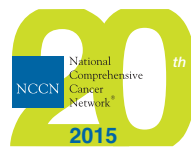


The Birth of NCCN

Joseph V. Simone, MD



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Since 2000, Joseph V. Simone, MD, has been president of Simone Consulting Company, which advises organizations on cancer program organization, quality, and development. He spent most of his medical career at St. Jude Children's Research Hospital in Memphis, where he joined the staff in 1967 and served as its director from 1983 to 1992. There, he played a leadership role in the development of curative treatments for childhood leukemia and lymphoma. From 1992 to 1996, he served as physician-in-chief at Memorial Sloan Kettering Cancer Center where he instituted a disease management system and a satellite hospital system. He served as Senior Clinical Director of Huntsman Cancer Institute from 1996 to 2001, and was instrumental in the design of the Huntsman Cancer Hospital. He served as Director Pro Tem of University of Florida-Shands Cancer Center from 2008 to 2010. He is Clinical Director Emeritus of Huntsman Cancer Institute and Professor Emeritus of Pediatrics and Medicine at University of Utah School of Medicine.

Dr. Simone has served as chairman of the National Cancer Policy Board of the IOM, which has published several reports on the quality of cancer care. He was the founding medical director and chairman of the board of NCCN. He has served on the Board of Scientific Advisors of the NCI and he serves on the external advisory committees of 8 NCI-designated cancer centers. Dr. Simone is the founder of ASCO's Quality Oncology Practice Initiative. He is also a columnist for *Oncology Times*.

The ideas and viewpoints expressed in this editorial are those of the author and do not necessarily represent any policy, position, or program of NCCN.

A bit of background history will be useful to understand the foundation of NCCN. In the 1980s, Medicare changed its hospital reimbursement system from a cost-plus basis to one based on diagnosis-related groups, later called the *prospective payment system* (PPS), which attempted to control inpatient costs by using the average regional cost for a disease or procedure as a payer benchmark. This rule was applied broadly. However, specialty hospitals, such as children's hospitals and freestanding cancer hospitals, were later exempted from PPS because there were too few such hospitals in any region to set a valid average cost and because these centers had more patients with advanced disease. The original 8 cancer hospital exemptions went to Memorial Sloan Kettering Cancer Center, The University of Texas MD Anderson Cancer Center, Roswell Park Cancer Institute, Fox Chase Cancer Center, City of Hope Comprehensive Cancer Center, USC Norris Comprehensive Cancer Center, Dana-Farber/Brigham and Women's Cancer Center, and Fred Hutchinson Cancer Research Center/Seattle Cancer Care Alliance. This exemption allowed these centers to charge on a negotiated cost-plus basis, which was a huge financial advantage. Others were added later. Representatives of this initial group of PPS-exempt cancer centers met regularly, especially after the general election of 1992.

In 1993, the new Clinton administration attempted to radically change how hospitals were paid. This caused uproar among academic centers of all kinds because one of the provisions in the draft proposal was to redirect patients to community hospitals, which were far less expensive than academic hospitals. I had been at Memorial Sloan Kettering Cancer Center for only a year and became deeply involved in trying to deal with the potential changes.

Meetings with representatives of the PPS-exempt cancer hospitals were intense as we struggled to focus on a plan. This was not easy. Some felt that the goal should be to protect market share. We met with politicians, medical directors of large corporations, and insurers, trying to make a case for sending patients preferentially to well-known cancer centers. We did not get very far. We learned that insurers were made up of regional branches that operated under different laws.

A few of us then came to believe that we should promote the attraction of higher quality care. We tried that with medical directors, insurers, and others, and soon discovered a big problem: there was no objective evidence that the marquee cancer centers provided better care or cured more patients than community hospitals.

Nonetheless, I was asked to lead a subgroup to develop a plan around the idea of higher quality and, incidentally, to serve as the first head of the project. We pitched the idea of developing cancer care guidelines to the PPS-exempt centers and received a mainly cool reception. This was partly because of the fact that we needed money from each participating center to fund building the guidelines. But with the invaluable help of Catherine Harvey, DrPH, and Bruce Ross, we managed to get funding commitments from each center via annual dues (\$100,000 per year) and got rolling with the draft of a strategic plan.

We later realized we could not pull this off with only volunteers and needed a full-time leader and staff. NCCN hired Bill McGivney, PhD, and Rodger Winn, MD, came on as medical director, and, after an initially slow start, the program began to take off. Bill McGivney took over annual meetings in Florida the second year (started by Dr. Harvey and others), which were highly successful. Dr. McGivney also promoted the convening of disease-specific committees of volunteers from the participating cancer centers.

I'm pleased to say that after I left Memorial in 1996, NCCN continued to do very well and has become a reliable national and international source for cancer care guidelines.