

# Value-based cancer care and the patient perspective

David Cella, PhD

The business of cancer care is in transition. Driven by the Centers for Medicare & Medicaid Services' (CMS) Oncology Care Model (OCM) program, practices around the country are working to re-engineer the way they provide services, and the way they charge for those services. The implicit goal of all this is to manage (as in reduce) the overall cost of cancer care. A more frequently stated goal is to improve value, typically defined as outcome (numerator) relative to cost (denominator). Alternative payment models are challenged to assess the value of transformational improvement in cancer care. Innovations such as reducing service redundancy, patient navigation, and other practices to minimize costly acute care, and increase the use of generic drug prescriptions, remain focused primarily on the cost denominator, and compete mightily with the massive effect of an increasing supply of new and expensive drug treatment options. This is compelling insurance companies to reward use of generic drugs and keep patients out of hospitals and emergency departments. Still, drug and hospital costs continue to drive up the denominator in the value equation.

What about the numerator? How can oncology practices improve outcomes? One popular way, encouraged by organizations ranging from the National Quality Forum to the American Society of Clinical Oncology (ASCO) and the National Comprehensive Cancer Network (NCCN), is to reduce unwanted practice variation. Differentiating unwanted practice variation from patient-centered personalized medicine which, by definition, varies across patients, remains something of a holy grail in cancer care. Mere standardization of care pathways can appear to the individual oncology provider as imposing "cookie cutters" onto practice. When this happens, providers cannot be expected to participate enthusiastically. Reducing practice variation without introducing some version of patient-centered variation, will ultimately fail to deliver on the value promise. Put another way, the way to influence the numerator of the value equation is to embrace and enact some version of

patient-centered practice variation into the structure and processes of cancer care.

There are several available value frameworks, including those from NCCN and ASCO. Many of these are guidelines to help maximize the cost-effectiveness of prescription drugs. Most of these frameworks are oriented to the payer and provider; they typically exclude the perspective of the patient. Those that do include the patient perspective do not make it clear how that perspective is factored into the value equation. Much work remains to be done to help patients, individually or collectively, participate in this process. Instituting these frameworks as guidance for determining therapy on an individual basis is a good start. As costs rise, justifying a drug that has been shown to extend survival or progression-free survival has met with increasing difficulty, and is becoming a major topic of public debate. Providers must manage not only the patients' disease, but also their outcome expectations and financial liability.

This year's new OCM introduced by CMS aligns financial incentives to improve oncology care and outcomes. The program targets patients from the start of chemotherapy through their first several months of care. Participating practices are required to provide patient navigation, document a care plan, have an informed clinician available to patients at all times, deploy peer-endorsed clinical treatment guidelines, and monitor their data to improve quality, using a government-certified electronic health record. These requirements provide many opportunities – even requirements – to engage patients meaningfully in the provision of value-based cancer care. Ideally, patients and their families will truly be placed in the center of care, with treatments designed around what is best for them rather than the provider or payer. But will it really happen the way it is envisioned? Perhaps. The key to success will be patient and family engagement. Patient perspectives on outcome can be pulled from the many clinical trial reports that include patient-reported outcome data alongside more traditional outcomes of tumor response, progression, survival, and tox-



icity. We have accumulated extensive data on the impact, or lack of impact, that cancer treatments have had on quality of life. In addition, it is now possible to incorporate patient-reported outcomes into routine clinical practice, aided by electronic health records that include standardized assessments.

Unfortunately, we have fallen short of providing easily understood patient-centered outcome information associated with emerging and expensive new therapies. Ironically, we have data on this; they can be found in numerous published clinical trial reports. Nevertheless, we remain very dependent on valuing length of life over quality of life. Survival probability remains the primary basis for discuss-

ing treatment options in ways that patients can digest and use meaningfully. The new wave of emphasis on value-based cancer care, with its push to more explicitly engage and include patient-centered outcomes, provides an opportunity to do a better job of truly engaging patients in care decisions, making quality of life as important as quantity of life. Steps toward that goal include improving our commitment to gathering information about symptoms, function and quality of life, and using that information in clinically meaningful ways to drive care decisions and outcome evaluations. We have the measures. We have the technology. Perhaps the force of payment reform will help us find the will.