INSTITUTE FOR THE FUTURE OF
ONCOLOGY

EMPOWERING PATIENTS, ENGAGING PROVIDERS
The Future of Patient-Centered Care in Oncology

FALL 2016

EXECUTIVE SUMMARY

Creating a quality healthcare system that meets the Institute for Healthcare Improvement (IHI) Triple Aim – improved patient experience, improved outcomes, and reduced costs – requires the provision of patient-centered care.[1] Indeed, the shift from volume to value-based reimbursement has, at its core, the patient experience with many of the new payment models tying part of overall compensation to patient satisfaction or experience surveys. But what does patient-centered care look like in oncology?

This is the question that more than 20 leaders in the oncology field grappled with during the Association of Community Cancer Centers (ACCC) fourth annual Institute for the Future of Oncology forum in June 2016. The invited participants, comprising oncologists and cancer program executives from hospitals, oncology practices, and healthcare systems across the country; representatives from patient advocacy groups; researchers; and supportive care providers convened for a discussion focused on identifying the concept of patient-centered care in oncology; exploring current models; highlighting existing barriers; and recommending options to move from theory to practice.

Through the forum discussion, participants identified seven key elements required to provide true patient-centered care: patient stories, navigation and coordination, interdisciplinary teams, appropriate reimbursement for services rendered, greater education, information technology connectivity and transparency, and decision support tools.

Getting there, participants concluded, will require overcoming numerous obstacles and restructuring the way in which cancer care is delivered and reimbursed.

THE FUTURE OF PATIENT-CENTERED CARE IN ONCOLOGY
Overcoming the Barriers; Envisioning the Possibilities

The Institute of Medicine's landmark 2001 report, *Crossing the Quality Chasm*, identifies patient-centered care as one of six fundamental requirements for improving the U.S. healthcare system. It defined patient-centered care as: ". . . *care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions,*" a definition echoed in its 2013 report, *Delivering High-Quality Cancer Care: Charting a New Course for a System in Crisis*.[2,3] The American Society of Clinical Oncology (ASCO) builds its definition of patient-centered care on the IOM's framework highlighted in its 2013 report: "*patient-centered, evidence-based, high-quality cancer care that is accessible and affordable to the entire U.S. population regardless of the setting where cancer care is provided*."[3,4]

> "*Patient-centered care starts with making sure the patients have care, and that when they get access to that care, their values, wishes, and requests are known and respected as part of the process.*"
>
> —Executive with a large non-profit cancer organization

This includes engaged patients; an adequately staffed, trained, and coordinated workforce; research to develop new therapies and evidence of effectiveness; a learning healthcare information technology (IT) system for cancer; translation of evidence into clinical practice, quality measurement, and performance improvement; accessible, equitable, and affordable cancer care; and high-value cancer care.[4]

According to the National Cancer Institute's monograph, *Patient-Centered Communication in Cancer Care*, a patient-centered system should function to foster healing relationships, exchange information, respond to patient and family emotions, manage uncertainty, help make decisions, and enable patient self-management.[5]

An environmental scan conducted by the Association of Community Cancer Centers for its Achieving Excellence in Patient-Centered Care initiative identified six overarching elements across nine models of patient-centered care with varying definitions and descriptions:

- Communication, education, and shared knowledge
- Involvement of family and friends
- Coordination, collaboration, and team care
- Sensitivity to non-medical and spiritual dimensions
- Respect for patient needs and preferences
- Free flow and accessibility of information.

These elements have been repeatedly validated as important features of patient-centered care by patients and families through numerous focus groups and interviews. They also form the basis of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys of patient experiences that are increasingly tied to Medicare alternative payment models (with survey results available online for consumers). A cancer-focused CAHPS survey, CAHPS for Cancer, is under development.

However, as the Institute's 2016 forum participants discussed, these definitions do not go far enough in addressing the many dimensions of patient-centered care. The discussion also highlighted numerous barriers that prevent the delivery of patient-centered care, and identified opportunities to reduce or remove those obstacles.

"Nurses have been providing patient-centered care for decades but our healthcare systems are not set up for this in any way, shape, or form. It's going to be a very tough row to hoe to make this [change] manifest and make it something other than lip service."

—Cancer center director and oncology nurse researcher

Understanding the Gap: Inheriting a Broken System

The 2013 IOM report on the delivery of quality cancer care concluded that patient-centered communication and shared decision-making in oncology was "suboptimal."[3] Institute forum participants agreed, noting that, with a few exceptions, most patients do not receive care that is fully patient-centered. They highlighted numerous gaps and barriers:

- **Misaligned financial incentives.** Participants repeatedly pointed to the current fee-for-service (FFS) reimbursement system as the greatest barrier to patient-centered care. Support services such as patient navigators, nutritional counseling, psychosocial support services are rarely reimbursed. The healthcare system has developed to incentivize "doing more . . . instead of doing better," said one participant, whether that care is evidence based or even in the best interest of the patient.

  Another participant noted that while providers can be reimbursed for giving a drug that costs $10,000 and might extend a patient's life by a few months, there is no reimbursement for home visits from advanced practice nurses that have been shown to have the same effect at a cost of about $1,000 a month.

  The reimbursement system is also payer-centric. "What drugs I use depends on what the payer has approved within its formulary," said one participant. "As providers we follow payers' rules in order to get paid for the services we provide." Another participant described her practice's plan to visit nursing homes twice a week to administer a medication to patients with myelodysplasia so they didn't have to be transported to the office or hospital setting. However, payers would not reimburse for the drug because it wasn't given in an office or hospital setting. "Because of that, patient-centered care was killed; cut off at the knees," she said, because the practice couldn't afford to provide the drug without reimbursement.

- **Bureaucracy.** "There has always been tension between the administrative and business side of medicine versus the very personalized relationships and elements of need individual patients require," said an oncologist who practices at a large academic medical center in the Midwest. "But I think it's worse than ever. . .it's just mind-numbing trying to deal with the bureaucracy of medicine and get the elements of care patients need." He cited the requirement for precertification for many services. "In the end, is that providing any true benefit for the individual patient?" he asked.

  "I feel we're actually moving away from patient-centered [care] because of all the bureaucracy and payment issues," added an oncology practice clinical director.

"We've evolved into a provider-centered model of care rather than a patient-centered model of care and our institutions, payment systems, and infrastructure have evolved around the needs and the availability of the provider."

—Mid-Atlantic-based oncologist

- **Fragmentation.** Over the decades the healthcare system has evolved into a provider-centered model of care rather than a patient-centered model, said an oncologist. ". . . our institutions and our payment systems and our infrastructure have evolved around the needs [and] the availability of the provider. It's a very structural problem." Patients continue to face care structured in siloes. "Patients come to the physician with lung cancer. They don't 'have' thoracic surgery, radiation, and chemotherapy. They have a need to be cared for their lung cancer. We have a fundamentally fragmented system that we're stuck with right now and we have to figure out how to reconfigure [it]."

- **Lack of education.** Physicians simply do not receive the training required to provide patient-centered care, said participants, unlike nurses, who are trained in a psychosocial paradigm. As one participant commented, "The difference in how medical students are educated and how nursing students are educated and how they approach the patient is drastically different. . . there needs to be some confluence of those two." ACCC offers a solution to this through a variety of peer-developed education programs and resources that engage the entire multidisciplinary team delivering cancer care.

- **Lack of transparency.** There is little transparency in terms of information and data, ranging from the cost of research to the cost of acquiring drugs to reimbursement and best practices. This prevents peer learning and the sharing of best practices that would benefit the patient and free up provider time, said the administrator of a Mid-Atlantic oncology cancer program. It also limits the ability of providers to implement shared decision-making in their practices, she added.

- **Lack of interoperability.** Electronic health records (EHRs) can rarely communicate across care settings, even within a single healthcare system. This creates a significant barrier to patient-centered care, participants said. One participant described how the inpatient and outpatient EHRs are not connected in her organization. Thus, she said, patient navigators can't easily answer patient questions about their medical records and financial obligations. A more interoperable, transparent system should also enable patients to enter data, such as reporting symptoms.

  One cancer program director described a nurse coordinator who was hired to prepare patients for their appointments, but who couldn't access new patient information in the system to know what they needed before they met with the doctor.

- **Industry consolidation.** Consolidation in the healthcare industry and the resulting "mega systems" make it more difficult for patients to receive the individualized care that is so critical to providing patient-centered care.

"We have shifted away from the art of medicine to the science of medicine and a paternalistic arrogance; away from the patient and the single most important thing, compassion. When we measure, we don't measure compassion, we don't listen to the patient. We measure quality metrics, which do not include compassion."

—Southern-based oncologist

- **Time.** Clinicians are focused on treatment and extending life, not on the costs of that treatment. Part of that relates to time, said one participant. "It becomes very difficult to have a patient-centric view as a clinician with 15 minutes per visit." Another commented: "Even the best data we have I think allows us to make short-term decisions. There aren't any decision tools that help. So you've got one situation, one interaction, the care is fragmented. You're the patient's cancer doctor for a short period of time. You're [dealing with] the patient's insurance company for a short period of time. We're talking about inadequate decision-making tools? This is even at the point-of-care for a single decision, which is a very short decision."

- **Treatment complexity.** "Lung cancer is not a disease with one treatment," said a medical director at a southern practice. "There are genetic mutations and different options for every mutation. Yet there are no head-to-head comparisons of those drugs. . . and there is a lack of clear guidelines as to which drug is the right drug for the right patient."

  "The example I give is the 90 year old with kidney dysfunction and pancreatic cancer," he continued. "I can give him Folfirinox, I can give him gem-Abraxane, I can give him gemcitabine." But without any comparative trials, he said, he has to go with a "gut feel, and there's no way to get value into that equation."

- **System complexity.** Too often the burden of care coordination is put on the patient who does not have the tools nor the resources to coordinate care that is becoming increasingly complex, said one participant.

- **Missing input from patients.** The definition of patient-centered care is often developed without considering the patient's wants and needs, participants emphasized. Any definition should be individualized, recognizing the cultural, ethnic, and even sexual orientation and gender-related issues that may affect patients, they said. It is also important to ensure that the *patient* defines the value of the care, not the system. For instance, while the various definitions of patient-centered care call for educating and supporting the patient in decision making, some patients do not want to know much about their condition nor make the decisions, commented one participant. "It can't be a passive patient-centered [care approach]," added another participant. " . . . [to deliver patient-centered care] we're creating systems and people that interact. We have to empower and engage the patient with the right skills, knowledge, attitudes, and behaviors that are going to help them to be in that system."

Addressing these issues, participants agreed, provides a more holistic definition for the concept of "patient-centered care."

"We gave up the right to steer the system, advise the system, gain the trust of the system many years ago when we chose that we were going to take fee-for-service, run [with] it as fast as we could. . . [today] there's an absolute lack of trust between all the different elements of this system and that has led to fragmentation. So we're here today trying to reinvent something that has been literally decades in the making."

—Executive of a large nonprofit cancer organization

A patient advocate participant was discussing patient-centered care at a survivorship conference when a cancer survivor stood up. "You know," he said, "when you say patient-centered and you describe it, it sounds as if I'm a zoo animal in a cage and everything is happening around me. I don't want to be passively in the center."

INCENTIVIZING PATIENT-CENTERED CARE

As numerous participants noted, the current reimbursement system is simply not structured to support patient-centered care.[4] However, several alterative payment models are emerging that are designed to change that paradigm.

The Oncology Care Model

The Center for Medicare and Medicaid Innovation launched the Oncology Care Model (OCM) July 1, 2016, with approximately 200 physician group practices representing 3,200 oncologists and 155,000 Medicare beneficiaries, and 17 health insurance companies.

It brings Medicare's first large-scale specialty alternative payment model to the field of oncology. The goal is to improve care coordination, curtail unnecessary services (including emergency room visits and inpatient admissions), and reduce expenditures.

Participating practices are still reimbursed under the traditional FFS system, but they receive an additional $160 per-beneficiary-per-month payment every six months a patient is under active treatment, and they have the potential for performance-based payments. Providers may also assume financial risk under this model.[6]

". . . the OCM and the pilots by Blue Cross and Aetna and others are good steps in the right direction. But this is the Institute for the Future of Oncology. So let's imagine a future in which doctors and providers are providing patient-centered care. It's stressful and time consuming and risky. But let's imagine doing that and being fairly well compensated for it . . . Imagine that future and how we could just exhale and be happier in practice."

—Southern-based oncologist

"When the Oncology Care Model came out with a 13-point care plan I thought it was crazy, that it would be a mess and lead to bad outcomes. But it's been amazing how much putting that [the OCM] in front of people, putting it in front of me as a doctor having to sit with the patient, as well as putting it in front of our technology folks and saying how do we build to these 13 fields, has been an amazing transition."

—Medical director with information technology organization

In return for the additional payment incentives, clinicians must provide patient navigation; a care plan in line with the IOM's Care Management Plan outlined in the *Delivering High-Quality Cancer Care* report; 24/7 access for patients to an appropriate clinician with access to patient medical records; and therapeutic treatments consistent with nationally recognized clinical guidelines.[6]

The model represents the essence of shared decision-making and patient-centered care, said the medical director of a Mid-Atlantic cancer program. "It requires that you provide a clear diagnosis; the cancer stage; state whether you have curative or palliative intent; and explain how the chemotherapy is likely to affect a person's quality of life," he said. It also requires a formal shared decision-making process in which the patient understands they have a choice and are given time to take a "pause" after diagnosis before making any decision.

"I'm very positive about the OCM," said the director of a Mid-Atlantic cancer practice that is participating in the program. He is particularly optimistic about its emphasis on navigation and coordination.

It is too soon to know if the model will be successful. Several concerns have emerged, including a delayed portal launch to upload data, unclear parameters, and the concern that the more efficient practices become, the more difficult it will be to meet the same goals the following year.[7]

Participants were also worried about the resources needed to implement OCM without the requirements becoming "burdensome" for patients and clinicians.

Patient-Centered Specialty Practice

The National Committee for Quality Assurance (NCQA), with input from ASCO, created the Patient-Centered Specialty Practice (PCSP) Recognition Program, essentially creating a pathway to a specialty-based medical home modeled on the primary care medical home. The standards are rooted in the components of patient-centered care, including care coordination, communication, and shared decision-making.

One of the first NCQA-recognized PCSPs, Philadelphia-based Consultants in Medical Oncology and Hematology, created a team approach to care. Five years later, the practice had grown by a third even while reducing its staff-to-physician ratio. Hospitalization rates dropped by half, lengths of stay by 21 percent, and ER visits by 69 percent, while hospice length of stay increased 26 percent. In addition, the practice increased its compliance with National Comprehensive Cancer Network (NCCN) guidelines while reducing documentation turnaround time from more than 28 days to 1.9 days. The practice estimates it saves $1 million in costs each year.[8]

One Institute forum participant explained that when his practice became a PCSP, its largest commercial insurer began paying for codes such as patient education, advance care planning, nutrition, and therapy. "So there are rewards for changing the process from the improved payment perspective," he said. The group has also begun a pilot program with its major commercial payer for a capitated payment in addition to fee-for-service.

Patient-Centered Oncology Payment (PCOP)

ASCO introduced parameters for an alternative payment and delivery model in 2015: the Patient-Centered Oncology Payment Model (PCOP).[4] Under the model, practices would still receive fee-for-service reimbursement for evaluation and management services, tests, and other procedures and services, but they would also be paid for providing services in four new areas designed to support patient-centered care:

1. **Payment for new patient treatment planning.** The practice would receive a $750 payment for each new oncology patient who begins treatment. This payment is designed to ensure the accuracy of diagnoses, identify appropriate treatment options, help patients choose the most appropriate treatments, and provide the education and support services patients need when first diagnosed. It would also cover a portion of the ongoing support services patients need during treatment.

2. **Payment for care management during treatment.** The practice would receive a $200 payment for each month in which an oncology patient is receiving parenteral or oral anti-cancer treatment, as well as for patients in hospice if the oncologist is the hospice physician.

3. **Payment for care management during active monitoring.** The practice would receive $50 per month when an oncology patient is not receiving anti-cancer treatment but is being actively monitored by the practice. The goal is to help the practice provide effective survivorship care and end-of-life care.

4. **Payment for participation in clinical trials.** The practice would receive $100 for each month in which a patient participates in a clinical trial if the trial sponsors do not provide support for practice expenses related to participation in the trial.

Bundled Payments

Several commercial insurers are testing bundled payments like those described above. A UnitedHealthcare program, for instance, caps the profit the oncology practices can make on the chemotherapy drugs they prescribe while adding a payment meant to cover physician care in the hospital, hospice management, and case management services.

A pilot program with five oncology practices realized an overall savings of approximately $33 million despite higher spending on drugs.[9] Much of the savings appeared to come from reduced hospitalizations and the use of services such as radiation. UnitedHealthcare expanded the program in 2015 to more than 650 oncologists in seven states. Similar programs by other health insurers, however, demonstrate lower savings.[10]

There are downsides to these alternative payment models, said one participant. For instance, many require adherence to certain clinical pathways that may or may not be clinically appropriate.

These approaches also require a tremendous investment of capital and human resources. "If you have good, committed leadership that is not spending their days seeing patients, then you may be able to make those human capital investments," said one participant. "But it's not easy to do." In addition, practices that already operate at a high-value level may have more difficulty demonstrating enough savings to compensate for the cost of the additional resources.

IDENTIFYING WHAT WORKS

A portion of the day was devoted to identifying existing patient-centric approaches that other cancer programs could adopt. These included:

▮ **We Honor Veterans.** This is a program of the National Hospice and Palliative Care Organization (NHPCO) in collaboration with the Department of Veterans Affairs. It is focused on providing specialized care and support to veterans at the end of life, including an opportunity to tell their life story and receive care commensurate with their experiences.

▮ **Personal Patient Profile for Prostate (P3P).** This model uses a personalized decision support system that incorporates customized text and video coaching to help patients with newly diagnosed prostate cancer understand their treatment options. A randomized controlled trial involving 494 men found that it significantly reduced decisional conflict, thus helping address patient uncertainty and enabling patients to choose a treatment option that met their own values.[11] It helps patients "build" their story, said the nurse scientist who participated in the trial, and share it with their physician. "Then together they can determine the next step," she said. It should be available soon.

▮ **Open to Options®.** This program from the Cancer Support Community was developed with a grant from the Centers for Disease Control and Prevention (CDC). It pairs patients with trained facilitators who help them develop a personal list of questions and concerns to facilitate patient/physician communication. A pilot study with the CDC found that the support reduced patient distress, anxiety, and decisional regret. Physicians reported it helped focus their time with patients and improve communication around treatment options. It also significantly increased the number of patients who decided to participate in a clinical trial compared to the national average.[12]

"It's a very simple way of collecting the patient's story in a brief, relevant format so it becomes part of that treatment decision discussion," said a participant who works with the program.

"We've been used to treating a disease in a patient and now we're going to treat a patient with a disease. This requires managing the ecosystem at the office as well as reaching into the home to provide a holistic concept rather than the (current) fragmented, siloed approach."

—Southern-based oncologist

"I think you can sit with a person for five minutes and know the patient's story, know where they're coming from. It doesn't always take a whole lot of time to do it, to really understand what that person is about, and that will color our physical care that we give."

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—Mid-Atlantic-based oncologist

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ACCC has a range of new tools designed to help clinicians improve communication with patients. These include:

■ **Steps to Success: Implementing Oral Oncolytics**

Tools and resources for providers to help patients start and adhere to anticancer treatment with oral agents. Available at accc-cancer.org/oraloncolytics.

■ **Psychosocial Distress Screening: Lessons Learned from Three ACCC Member Programs**

Indepth review of successful implementation of distress screening in cancer programs of varying size and structure. Available at accc-cancer.org/distress-screening.

■ **ACCC Metastatic Breast Cancer Project**

This patient-centered project aims to expand the current breast cancer conversation to address gaps between early and metastatic disease and improve patient–provider communication for this patient population. Available at accc-cancer.org/MetastaticBreastCancer.

Additional resources identified by participants include:

■ **PN-BOT, Barriers and Outcomes Tool.** This tool for navigators captures patient demographics, interactions, and stories in one place to improve case management. It is available at https://smhs.gwu.edu/gwci/BarriersTool.

■ **Patient-facing mobile apps.** Hundreds of health-related apps are now available for consumers to help them better manage their medical conditions. Such apps, studies find, better engage patients in their own health, and can contribute to improved patient/physician communication.[13,14] They can also, as one participant said, help clinicians obtain the patient's story at the beginning of their clinical journey.

■ **Distress screening.** The American College of Surgeons Commission on Cancer requires that cancer centers conduct psychosocial distress screening as a criterion for accreditation. Numerous quality care organizations have endorsed standards for such screening. ASCO, the American Psychosocial Oncology Society (APOS), the Association of Oncology Social Work (AOSW), and the Oncology Nursing Society (ONS) have also adopted guidelines or released statements related to the screening, assessment, and care of psychosocial distress.

"The benefit of this is that the results are in the EHR," said an oncology social worker participant. "So patients are not just telling their story for the therapeutic part of telling their story, but the story can be relayed to physicians through the EHR. It's a snapshot of where they are that day that can prompt a thorough bio-psychosocial and spiritual assessment."

- **Medical education.** Some medical schools, such as Hofstra School of Medicine, are training students in how to elicit the patient's story, and how to incorporate it into their treatment plan.

- **Multidisciplinary rounding.** One participant told the group that in his practice, every employee, even those who cover the front desk, hold patient rounds to discuss the patient. "If a person's pet died, that can impact their treatment," she said.

- **Medicare Chronic Care Management Initiative.** Under this program, which began January 1, 2015, the Centers for Medicare & Medicaid Services (CMS) will now pay physicians an average of $42 a month to develop a proactive care plan for patients with multiple comorbidities and to follow up on a monthly basis to ensure the plan is working. It does not require face-to-face interactions.[15] However, this initiative is largely aimed at primary care providers.

- **NCCCP navigation matrix.** This tool developed by the NCI Community Cancer Centers Program (NCCCP) provides a multi-domain assessment tool with five levels of activity. It is available online at: accc-cancer.org/oncology_issues/supplements/NCCCP-Navigation-Matrix-Tool.pdf.

- **Oncology Nursing Society core competencies for navigators.** One participant described the impact of the training a year after two of its nurses completed the course. Hospitalizations dropped 20 percent, she said, and patient phone calls 30 percent, representing a significant cost savings.

IN SUMMARY

While forum participants agreed that patient-centered care should be the foundation of quality cancer care, they also agreed that the current system is far from providing it. One of the most significant barriers is the current fee-for-service system that rewards volume over outcomes and rarely reimburses for the very services required to deliver high-value, patient-centered care.

But numerous other obstacles also exist, including a lack of training, the complexity of the healthcare delivery system for patients and providers, bureaucracy, the information technology infrastructure, and time constraints.

It is also critical that patients have the opportunity to articulate the type of care they want and value, and are empowered to participate in shared decision-making with providers. Getting at their true desires requires eliciting their "story" to identify what is important to them and to their quality of life.

New programs designed to address the financial barriers to providing patient-centered care, particularly the Oncology Care Model, have the potential to address many of these obstacles. True patient-centered care, forum participants said, must include seven important domains: patient stories, navigation and coordination, interdisciplinary teams, appropriate financial incentives, greater

education, information technology connectivity and transparency, and decision support tools. Only then, participants concluded, will patients receive the quality of care they desire and deserve.

LOOKING INTO THE FUTURE

The final session of the day was devoted to envisioning the patient-centered system of the future. Participants were asked to look five to ten years ahead and answer the question: "What one change enabled us meet the Institute participants' augmented definition of patient care?" The following are among the responses from forum participants on the change they envision transpiring to achieve this transformation in cancer care delivery.

- We made a commitment to use technology and personnel to address the patient-centered needs of every patient we come in contact with.
- We involved activated and engaged patients to define, implement, and evaluate patient-centered care.
- We learned how to have the kind of conversations that bring about decisions that honor patients' values.
- We initiated a single-payer healthcare system.
- We found effective ways to talk to and listen to patients and to incorporate what we learned into the data and payment systems.
- We added appropriate data fields to the EHR that reflect patient identities and values and mandated that EHRs were interoperable.
- We moved from providing more care for more people to providing the right care for everyone.
- We proved you can demonstrate high-quality, patient-centered care when you change the incentives to do so.
- We defined the essential elements of comprehensive cancer care and provided access to such as a continuum for every patient.
- We created a payment system that accurately identifies and rewards high value, patient-centered cancer care and aligns incentives with the desired outcomes.
- We shifted our paradigm from treating the tumor in the patient to treating a human being with a disease.
- We each took personal responsibility for implementing shared decision-making in every patient interaction and modeling that behavior at our own institutions.
- We received payment for defined metrics and domains that reward transparency, patient choice, quality, and value.
- We shifted to global payment with the risk devolving to providers, incentivizing them to reassess the model of care and use the savings to better patient care.

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About the Association of Community Cancer Centers
The Association of Community Cancer Centers (ACCC) serves as the leading advocacy and education organization for the multidisciplinary cancer care team. Approximately 23,000 cancer care professionals from 2,000 hospitals and practices nationwide are affiliated with ACCC. Providing a national forum for addressing issues that affect community cancer programs, ACCC is recognized as the premier provider of resources for the entire oncology care team. Our members include medical and radiation oncologists, surgeons, cancer program administrators and medical directors, senior hospital executives, practice managers, pharmacists, oncology nurses, radiation therapists, social workers, and cancer program data managers. For more information, visit the ACCC website at accc-cancer.org. Follow us on Facebook, Twitter, LinkedIn, and read our blog, ACCCBuzz.

About the Institute for the Future of Oncology
The Institute for the Future of Oncology, an institute of the Association of Community Cancer Centers (ACCC), is a forum for meaningful discussion on issues unique to the multidisciplinary oncology team. The Institute serves as a clearinghouse of information and knowledge addressing these issues and offering solutions that can be utilized across the community oncology continuum. For more information visit accc-cancer.org/institute.