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Come Together (and Work Together) Right Now

Integrated Oncology Consulting Solutions
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By Steve Black, MBA

We're already well into the second month of 2014, and we're celebrating some milestones. A much-publicized one is the 50th anniversary of the Beatles coming to America. And we also celebrated another one—this one in our industry—when the Association of Cancer Executives (ACE) held its 20th anniversary meeting in San Francisco.

If one consistent theme prevailed at the ACE meeting, it was that of rising health care costs and how the U.S. outspends (per capita costs) almost all other industrialized countries—by significant amounts—for overall healthcare with no mortality improvements. This phenomenon is even more dramatic in our specialty: cancer care costs have risen 18 percent between 1990 and 2011 while U.S. health care costs have risen 9 percent and the U.S. GDP 3 percent (NCI).

Dr. John McConnell of the Center for Health Systems Effectiveness at Oregon Health & Science University focused on the fact that the majority of increases relative to GDP for cancer care are due in large part to an aging population, and that we should concentrate on what he defined as "excess growth" and spending versus quality. Our focus should be on appropriate care at the lowest cost with the greatest impact on life expectancy.

Additional presentations highlighted developing organization models that create a formal relationship between academic and community-based cancer programs along with ways quality improvement and evidence-based treatments will affect the cost of providing cancer care in the future.

Conference speakers agreed that we need to fundamentally change the way we deal with cancer care in this country. While our ultimate goal should always be cure, cure is not always possible, even with the best targeted therapies that we have today. There has been a shift from talking only about "the cure" to talking about the cancer care continuum, which starts at prevention and risk reduction and extends through end-of-life care. Patients are concerned as much about quality of life as they are about being a cancer survivor. We need to tell them the facts about their prognosis and the costs of different treatments. We must help them understand goals and be realistic about outcome versus cost, in both monetary and quality-of-life terms.

Many speakers talked about the need to stop the rhetoric. Paul Goldberg, editor of the *Cancer Letter,* and Dr. Derek Raghavan, president of the Levine Cancer Institute in Charlotte, North Carolina, discussed the "war on cancer" themes we've heard throughout the last few decades and how false expectations are being raised that cancer can be eradicated if the U.S. puts enough money toward it. Scientists dispel that "a cure" is forthcoming.

Dr. Raghavan is leading an effort to create a seamless organization that combines basic and translational research with traditional and complimentary therapies to provide the best care for patients close to where they live. He is a co-author of "American Society of Clinical Oncology identifies Five Key Opportunities to Improve Care and Reduce Costs: The Top Five List for Oncology," which offers a response to the American Board of Internal Medicine (ABIM) Foundation's Choosing Wisely® initiative. To read the article, visit http://jco.ascopubs.org/content/31/34/4362.full.

The bottom line is that healthcare costs continue to rise. Echoing the Beatles' song title, we need to come together—work together—with departments and organizations outside of the normal cancer center structure to control costs and eliminate duplicate diagnostic tests and treatments that do not provide a good quality of life for patients.

And it starts locally. Each organization or practice needs to develop methods to reduce costs and increase quality—and be able to prove it. The cancer program's physicians and leadership will need to be prepared to deal with an uncertain future. Examples of ways programs are doing this include:

- Development and adherence to treatment guidelines within the program/practice.
- Process mapping of services to find ways to reduce redundancy or improve throughput.
- Development of a quality measurement plan to benchmark against national standards.
- Development of a palliative care program which sees each patient at the beginning of the treatment phase to prepare the patient for end of life issues and determine in advance what the patient's needs are if treatment fails.
- Addition of patient navigator programs.

The Oncology Group can help your organization determine the best structure and strategy for your program. To learn more about the expertise of The Oncology Group and our outstanding team of consultants, please contact Steve Black, Vice President of The Oncology Group, at 512.583.8815 or by email at info@theoncologygroup.com.