ASCO's Clinical Practice Committee

Planning for Success

Peter Paul Yu, MD

By Peter Paul Yu, MD

In East Coast medical schools, students were often taught by their residents that surviving residency depended on two principles of conduct: trust no one, and if you want it done, do it yourself. Hopefully, these rules have gone the way of the 24-hour on, 24-hour off on-call schedule. Today, they seem anachronistic in a world where the complexity of patient care increasingly requires

collaborative effort among health care providers. There are an increasing number of health care providers contributing to the cancer patient's care due to advances in diagnostic and interventional radiology, combined modality treatments, and wider acceptance of mid-level providers. In addition, patients and their families have begun to accept a larger responsibility for the success of their own treatments, and they must be provided with the means to participate in their care. Coordination of care has become increasingly important to achieve quality cancer care and clinical outcomes that match those reported in closely supervised clinical trials. The Institute of Medicine (Washington, DC) has identified this as a major issue for improving the quality of cancer care.

Sen. Dianne Feinstein (D-CA) introduced the idea of the medical oncologist as a cancer care "quarterback" in her bill, the National Cancer Act of 2002. This is a role with which medical oncologists are already comfortable. We are all familiar with the relief that patients and families express when they first see a medical oncologist and are able to identify a physician who can provide a cohesive synthesis of their work-up, detail a plan of action, and take responsibility for the coordination of their care. A detailed plan of action is the first order of business in delivering quality cancer care.

Recently, Dr Deborah Schrag from the Memorial Sloan-Kettering Cancer Center (New York, New York) has led the American Society of Clinical Oncology's efforts to develop treatment plan and summary templates for adjuvant therapy of colorectal cancer. The templates have been reviewed by the Clinical Practice Committee, and similar documents for lung, breast, and prostate cancer will be produced. The treatment plan begins with details of the patient's work-up, including information beyond simple American Joint Committee on Cancer staging. An intended plan of care is detailed for the

benefit of both the patient and the health care team. At the completion of treatment, details such as treatment dates, dose modifications, and toxicities are documented in the treatment summary. A survivorship plan for follow-up with appropriate surveillance testing and identifying relevant specialists concludes the document at the end of active treatment. (See the *Journal of Oncology Practice's* March 2006 cover story for a detailed survivorship care plan.)¹

The document, while a powerful tool, requires significant effort to populate the data fields. This effort can be greatly facilitated by integrating the treatment plan and summary into electronic health record systems. Optimally, if the different vendors for electronic records could generate consistent treatment plan and summary reports, transfer of records could be facilitated. Ideally, patients with cancer will be able to readily download their treatment plans and summaries onto portable memory devices for use by health care providers in other locations.

For the treatment plan and summary to become widely adopted, adequate reimbursement for that work effort will be necessary. To this end, Rep. Lois Capps (D-CA) and Rep. Tom Davis (R-VA) introduced H.R. 5465 in 2006. This bill would require the Centers for Medicare & Medicaid Services to reimburse the work effort of creating a treatment plan and a summary at a proposed rate equal to the sum of a new patient consult and home health certification codes (\$298 at 2006 reimbursement code levels). A treatment plan would be required to be constructed and presented to the patient within 1 week of diagnosis, helping to ensure prompt referral to an oncologist.

In 2007, the Clinical Practice Committee will work with the electronic health records community, the Oncology Nursing Society (Pittsburgh, Pennsylvania), the patient advocacy community, and legislators to help introduce the treatment plan and summary into clinical practice.

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Reference

1. Building a bridge of continued care for cancer survivors. *J Oncol Pract* 2:77-82, 2006

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