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Negotiating the Challenges of the Millennium

by Donald Jewler

More than 350 cancer care professionals gathered in Long Beach, Calif., for ACCC's 16th National Oncology Economics Conference, held September 22-25, 1999. The implementation of the Ambulatory Payment Classification (APC) system and the proposal in Congress to reimburse for drugs at the Federal Supply Schedule were key areas of discussion. Attendees were also treated to expert presentations that covered a broad range of topics from facility design to implementing paperless patient records and changing physician behavior as a means to improve outcomes.

THE FUTURE OF ONCOLOGY REIMBURSEMENT

"We have very, very grave concerns about the Prospective Payment System as it was proposed by HCFA," said Linda M. Magno, managing director for policy development with the American Hospital Association, "...concerns about what this system will do to our ability to deliver care. Implementation of the PPS as proposed will result in an additional 5.7 percent reduction in total payments to hospitals for outpatient procedures, including chemotherapy, beyond other cuts already implemented under the Balanced Budget Act of 1997."

In its mission to salvage the beleaguered Medicare system, the Health Care Financing Administration is proposing sweeping cutbacks as part of the "Prospective Payment System for Hospital Outpatient Services." The system is based on a procedure classification developed by HCFA called ambulatory payment classifications, which group related procedures into categories and pay a predetermined price for each category. The new payment system is scheduled to go into effect in June 2000, and HCFA hopes it will bring down Medicare expenditures by 2002 in compliance with the Balanced Budget Act of 1997 (BBA). The BBA reduces payments to hospitals by about $44 billion for inpatient and outpatient services and about another $9 billion for skilled nursing and home health services.

Magno noted that the American Hospital Association (AHA) delivered comments on the BBA before the Commerce Committee, indicating strong concern about the data with which HCFA is calculating its payment rates under the outpatient prospective payment system. AHA believes that there are serious problems with the data HCFA is using to determine payment for chemotherapy.

In its comments, AHA has recommended that HCFA carve out the costs for chemotherapy and chemotherapeutic agents and pay "on a reasonable cost basis until the agency fixes the underlying coding problems, collects new data, and proposes new groups or rates.... Otherwise hospitals may be forced to close their cancer centers rather than provide lower quality or inappropriate care."

Echoing Magno's concerns about HCFA's proposed regulations was ACCC Executive Director Lee E. Mortenson, D.P.A. "Our studies show that by 1998, *if* HCFA's ambulatory payment classifications had been in effect as proposed, hospital cancer programs around the country would be reimbursed at less than fifty cents on the dollar for their Medicare-allowed costs for chemotherapy and supportive care drugs—$223 million below allowed costs."

Mortenson noted that APC methodology causes "perverse incentives to use older drugs." (See Figure 1.) In addition, APCs include no payments for supportive care drugs and inadequate payment for radiation oncology, which would lose substantially under the proposed system. For example, treatment planning (Level 1) would be reimbursed at $74 million below costs, treatment planning (Level 2) at $8.9 million below costs, and treatment delivery at $75 million below costs.

If all this weren't bad enough, further federal reductions are looming. According to presenter James L. Wade III, M.D., F.A.C.P., Congress is considering a number of other proposals to reduce Medicare costs, including reducing funding to hospital teaching programs (saving $50.3 billion); reducing inpatient capital costs (saving $5.9 billion in addition to the BBA); establishing copayments for lab services and home health care services (saving $74.4 billion); and tying premiums for physician services to enrollees' income (saving $33.57 billion).

"In addition, the Office of the Inspector General (OIG) has calculated that Medicare paid out $2.75 billion for drugs in 1997," said Wade, who is chairman of the American Society of Clinical Oncology's Clinical Practice Committee. "About 60 percent of that was for oncology drugs." The OIG argues that $1 billion a year could be saved if Medicare pays what the Veterans Administration pays, that is, the Federal Supply Schedule. ACCC will initiate a

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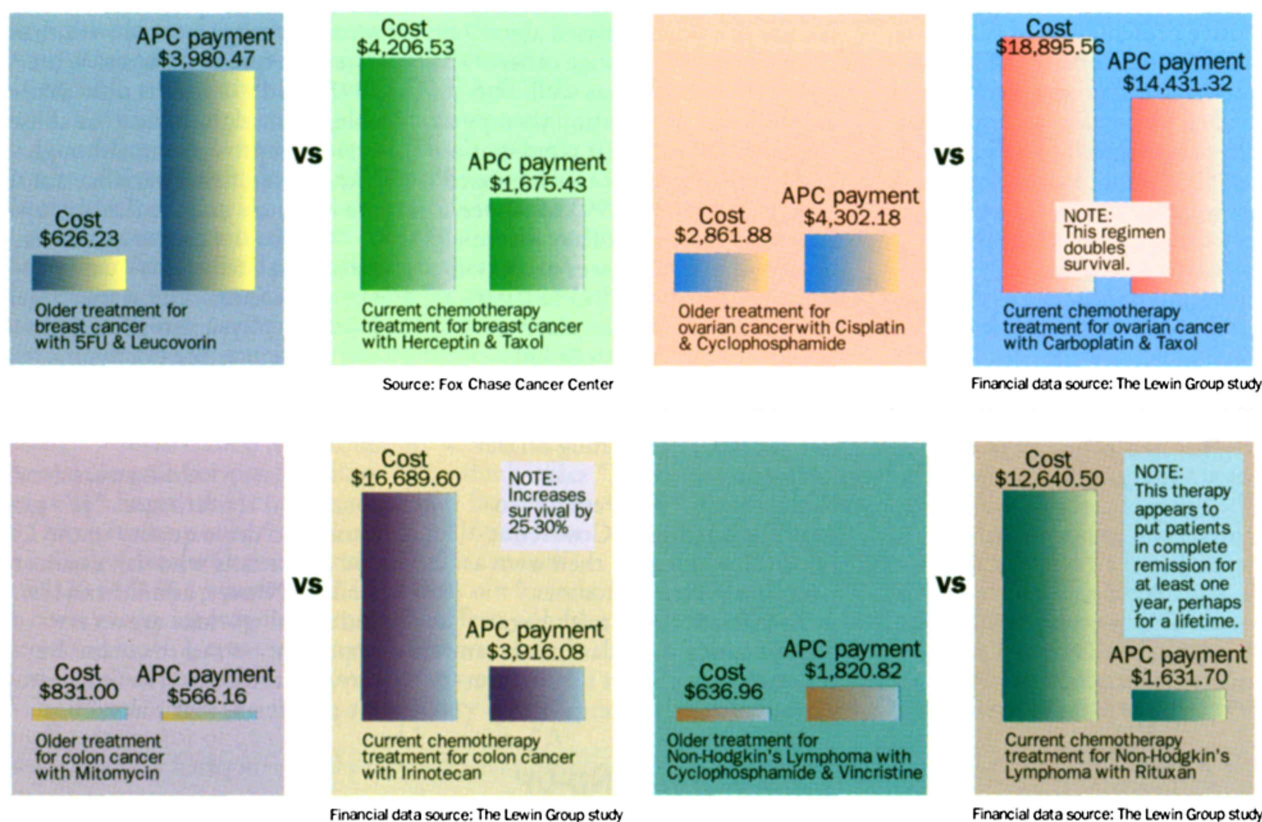

large-scale study to assess the potential financial impact on providers of changing Medicare to the Veterans Administration fee schedule.

"Managed care is not as big an issue as it used to be. The central issue this year is what the government is doing to our ability to deliver cancer care," said Wade. He called on all cancer care professionals to develop and strengthen their relationships with their congressional representatives. "Show them the good work you do, so they begin to realize the deleterious effects of these legislative and regulatory proposals."

To alert Congress about the detrimental effects of APCs on patient access and cancer program survival, ACCC is working closely with key organizations, including the American Hospital Association, the Oncology Nursing Society, the American Society of Clinical Oncology, and the American Cancer Society. According to Mortenson, ACCC has already met with key congressional leaders, and meetings between key congressional representatives and ACCC members are planned for the fall.

CHANGING PHYSICIAN BEHAVIOR

"We believe there is an inverse relationship between quality and cost," said Gale Katterhagen, M.D., medical director of the cancer program and breast center at Mills-Peninsula Hospital (a member of Sutter Health) in San Francisco, Calif. "If you meet your quality standards, if you meet your outcome standards rather consistently, your costs hold, or more often they start to fall. And if your costs are rising, more likely your quality is starting to fall."

Katterhagen described an ambitious attempt at the Mills-Peninsula Breast Center to improve outcomes, drive down costs, and increase market share for the hospital, medical group, and physicians. The goal was to directly change physician behavior.

He and his colleagues selected outcomes with quantified targets (such as reducing the DCIS axillary dissection rate to 0-2 percent in a certain number of months) that would impact mortality and/or morbidity in breast cancer patients. They set outcomes to measure, manage, and improve, including: 1) improving the percentage of cancers diagnosed at stage 0 to 1; 2) increasing the percentage of patients diagnosed at 1 cm or less; 3) increasing the percentage of patients diagnosed at 2 cm or less; 4) increasing needle biopsy rates; 5) decreasing axillary dissection rates for DCIS; 6) improving surgical breast conservation rates; and 7) expanding use of radiation therapy as a component of surgical conservation. Patient satisfaction and quality of life measures were also tracked.

"We made a commitment that this would be an evidence-based program in which data will overcome anecdote and local custom," said Katterhagen. "We recognized early on that data are key. If you can't measure it, you can't manage or improve it." He stressed the tremendous value of a hospital's own cancer registry as a source of information.

Katterhagen noted that changing physician behavior with regard to needle biopsies, for example, required repetitive presentation of the current literature on the advantage of core biopsy at weekly breast tumor boards, at weekly general tumor boards, at the cancer committee, at departmental meetings,

and in newsletters. Impacting physician behavior also required repetitive presentation of valid data (from the tumor board and breast center database) on the hospital and individual physician performance.

Physicians agreed to a quantified target: 50 percent of all breast cancers were to be diagnosed by needle biopsy technique, with the bar to be raised yearly. "This is a very efficient tool, as accurate as the surgical J wire, with much less morbidity and half the cost," said Katterhagen. There is a $1,200 to $1,400 cost advantage with each stereo core needle biopsy as opposed to surgical J wire, he noted.

The Breast Tumor Board developed and implemented evidence-based algorithms, and there was ongoing monitoring of needle biopsy rates. Results were impressive. The needle biopsy rate increased from 30 percent in 1994 to 80 percent in 1998.

Repetitive presentation of current literature and valid data and the use of evidence-based algorithms helped to change other physician behaviors as well. For example, use of radiation therapy as a component of breast conservation in T1 and T2 breast cases increased from 80 percent in 1993 to 90 percent in 1998. And axillary dissection rates in DCIS cases decreased from 44 percent in 1993 to 0 percent in 1998. That decrease was significant to the bottom line: each DCIS axillary dissection costs $2,500 to $3,000.

"We were not leaning on our doctors to cut costs," said Katterhagen. "We were out to improve outcomes. Cost reductions came along on their own as a result of better outcomes."

In 1996, Sutter Health began implementing a similar breast cancer outcomes project throughout its vast system of twenty-three hospitals and eight allied medical groups. All hospitals and medical groups were presented with their data on a quarterly basis. With 1997 and 1998 results now available, six of eight indicators show system improvement, although there is significant variance among the hospitals and medical groups.

"Our breast cancer quality is directly related to the quality of our physicians," said Katterhagen. "Quality physicians produce excellent outcomes. Mediocre physicians produce mediocre outcomes. And poor physicians produce poor outcomes.

"Let's stop kidding ourselves," concluded Katterhagen. "It's physicians who drive quality in the U.S. and physicians who drive cancer quality. Nurses, administrators, and social workers are a very important part of the team. But boy, it's the quarterbacking, i.e., the physician, that's key."

SIG ROUND-UP

Community Research/CCOP SIG. Three topics were discussed.

- "Update from the NCI: The STAR Trial." Leslie G. Ford, M.D., associate director for clinical research, Early Detection and Community Oncology, Division of Cancer Prevention, NCI, Bethesda, Md., noted that 18,840 risk assessment forms have been filed and 628 women randomized in the STAR Trial as of June 1, 1999, at 100 enrolling sites. On other fronts, ECOG will begin a new protocol on the prevention of primary non-small cell lung cancer with selenium.
- "Issues in Protocol Design and Trial Management" was the topic of a presentation by Michael R. Kurman, M.D., vice president of clinical and scientific operations, Quintiles Oncology Therapeutics, Cranford, N.J.
- "New Methodologies in Data Management" was led by Leslie A. Quinn, director of data services, Quintiles Oncology Therapeutics, Chesapeake, Va.

Medical Director SIG. "Affiliating with Comprehensive Cancer Centers" was presented by Jeanne M. Reiter, M.B.A., C.M.P.E., director, University of Wisconsin Comprehensive Cancer Center, Wausau Hospital, Wausau, Wisc., and Mark A. Dalebroux, M.P.A., director of regional development, University of Wisconsin Comprehensive Cancer Center, Madison, Wisc.

Radiation Oncology SIG. "Maintaining Quality of Radiation Oncology Care in an Age of Declining Reimbursement" was presented by Michael L. Steinberg, M.D., F.A.C.R., managing partner with Cancer Care Consultants Medical Associates and with the Santa Monica Cancer Treatment Center, both in Santa Monica, Calif. He examined significant variations in radiation oncology practice and quality care by physicians.

Nursing SIG. "Oncology Nursing Outcomes: Realities and Solutions" was led by Susan Lasker Hertz, R.N., M.S.N., A.O.C.N., oncology network director, HealthONE, Denver, Colo. She discussed an outcomes management model that includes identifying values, defining areas of study, protocol development, measuring outcomes, analyzing variance, and corrective action.

Administrator SIG. Three sessions were offered.

- "Site-specific Programming" was presented by Patti A. Jamieson-Baker, M.S.S.W., M.B.A., oncology service line administrator at the University of Illinois at Chicago Medical Center in Chicago, Ill., and Steven Shore, M.B.A., executive director of the Cancer Program at Holy Cross Hospital in Rockville, Md.
- "Facility Design" was led by Marsha Fountain, R.N., M.S.N., of The Stichler Group in Arlington, Tex., and Laura E. Potts, Ed.D., F.A.C.H.E., executive director of operations with U.S. Oncology—Texas Cancer Center, Fort Worth, Tex. (See accompanying article for details.)
- "Strategic Planning for Systems" was the topic of a presentation by Joseph F. Woelkers, vice president for clinical outreach programs, H. Lee Moffitt Cancer Center and Research Institute, Tampa, Fla. He examined the opportunities and selection criteria for strategic alignment.

A FACE LIFT OR A NEW FACILITY?

Despite threats to oncology reimbursement, cancer facility construction and renovation are on the upswing, according to presenters Marsha Fountain, R.N., M.S.N., and Laura E. Potts, Ed.D., F.A.C.H.E. In 1998, 109 cancer centers completed construction of new facilities and 74 broke ground. That's up from 1996 when 79 were completed and 48 broke ground.

According to Fountain and Potts, reasons for renovation or new construction included consolidation or integration of services, patient convenience, access to new radiotherapy equipment and more complex outpatient treatments, response to competition, and provision of one-stop shopping. Fountain is vice president of health care planning at The Stichler Group in Arlington, Tex. Potts is executive director of operations with U.S. Oncology—Texas Cancer Center in Fort Worth, Tex.

Renovation can be very expensive. "You think it is going to be cheaper than constructing a new facility but many times it may not be," said Fountain. "If you have a major renovation with major demolition, it can cost up to $130 to $150 a square foot." That does not include such costs as contingency fees, professional fees, administrative and moving costs, the owner's reserve, and important incidentals such as plants and artwork.

"The environment of a health care facility is an important indicator of quality," noted Fountain. "A one-stop approach can make for a more efficient, less stressful treatment."

PAPERLESS TECHNOLOGY

The University of Illinois at Chicago Medical Center is a 450-bed institution with 43 ancillary departments and a 400,000-visit ambulatory practice. Joy Keeler, interim chief information officer, had a tall order: eliminate duplicate data stored in multiple locations, facilitate attending co-signature requirements, and make clinical information in clinics dispersed across campus readily available. In other words, implement an electronic, or paperless, health record. By reducing clinician dependency on the paper record, Keeler and colleagues were confident that workflow would be improved and the redundancy of data entry and duplicative entry diminished.

Working with Paul Sinclair and others at the Cerner Corporation, Keeler introduced the Gemini Project to clinicians in 1997. Automated systems would be local (at 2,200 PCs throughout the medical center), remote, and web accessible.

After two years of hard work, today an electronic inbox features results to endorse, documents to sign, and telephone messages. Results, including lab, pathology, radiology, and echo, can be reviewed electronically. Paperless clinical care documentation includes directly entered notes using a template, the patient data and ambulatory intake forms, transcribed documents, and care documentation and routing.

The cost for the network and infrastructure: about $20 million over five years.

Future plans are to provide paperless inpatient physician order entry, as well as charting and charging from electronic forms; electronic task lists for nursing and ancillaries; and electronic medications documentation.

PROFESSIONAL OPPORTUNITIES

Administrative Director of Cancer Care

Witt/Kieffer has been retained by University Community Hospital in Tampa, Fla., to recruit a new Administrative Director for The Center for Cancer Care. This expanding, financially successful hospital system located in the northern suburbs of Tampa established The Center for Cancer Care approximately eight years ago. Cancer care services have grown as the system has expanded, and today its prostate cancer services, which are 50 percent of business, have a national reputation. With the addition of new hospitals to this system, opportunities to expand cancer care services have increased dramatically.

This is a wonderful opportunity for a dynamic, business focused, service line manager to take over a product line with a tremendous upside potential and the backing of a financially strong health system.

Please send a resume in confidence to: Peter Goodspeed, Witt/Kieffer, Ford, Hadelman & Lloyd, 5420 LBJ Freeway, Suite 460, Dallas, TX 75240. Phone: 972-490-1370; fax: 972-490-3472; e-mail: peteg@wittkieffer.com.

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