Patient Care and Economics

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This issue of *Journal of Oncology Practice* focuses on multidisciplinary care. Associate Editor Joe Jacobson conceived and guided the development of this topic. His series introduction outlines the patient-centered principles that are driving strategies to integrate disciplines in medical decision making. Two concepts he presents deserve emphasis. The first is the need for greater awareness of the individual patient's perspective on our delivery of care. Second is the recognition that structural, systematic change in the financial incentives that govern our health care system is needed to support integrated, multidisciplinary care as described in these pages.

I have had the pleasure of many discussions with Ellen Stovall, former CEO and current Senior Health Policy Advisor of the National Coalition for Cancer Survivorship, cancer survivor, and *JOP* editorial board member. One such discussion focused on the fragmentation of our health care system, especially that seen in oncology. I described to Ellen the multiple projects that our practice group had undertaken to make the patient experience better – yet, her retort put me on my heels. She acknowledged the many professionals' efforts to improve efficiencies of care and “fix” things but noted an immediacy to these issues that providers do not understand. Physicians and institutions look at macro-level issues and congratulate themselves with incremental improvements in process, such as decreased wait times, improvement in satisfaction scores, or other metrics of efficiencies. However, Ellen emphasized that an individual patient has only one experience—theirs. Cancer treatment is a very personal journey that, on the basis of current realities, will have multiple frustrating components. It seems that the more coordination is needed between the specialists needed for their care, the more lacking is our ability to provide a tolerable and supportive experience.

And why is our health care system like this? A wise soul once reflected that this system is the best that one could design on the basis of the incentives it contains. We provide a health care service, but we are also business people with employees to pay, obligations to meet from capital investments made, and families to feed.

This system provides remarkable access to the highest levels of technology in health care for most Americans. In fact, the health care system's rules promote the development and use of the highest technologies. However, the rules also provide disincentives for spending time with patients, contemplating care plans, providing preventative care or counseling, touching patients, cognitive services, or promoting primary care homes where active coordination of care could reside. I often tell patients that oncology care is a team sport. However, as I read Jacobson's rendition of Jane Forbes' experience, I recognize in my community the type of team play that she outlines.

I am struck by Jacobson's summary, acknowledging that the majority of oncology care is provided in the community; however, most multidisciplinary systems of care are found largely in institutional settings. In oncology care in the United States, the

multidisciplinary models outlined in this issue of *JOP* are largely not supported by the existing incentives.

What do we make of Jacobson's comments? How do we improve the experience of each individual patient and adapt to the demands of oncology multidisciplinary care? There are fledgling efforts in practices to take on some of these issues, but they are often guided by institutions' attempts to develop a more robust “oncology service line,” in which proceduralists are enlisted as champions. Interestingly, from an economic view, it is in both the institutions' and proceduralists' interest to promote multidisciplinary support. Both gain a marketing tool, striving to attract new patients and providing support for patients undergoing complex procedures. Procedures are reimbursed well in our system, and they enrich the institutions where they are performed. However, these incentives do not benefit or recognize the roles of the cognitive and coordinating specialties. If we and our patients desire a system of care that embraces the multidisciplinary ideals that Jacobson outlines, we will need to embrace new structures of payment.

Within this issue, Dean Gesme et al describe other market-driven efforts to meet the demands for multidisciplinary care and support the development of oncology multispecialty groups. In addition, Teri Guidi introduces us to the economics of the outpatient payment system. Physicians are familiar with Part B Medicare reimbursement for their offices; however, understanding the way institutions are paid under the Part A OPSS is of increasing importance. Elsewhere in this issue are original reports that provide information on patterns of care in colon cancer, recognition of unusual symptoms found in cancer survivors, and further reflections on the effective integration of nonphysician providers in practice. An ongoing feature of *JOP* has been to present information on the facets of exemplary practices of effective research sites. Baer et al review these attributes and the high points of the series past.

This issue also marks an ongoing effort to provide interesting and high-quality content online. Several articles in this issue are published as Web-exclusive content, providing readers with first-hand descriptions of efforts to promote and institute multidisciplinary care in practice. Web-exclusive content is a part of *JOP*'s official body of work and is presented in the table of contents.

Please forward any letters or comments to us about the subjects or opinions presented to jopeditorsdesk@asco.org. We wish you good reading.

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