

Quality and oncology: who's on first?

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Defining quality care in oncology may be a slippery task, but clinicians must take the lead in the debate. Your practice and patients depend on it.

As football season fades and we look toward baseball's spring training, I laugh when I think of the famous Abbott and Costello sketch "Who's on First." In this routine, the names for each player are "Who," "What," "I Don't Know," "Why," "Because," "Tomorrow," "Today," and "I Don't Care."

The same confusion that reigns during the hilarious rendition of this sketch applies to discussions of quality and oncology. Some of the questions ("who," "what," and "why") are familiar. The answers are sought "today" even if they won't really be available until "tomorrow." "I don't care" doesn't apply in cancer and never has, but "I don't know" reigns supreme. Everyone wants to define quality and reward quality care. But the execution of these good intentions gets bogged down by challenges in technology and language, and the wide variation found in both.

There are other complications: a number of companies, such as disease management and specialty pharmacy firms, for example, want to enter the fray and manage oncology and oncology drugs. Payers feel the rising pressures of drug costs, member demand for the newest drugs to beat cancer, and the desire of employers to control premium costs. Because there is so little about the oncology spend that they can understand, payers feel frustrated. On the other side of the equation, physicians have historically assumed

that others grasp just how complex it is to deliver cancer care outside of the hospital setting in a manner that keeps the patient functioning in their family, work, and community.

Many voices

We hear from several respected organizations in this issue, each talking about its valuable contributions to the quality debate. The most common theme is that the definition of quality in oncology needs to grow out of experience, evidence, and analysis all along the continuum of care. This is still a major challenge, since most of the data needed for analysis is divided among the physician chart, hospital chart, payers' claims data, lab and imaging software, and missing key elements from other silos. Tumor registries are the most readily available source of outcomes data, but they rely on hospital-reported events.

There is a narrow window of opportunity in which the oncologist can establish control over the debate about quality care. Asserting this control will need to happen on many fronts: the specialty societies and provider organizations (such as American Society of Oncology [ASCO], Association of Community Cancer Centers, and National Comprehensive Cancer Network); networks of practicing physicians, both regional and national, including US Oncology and Cancer Clinics of Excellence; advocacy and volunteer organizations (such as the Community Oncology

Alliance); state associations and societies; and even local practices—especially local practices.

Although there are a number of measures currently out there, we still do not know what will define quality of oncology care. Many of the measures we now look at are not considered ultimate indicators of value by those paying for the care.

One of our biggest challenges in this debate is variation in care, both within and across practices. This variation is not driven by drug revenues as might be surmised by listening to the television sound bites of those seeking to manage oncologists' choices. Rather, the variation is the result of what happens when thousands of physicians, with all good intentions, seek to provide the right care for their individual patients who vary widely in health status, insurance requirements, support networks, living status, and personal or family preferences. And layered on top of all these variations are the choices not just of regimens but of dosing within regimens.

Where do we stand?

Before we can define quality in oncology care, we need to identify and understand what is happening and where we stand. This will require data registries that cross the continuum of care, including diagnostics, imaging, radiation therapy, surgery, medical oncology, hospice, alternative therapies, palliative care chemotherapy, biologics, and supportive care drugs.

Having Your Say

Unfortunately, no complete databases exist on oncology treatment. There are databases for each silo of care, and payer databases, but each one only covers its individual piece of the pie.

Constructing a universal database requires management and control, as well as access. Obviously, there are HIPAA issues; patient information would need to be protected. Building such a database across the full continuum of care would necessitate linking data coming in from many sources and would thus require some common identifiers to build a picture of each individual's disease course. And then there is the issue of who should manage the database. No individual payer, pharmaceutical company, pharmacy manager, specialty pharmacy or drug distributor, or for-profit company is sufficiently trusted to be given that responsibility.

Ultimately, the bond of trust between patient and physician is the strongest. Here is what is needed to

construct a platform and mechanism whereby treating physicians would oversee, manage, and learn from a universal database:

- Funding sources from other arenas such as payers, employers, or pharma;
- Universal access for providers and probably payer partners;
- Restricted access for all others, confined to the aggregated wisdom and analytics derived from the trends and outcomes shown in the database. Patients would, and should, expect no less.

Until such universal information helps us reduce the variation in care, each practice must take up the challenge of addressing these issues internally and locally. Participate in ASCO's Quality Oncology Practice Initiative project, and any other benchmarking and data aggregation opportunity you find that you can trust. Work with your local payers, hospitals, and tumor registries to craft local solutions. Be sure to ask the following questions:

- Who will see the data?
- Are the data being sold and for what purposes?
- What information will I receive from the database?
- How far across the continuum does the database reach?
- How flexible can we be in integrating this information into our daily practice and watching the effect of changes as we learn from the data?

In the meantime, we need to roll up our sleeves and create solutions that address this issue on a more global basis. I invite you to send me your ideas and information on any projects you start so we can continue to work on behalf of those practices struggling every day to provide the best care they can. We do need to know "Who's on First" and what constitutes quality care. To me, that starts with the physician, the patient, and usable information from the past to shape the future.

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