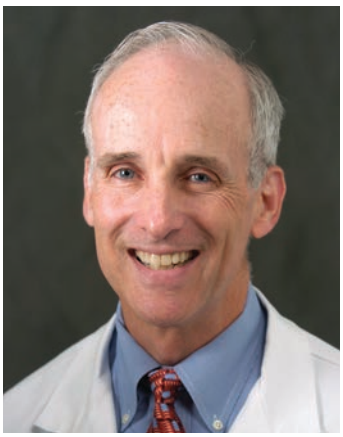
Repeal and replace? How about retain, review, and refine?

David H Henry, MD, FACP

A suggestion for Congress: keep what's working in the Patient Protection and Affordable Care Act (PPACA), adjust what isn't working – just make the whole thing better and call it what you will.

As we go to press with issue, I am very disappointed to see what has transpired in Washington around the health care law. Once again, the Democrats and Republicans have pitched their camps against each other, with one side saying the PPACA, which was signed in to law by President Obama in March 2010, is a huge failure and has to go, and the other saying access to and delivery of health care under the PPACA is a success and although it needs refinement, we should leave it alone. It's not evident that either side really knows how to fix health care. Perhaps the best summation of the process came from the new president, who had promised to repeal and replace the law on the first day of his presidency, when he told a gathering of the nation's governors back in February: "I have to tell you, it's [health care is] an unbelievably complex subject. Nobody knew that health care could be so complicated."[1] Well anyone practicing in health care today has known that since graduation, as do our patients – and the insurers for that matter.



A good thing, but needing work

The PPACA, which is also referred to as Obama care, had a lot in it that any reasonable person would consider good. Let's take a look. As Dr Valerie Arkoosh wrote in our journal in 2012,[2] the law attempted to expand access to health care to the embarrassingly large 30 million or more Americans who were not insured. How would it do this? By expanding Medicaid, enhancing consumer protections in the private health insurance market, requiring large employers to offer insurance or pay a fine, giving tax credits to increase affordability of insurance for small businesses, creating state-based competitive market places, and requiring individuals to purchase health insurance plans (the so-called insurance mandate), thereby creating a pool of large numbers of healthy people who would help defray the costs of those not so fortunate. The law also guaranteed insurability despite any preexisting condition, surely a step in the right direction. Likewise, the need for employers to provide health insurance, the state-based health insurance exchanges, and especially the individual mandate to buy insurance or pay a fine, were all steps in the right direction.

And the law went further – it also addressed preventive care. Medicare and all new insurance plans would have to cover, without copay, co-insurance, or deductible, high-certainty preventive services such as screening for breast, cervical, colorectal, lung, and skin cancers, the annual well-woman visit, breast cancer preventative medications, and many others.[3] Medicare recipients would be eligible for one non-copay annual wellness visit to their caregiver. Beyond providing increased access to health care, the PPACA added incentives to caregivers who were coming out of training programs to serve in underserved areas and benefit from a decrease in their med school loans or in their loan repayments.

Finally, and especially important, under the PPACA, our age-old insurance system of fee for service, which tends to incentivize more care, would change to incentivizing high-quality, outcomes-based care , thus replacing "quantity of care" with quality of care. So what's wrong with the features of the law outlined in the preceding paragraphs? Well, of course, for every 100 ideas, only a few will be implemented and actually pay off. Certainly some of the PPACA could have been better implemented, and perhaps the task now facing Congress, if it could ever abandon its current pitched-camp approach, should be to take the ideas that health care policy scientists have established as being valid and find a way to make them work. Surely that would be best for all players, rather than carping about the repeal-replace approach versus staying with the PPACA.

So my response to the repeal-replace assertion? Retain, review, and refine.

Practitioner-friendly content

Health care calamities notwithstanding, we have a line-up of articles in this issue that uniformly address some of the

JCSO 2017;15(2):59-61. ©2017 Frontline Medical Communications. doi: https://doi.org/10.12788/jcso.0337.

pressing needs many of us face in our daily practice. On page 89, Barry and colleagues examined the patterns of care with regard to whole brain radiotherapy technique and delivery at US-based academic centers. Their results show some interesting differences in the way younger and older practitioners deliver that care, with older practitioners placing more importance on tumor histopathology when considering brain irradiation. Speaking of access to care in the context of health reform, how often do our cancer patients use the emergency department? Lash and colleagues (p. 95) looked at the ED-use numbers from two databases in California and found that patients go to the ED at higher rates than previously reported and with notable variability by cancer type. Now we need to examine the reasons for those visits and establish ways to identify predictors of ED use to improve patient quality of care and rein in the higher costs of ED use.

In regard to symptom management, we can never have enough about nausea and vomiting prevention. On page 82, Schwartzberg and colleagues report on a trial in which they evaluated the clinical benefits of APF530, a subcutaneous formulation of granisetron, compared with ondansetron in patients who had received cisplatin therapy. This longer-acting formulation of granisetron performed very well against a standard of care and might give our patients another option in the clinic for highly emetogenic chemotherapy.

Still on the topic of symptom management, preventing and treating mTOR-inhibitor–associated stomatitis (mIAS) is the subject of a review by Ramchandran and colleagues (p. 74). The inhibitors have been approved for treatment in renal cell, neuroendocrine, and breast cancers, but of course, many of our newer molecules have some associated toxicity. Based on their literature scan, the authors report that management of mIAS should focus on three major approaches: prevention, early aggressive treatment, and, when needed, more aggressive pain management. Early recognition and diagnosis of mIAS facilitate early intervention to limit potential sequelae of mIAS and minimize the need for mTOR inhibitor dose reduction and interruption.

In a way, stress management could also fall under the symptom management category. I often remember being told during my training that we should always discuss with your patients their level of anxiety and depression. But I think sometimes we are so busy addressing the cancer, its treatment, and treatment side effects, we overlook the fact that the patient is suffering psychologically and might need additional intervention in the form of talk therapy and/or medication. On page 68, Ramírez-Solá and colleagues describe in our How We Do It section the process of developing and implementing a psychosocial distress management program at their institution in Puerto Rico. The authors also summarize the results of a pilot study to validate the Patient Health Questionnaire (PHQ-9) as a measure to improve the process of emotional distress management in particular.

In recent years, the number of approvals and new indications for therapies for different cancer types has increased significantly. We highlight two such approvals in this issue. One is the PARP inhibitor, rucaparib, which was approved in both the platinum-sensitive and -resistant settings for BRCA1- and BRCA2-mutant patients with ovarian cancer (p. 62). The other is the new CD38 antibody daratumumab, which was originally approved as a single-agent therapy for relapsed myeloma and which has now received a second approval with demonstrated improvement of progression-free survival when given with the lenalidomide-dexamethasone or bortezomib-dexamethasone combinations (p. 65).

When it comes to new therapies, immunotherapies are at the cutting edge. Who hasn't heard of the new checkpoint inhibitor drugs for a range of cancers that have either been approved or are in trial? Until now, we have used these immunotherapies as single agents, but on page 116, Jane de Lartigue writes of the potential of combining more than one immunotherapy drug and/or combining an immune checkpoint inhibitor with a chemotherapy drug. The key behind this concept is that the more antigenic differentiation and tumor infiltrating lymphocytes in the system, the better the immunotherapy might work.

In the previous issue of the journal, one of our Editors, Thomas Strouse, discussed the issue of physician aid in dying (PAD)[4] and asserted he had come to view "active non-participation" in legal PAD as a "toxic form of patient abandonment." This is, of course, a very challenging and complex topic, and one that we likely have to address on a weekly basis with some of our cancer patients: if palliative care and end-of-life is the goal, how can we most humanely achieve that ethically and legally in concert with our patients' wishes? Is it right or wrong to aid in some way in the dying process? On page 122, Dr Alva Weir responds to Dr Strouse's editorial, taking the view point that physician-assisted suicide is toxic abandonment. Dr Strauss responds, and I encourage you to read this very interesting exchange that highlights the point-counterpoint views of physician involvement in the dying process.

We round off the issue with a bumper crop of Case Reports (pp 103-113). They include two that document diagnostic challenges: one in a patient with pulmonary sarcomatoid carcinoma presenting as a necrotizing cavitary lung lesion and another in which atraumatic splenic rupture is the initial presentation of CML. Also included is a report on a case of primary cardiac prosthetic valve-associated lymphoma and another on how a collaborative effort between oncologists and dermatologists contributed to the resolution of palmoplantar exacerbation of psoriasis in a patient who had been treated with nivolumab.

Going digital

I will close by remarking that the Journal of Community and Supportive Oncology, or JCSO, will be going digital only after this print issue. We will continue publishing the same content as a bimonthly digital issue, posting articles directly to our website, and mailing out our regular electronic newsletters. So visit the website, www.jcso-online.com, where you can read the articles as soon as they are posted and also find instructions for downloading the app for the digital edition – it's quick, easy, and free, in case you were wondering. For a shortcut to the download the app, you can also use http://bit.ly/2nCEPIa.

Finally, if you would like to submit a paper to us for consideration for publication, you can do so by going to www.editorialmanager.com/jso/. We will consider submissions in original research, reviews, How We Do It, case reports, and tumor board summaries – you'll find all the information you need to submit a paper at the EditorialManager platform. And let's not forget social media – we're on Twitter where our handle is @jcs_onc, my personal Twitter handle is @davidhenrymd, so connect with us – follow us, like us, and retweet us.

References

1. Pear R, Kelly K. Trump concedes health law overhaul is 'unbelievably complex.' https://www.nytimes.com/2017/02/27/us/politics/trump-concedes-health-law-overhaul-is-unbelievably-complex.html?_r=0. New York Times. February 27, 2017. Accessed April 4, 2017.
2. Arkoosh VA. The Patient Protection and Affordable Care Act: no rhetoric, just the facts. Commun Oncol. 2012;9(6):206-209.
3. USPSTF A and B Recommendations. US Preventive Services Task Force. https://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/. January 2017. Accessed April 4, 2017.
4. Strouse T. End-of-life options and the legal pathways to physician aid in dying. J Community Support Oncol. 2017;15(1):1-3.