropoietin, and antiemetics.

Next year SalickNet plans to embark on development of guidelines for breast and prostate cancer as well as refine pain guidelines from the Agency for Health Care Policy and Research. Plans are also underway for about a dozen radiation therapy guidelines. Most guideline development in the field of cancer treatment has tended to focus on the medical oncology specialty, ignoring the radiation and surgical contributions to the overall disease management process. However, SalickNet's breast guidelines, for example, will include surgical, radiation (plus imaging and other diagnostics), *and* medical oncology components.

The process of developing guidelines is extremely labor and resource intensive. When scientific evidence was available, a meta-analysis of the literature was conducted by a team of about a half dozen experts based at the corporate office and reviewed by Salick Health Care medical directors in all specialties across the country, as well as by a national panel of independent experts.

When the scientific literature was inconclusive, as in the case of bone marrow transplantation in breast cancer, another methodology was used, one first developed by the Rand Corporation. More than 1,000 different breast cancer scenarios were ranked for appropriateness of treatment. The resulting opinion ratings formed the basis of the guideline.

The knowledge developed through guidelines allows physicians and patients to focus on treatment options with the greatest potential to improve outcomes. It also helps guard against over- and under-use and can ensure some consistency in the application of costly and high-risk procedures. However, a guideline is only as good as its use. If it does not impact actual care, development is an effort in futility.

A key part of any guideline system is the profiling of outcomes. SalickNet includes measures related to short- and long-term mortality, morbidity, patient and referring physician satisfaction, quality of life, overall effectiveness, and availability of service. SalickNet has invested a great deal of time in data collection instruments that allow it to evaluate the components and utility of each guideline, as well as compliance with them. Guideline usage is being carefully tracked.

Already, the first set of guidelines is being updated and modifications are being made. Guideline development is a never-ending process.

—Bettina Kurowski, D.P.A.
Vice President, Managed Care
Salick Health Care, Inc.

Texas Oncology, Inc., based in Dallas, Tex., has more than forty-five practice sites, of which eighteen are full-service cancer centers. In 1994 Texas Oncology saw more than 25,000 new patients with cancer. The company is moving into relationships with practice entities in other states through Physician Reliance Network, Inc.

Managed care mandates a clear definition of the oncology service/product. In a fee-for-service setting, guidelines set general maximums for care. In a capitation-based setting, they set general minimums for care. Both are needed to define what is representative of the best current practice. While guidelines fill the need for a normalization of treatment strategies to enhance the quality of cancer care, they must be flexible enough to allow physicians to adapt to special situations.

Texas Oncology is well along in the development of medical oncology guidelines in the management of breast and ovarian cancers. Work is underway on radiation oncology guidelines for cancer of the lung, prostate, and skin.

As a large organization with practice sites hundreds of miles apart, Texas Oncology works

toward maintaining a "common look" as to how it manages patients in these sites. The company is developing new patient conferences. It is also working toward practice pattern assessments in which it can develop models using the relative value units of patients served, which allow comparisons between the observed and the expected consumption of services. Site visits enhance awareness of guideline compliance. Outliers are counseled, and physicians are told how their performance compares with the group's.

At Texas Oncology the process of guideline development begins with finding the people best qualified by interest and expertise. These are the people who can best enlist others to enhance the probability of practitioner buy-in. Rather than mandate acceptance of guidelines, our goal is to lead and to look for ways to avoid resistance to following directives.

As standards evolve, they are circulated in draft form to membership for their comments, corrections, and suggestions. Changes are incorporated and circulated in a second draft. Then the final draft for adoption and implementation is prepared.

We believe that consensus-based guidelines remain important, although we recognize the value of evidence-based guidelines as well. Consensus unsupported by evidence is a most unusual occurrence within a strong physician group. Major decisions must therefore be backed by appropriate peer-reviewed literature.

For physicians to buy in to guidelines, they must maintain a step-by-step involvement in the development process, and we must help them overcome any difficulties with conflicts in time or priorities. Physicians should be compensated for their participation in this effort. At Texas Oncology, we have both time-based and project-based compensation formulae.

Once guidelines are developed, outcomes must be monitored and guidelines must be modified based on local and/or national experience. We are making improvements to our management information systems to accomplish both.

Finally, it is a source of some dismay that almost every entity engaged in the practice of medicine with more than two physicians seems to be working on some form of practice guidelines. Although larger organizations such as the nation's major cancer institutions have begun to work together in this regard, it appears for the moment at least that this work will be considered proprietary by many of the various authors. If we were to work together in the best interest of our patients, we would likely come to a worthy product faster and at less cost than will be the case if we work "together" independently.

—Dale E. Fuller, M.D.
Texas Oncology, Inc.

American Oncology Resources® in Houston, Tex., is a national network of physician-directed comprehensive regional cancer centers. The network is dedicated to providing access to multidisciplinary oncology groups and to establishing the oncology specialist as the disease management gatekeeper for the cancer patient. AOR is in nine states, delivering care in 51 locations with 95 oncologists who provide medical, hematological, and radiation oncology care. The network continues to grow and is adding other specialties in the delivery of state-of-the-art cancer care.

The ultimate survivor in today's health care environment will be the provider network that offers the highest quality and most cost-effective care in their markets. The challenge is to define benchmarks for the best quality and most cost-effective cancer care by stage, disease type, and other parameters. We must ask, for example, as Dr. Moertel wrote in a recent *New England Journal of Medicine*, "is it justified to treat colon cancer with such a wide variety of treatment and expense when outcomes are for the majority of patients, pretty much the same?"

From a national perspective, guidelines offer the best opportunity to truly control health care costs in general, and cancer care costs in particular. Practice guideline development is a major cost and quality opportunity for oncologists. Guidelines form the basis on which to take care of patients as well as to identify and control costs, and then negotiate with insurance companies.

Guidelines do *not* mean that every patient becomes a cookie-cutter image of the previous one. Treatment is not taken out of a recipe book. Instead, the challenge is to make sure that the 10 to 20 percent of patients who are outliers have access to the special or innovative treatment approaches they need, while the majority of patients also receive appropriate treatment.

AOR has assembled guidelines for many of the top cancers. The network has put together capitated risk-sharing arrangements with bone marrow transplantation and stem cell components and is in the process of working on risk-sharing arrangements in every one of its markets.

Developing guidelines requires extensive and expensive talent, much coordinated effort, defining actuarial and underwriting issues, ancillary testing, and execution of protocols without redundancy and duplication. The process is a continuing one; it is complex and involves integrating computer systems, standardizing medical records, and defining key data and field elements.

AOR is a physician-driven organization and believes that the key to a successful managed care strategy is to partner with and optimize the physician leadership in all of the AOR network practices. The physician is in the best position to judge appropriate treatments and to help develop guidelines. This position of clinical decision making and patient advocacy is the responsibility of the physician. It is in danger of being forfeited unless actively pursued and strengthened.

—Lloyd K. Everson, M.D.
President, American Oncology Resources