Cancer medical home model cuts costs, improves care

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When Larry, an 84-year-old retired physics professor, learned he had metastatic pancreatic cancer, he made his wishes known to his oncologist, Barbara McAneny, MD: He wanted to live one more year, and he didn't want to die in a hospital. On a morning soon after, Larry's family found him suddenly very sick and confused. But instead of calling 911 or taking Larry to the emergency room, they called Dr. McAneny's practice, the New Mexico Cancer Center in Albuquerque.

The call was answered on the second ring and transferred to a triage nurse, who opened the pathway for sudden-onset confusion. When Dr. McAneny's triage nurse spoke to Larry on the phone, she told him to come to the Albuquerque office right away.

"When [he] arrived … he was really sick. He was making no sense," Dr. McAneny said during a presentation as part of the National Committee for Quality Assurance's Quality Talks event. "[The nurse had already] activated the order set that goes with that pathway ... and within the next hour and a half, he had fluids and antibiotics and a CT scan to make sure he didn't have blood clots."

Dr. McAneny decided to send Larry to the hospital when a bed became available, and by the next morning, he was lucid again and able to go home. He had avoided the long wait in the emergency room and his hospitalization was brief, but to Dr. McAneny there was still a problem.

"There are no quality measures [for] anything we did," said Dr. McAneny, immediate-past chair of the AMA Board of Trustees. "Now suppose that it wasn't my practice but it was a non-medical home practice. He would have called up [and heard], 'If this is a medical emergency, hang up and dial 911.' He would have gone to the understaffed, overworked emergency department where, while he was waiting five hours to be seen by the doctor, the nurse would have checked his hemoglobin A1c, confirmed his code status, queried him about smoking and given him yet another Pneumovax. That's meeting four quality measures right there."

Yet little would have been done in that intervening time to treat a patient like Larry, Dr. McAneny noted, and he could have become much sicker.

“So sick that his hospital stay might have been a week. He might have had to go the ICU. He might have died,” she said. “But all of the quality measures would have been met, except for one: The oncologist would have gotten a black mark for having given him chemotherapy two weeks before death. So which do you think is the better quality of care?”

Upending typical practice

Dr. McAneny’s cancer medical home model, known as Come Home, grew out of her observation that every time she sent cancer patients to the hospital, they would come out in worse condition. She also noticed that the biggest cost in oncology is not the drugs—which only make up about 14 percent of spending—but the hospitalizations, which account for half of cancer costs.

Her goal became to prevent emergency room visits and hospital admissions, and she quickly realized this would require changes throughout her practice, from staffing to decision support.

But many of those changes would not be funded by the existing Medicare payment model, so she applied for and received a $19.8 million grant in 2012 from the Center for Medicare and Medicaid Innovation (CMMI) to roll out the model to seven oncology practices from New Mexico to Maine.

“When I got the money from CMMI, I could use some of [it] to hire software engineers to put those triage pathways in an electronic form,” which would prompt the right questions and streamline ordering, Dr. McAneny explained. “And because nobody pays, in our fee-for-service world, for nurses to be on the phone talking to patients, I could pay ... the salaries of those nurses.”

The change in practice also required educating patients and their families that they should call Dr. McAneny’s office before calling 911, as Larry’s family did, and that they should call before the situation became a medical emergency. There was no fee for that service either, Dr. McAneny added.

“Then we had to leave gaps in our schedule, and we had to extend the hours we were open so that we would be there when the patients needed us, not when it was convenient for me to be there,” she explained. “And if no one happens to shows up, I still have to pay the light bill, so there’s an opportunity cost.”

The seven participating practices enrolled about 29,000 patients in the pilot, which sought to determine whether rapidly responding office-based medical teams and better coordination of care could achieve the triple aim of lower costs, better population health and improved quality of care.

One of the practices covered by the grant, New England Cancer Specialists, cut the cost of treating its cancer patients by about $20,000 per year, from just under $55,000 to a little more than $35,000. Dr. McAneny estimates that together the seven practices saved Medicare about $1.6 million per month over the last two years of the grant.

And on a quarterly basis, the program avoided ten emergency room visits, three hospitalizations and four readmissions per 1,000 patients.

Dr. McAneny feels Come Home has application in a variety of specialties.

"It's symptom-based pathways, so anyone who's managing chronic disease that has acute exacerbations can use a system like this," she said.

Building a viable alternative

Since July 1, parts of Come Home have been adopted nationwide by 3,200 oncologists who administer chemotherapy. Yet for all of its promise, Come Home still has a serious barrier to widespread implementation in oncology: the site-of-service differential.

Since 2004, Dr. McAneny said, physician practices have seen an effective cut in their payment rates, while hospitals have enjoyed a 2.5 – 3.5 percent raise due to the market basket increase, causing a sharp drop in the number of independent oncologists. According to a report from the Community Oncology Alliance, since 2010, more than 1,100 community oncology practices have closed or lost their independent status as the result of an acquisition or merger.

"There's a lot of data that shows that [office-based oncologists] are less expensive—it's about $6,000 per chemotherapy course—than a hospital-based system," Dr. McAneny said. "We are on the verge of losing our low-cost, high-quality providers."

Which makes Department of Health and Human Services' approval of approaches such as Dr. McAneny's as Medicare alternative payment models vital to the future of cancer care.

"I feel a sense of urgency," Dr. McAneny said, "because if we lose those independent practices, how are we ever going to afford to rebuild them?"

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