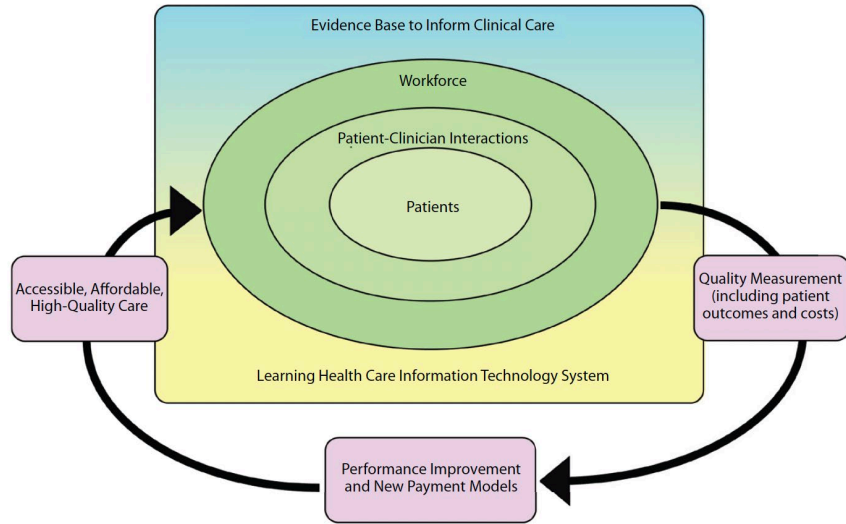


A High-Quality Cancer Care Delivery System



**Access, Affordability,
and Value:**
*Key Components of High
Quality, Patient-Centered Care*



Memorial Sloan Kettering
Cancer Center

Fumiko Chino, MD





NATIONAL CANCER OPINION SURVEY 2018 KEY FINDINGS

Cancer's Financial and Access Challenges

Just as many Americans are worried about **cancer's financial impact** as about **dying of cancer**



Financial
Burden



Death



61%

of **caregivers** say they or a loved one have taken at least one onerous step to **pay for cancer care** including:

35% dipped into **savings account**

23% worked **extra hours**

14% postponed **retirement**

13% took on an **additional job**

43%

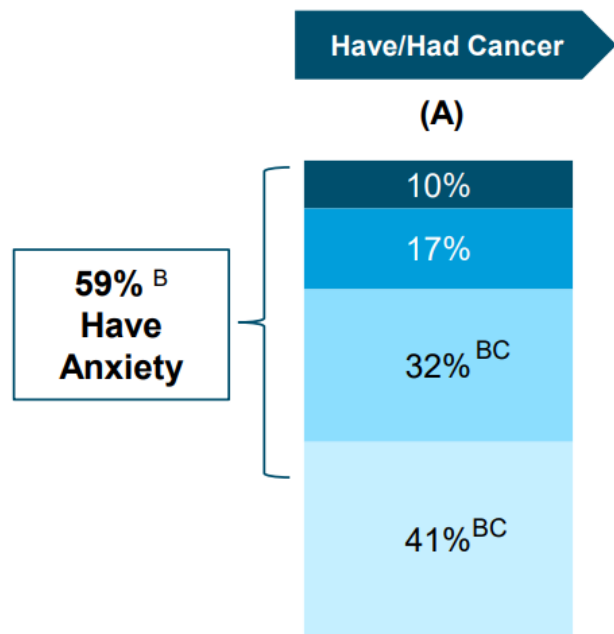
of **cancer patients** experienced barriers to accessing the best possible care due to **health insurance coverage**



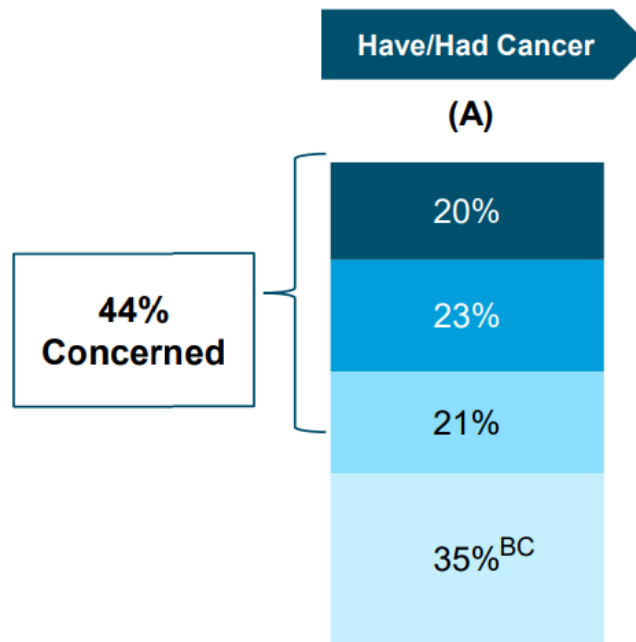
n=4,016

ASCO 2018
National Cancer
Opinion Survey

A Cancer Diagnosis Causes Anxiety about Finances



Treatment Affordability is a Concern



■ An overwhelming amount ■ A lot ■ A little ■ None

■ Very concerned ■ Somewhat concerned ■ Not very concerned ■ Not at all concerned

n=1142

ASCO 2020
National Cancer
Opinion Survey



We Won't Get Value-Based Health Care Until We Agree on What "Value" Means

by Robert C. Pendleton

February 27, 2018



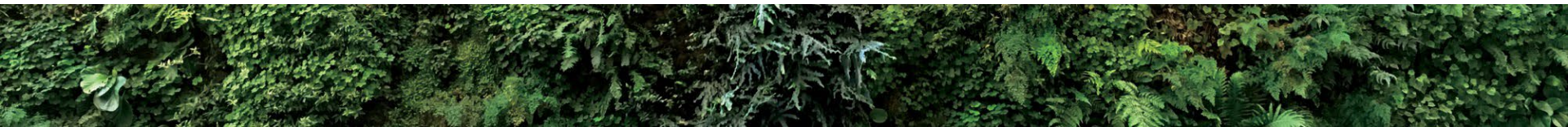
“Stakeholders in the U.S. health care system — *patients, providers, hospitals, insurers, employee benefit providers, and policy makers* — have **no common definition** of “value” and don’t agree on the mix of elements composing it (quality? service? cost? outcomes? access?).”

<https://hbr.org/2018/02/we-wont-get-value-based-health-care-until-we-agree-on-what-value-means>

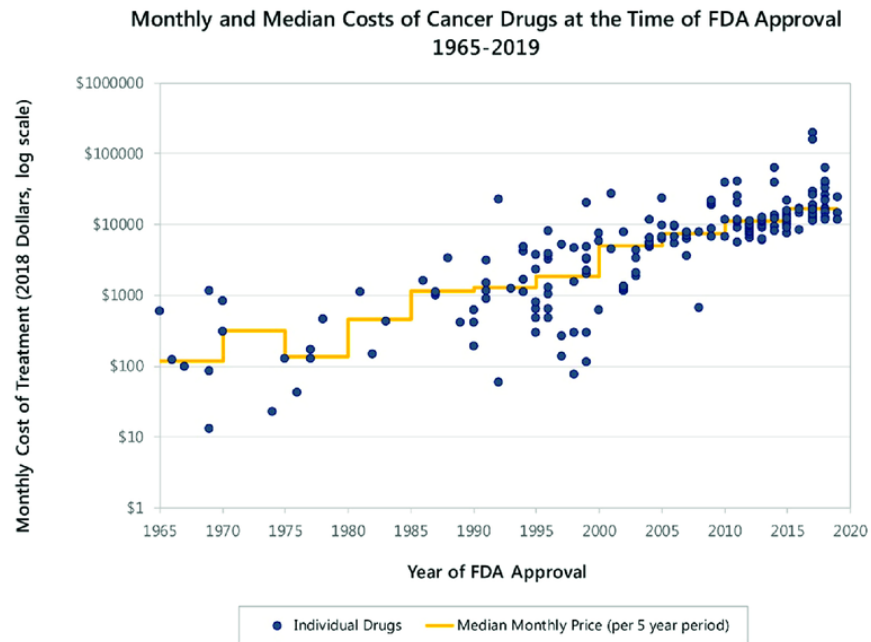




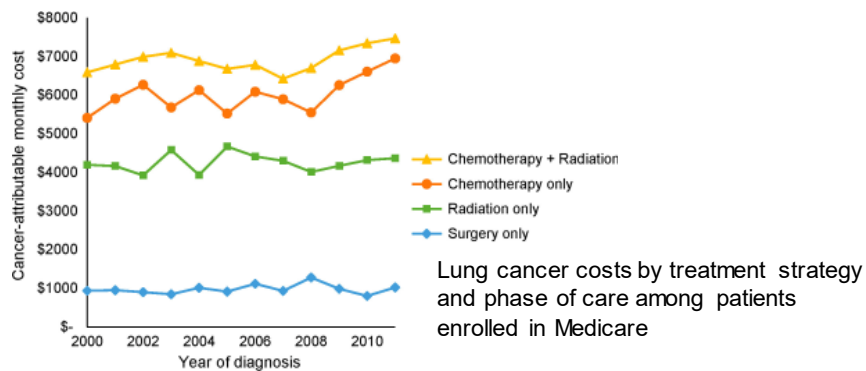
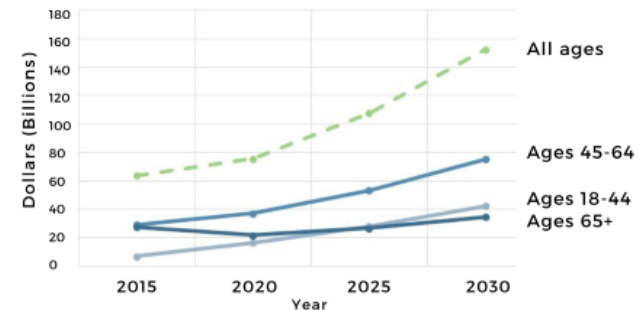
<https://www.healthcareitnews.com/sponsored-content/solving-healthcare-value-equation-0>



The Costs of Cancer Treatment Continue to Rise

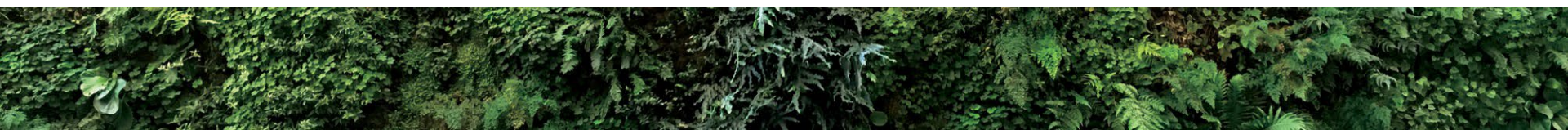


PROJECTED MEDICAL AND PRODUCTIVITY COSTS FOR METASTATIC BREAST CANCER BY AGE GROUP

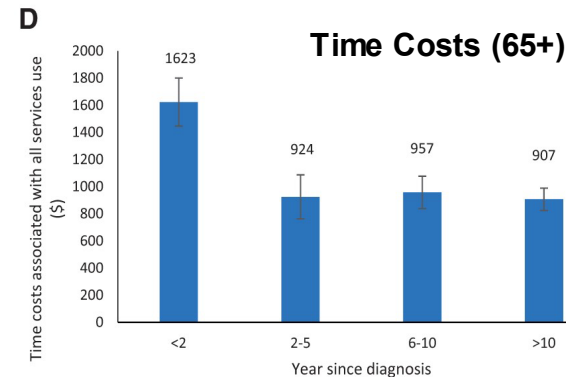
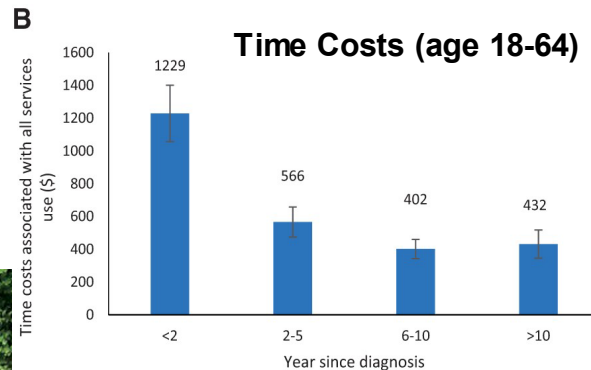
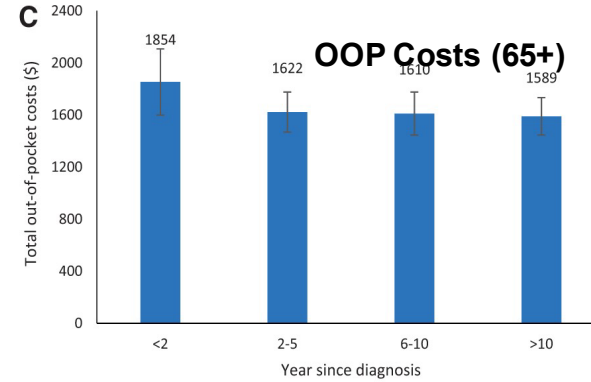
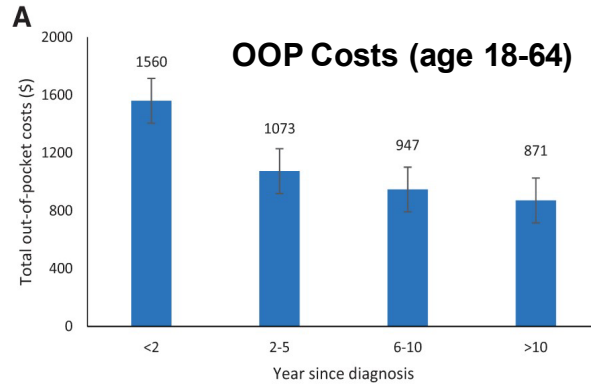


www.mskcc.org/research-programs/health-policy-outcomes/cost-drugs

Grogate, *JNCI Cancer Spectrum* 2021; Sheehan, *Cancer Medicine*, 2018



Yearly national **patient economic burden** (including out-of-pocket & time costs) is ~\$21.1 BILLION



Yabroff, *JNCI* 2021

When Care is **Unaffordable**, You Get “Financial Toxicity”

Problems a patient has related to the cost of medical care. Cancer patients are more likely to have financial toxicity than people without cancer.

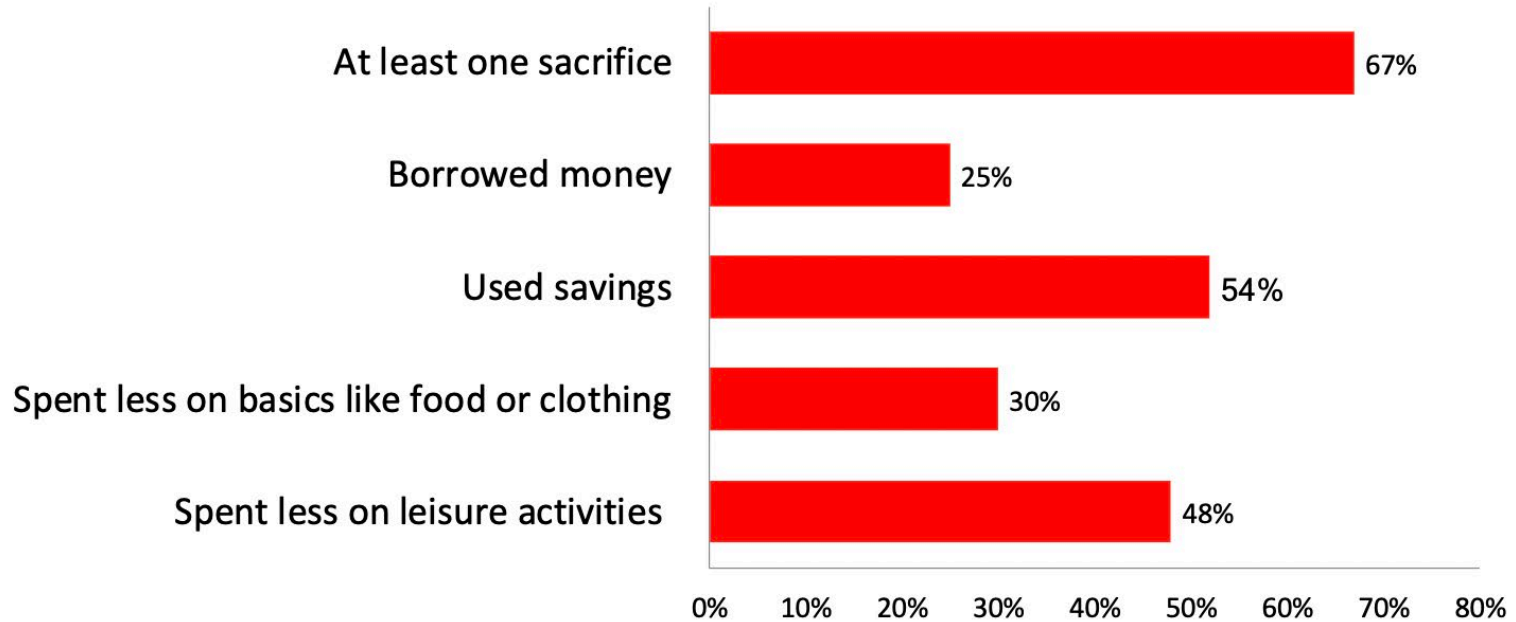
-National Cancer Institute

“Even with health insurance, the high costs of cancer care are leaving some vulnerable American families adrift in debt. [...] Out-of-pocket costs can have real effects on *quality of life* and *quality of care*.”

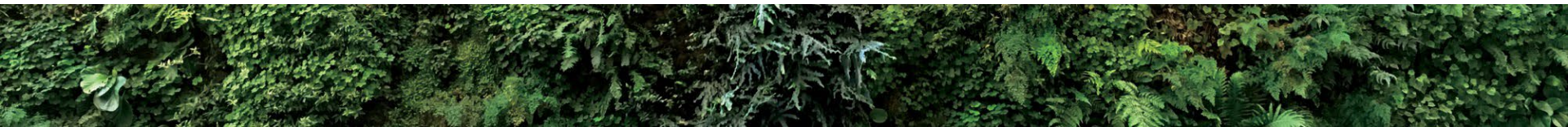
-Chino, *JAMA Oncology*, 2018



Increased **Personal/Family Burden**



Chino, *JCO OP*, 2018
n=300 on active treatment



Decreased **Quality** of Care



Total medication nonadherence due to cost = 27%

22% didn't fill Rx

14% skipped doses to make meds last longer

5% skipped, took less, or didn't fill their chemotherapy prescriptions



Objective and Lasting Financial Harms



45%

put off major purchases



45%

took on credit card debt



44%

post-cancer credit score
decrease

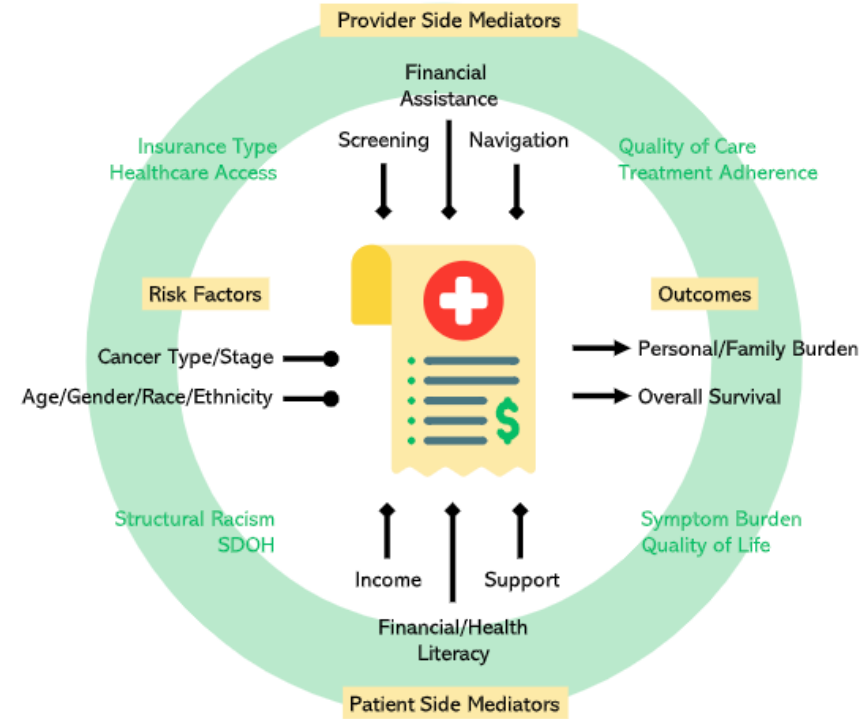
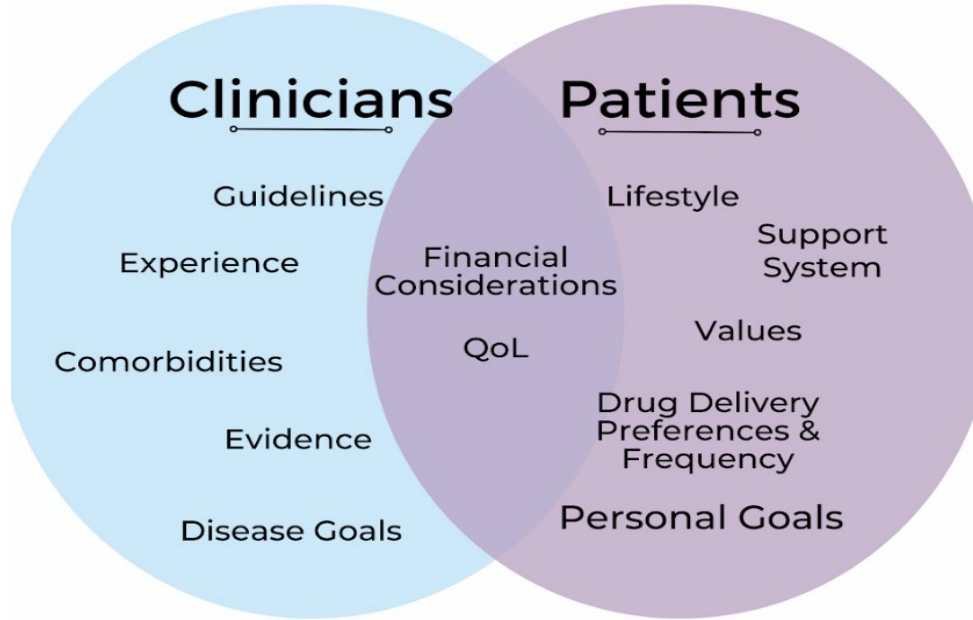


39%

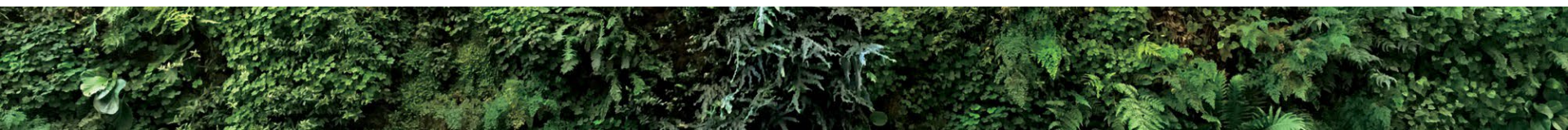
debt collection contact

Thom...Chino, JCS 2022
n=267 (AYA survivors median 8.3 years post-diagnosis)

Shared Decision in Medicine



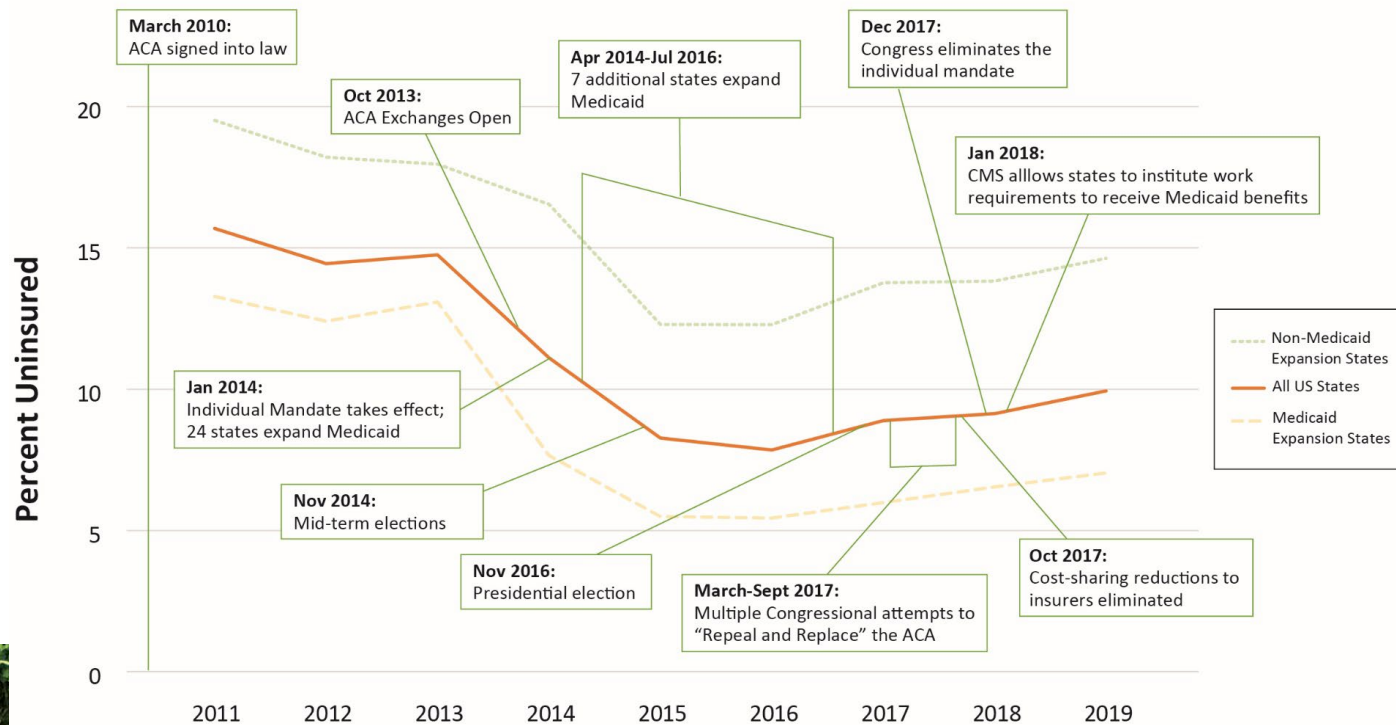
Karukonda, *IJROBP* 2023; ACS "Making Treatment Decisions"
www.cancer.org/cancer/managing-cancer/making-treatment-decisions/making-decisions.html





Is Access to Health Insurance a Quality Metric?

Uninsurance in Adult Cancer Patients and Survivors (Age 18-64)



Moss....
Chino, *Lancet
Oncology*,
2020

Measuring Quality: How Can We Eliminate Waste?

Choosing Wisely
An initiative of the ABIM Foundation

American Society of Clinical Oncology
ASCO
AMERICAN SOCIETY OF CLINICAL ONCOLOGY
Five Things Physicians
and Patients Should Question

ASCO, ASTRO and SSO **Choosing Wisely:** *Cancer Tests and Treatments Routinely Performed Despite Lack of Evidence*

The American Society of Clinical Oncology (ASCO) has published guidelines for testing currently used cancer drugs through research, laboratory, innovation, and delivery of high-quality patient care. ASCO encourages the use of evidence-based medicine and supports the use of evidence-based medicine in the management of patients with cancer. The guidelines are intended to help physicians and patients make informed decisions about the use of cancer tests and treatments. The guidelines are based on the best available evidence and are intended to be updated as new evidence becomes available. The guidelines are intended to be used as a guide, not a rule, and are not intended to be used in a way that would be inconsistent with the physician's judgment or the patient's wishes. The guidelines are intended to be used in a way that would be consistent with the physician's judgment or the patient's wishes. The guidelines are intended to be used in a way that would be consistent with the physician's judgment or the patient's wishes.

1 Don't use cancer-directed therapy for solid tumor patients with the following characteristics: low performance status (3 or 4), no benefit from prior evidence-based interventions, not eligible for a clinical trial, and no strong evidence supporting the clinical value of further anti-cancer treatment.

• Studies show that cancer directed treatments are likely to be ineffective for solid tumor patients who meet the above listed criteria.
• Guidelines indicate patients with functional limitations due to other conditions resulting in a low performance status or those with disease characteristics (eg, metastatic) that suggest a high likelihood of response to therapy.

2 Don't perform PET, CT, and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.

• Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve decision of treatment, disease or survival.
• Evidence does not support the use of these tests for staging of newly diagnosed low-grade or intermediate-grade prostate cancer (eg, prostate-specific antigen [PSA] <10 ng/mL). Gleason score less than or equal to 6 with the risk of distant metastasis.

3 Don't perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.

• Imaging with PET, CT, or radionuclide bone scans can be useful in the staging of specific cancer types. However, these tests are often used in the staging evaluation of low-risk cancers, despite a lack of evidence suggesting they improve decision of treatment, disease or survival.
• In breast cancer, for example, there is a lack of evidence demonstrating a benefit for the use of PET, CT, or radionuclide bone scans in asymptomatic individuals with newly diagnosed ductal carcinoma in situ (DCIS), or clinical stage I or II disease.

4 Don't perform surveillance testing (biomarkers) or imaging (PET, CT, and radionuclide bone scans) for asymptomatic individuals who have been treated for breast cancer with curative intent.

• Surveillance testing with biomarkers or imaging has been shown to have clinical value for certain cancers (eg, colonized). However, for breast cancer, there has been no evidence showing that surveillance testing with biomarkers or imaging has shown that it can benefit from the imaging or avoid treatment of disease that is asymptomatic in patients.

5 Don't use white cell stimulating factors for primary prevention of febrile neutropenia for patients with less than 20 percent risk for this complication.

• ASCO guidelines recommend using white cell stimulating factors when the risk of febrile neutropenia, secondary to recommended chemotherapy regimens, is approximately 20 percent or greater. Effective treatment programs that use white cell stimulating factors are available.
• Guidelines should be made when using regimens that have a lower chance of causing febrile neutropenia if it is determined that the patient is at high risk for the complication (eg, age, medical history, or disease progression).

Disclaimer: These guidelines are provided solely for informational purposes and do not constitute a medical professional's independent judgment or a substitute for consultation with a medical professional. Patients who use these guidelines do so at their own risk. The American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH) are not responsible for the development of these guidelines.

Revised April 4, 2012 (Items 1-5) and October 28, 2012 (Items 6-10)

8 Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.

- PET and PET-CT are used to diagnose, stage and monitor how well treatment is working. Available evidence from clinical studies suggests that using these tests to monitor for recurrence does not improve outcomes and therefore generally is not recommended for this purpose.
- False positive tests can lead to unnecessary and invasive procedures, overtreatment, unnecessary radiation exposure and incorrect diagnoses.
- Until high level evidence demonstrates that routine surveillance with PET or PET-CT scans helps prolong life or promote well-being after treatment for a specific type of cancer, this practice should not be done.

10 Don't use a targeted therapy intended for use against a specific genetic aberration unless a patient's tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.

- Unlike chemotherapy, targeted therapy can significantly benefit people with cancer because it can target specific gene products, i.e., proteins that cancer cells use to grow and spread, while causing little or no harm to healthy cells. Patients who are most likely to benefit from targeted therapy are those who have a specific biomarker in their tumor cells that indicates the presence or absence of a specific gene alteration that makes the tumor cells susceptible to the targeted agent.
- Compared to chemotherapy, the cost of targeted therapy is generally higher, as these treatments are newer, more expensive to produce and under patent protection. In addition, like all anti-cancer therapies, there are risks to using targeted agents when there is no evidence to support their use because of the potential for serious side effects or reduced efficacy compared with other treatment options.

"Opportunities to improve the quality and value of cancer care"



Incentivizing Quality: Can **Payment Reform** Improve Quality and Value?



The goal of OCM was to “utilize appropriately aligned financial incentives to enable **improved care coordination**, **appropriateness of care**, and **access to care** for beneficiaries undergoing chemotherapy”

Five-year model (2016-2021) to test innovative payment strategies that promote high-quality and high-value cancer care

- 1) Provide Enhanced Services
- 2) Use certified electronic health record technology
- 3) Utilize data for continuous quality improvement

OCM Measure Number	Measure Name	Measure Source
OCM-2	Risk-adjusted proportion of patients with all-cause emergency department visits or observation stays that did not result in a hospital admission within the 6-month episode	Claims
OCM-3	Proportion of patients that died who were admitted to hospice for 3 days or more	Claims
OCM-4a	Oncology: Medical and Radiation – Pain Intensity Quantified (MIPS 143, NQF 0384)	Practice Reported
OCM-4b	Oncology: Medical and Radiation – Plan of Care for Pain (MIPS 144, NQF 0383)	Practice Reported
OCM-5	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (CMS 2v8.1, NQF 0418)	Practice Reported
OCM-6	Patient-Reported Experience of Care	CMS-Acquired Data

