



Oncology Medical Home Initiative

Overview (Updated 9/21/12)

Community Oncology Alliance

The cost of health care has become part of the national dialogue on the fiscal health of the United States. Regardless of political ideology, there is a common belief that the federal government — the single largest purchaser of health care — needs to accomplish two things concurrently: purchase quality and efficient health care. The two operative words are “quality” and “efficient,” the latter referring specifically to cost. And private payers have adopted a similar quest in terms of ensuring quality health care delivery in a cost-contained environment.

This is certainly true of cancer care, where costs have increased substantially with new therapies. Attempts by Medicare and private payers to contain costs by cutting provider reimbursement have had the unintended consequence of consolidating the cancer care delivery market. This consolidation is creating patient access issues, and is increasing costs for both patients and payers. We also believe that reimbursement changes are the root cause of the shortages of low-cost injectable cancer drugs.

The medical home model of cancer care that the Community Oncology Alliance (COA) is pursuing provides elements that all primary stakeholders — patients, payers (both primary and secondary), and providers — want in ensuring quality, efficient cancer care delivery. We know this because that is exactly what the stakeholders have communicated to us. What this document is intended to do is to answer the following questions:

- What is the Oncology Medical Home?
- Why is it a viable model for all stakeholders?
- How is COA implementing the model?

What is a “Medical Home?”

In basic terms, the patient has a “medical home” that is the central “coordinator” or “gatekeeper” of their medical care, and as importantly becomes a source of hope and comfort. Typically, the medical home is a primary care physician who becomes the point person for coordinating the patient’s total care, including both primary and specialty care. The theory is that the medical home model of patient-centered care results in important positive outcomes relating to the quality, efficiency, and cost of patient care by optimizing care coordination. The medical home model has been around for over 40 years and has been evolved and piloted since its introduction.

What is the Logic of an Oncology-Specific Medical Home?

At first glance, it would appear that the concept of an oncology-specific medical home flies in the face of reason by defeating the purpose of a medical home managed by the primary care physician. However, the rationale is seen in the complexity and severity of cancer treatment. When a person is diagnosed with cancer, in the majority of cases, the treatment of the cancer becomes the primary focus of medical care. Other medical care needs to be coordinated in the context of the primary goal of treating the cancer. In many cases, the patient receives highly specialized treatment, such as chemotherapy and radiation. Chemotherapy and other types of cancer drugs are potentially toxic and require administration at the site of care by specially trained oncology nurses. These drugs can cause serious side effects that need to be treated in the context of the patient’s overall cancer care.

Few primary care physicians have the expertise and facilities to administer cancer treatment. Additionally, primary care physicians are not trained or comfortable with the intensity of symptom management (e.g., related to pain, nausea/vomiting, neuropathy, and blood count management) typically required in providing cancer treatment. As such, because treating the cancer becomes the medical priority, in most cases the oncologist functions as the patient's primary medical caregiver during the phase of active cancer treatment and follow-up care.

As the medical home for the cancer patient, the oncologist is in the best position to ensure that treatment is optimized and that adverse events are minimized — with a goal of eliminating them based on process improvements. These events include treatment side effects that require additional care and, in cases, can lead to emergency room (ER) visits and/or hospitalizations, which can be detrimental to patient outcomes and substantially increase the cost of patient care.

What is the Research Supporting a Medical Home Model in Oncology?

There are 2 reports that support the implementation of an oncology medical home model.

An Institute of Medicine (IOM) report in 1999, *Ensuring Quality Cancer Care*, identified specific ways to improve cancer care. The report established that cancer care is optimally delivered in systems whose processes of care provide:

- Standardized evidence-based guidelines for prevention, diagnosis, treatment, and palliative care
- Measurement and continuous monitoring of a core set of quality measures
- Agreed upon care plan prepared by experienced professionals, outlining the goals of care
- Access to clinical trials
- Policies to ensure full disclosure to patients of information about appropriate treatment options
- Mechanisms to coordinate services
- Quality care at the end of life
- Policies to address the barriers to receiving appropriate cancer care in specific segments of the population

Another IOM report, *Assessing and Improving Value in Cancer Care*, focused on the uncertainty of where we are currently wasting resources (paying for goods and services of little value) and where we should be increasing our resource commitments (high-value goods and services that patients underutilize). High value services are defined as services that improve results, reduce potentially avoidable complications, and reduce unnecessary resource utilization. Scott Ramsey, MD, PhD, the Committee Chair of the Planning Committee, eloquently pointed out that, “*Nowhere is this issue more contentious than in the care of cancer patients... Unlike many areas in health care, the practice of oncology presents unique challenges that make assessing and improving the value of care especially complex... A practical working description of value in oncology would benefit many stakeholders and serve as a useful model for other fields of medicine.*” The report states that true value in cancer care can only be defined by the convergence of perspectives of the patients, their families, and payers, and be based on verifiable data collected at the point of care.

The basic problem is that there is no defined template, approach, or incentive to re-engineer the processes of care within individual oncology practices and to collect data to measure important endpoints/outcomes. This is exactly what the Oncology Medical Home model that COA is pursuing is intended to accomplish.

What is the Oncology Medical Home Model?

The Oncology Medical Home model is about delivering, ensuring, and measuring quality cancer care. In short, it is a patient-focused system of delivering quality cancer care that is coordinated, and efficient. As such, it will be designed to meet the needs of patients, payers, and providers. Some of the key aspects of the Oncology Medical Home model are:

- Cancer care that is coordinated with the central focus on the patient and their entire medical condition
- Cancer care that is optimized based on evidence-based medicine to produce quality outcomes
- Cancer care that is accessible and efficient, with treatment provided in the highest quality, lowest cost setting for the patient
- Cancer care that is delivered in a patient-centric, caring environment that optimizes patient satisfaction
- Cancer care that is continuously improved by measuring and benchmarking results against other facilities providing care so that best practices “raise the bar” in delivering care

In terms of provider reimbursement, there are several different payment models — modified fee-for-service, management fee, episode-of-care, shared savings, etc. — that can be utilized in the Oncology Medical Home model. What is necessary in terms of reimbursement are:

- A payment system based on results (i.e., quality and value)
- Payment that is realistic in terms of maintaining the viability of the model
- A payment system that allows the right care to be delivered at the right time, without hurdles to providing care

What Does COA Want to Accomplish by the Development and Evolution of a Medical Home Model in Oncology?

COA wants to provide oncology providers with a model of care that will accomplish 2 things:

- Enhance the quality of cancer care while controlling overall costs of care in a system where quality and value are measured and continuously improved
- Provide the foundation for different reimbursement models that associate appropriate payment with results in an environment that places the patient first

Cancer care has evolved dramatically over the past 40 years from academic, in-patient treatment to community-based, comprehensive, and coordinated cancer care. In the process, the United States has developed the world’s best cancer care as documented by actual outcomes. However, cancer care is in crisis as the system of community-based care is contracting and drug shortages threaten patient care.

COA is intending to provide oncology providers with a model that puts patient care first while insuring the survival and viability of the cancer care delivery system. In this model, reimbursement needs to be more appropriate, aligned with the quality and value of cancer care delivered, and recognize the cognitive services provided by oncologists and allied clinic care providers.

How Does COA Intend to Provide the Oncology Medical Home Model?

As a non-profit organization founded to support community oncology patients and providers, COA intends to offer, without any commercial interest, a model that allows practices to become oncology medical homes. This will be accomplished by providing practices with a 3-step approach that allows

them to move along a trajectory of increasing thoroughness towards becoming a medical home. Some of the specific tasks that will be necessary to accomplish this overall goal are as follows:

- Defining a core set of standardized quality and value measures to document performance
- Developing a benchmark capability that allows providers to compare performance against their peers in a systematic and highly efficient manner
- Developing a set of services and tools — including information, materials, etc — that provide a stepped approach for providers to move along the trajectory of becoming a fully-functioning medical home
- Establishing a forum of information exchange for practices to continually improve processes and outcomes
- Developing different payment models and contracts with Medicare and private payers to make the medical home a viable model for oncology

It is important to understand that the nature of oncology practice is such that providers currently function anywhere from 75-85% of a medical home, especially in terms of care coordination and reliance on evidence-based medicine. This and the fact that the oncology practice inherently becomes the “medical home” for the cancer patient, positions most practices well to evolving into a fully functioning medical home model. What needs to happen in order to realize that evolution is practice process change that accomplishes 2 important facets of care:

- Places the patient clearly at the center of care
- Measures both quality and value; and has in place a mechanism for continuous improvement based on measurements

Medicare and private payers are demanding health care delivery accountability from providers. COA believes that oncology needs to take the lead in developing an accountable model that also justifies appropriate reimbursement. Without this, the landscape of cancer care delivery will continue to condense, and patients will face less accessible and more expensive care, which also will be borne by patients and payers.

How is COA Proceeding and What Has Been Accomplished to Date?

The Board of Directors of COA has empowered the establishment of a Steering Committee to direct the overall efforts of the COA Oncology Medical Home initiative. The committee is comprised of oncologists (4), private payers (5), practice administrators (2), a PharmD, a patient, industry (ION), and cancer community group representation (ASCO, NCCN, NPAF). The committee is chaired by Bruce Gould, MD, a practicing community oncologist with Northwest Georgia Oncology Centers. To date, the committee has helped define the model of the Oncology Medical Home, starting with identifying the needs of patients, providers, and payers in the delivery of cancer care. This effort then allowed the committee to identify and endorse an initial set of 16 quality and value measures of cancer care. Additionally, the committee backed the development of a patient satisfaction tool, which is modification of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey tool.

An Implementation Team was also formed to identify the information, tools, software, etc. required to turn oncology centers into fully functioning Oncology Medical Homes. This team is chaired by Carol Murtaugh, RN, a practice administrator with Hematology & Oncology Consultants (Nebraska & Iowa). To date, the team comprised of oncology practice administrators has identified the resources (over 50 and counting) and is working to pull those together into an oncology medical home “tool kit.” The goal is to provide practices — according to an oncology medical home assessment — a customized set of tools to move along a path of increasing sophistication.