2015 PACT ACT

PLANNING ACTIVELY FOR CANCER TREATMENT

PLANNING ACTIVELY FOR CANCER TREATMENT (PACT) ACT

Providing Cancer Patients a Plan for Treatment and Survivorship

The bi-partisan Planning Actively for Cancer Treatment (PACT) Act will encourage the development of a personalized cancer care plan for Medicare beneficiaries.

The PACT ACT will:

- Help cancer patients through the difficult process of cancer diagnosis, treatment choices, treatment management, and survivorship care by supplying them a written plan or roadmap.
- Encourage a shared decision-making process between patients and their cancer care teams.

  Support informed decision-making, which is essential for patients as treatment choices are becoming increasingly complex.
- Empower patients with tools to manage care from active treatment through long-term survivorship.

How does the PACT Act encourage cancer care planning?

The PACT Act would establish a new Medicare service for cancer care planning. The planning service could be provided to patients at the time of cancer diagnosis, at the end of active treatment and beginning of long-term survivorship, and when there is a significant change in treatment.

The cancer care planning process will produce a written plan of care provided to the patient for use in managing care.

Why is a cancer plan necessary for each patient?

In several evaluations of the cancer care system, the Institute of Medicine (IOM) National Cancer Policy Forum has found that cancer patients rarely receive a plan of care. The IOM has said that patients should receive a cancer care plan because the planning process triggers a solid treatment decision-making process and facilitates the coordination of treatment and supportive care, including management of nausea and vomiting, fatigue, anxiety, and depression.

After patients finish active treatment, they may transition into a different system for long-term survivorship care. These patients require monitoring of the effects of their cancer treatment and for cancer recurrence, as well as follow-up care provided according to recommended schedules. A written plan facilitates the transition to survivorship and the long-term follow-up that is required.

NCCS
NATIONAL COALITION FOR CANCER SURVIVORSHIP

Why is a new Medicare service necessary?

The Centers for Medicare & Medicaid Services (CMS) has placed a high value on care planning and coordination for all Medicare beneficiaries by establishing the transitional care management service and the complex chronic care management service. In addition, CMS plans in 2016 to launch the Oncology Care Model demonstration project that requires participating oncology practices to undertake cancer care planning as a core service.

The PACT Act is still necessary, in spite of the strong efforts by CMS to foster care planning for Medicare beneficiaries. Cancer care is especially complex because it is typically multi-disciplinary, requires coordination of active treatment and aggressive management of cancer symptoms and side effects of treatment, and encompasses elements of acute and chronic care. The transitional care management service and complex chronic care management service are not adequate for cancer care management. In addition, many patients will receive their care in practices outside the Oncology Care Model and as a result will not benefit from the cancer care planning service in that model.

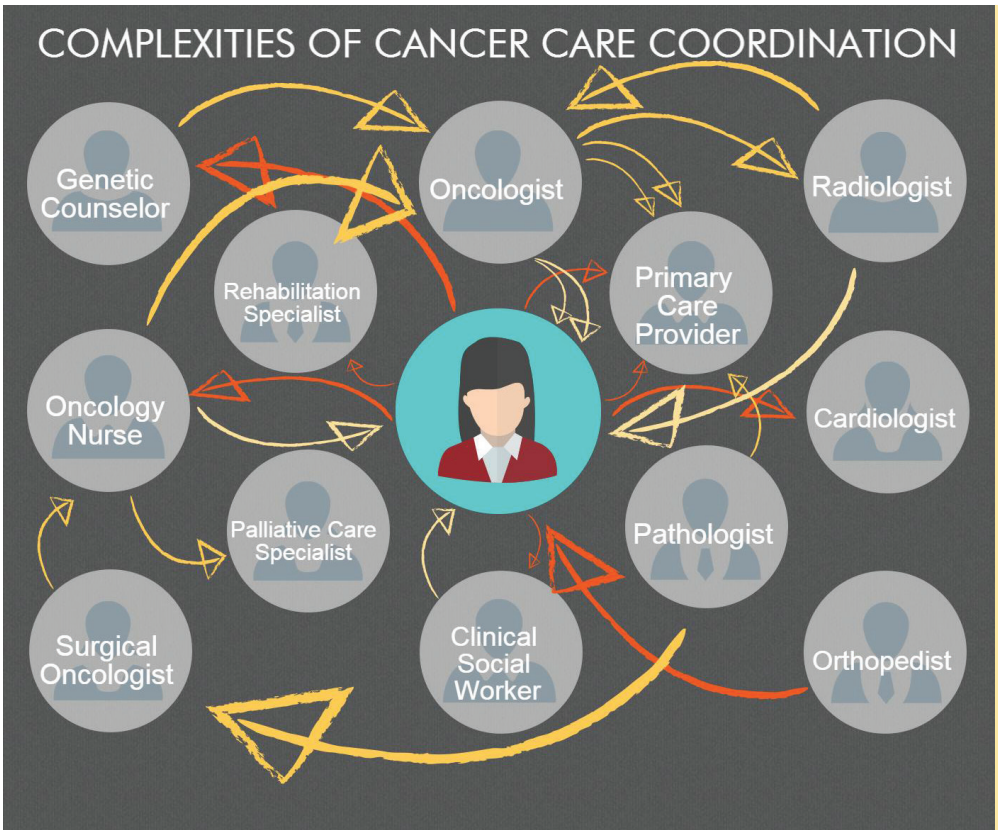
The PACT Act will amend title XVIII (Medicare) of the Social Security Act to provide coverage of cancer care planning and coordination services. It is co-sponsored by Reps. Lois Capps (D-California), a registered nurse, and Charles Boustany Jr, MD, (R-Louisiana), a surgeon.

Contact your representative and let them know that cancer care planning is important for cancer patients and their families

For more information visit:

www.cancerplanact.org

Planning Actively for Cancer Treatment



This diagram illustrates the complexity of cancer care coordination. With clinical, procedural, and other supportive office visits, cancer patients may need to coordinate care with additional members of their care team, including a nurse navigator, a psychotherapist, occupational therapist, neurologist, hematologist, gynecologist, urologist, pulmonologist, or other providers. This diagram is adapted from Ambulatory Care Coordination for One Patient from the "Instant Replay — A Quarterback's View of Care Coordination" perspective piece by Matthew J. Press, M.D.