The Impact of Managed Oncology Care: Integration or Disintegration?

Cara Egan & Donald Jewler

To cite this article: Cara Egan & Donald Jewler (1997) The Impact of Managed Oncology Care: Integration or Disintegration?, Oncology Issues, 12:6, 22-27, DOI: 10.1080/10463356.1997.11904721

To link to this article: https://doi.org/10.1080/10463356.1997.11904721

The Impact of Managed Oncology Care: Integration or Disintegration?

by Cara Egan and Donald Jewler

Managed oncology care, a concept born more than a decade ago in the state of California, is increasingly spreading throughout the nation with the promise of reducing health care costs and promoting efficiency and quality by integrating the often disparate elements of cancer care. Without question, managed care has successfully contained health care costs—the national rate of health care spending is currently lower than the overall inflation rate. However, whether managed care has delivered its promise to create more fully integrated, quality cancer care is still subject to debate.

This debate was the focus of the Association of Community Cancer Centers' 14th National Oncology Economics Conference, entitled, "The Impact of Managed Oncology Care: Integration or Disintegration?" held September 17-20, 1997, in San Diego, Calif. One theme resonated throughout: Too often managed care organizations interfere with oncology providers' ability to administer critical elements of quality patient care and threaten such indispensable program components as clinical research and oncology nursing. Presenters offered strategies for living with managed care, including lessons on capitation, acquiring oncology information systems, and developing outcomes measures, as necessary means for surviving in this environment. Also emerging is the growing voice of provider-sponsored organizations, which may serve as the answer to oncology providers' dissatisfaction with the current managed care system.

Cara Egan is ACCC assistant editor, and Donald Jewler is ACCC publications director.

INTEGRATION OR DISINTEGRATION?

At its best, managed care is intended to provide a "one-stop shopping" setting for oncology patients who are treated by a team of coordinated, interdisciplinary providers along a seamless continuum of care. Using care paths and guidelines, these providers collaboratively develop a plan of care for patients, which is complemented by an array of support services that are present at all points of the continuum. This ideal scenario, however, often falls short of the stark reality of managed oncology care, stated ACCC President James L. Wade III, M.D., a medical oncologist with Cancer Care Specialists in Decatur, Ill., during a panel discussion of managed care's impact.

"Because of the way that managed care contracts are awarded, an oncology patient may have to get blood tests drawn at the lab facility twenty miles away, receive chemotherapy at the medical oncologist's office, and then must catch a bus to travel across town for X-rays, past four or five hospitals with radiation therapy units, to the hospital that holds the managed care contract," Wade stated. "The result is tremendous inconvenience for the patient and fragmented care."

Fragmented care is just one area in which managed care has failed to deliver, added R. Lawrence White, M.D., F.A.C.R., ACCC president-elect and director of medical education and a radiation oncologist at the Washington Cancer Institute at the Washington Hospital Center in Washington, D.C. "Managed care promised hospitals and physicians to cut-through the red tape and provide rapid reimbursement for services," White said. "What we have instead are restrictions on reimbursement and delays that can sometimes take as long as four months." White described a reimbursement reality in which high-level nurses spend significant time on the telephone seeking preapproval for patients' radiation oncology treatment from the office staff of primary care physicians. "Approval eventually comes, but only after four or five extra steps of increased administrative time, coupled with the time it takes to educate the primary care physician's office staff," stated White.

Communication also suffers among related providers at distant locations. In many cases a medical oncologist rarely has an opportunity

to sit down with the pathologist or the radiation oncologist to review a patient's X-rays or slides. This lack of coordination also impedes follow-up care. "As a medical oncologist treating a patient in a managed care environment, I may be working with other physicians who are part of a different contract or located at a different hospital," Wade said. "After I have treated my patient with x, y, or z, he or she moves on through the system and I may never see that patient again. I may have no idea what happened, whether the patient did well or not."

As the trend toward multimodality care continues, a network for treatment planning that includes follow-up throughout a patient's course of treatment is as vital for physicians as it is for patients. Primary care physicians may overlook symptoms of recurrence in cancer patients. In addition, physicians' own professional growth is at risk when they are prevented from providing follow-up care to patients. "As physicians, we experience a professional learning curve that decreases with each lesson about the long-term results of our treatment decisions," Wade said. Patient follow-up, he said, is critical to master the learning curve.

Care pathways and treatment guidelines developed by providers are helping to define quality cancer care. The next step is development of outcomes studies to show payers the value of each member of the oncology team, especially during managed care contract negotiations, according to James Zabora, M.S.W., associate director for community research at Johns Hopkins Oncology Center in Baltimore, Md. "All too often when managed care contracts are being negotiated, it is unlikely that a social worker is at the table," Zabora stated. "In my experience with contract negotiations, the emphasis has been on survival and costs." However, Zabora reported a growing awareness by managed care companies of the value of patient satisfaction and quality of life measures—"those areas where psychosocial providers such as social workers can make a serious contribution to contract negotiations and quality issues," he said.

The panel conceded that while some progress has occurred with managed care delivery, the system is still far from ideal. "Integration and disintegration are occurring simultaneously in all settings of oncology care," Wade declared. The evolution of information systems and the development of national oncology standards for managed care, however, will favor integration over time, said Wade.

ACCC's Clinical Research Award

Betty R. Ferrell, R.N., Ph.D., F.A.A.N., associate research scientist at City of Hope National Medical Center in Duarte, Calif., is the recipient of the Association of Community Cancer Center's 1997 Clinical Research Award, presented at ACCC's 14th National Oncology Economics Conference in San Diego, Calif. She is shown here with ACCC President James L. Wade III, M.D. At City of Hope Dr. Ferrell oversees the Mayday Pain Resource Center, a clearinghouse of information and resources to help clinicians and health care institutions improve the quality of their pain management. Through the Mayday Pain Resource Center, Dr. Ferrell is involved in the NCI-funded Institutional Commitment to Pain Management Project, in which clinicians, along with practice managers and administrators, travel to City of Hope to receive training in pain management to incorporate pain management in the practice setting. Dr. Ferrell has studied numerous pain management programs in cancer centers throughout the nation.

ONCOLOGY NURSING: CHANGING TIMES

The oncology nursing profession is well aware of the need to contain the spiraling costs of care and the ways in which nurses can better provide care across the continuum, stated Linda U. Krebs, R.N., Ph.D., A.O.C.N., a senior instructor at the University of Colorado School of Nursing and president-elect of the Oncology Nursing Society. "However," Krebs added, "many oncology nurses are struggling, and even a few are drowning, in the tidal wave of managed care."

Krebs described a world in which oncology nurse positions are being lost at all levels—from staff nurses to clinical nurse specialists to nurse researchers. Specialty units are closing or merging. Registered nurses are encouraged to become generalists and are increasingly expected to delegate tasks to unskilled assistive personnel. Many nurses are uncomfortable with, or unexperienced with, this kind of delegation.

Managed care is expecting a great deal from nurses, Krebs said. "Nurses are expected to be all things to all people." This unrealistic expectation is thwarting the nurse's ability to provide quality care to patients, Krebs said.

The increase of licensed practice nurses and unskilled assistive personnel will certainly change oncology nursing, but not necessarily threaten it, according to Susan B. Baird, R.N., M.P.H., M.A., vice president of publications with Meniscus Limited in Bala Cynwyd, Pa. The nursing community must determine what the core values of nursing are, Baird said. "Nurses must realize that it's not what they do, it's what they know, and how they apply their knowledge in clinical practice."

Baird described a patient-centered care model in a Rochester, N.Y.-

based hospital, where registered nurses are paired with unlicensed personnel who have been trained to add such procedures as providing unmedicated respiratory therapy, doing electrocardiograms and phlebotomies, and administering bed baths. The response from patients and nurses has been positive. "These nurses are now able to focus more on individual patient needs and promote continuity, instead of fitting assessment in between vital signs and bed baths," Baird reported. Satisfaction surveys show that patients feel they are getting more nursing attention, not less.

What is the future of oncology nursing? "No one has all the answers," Baird said. "The answers must come collectively in response to the changing times." Nurses, however, should work collaboratively with their physician colleagues to clarify the role of the nurse in oncology practice. "If we look realistically at the training people need to have, and give them that training, but also retain the value of what the nurse does, we can find solutions that benefit physicians, nurses, administrators, and patients," Baird concluded.

THE PUBLIC SECTOR FOLLOWS SUIT

"The public sector, like the private sector, is moving away from unstructured delivery systems to more integrated health care delivery models," stated Gail Wilensky, Ph.D., John M. Olin Senior Fellow with Project HOPE in Bethesda, Md., and chair of the Medicare Payment Advisory Commission. Dr. Wilensky, a former advisor to President George Bush on health and welfare issues, delivered to attendees an overview of the impact that this trend will have on oncology programs.

As a result of the Balanced Budget Act of 1997, Medicare will establish a prospective payment system to curtail spending in what have been the fastest growing areas of Medicare in recent years: outpatient services, home care, and skilled nursing facilities. In addition to Medicare HMOs, a number of new choice plan offerings will be introduced, including provider service organizations, preferred provider organizations, and medical savings accounts. Medicare will also reduce geographic payment variations to HMOs.

Too many hospitals are operating at occupancy levels of 60 percent and lower, which doesn't make a lot of economic sense...

Movement away from unstructured delivery systems to more integrated models in both the public and private sectors will unleash competitive forces brought about by increased pressure on prices and an oversupply of hospitals and physicians. Hospitals will especially feel the crunch, said Wilensky. "Too many hospitals are operating at occupancy levels of 60 percent and lower, which doesn't make a lot of economic sense," Wilensky stated.

Physicians, particularly specialists, will also be pressured by more integrated cost-driven delivery systems. Residency programs and physician incomes are being cut back in response to the steady pipeline of physicians graduating from medical schools. "This oversupply of physicians, coupled with advances in technology and an influx of specialty technology centers, will collide with the aggressive purchasing on the part of people who are either arranging insurance contracts or doing direct buying," Wilensky explained.

What can hospitals and physicians do? "First, try to find people who have some of the same incentives and form alliances," Wilensky advised. "Next, be aware that aggressive purchasers, especially in the private sector, understand that low price does not necessarily mean best value." To be able to claim better value, providers must have data that are acknowledged by outside users as credible measures of value. Otherwise, Wilensky warned, they will be very hard pressed to accept low price.

THE RIGHT ONCOLOGY PACKAGE

"Managed care companies have been hired by purchasers to get the most value for their money," stated Robert E. Hurley, Ph.D., associate professor within the Department of Health Administration at the Medical College of Virginia. "If managed care companies fail to provide value, they will be replaced."

All types of cancer providers—hospitals, university cancer centers, oncology carve-outs, and physician networks—are forming provider-sponsored organizations through which they negotiate directly with business coalitions and other purchasers of health care services, giving providers more control and more financial risk. To be successful, Hurley said, providers must demonstrate their superiority to managed care organizations in care management, customer service, and provider relationships. "Forming a provider-sponsored organization has ideological appeal, but it means providers taking responsibility for things they have never had to do," Hurley said.

How can providers best package oncology services for employer groups? "Design a flexible package of oncology services, particularly with a focus on total oncology care. Stay away from creating narrow PM/PM arrangements around medical or radiation oncology only," said presenter Tamra Lair, Ph.D., senior health consultant with Watson Wyatt Worldwide in Minneapolis, Minn. "Also, consider primary and secondary prevention activities as a value-added service to wrap around a larger program."

Lair told meeting attendees to consider marketing directly to larger coalitions or purchasing entities as well as to regionally based programs. Finally, key to creating the value proposition for oncology services to purchasers will be demonstrating performance in a meaningful way to employers. "Expect to have to guarantee it!" she said.

According to Lair, this past year has seen an increased concern that a focus on costs is indeed hurting

continued on page 27

Special Interest Group (SIG) Round-Up

Nursing SIG. "Nursing's Agenda: Change or Chattering Hope?" was presented by Susan B. Baird, R.N., M.P.H., M.A., vice president of publications, Meniscus Limited in Bala Cynwyd, Pa. She examined threats to professional nursing, including new multiskilled certified or licensed personnel to replace RNs, and areas of opportunity for nurses, including home care, skilled nursing settings, and prevention. (See accompanying article for more information.)

Medical Director SIG. Steven Valenstein, M.D., F.A.C.P., an oncology consultant in Pacific Palisades, Calif., discussed "Developing and Strengthening Relationships with Regional Medical Directors of Managed Care Organizations (MCOs)." He told medical directors to organize oncologists in their area, meet regularly with MCO medical management teams, learn the policies and procedures of MCOs as they apply to their practices, and try to modify behaviors to help the MCO's medical director look good.

Administrator SIG. Three sessions were offered. "Developing an Oncology Satellite Network" was led by Patti Jamieson, M.S.S.W., M.B.A., oncology service line administrator, University of Illinois, Chicago Medical Center, Chicago, Ill., and Steven J. Shore, M.B.A., director, financial and analytical services, ELM Services, Inc., Rockville, Md. Satellite clinics can help protect existing market share, capture new markets, provide specialty care to rural areas, and eliminate the travel hardship for patients. However, a well thought-out development and business plan is crucial to success. Any development strategy must include analysis of demographic data, a discussion of the politics involved and of network options, and an understanding of the value-added services.

"Integrated Oncology Home Care" was presented by Ann H. Ressing, B.S.N., O.C.N., manager, Washington Cancer Institute (WCI) Home Care Program, Washington, D.C. An efficiently coordinated, multidisciplinary oncology home care program has allowed WCI to approach managed care companies with such documented results as a decrease in use of inpatient days, a decrease in readmissions, shorter home care episodes, and less duplication of cost, time, and effort.

"Turbulent Times: A Primer for Survival" was led by Susan B. Baird, R.N., M.P.H., M.A., vice president of publications, Meniscus Limited, Bala Cynwyd, Pa. She offered insights on the turmoil involved in organizational downsizing and what happens when "letting good people go."

Radiation Oncology SIG. Timothy G. Ochran, M.S., vice president of technical services, Physician Reliance Network, Inc., Dallas, Tex., discussed "Technological Innovations in Radiation Oncology." He reviewed virtual simulation, 3-D treatment planning, and integration of radiation oncology within the cancer program.

Community Research/CCOP Special Interest Group. Today, clinical trials are perceived as a nonrevenue-generating cost burden, and clinical research is often the silent casualty of reorganization. Can clinical trials survive in a managed care environment? Is clinical research a luxury that hospitals can no longer afford? These questions were explored by Robert Comis, M.D., chairman, Eastern Cooperative Oncology Group, in a session entitled "Are Cooperative Groups Dinosaurs?"

"Dinosaurs were around longer than any land animal in the history of the planet. They are the most adaptable creatures that have ever lived. If the research community is to survive, we, too, must be very adaptable," said Comis.

If cooperative groups are to receive the funding they deserve, they must offer "compellingly strong science," function in a contemporary information environment, and ensure accruals, according to Comis. To improve accruals, Comis is working to integrate ECOG algorithms into the health care delivery system, market ECOG algorithms to the public and to payers, simplify studies, make it easier for patients to enter trials, and redefine the responsibilities of member institutions.

Comis spoke of the need to develop a framework that assures payment for the clinical costs associated with the trials. He also reviewed how ECOG is working with other cooperative research groups to establish the administrative, scientific, and legal structures whereby the groups can work more closely among themselves and with industry and payers, such as Blue Cross/Blue Shield, in developing research programs.

SIGN UP NOW!

The Association of Community Cancer Centers currently recognizes five Special Interest Groups (SIGs): Administrator, Community Research/CCOP, Medical Director, Nursing, and Radiation Oncology. The SIGs provide a forum for members to discuss ongoing ACCC activities, including the annual meetings, *Oncology Issues*, strategic planning, and other critical issues. Increased SIG participation by the membership will continue to strengthen the Association's ability to be a national leader on issues of importance to all cancer care disciplines. For a SIG membership form or more information, please contact Steve Chan, ACCC SIG Membership, 301-984-9496.

quality. Reporting on a two-year survey of companies responsible for a total of $35 billion in annual health care purchasing, Lair noted that in 1997 33 percent of respondents indicated that costs are hurting quality, compared with 28 percent in 1996. The survey is sponsored by the Washington Business Group on Health/Watson Wyatt Study in Health Care.

Companies were asked about the information they use to make decisions about purchasing health care. Cost is the key measure, followed by member services to employees and customer service to employers. Although HEDIS and report card measures are used by less than one-third of respondents, their use has increased from 1996 to 1997 and is expected to rise further in the near future.

Charles Cangialose Ph.D., vice president and chief operating officer of the Kerr L. White Institute for Health Services Research in Atlanta, Ga., reviewed a series of issues that will be considered in developing recommendations to assist health care purchasers in making better informed decisions when procuring benefit packages for oncology services. These recommendations are being developed by a thirty-member multidisciplinary task force that is made up of purchasers of oncology services, including government and private sector employers; suppliers of oncology care (clinicians, leaders of managed care organizations, and administrators of cancer centers); representatives of insurance companies; and consumer/advocacy groups. The task force was assembled by the Kerr L. White Institute for Health Services Research, a not-for-profit public charity that conducts public domain health care research, and the American Cancer Society.

In developing its recommendations for purchasers, the task force is considering these issues:

- structure and process of including patients in decision making
- evidence-based oncology care
- access to accredited clinical trials
- access to comprehensive treatment
- comprehensive benefits with additional options and opt-out provisions
- access to prevention and screening services, appropriate follow-up care, and end-of-life and palliative care
- reporting on standardized performance measures
- a commitment to continuous quality improvement.

Cangialose reported that final recommendations will be submitted for publication and widely disseminated so purchasers and providers can use the information to measure what they are purchasing or offering in the marketplace.

The organizational changes brought on by managed care may cause oncology professionals and patients to feel powerless against a force beyond their control. However, everyone has within him- or herself the power to change. That was the message from Edith Eva Eger, Ph.D., a clinical psychologist, lecturer, and Holocaust survivor. Dr. Eger shared with attendees her own inspiring story of fear, courage, and survival in the death camps at Auschwitz. "You can't always control your circumstances, but you can control how you respond to them," Dr. Eger stated. Those facing professional or personal change shouldn't allow fear to paralyze personal growth, she said. "Without change, nothing can grow."

ACCC's 24th Annual National Meeting

Thinking Outside the Box

Preparing for Oncology at the Millennium

March 11–14, 1998
Crystal Gateway Marriott
Arlington, Virginia

ACCC's 24th Annual National Meeting, "Thinking Outside the Box: Preparing for Oncology at the Millennium," will be held March 11–14, 1998. The site is the Crystal Gateway Marriott, overlooking Washington, D.C., from the Virginia side of the Potomac. Topics will include expert presentations on oncology contracting, outcomes measurements, benchmarking, information systems, marketing your program, regulatory issues, including new audits, new codes, and new attempts to regulate drug use...and much, much more. Look for your meeting program to arrive soon.

Mark Your Calendars!