Changing oncology compliance standards: step 1 in re-valuing clinician workload for value-based cancer care

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As the US health care system moves from incentivizing clinicians for high-volume oncology care to incentivizing them for high-value oncology care with benchmarked clinical and financial outcomes, we will need to understand and restructure existing oncology clinician workloads in an already overworked workforce if the new goals are to be met. A good starting point would be to change compliance standards, which would eliminate the meaningless, burdensome tasks that now consume clinicians' time and go a long way to drive the desired value-based cancer care delivery system.

In my more than 30 years of oncology practice, I have observed and experienced the significant expansion of the clinician workload – some of it meaningful, but a growing portion of it not – which has led to high rates of burnout and fewer clinicians entering oncology practice. This is putting the US oncology workforce on a collision course with the need to deliver value-based care for a growing population of oncology patients who have an increasing complexity of care needs.

The emerging shortage of medical oncologists has been reported,[1] and indications are that by 2020 we can expect a 40% increase in the number of cancer patients, in part because of a significant growth in the geriatric population. An older population will require more clinician time for eliciting symptoms and explaining options so that they can engage in shared decision making. In addition, older patients are poorly represented in clinical trials, which means that oncologists do not currently have robust outcome metrics and tools to draw on to support their more personalized advice.[1] Pair those challenges with the rising complexity of oncology patient care, and the need to implement workload reductions for all nonessential services becomes clear.

We can agree that the workload of medical oncologists needs to encompass participation in multidisciplinary care planning, coordination, and management, which includes considerations for patient participation in clinical trials. Clinicians have to understand how to order and use the new diagnostic and therapeutic options across the cancer care continuum, and be current in their grasp of the ever-increasing number of molecular diagnostics that guide the practice of evidence-based, precision care. For oncologists to be able to deliver such care, there needs to be more detailed and efficient collection of data at every stage and for every aspect of medical care. This means engaging with patients to document their medical histories, treatment preferences, and therapy-related toxicities. It means leading clinical and administrative teams to gather complex clinical data documenting detailed tumor staging and progressions, the therapies that are selected and delivered as well as their sequencing and responses to them, and the plans for survivorship, palliative, and end-of-life care. Structured data is needed in this detail to effectively analyze complex clinical and financial outcomes across the spectrum of a patient's cancer care as the delivery system is reorganized and providers compete to provide the best outcomes for the lowest cost with increasing transparency to consumers. Clinicians and their administrative teams will need time to study and understand analytic reports and translate that data into meaningful educational platforms for patients.

The opportunities are daunting but exhilarating because it means providing more comprehensive, patient-centered medical care. However, the practical realities currently translate into a burdensome, unsustainable workload for medical oncologists. Before we can get to these more individualized patient care programs, we have to ensure that the workforce is adequate and comprised of energetic, well-educated, compassionate, team-oriented clinicians whose workloads are sustainable over time.

Workloads can already be expected to expand as we collect, analyze, and integrate more personalized molecular and health data into evidence-based medicine. Our current evidence base has been extrapolated from relatively small

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clinical trials of healthy, younger, less diverse populations, and until more recently, without the rich molecular subtyping that can help us better target meaningful clinical therapies. This expanded testing and knowledge will need validation in specific populations if it is to help us deliver truly personalized care and education for our diverse and growing patient population. Data collection to date has not focused on the expansive list of structured data we need to evaluate clinical and financial health outcomes, which would include consideration of patient comorbidities and concomitant medications that could affect overall health outcomes. Getting to a point where such analytics can be done will require commitments from the patient and every member of the clinical care team to contribute to the collection of data. In addition, it will take new teams of clinician scientists to understand the data, and others to help build the tools to facilitate patient-centered decision making so that clinicians can draw on those improved databases to expand their understanding of total costs of care and value.

However, we won't be able to reach those stages without altering the current oncology clinician workload, which has resulted in high rates of burnout and fewer trainees in oncology.[2] We must advocate for reforms to reduce administrative burdens and the aspects of data capture and documentation that do not meaningfully contribute to improving patient health outcomes if we are to expand the ability of team-based care. To get to value-based care, we have to start valuing clinician time, including the growing amount of non-face-to-face time for care planning, analytics, coordination, and management.

A start in addressing this issue would be to change the current volume-based compliance requirements by the Centers for Medicare and Medicaid Services and private payers for billing and coding and develop compliance standards for billing and coding, work responsibilities and compensation models that support value-based care. Our volume-based standards for billing and coding have spawned a massive workforce of people who code, bill, and collect and of administrators and legal teams that evaluate compliance with coding for patient care with concomitant costs and threats of significant financial penalties. None of those individuals, who add untold costs to our health system and meaningless demands on clinician time, contribute to improved patient health outcomes. At a time when we must leap-frog into value-based care transitions, the prevailing time-consuming compliance requirements are a major road-block to improving cancer care for our patients.

It is essential that leaders in medical oncology support this transition to value-based cancer care by advocating for and engaging in research and pilot studies to understand oncology clinician workloads by eliminating all nonessential clinician work. There needs to be study and analysis of the many clinical and intellectual time demands for medical oncologists to remain up to date, energized, and able to lead talented clinical teams. A first step would be to change compliance requirements and then payment standards to support value-based care. Evaluation and management (E&M) codes remain the primary billing and workload evaluation standards for clinician services. They remain a mish-mash of numerical data on time spent, patient history, reviews of systems, and physical exams, as well as arguable levels of decision-making complexity. The required collection of data, such as whether 3, 5, or 8 review of systems were documented, and the increasing focus on time and training, monitoring, and oversight of coding components has nothing to do with capturing the structured and relevant clinical and patient data needed to improve health care decision making and analytics.

Instead of the current E&M coding components, we need Medicare and private payers to begin incentivizing for collection, use, and reporting of relevant data. This includes data on patient status, comorbidities, cancer diagnosis, disease stage, tumor-node-metastasis classification, molecular features and their changes over time, therapies by guidelines or warranted variations for health or patient preferences, response to therapies, sequencing and outcomes of therapies for recurrences or advanced disease, toxicities and their management including additional clinical care, emergency room and hospitalizations, and long-term health outcomes with associated financial costs. We need recognition for the time it takes to collect, analyze, and integrate useful data into clinical practice. We need to optimize the roles of clinician-led team members because while clinicians can lead a team, they cannot individually complete all the required tasks, nor is their time well spent doing so. Restructuring the workload and the workforce to meet the growing complexities in oncology disease management and patients' needs is crucial if we are to achieve positive patient, clinician, financial, and clinical health outcomes.

This gathering of data would not have been possible before the advent of electronic medical records (EMRs). However, we now need these programs to become as empowering as the apps we have on our phones. We need EMRs that facilitate the efficient collection of structured data on patient health and preferences that also prompt members of the oncology team to order the most cost-effective targeted workups, therapies, and follow-up care for any given diagnosis. These EMRs need to facilitate clinical research at the clinic where the patient is cared for while also collecting the clinical and financial outcome data needed for health care practices and systems to understand and benchmark their outcomes so that we can continue refining and improving care.

The cost of health care in the United States should not be twice as costly as it is in other developed countries, with

no better outcomes.[3,4] Cancer is one of the top 5 chronic diseases in adults, and the rising costs of care threaten to thwart attempts to improve health outcomes going forward. A clinically meaningless administrative burden on an already burnt-out and inadequately supported medical oncology clinician workforce must be addressed. At the same time, we need to figure out how to collect the many key data points to achieve relevant clinical and financial outcomes in cancer care. Relief from compliance with the current E&M coding would free up clinician and administrator time and resources to focus on more meaningful data collection. This is a good first step to facilitate meaningful data collection, a more manageable oncology workload, and the move to value-based health outcomes.

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