Commentary

Journal of the National Comprehensive Cancer Network

The Future of the NCCN

David C. Hohn, MD

David C. Hohn, MD, came to Roswell Park Cancer Institute (RPCI) in 1997 from the University of Texas M. D. Anderson Cancer Center, where he served as Vice President of Patient Care.

Dr. Hohn has aggressively positioned RPCI as a national and international leader in cancer; transitioned the Institute from a state-run facility to a Public Benefit Corporation; reorganized senior leadership teams, clinical departments, and scientific programs; and successfully coordinated a massive recruitment effort.

JNCCN spoke with David C. Hohn, MD, President/Chief Executive Officer of Roswell Park Cancer Institute and NCCN's newly elected Chair of the Board of Directors, about his vision of NCCN's role in today's changing health care environment and its involvement in changing the way cancer treatment of the future is delivered.

JNCCN: Dr. Hohn, you've been an academic cancer surgeon as well as a high-profile executive leader at two of this country's premier NCI-designated cancer centers. From your experience, what is the single greatest challenge that NCCN members face today?

DCH: When I became a practicing physician in the 1970s, I focused fully on delivering quality cancer care, performing laboratory research, and conducting clinical trials—the hallmarks of the academic medical profession. In those days, I gave little thought to medical economics, reimbursement issues, cost-efficacy, and standards of care, and absolutely no thought to outcomes measurement beyond the relatively simple measures of morbidity, mortality, response rate, time to recurrence or progression, and survival.

Although the priorities of medicine have remained essentially the same, the *practice* of medicine is now heavily influenced by the *business* of medicine, with the shadowy outlines of concepts like "pay for performance" and "quality or outcome based reimbursement" looming as the sequels to fading images of "managed care." In other words, medicine, for better or for worse and for the foreseeable future, will be largely driven by the business of medicine and the chilling realities of the rising fraction of gross domestic product allocated to health care (approaching 15%), rising numbers of uninsured or underinsured, and the increasing recognition that a substantial fraction of the national health care budget is spent on services that are "non-value-added" (pardon my euphemism).

Physicians, insurers, hospitals, and academic medical centers all face and share increasing fiscal responsibilities and challenges. Cancer centers also will be required to rigorously justify and standardize (with evidence and data) our evolving treatment approaches. If we do not, we can rest assured that others who are less qualified will do it for us. So I would say that influencing the changing reimbursement mechanisms and responding to those changes will be our greatest challenges.

JNCCN: What other issues concern you?

DCH: Many do, such as funding our research as we face gaping chasms in the federal budget, addressing the scarcity of clinician-scientists, and solving the problem of the escalating shortage of health personnel to care for our expanding, aging population of patients who will expect and deserve the best that medicine has to offer. The NCCN should take the lead in opening the dialogue to begin meeting these and other emerging challenges.

JNCCN: What do you believe the top priorities for NCCN members over the next 5 years will be?

DCH: Given the challenges I have described and perhaps others, it is clear that NCCN members will need to grapple strategically with national health policy matters if we are to succeed. The overriding priority will be to exploit the most

promising leads in the pursuit of more effective approaches to cancer treatment and prevention.

A related priority that will absorb a great deal of time and energy will be the pursuit of diverse funding to support the substantial un-reimbursed costs of cancer research. Equally important is maintaining current levels of scientific research funding to avoid even short-term funding disruptions that may have a long-term negative impact.

Many cancer centers are investing increasing time and money into recruitment of staff from an insufficient pool of candidates, so training and hiring talented staff to replace and expand our ranks will be a dominating priority. Funding for training the next generation of scientific and clinical investigators should be pursued vigorously, and careers in oncology should be encouraged at every opportunity.

I am certain that we will not be able to meet the challenges posed by expanding patient demand for our services and the need to translate our best research more quickly through the clinical trials pipeline without developing new models for integrating cancer care on a community and regional basis. This can only be achieved by developing synergistic partnerships between cancer centers and referring physicians, community oncologists, and others. This is a major priority for my own institution (Roswell Park), and I believe that application of the NCCN guidelines and outcomes data will prove to be an invaluable asset in building new integrated cancer care systems. When community and academic cancer specialists can measure, compare, and modify practice patterns against these standards, many of the barriers to such integrated systems may begin to fall. For reasons that I have already mentioned, cancer specialists practicing in academic and community settings will increasingly recognize how much they need each other in the years ahead. Implicit in my forecast is the assumption that application of the NCCN guidelines in every day practice will become increasingly pervasive.

JNCCN: Do you believe that the changes in reimbursement to community medical oncologists mandated by the recent Medicare legislation will impact our cancer centers?

DCH: If not modified, the provisions of this legislation will, in my opinion, cause significant disruption in the cancer care delivery system, will reduce access to basic cancer care services, and will create pressure on the nation's cancer centers. The shock waves will be felt by cancer patients throughout the country. The tremors are already being felt in some communities as established oncologists consider other options, including early retirement.

These changes will have ripple effects. First, they will trigger similar reductions by the commercial payers. Second, in the face of an insufficient number of medical students entering medical oncology, the reduced incentives will have further negative impact. The forces at play are pretty simple. If earned income is not significantly greater than for general medicine, trainees are less likely to spend an additional 2 to 4 years in fellowship training.

JNCCN: As you know, the NCCN has pioneered the development of collaborative, multidisciplinary cancer treatment guidelines. Do you see other ways in which the NCCN can build on this collaborative model?

DCH: Multidisciplinary teams of experts from the 19 member institutions of the NCCN have provided leadership in developing cancer care guidelines and, thereby, have established standards on how that care should be delivered and measured; this is a remarkable, unprecedented achievement. Going forward, we will need to rely on the same collaborative approach to establish outcomes parameters linked to the respective guidelines to allow quantitative benchmark assessment. NCCN members are already pursuing such efforts in breast cancer and non-Hodgkin's lymphoma. Similar efforts will need to follow for the other common types of cancer. Quality assessment based on outcomes will no doubt be incorporated into future reimbursement models and, as I mentioned earlier, will be invaluable to creating requisite integrated cancer care systems.

Further, the NCCN can enlist the expertise of the best subspecialists in the field to drive the process of developing and defining additional measures in determining quality care. Given its complexity and biologic variability from patient to patient, this will be a greater challenge for oncology than it has been for other specialties. However, it is a challenge that must be overcome. I am confident that the outcomes data NCCN members are collecting and analyzing will be critically important in this effort.

JNCCN: How do you see outcomes data being used in the delivery of cancer care in the future?

DCH: I would say that outcomes data will play a significant and continuous role in the delivery of cancer care. We have built a comprehensive library of NCCN guidelines, and they are being used by an ever-expanding group of interested parties, including physician groups, hospitals, insurance companies, governmental agencies, and the public. We now need to turn our attention to finding ways to encourage wider application of guideline-based care for cancer patients. We also need to develop measurement tools to facilitate determination of guideline compliance by health providers. We have every reason to believe that efforts will be made to incorporate this sort of information into future reimbursement models.

JNCCN: From your perspective, what are the unique roles of the NCCN members?

DCH: The most unique feature of NCCN member institutions is their provision of the dedicated expert faculty members who write and continually update the guidelines. Faculty members from several NCCN institutions are developing disease- and guideline-specific outcomes databases that are enabling measurement of treatment efficacy. The member institutions perform many of the trials that ultimately provide the evidence on which the guidelines are built. Member institutions also provide a variety of unique, innovative therapeutic resources, training for the next generation of cancer researchers, public outreach programs, and continuing education for the practice community.

JNCCN: Finally, what do you hope to achieve during your tenure as chair of the NCCN board of directors?

DCH: We've watched the NCCN evolve into a force that is changing the way cancer care is delivered and measured. As the NCCN grows, so does its influence, regionally, nationally, and internationally. We must remain focused on upholding the exemplary standards that identify NCCN member institutions as centers of excellence. We must also ensure that the new and enhanced programs and services provided through the NCCN will improve the lives of cancer patients, not only in our individual regions, but throughout the world.

Specifically, I hope to foster continued growth of the NCCN by:

- Maintaining and updating cancer care guidelines to ensure that they are comprehensive and based on contemporary knowledge;
- Facilitating the use of cancer care guidelines throughout the health care system;
- Maintaining, expanding, and more fully using outcomes data;
- Determining how outcome and quality indicators may be utilized in new and evolving reimbursement models such as "pay for performance;"
- Fully engaging the leadership of member institutions to ensure that their needs are being met and that their input is being incorporated into NCCN strategic plans;
- Providing a forum for member institutions to address and solve some of the serious challenges and problems that I outlined in my response to the first two questions.

JNCCN: Thank you, Dr. Hohn, and good luck.