ACCC Guidelines: Is Simpler Better?

ACCC Guidelines: Is Simpler Better?

As I mentioned last spring in the ACCC President's Interview (*Oncology Issues*, May/June 1996), everyone seems to be in the guidelines business these days. Following the initial success with inpatient clinical paths, medical centers are developing outpatient disease-specific guidelines as well. Provider networks are active in this area, producing treatment flow sheets suitable for cost containment while maintaining quality of care. National organizations such as the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN) have set up large committees of experts to design guidelines for treatment of major cancer sites or for appropriate use of expensive technologies. Some individual physician practices have begun work on limited guidelines for their own patient populations. Each of these groups is concerned about the maintenance of quality care in the face of limited financial resources, and these guideline efforts are of real benefit to the cancer patients in this country.

Much more ominous, however, is the appearance of another player in the guideline arena—the third-party payer. While quality of care is foremost in the development of provider guidelines, cost reduction is often the driving force behind payer guidelines. Although cost reduction and quality of care are not mutually exclusive, any guideline with reduction in cost to the payer as the major motive for development must be viewed with suspicion. This concern has prompted ACCC to initiate the development of major cancer site and supportive therapy guidelines useful for the practicing physician in a managed care setting.

ACCC's guideline initiative differs in several important ways from that of other organizations. The ACCC Guidelines Committee has felt an urgent need to have the guidelines completed and functioning. Past experience with other guidelines efforts has shown that the process can be very time consuming, particularly when many people are involved and many levels of review are necessary. While this cautious approach to guidelines has some appeal, it will place us at a distinct disadvantage when compared to payers who can turn out guidelines with seemingly little effort and can enforce them unilaterally. Therefore, ACCC is planning to publish at least ten guidelines over the next twelve months.

To meet this schedule, ACCC guidelines will differ from those of other organizations in two major ways. The most noticeable difference will be in the specificity of the recommendations provided. Rather than give specific treatment algorithms, ACCC has chosen to provide more general overview of treatment for major disease sites and stages, recognizing that there is often considerable local variation in treatment programs, with little if any change likely in patient outcomes from these minor differences. Secondly, ACCC will encourage local oncologists, through state oncology societies, to validate the guidelines as local standards of care. This practice will assure patients of receiving uniform and appropriate care within the community, regardless of the particular insurance contract they have. It will also reduce the risk of an unscrupulous provider underbidding by eliminating needed therapy for patients.

I have been asked why ACCC is in the guidelines business at all. After all, we could simply sign off on the NCCN guidelines as final consensus is obtained from the expert panels reviewing them. As you look at the NCCN guidelines, you will see that they are extremely detailed with the level of evidence clearly indicated for each part of the recommendation. While this precision may be helpful to the medical oncologist in treating a specific patient, the guidelines committee believed it would present some problems in dealing with payers. For example, small deviations from the algorithm, even those of no clinical significance, might provide an excuse for denial or delay in treatment. In writing its guidelines, ACCC has therefore decided to keep the algorithms simple and general. Each fits on a single page and can be attached to a claim if necessary. The guidelines will be broad enough to allow the normal practice variations seen from region to region, and yet detailed enough to assure quality care to the cancer patient.

At the same time treatment guidelines are being written, the committee is also working on the supportive therapy guidelines. Here there is less controversy (perhaps because there are fewer scientific studies), and the committee has felt more comfortable adopting established guidelines in some cases. Nevertheless, there are often significant practice variations in some types of supportive therapy (for example, the frequency with which erythropoietin is used in cancer patients), which may make standardization difficult.

Although it is important to develop patient care guidelines, the ultimate proof of their value will be established not in the review process but in the clinic. Guidelines must be user friendly if the busy practitioner is to follow them. They must produce positive results in terms of quality and reimbursable care, acceptable to the patient, provider, and payer. Will the ACCC guidelines accomplish these goals? Only time will tell. As our guidelines are circulated this year, ACCC looks forward to comments from everyone involved in patient care.