Delivery System Reform and Cancer

Providing More Coordinated, Patient-Centered Care to Cancer Patients

The Affordable Care Act and Delivery System Reform

Our nation's health care system is one of the most expensive in the world. Yet the quality of care we deliver to our citizens continues to lag behind that of other industrialized nations. To improve health care quality and reduce costs, the Affordable Care Act (ACA) takes steps to change the way we pay for and deliver health care in this country. The ACA created a Medicare and Medicaid Innovation Center to experiment with new health care delivery pilots and introduced financial incentives to encourage doctors and hospitals to work together to provide higher quality care. These new payment and delivery system models emphasize greater coordination among providers, increased access to primary care, the use of health information technology (HIT), and ongoing performance monitoring through quality reporting.

Delivery System Reform and the Cancer Patient

Currently, patients with a chronic disease such as cancer often receive health care services from multiple physicians and specialists who rarely coordinate care. Because of this lack of coordination, cancer patients and their families will often experience conflicting diagnoses, duplicate tests and procedures, and contradictory medical information from different physicians involved in their treatment. This is not only frustrating for patients, who essentially have to understand how to access and navigate our complex health care system on their own, but is also costly and inefficient. According to the National Institutes of Health (NIH), the total cost of treating cancer in America was $263.8 billion in 2010. Finding new ways to manage and treat illness, particularly for patients with chronic conditions such as cancer, is necessary to improve the quality of cancer care and reduce escalating health care costs.

> *I almost lost my son in the middle of [treatment] because this doctor said one thing, this doctor said something else, and this one said something else. I wanted to see every doctor who was on his team in a roundtable meeting. After that, we talked and it was much better. But communication – they don't do enough of sitting down and telling one another about the patient.* (Family Caregiver, Louisiana).
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> *My husband was treated for cancer at one hospital. Then he was treated at another hospital. And not only did he not have his cancer physician, he did not have his family physician. Instead he had a hospitalist, and the hospitalist wanted to do something that we knew not to do. It was very difficult for us to stop [that care]. The hospitalist didn't want to take our word for it.* (Family Caregiver, Michigan)
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> *You end up having so many specialists and that's a problem. I ended up going to the orthopedist for the broken bones, going to the neurologist for the neuropathy.* (Breast Cancer Survivor, Maryland)[1]

[1] Quotes extracted from discussion groups on the quality of cancer care held with cancer patients, survivors, and caregivers by ACS CAN and George Washington University. September 2011.

New Models for Reshaping our Delivery System

The ACA supports the development of three key payment and delivery reforms that could play an important role in enhancing the quality of care delivered to cancer patients: *Accountable Care Organizations (ACOs), Patient-Centered Medical Homes (PCMHs), and Bundled Payments*.

Accountable Care Organizations (ACOs): ACOs are typically modeled on integrated health care delivery systems such as the Mayo Clinic, Geisinger Health System, and Kaiser Permanente. ACOs are networks of providers that come together and agree to be held accountable for the full continuum of care they deliver to a patient. Primary care is often at the core of an ACO and care is typically managed by an interdisciplinary team of health care professionals. Quality measurement and ongoing performance monitoring are critical to the success of an ACO. ACOs that reduce costs and improve quality are eligible for bonus payments.

Medical Homes: The "medical home" is a care model that emphasizes primary care delivery. Within a "medical home", the primary care physician takes collective responsibility for patient care by providing and arranging for appropriate care. Although "medical homes" may be part of an integrated delivery system such as an ACO, they are typically single practice entities that do not include specialists and hospitals. Like ACOs, medical homes offer patients access to a team of health care providers that might include physicians, advanced practice nurses, physician assistants, patient navigators, nutritionists, social workers, and care coordinators.

Bundled Payments: Medicare, Medicaid, and many private health plans make separate payments to providers for every test and procedure they deliver to a patient. This creates an incentive for physicians to deliver more services to patients even when these extra procedures and tests do not improve a patient's health. By bundling payments to doctors for all of the care they provide in response to a health condition or hospital admission, health providers are encouraged to deliver care more efficiently.

ACOs, Medical Homes, and Bundled Payments share common elements directed at fostering coordinated, patient-centered care for patients with complex, chronic illnesses such as cancer.

The objectives of ACOs, medical homes and bundled payments are to improve health care quality and lower costs by incentivizing providers to deliver more efficient, coordinated care. Ideally, patients receiving care through a medical home or ACO would have fewer provider visits because all doctors involved in a patient's care would communicate and work together to avoid duplication and reduce unnecessary services. Common characteristics across payment and delivery reform models include an emphasis on holistic care delivered by an interdisciplinary health care team, shared decision-making between patients and physicians, the use of health information technology to facilitate care coordination, enhanced access to care, and ongoing quality reporting to assess performance. For the typical cancer patient who frequently experiences a variety of challenges navigating the U.S. health care system, these new delivery models demonstrate the potential to improve the quality of cancer care. In the coming months, ACS CAN will continue to monitor these innovative models to better understand their impact on cancer patients and their families.