The U.S. healthcare system is the most expensive in the world, and the most expensive disease to care for, per person, is cancer. The National Cancer Institute estimates that by 2020 the annual bill for cancer care could reach $173 billion. The burden is unsustainable, and all the stakeholders involved—hospitals, physicians, businesses, insurers, and the government—are searching for ways to cut the financial impact of cancer care.

The federal government’s Centers for Medicaid & Medicare Services (CMS) has initiated one promising experiment, a five-year program that began last July called the Oncology Care Model (OCM). CMS selected 192 group practices to take part in the program. Smilow Cancer Hospital is among those participating, and has about 3,500 patients in the program. OCM’s twin aims are to improve cancer care while reducing costs. To encourage innovations that achieve these goals, the program pays a monthly stipend of $160 for each Medicare patient on chemotherapy. Additional stipends are possible if a practice meets certain targets. OCM’s underlying purpose is to shift cancer care away from the traditional fee-for-service model and move it toward a payment model that rewards quality rather than quantity.

Smilow is participating in OCM for two reasons, explained Rogerio Lilenbaum, MD, Professor of Medicine and Smilow’s Chief Medical Officer. “First, we wanted to engage in a value-based payment model, because we believe that is where healthcare is going, and we wanted the opportunity to test the actual steps that an institution needs to take to be successful in that model.”

Second, he continued, OCM’s monthly stipend allowed Smilow to add clinical infrastructure to improve the quality of care, regardless of whether the payment model succeeds. The main additions are a new Oncology Extended Care Clinic, available to all Smilow patients 16 hours every day, the hiring of seven senior oncology nurses to coordinate the care of OCM patients, and implementation of clinical pathways for care.

How will these enhancements meet the other half of OCM’s mission, to reduce costs? Kerin Adelson, MD, Associate Professor of Medicine and Chief Quality Officer at Smilow, expects the Oncology Extended Care Clinic to cut down on unnecessary visits by cancer patients to Yale New Haven Hospital’s Emergency Department (ED). Several years ago, Dr. Adelson and colleagues analyzed these visits over five months and found that about half of them could have been managed outside of the ED, at a much lower cost.

After an extensive multidisciplinary planning process, the Oncology Extended Care Clinic (OEC) opened on April 1, 2017. It is quiet, uncrowded, and staffed by oncology APPs and nursing staff and attending physician, Dr. Bonnie Gould Rothberg. Unsurprisingly, responses to the clinic from patients have been enthusiastic. Since its opening, the clinic completed more than 1200 visits, and nearly 70 percent of the patients were discharged home rather than hospitalized—another savings. “The expertise of our OEC staff results in focused and specialized supportive care to our patients when they are experiencing complications of treatment or disease,” said Catherine Lyons, RN, MS, Vice President, Patient Services, Smilow Cancer Hospital.

Because Medicare patients in the OCM program are older, they often have co-morbidities. That’s where the seven newly hired care coordinators are invaluable. They advocate for their patients throughout their entire medical journey, inside and outside the hospital. That might mean finding extra homecare, attending appointments with patients, acting as liaisons between inpatient and outpatient doctors, and clarifying prognoses and treatment options. The OCM care coordinators have a dual goal: to improve care for patients and to help them avoid unnecessary and expensive hospitalizations, ED visits, and aggressive late-stage treatments.

“When you look at the total cost of cancer,” said Dr. Adelson, “30 percent is spent in the last year of the patient’s life, and much of that 30 percent is spent in the very last month, when it’s often futile.”

“Nationally, we see high rates of hospitalization, admission to intensive care units and chemotherapy being given near the very end-of-life—interventions that don’t improve outcomes,” said Dr. Adelson. “This is not in the best interest of the patient, because it prevents them from spending time with their family, from saying goodbye, and from getting their affairs in order. End-of-life care is an area where improving the quality of care will also reduce cost.”

Innovations to IMPROVE QUALITY and CONTROL COST

Steve Kemper writer
Peter Baker photographer

Dr. Kerin Adelson and Dr. Rogerio Lilenbaum
**The new Oncology Extended Care Clinic at Smilow is quiet, uncrowded, and staffed by oncology specialists 16 hours a day as an alternative to the ED.**

“With clinicians, the conversation can’t just be about dollars,” said Dr. Lilenbaum, “because their focus is on quality of care. But if we set out to change practice patterns that cause pain and suffering to patients and families, such as going to the ED or spending time in the ICU within 30 days of death, that resonates with clinicians.”

Dr. Adelson added, “There’s a growing understanding that we need to prevent those hospitalizations both for the patient’s wellbeing and for society’s healthcare expenses. I think our physicians are starting to talk about good deaths, a peaceful death in hospice, as opposed to the ICU.”

“Lots of data show that patients who receive earlier palliative care have a better quality of life, and their family members have less grieving and suffering to patients and families, changing practice patterns that cause pain and suffering to patients and families, and that resonates with clinicians.”

“Our care coordinators are experienced oncology nurses who are making a direct impact to ensure our patients have what they need to manage their disease, to prevent those hospitalizations both for the patient’s well-being and for society’s health care expenses. I think our physicians are starting to talk about good deaths, a peaceful death in hospice, as opposed to the ICU.”

Such conversations are difficult for doctors, not just emotionally but professionally, because they must acknowledge that they have no disease slowing treatments left to offer the patient. Dr. Adelson and her team are educating doctors about how to have these discussions, and are encouraging them to think of this moment not as withdrawal of treatment, but as a shift to another form that’s better for the patient—palliative care or hospice care.

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**When Marc St. Martin was diagnosed with cutaneous T-cell lymphoma (CTCL) in 2007, he had no way of knowing the impact it would have throughout his life. Over the course of five years, Marc underwent treatment with spot radiation, x-ray, total skin electron beam therapy, and chemotherapy, all in the hopes of achieving a durable remission. When this course no longer seemed to be working effectively, it was recommended by his dermatologist, Dr. Richard Edelson, Aaron B. and Marguerite Lerner Professor and Chairman of Dermatology at Yale School of Medicine, and an innovator in the field of cutaneous T-cell lymphoma.**

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All five of Marc’s siblings agreed to be tested to see if they were a match to be a stem cell donor and in 2012, Marc received a Hematopoietic Stem Cell Transplant (HSCT) using stem cells from his brother John, who was a 2 haplotype match. Marc commented that the transplant itself was relatively easy and painless, and it took a while before each doctor, disease team, and care center on certain metrics at the end of a patient’s life. This feedback will help doctors improve their practice patterns and reduce unwarranted treatments, while ensuring that patients know all their options.

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“Lots of data show that patients who receive earlier palliative care have a better quality of life, and their family members have less grieving and depression,” said Dr. Adelson. To that end, Smilow recently expanded from three clinical sessions of palliative care per week to ten.

Dr. Adelson is also collaborating with a healthcare technology company to create a dashboard that measures each doctor, disease team, and care center on certain metrics at the end of a patient’s life. This feedback will help doctors improve their practice patterns and reduce unwarranted treatments, while ensuring that patients know all their options.

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