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# ACCC's Guideline Initiative

by Lee E. Mortenson, D.P.A., and Eautha E. Harrigan, M.H.A.

For all our experience in guidelines and protocol research, the oncology community has historically seen the development of practice guidelines as daunting. Too many sites and stages, too many variations in the patterns of care, too many protocols, and too much change, complexity, and competition among medical specialties. Moreover, there has been little reward for the development of guidelines and less for their use.

Yet now, with a flurry, a number of oncology organizations, hospitals, and health care systems are developing guidelines to reduce costs and assure patient quality. Almost all carry the caveat that it remains to be seen whether the guidelines will be used by physicians or accepted by managed care organizations and other insurers.

The Association of Community Cancer Centers, with a large number of national and state oncology societies, is embarking on an effort to develop guidelines to assure adequate reimbursement of appropriate care. The first stage in the guideline initiative uses existing public and proprietary databases to identify approaches to prevention, detection, diagnosis, treatment, side-effect management, rehabilitation, and terminal care that cover 85 percent of standard care. These patterns will be published for major disease sites. Next, the best options for care and follow-up are being identified. In the final phase, guidelines for care specify the current information for major approaches that optimize outcomes and include cost-effective pathways for inpatient and outpatient management.

ACCC's intention is that the guidelines be descriptive of the primary approaches to manage patients and serve as mechanisms that can be used in several different ways. First, managed care providers and other insurers can use the guidelines as a representation of current standard care. Physicians and hospitals will use the guidelines as a means of costing standard cancer care. Hospitals, alliances, and physician groups can use the guidelines as a starting point for critical path development. Finally, guidelines will be a way for physician extenders, physician assistants, and oncology nurse practitioners to evaluate care.

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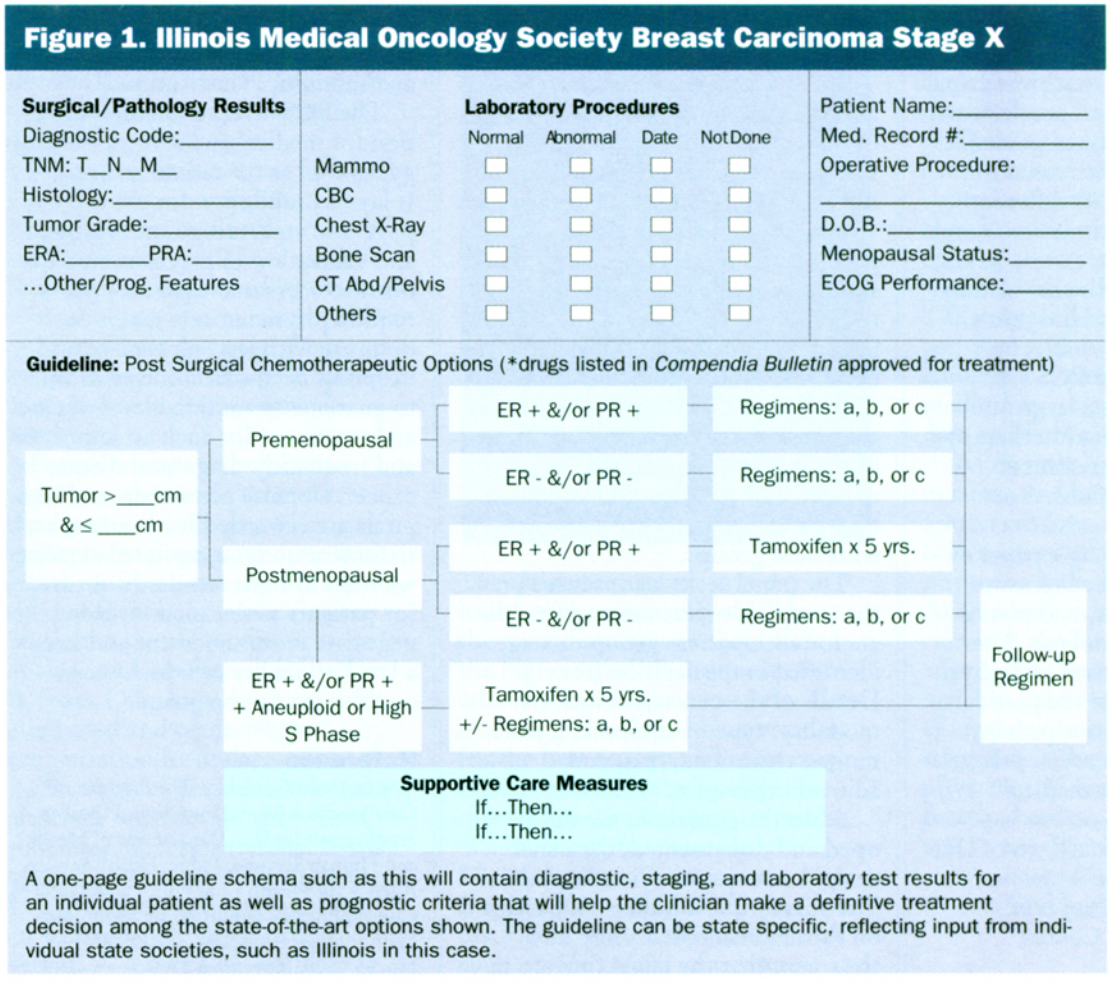
**Figure 1. Illinois Medical Oncology Society Breast Carcinoma Stage X**




A one-page guideline schema such as this will contain diagnostic, staging, and laboratory test results for an individual patient as well as prognostic criteria that will help the clinician make a definitive treatment decision among the state-of-the-art options shown. The guideline can be state specific, reflecting input from individual state societies, such as Illinois in this case.

## DEFINING AND DEFENDING QUALITY

Community cancer centers and providers have been involved in the development of guidelines for many years. In the 1970s, the National Cancer Institute

funded a series of evaluations of the quality of care in communities through the Community Hospital Oncology Program. Consensus guidelines were used as the templates for these evaluations.

Insurers and health care technology evaluators, however, have stayed away from oncology guidelines because there were too many unknowns and caveats. Oncology had the advantage for many years of being too complex a disease, with too much changing technology, for insurers to be able to "guide." However, as oncology emerges as the number one product line with budget revenues that surpass cardiology, ignoring this area is no longer an option.

Today the task of defining quality seems simple enough. There is a large literature base, the PDQ, multiple ongoing protocols from the national cooperative research groups and the pharmaceutical and biotechnology industry, and many patients and experts. It seems all the needed materials are at hand.

George Silbermann, M.D., the GAO investigator who conducted a number of sentinel studies on oncology practices, succinctly captured the reason for defining quality: "If you can't define quality, price wins." In other words, cost-effectiveness suffers without a clear definition of what constitutes quality cancer care. Moreover, if quality cannot be defined, it cannot be defended.

## WHAT INSURERS WANT

Insurers want first to treat the patient appropriately and, second, cost effectively. Do they want to shorten the patient's life and lower their costs? No, we don't believe that they do, although there is an ongoing ethical debate about whether oncologists "sell" patients on more aggressive therapy to prolong their lives when a kinder, gentler and cheaper therapy would be more appropriate.

Insurers do have questions about whether there is any significant difference in the outcomes of care on the basis of the therapy, and they have questions about what *is* standard therapy, because no one has defined it for them. In lieu of that definition, they tend to look for intermediate measures, and they completely ignore continuity of care.

The horror stories that we all hear are indicative of the problems facing physicians and patients. Only some drugs in a regimen may be approved by an insurer. Pre-approval denials knock out whole approaches to therapy for specific groups of insured. Oncologists are called upon to justify an entire course of care, appropriate supportive care therapies, and more than one day of radiation therapy.

Patients find that they must start to work with a different oncologist in the middle of therapy. Patients find that part of their therapy is provided by another facility across town because that facility won the contract to deliver part of their oncology care. Cut-up cancer care is replacing integrated, multidisciplinary cancer care. More is being lost here than patient convenience.

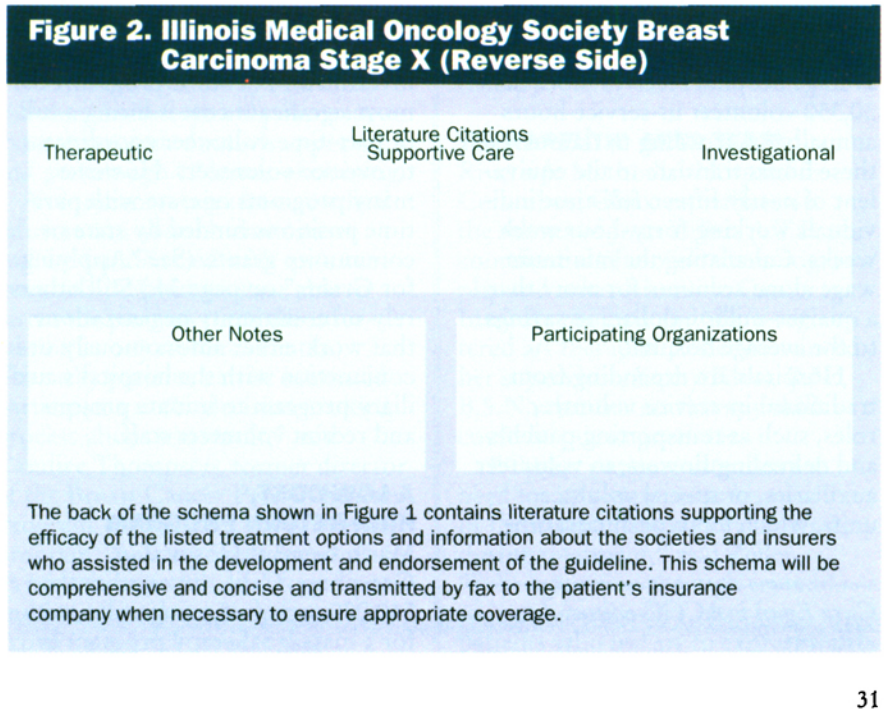
## HOW ACCC'S APPROACH AND GOALS DIFFER

Of importance to ACCC's leadership is the development of guidelines that can be used to assure that patients and their health care providers can minimize hassle while providing quality of care with well-documented outcomes. In other words, a key measure of a good ACCC guideline is its ability to illustrate in a one-page faxable format those standard therapeutic approaches that the literature suggests will deliver the best outcomes for the 85 percent of cancer patients who require only standard care. The guideline should allow an office manager or an administrator to show an insurer the value of a complete course of chemotherapy using current regimens. Thus, the physician does not have to debate the value of certain drugs or a few cycles of therapy. The guideline should allow a radiation oncologist to show a managed care organization that the patient requires the *total* course of therapy—not just one day's worth—to achieve the outcome that the literature documents.

This is not rocket science. The process requires development and regular updating of guidelines that reflect standard therapy and supportive care measures and the broad involvement of a large number of appropriate disciplines in the effort.

The development and widespread distribution of these kinds of materials to the physicians and providers involved in the field are key to their use. Guidelines must be easy to follow, frequent, reliable, descriptive of current technology, and endorsed by local physicians and providers as well as by national organizations. This endorsement is key. If a state oncology society reviews, approves, and distributes these guidelines, local courts and eventually insurers will recognize their validity and utility in assuring high-quality, cost-effective care. ■

**Figure 2. Illinois Medical Oncology Society Breast Carcinoma Stage X (Reverse Side)**




The back of the schema shown in Figure 1 contains literature citations supporting the efficacy of the listed treatment options and information about the societies and insurers who assisted in the development and endorsement of the guideline. This schema will be comprehensive and concise and transmitted by fax to the patient's insurance company when necessary to ensure appropriate coverage.