NCCN Roundtable: Value-Based Decision-Making at the Bedside

Presented by Peter B. Bach, MD, MAPP; Stephen B. Edge, MD; Linda House, RN, BSN, MSM; Jennifer Malin, MD, PhD; and James L. Mohler, MD; moderated by Clifford Goodman, PhD

Abstract

As part of the NCCN 20th Annual Conference: Advancing the Standard of Cancer Care, a distinguished and diverse group of experts on value-based decision-making in oncology discussed guidelines and pathways and how their use has impacted bedside evidence-based decision-making for both physicians and patients. Moderated by Clifford Goodman, PhD, the roundtable also reflected on the criteria used to assess shared decision-making and the relationship between outcomes and cost when determining value. (J Natl Compr Canc Netw 2015;13:659–661)

"Bridging the bedside to our megatrends" was how Clifford Goodman, PhD, of The Lewin Group, introduced the topic of a Roundtable Discussion at the NCCN 20th Annual Conference. Dr. Goodman convened a panel of physicians, policy makers, and patient advocates to discuss value-based decision-making "at the bedside," which, according to Dr. Goodman, "brings together on the ground the granular aspects of cancer care but within the broader context of pursuit of value."

Are Guidelines Used at the Bedside?

James L. Mohler, MD, Professor of Oncology at Roswell Park Cancer Institute and Chair of the NCCN Guidelines Panel for Prostate Cancer, indicated that as an NCCN member institution, Roswell Park is committed to following NCCN Guidelines and includes them as part of the patient visit. He personally finds them helpful in discussions with his urology patients because there are many treatment options for prostate cancer, and the Guidelines spell them all out.

"We use guidelines to turn things around so that the oncologist is more of a teacher, and the patient decides about his care," he said. For a cancer where multiple treatment options are essentially equivalent, he noted, "We believe we are empowering patients, because they can be right no matter what they choose."

Stephen B. Edge, MD, of Baptist Cancer Center in Memphis and a former NCCN Guidelines Panel member, stated that patient visits at his institution do not generally include use of the Guidelines, although the medical staff is schooled in them and refers patients to the NCCN Patient Guidelines if they exist for the specific cancer. He also noted that about 20% of cancer treatment at Baptist falls outside of NCCN Guidelines' recommendations, for various reasons. Dr. Edge believes an 80% guideline concordance rate is acceptable as long as the exceptions are well documented.

Several of the panelists commented that guidelines are not perfect and that clinician judgment must be part of any treatment decision.

Why Pathways When Guidelines Already Exist?

Dr. Goodman questioned why pathways are developed given that guidelines are already in place. Jennifer Malin, MD, PhD, Medical Director at Anthem Blue Cross Blue Shield and a practicing oncologist, pointed out that the NCCN Guidelines for non-small cell lung cancer include 64 different regimens for patients with metastatic disease and no mutation. "As a clinician, you won't sit there and go through each of those at the bedside," she said. "A pathway helps narrow down those 64 to a subset that would fit most situations. It helps find the best regimen for a patient, and all else being equal, it would examine cost and value as well."

She emphasized that while cost and value are both components in Anthem's pathways, those pathways were "not created for payers, because payers do not make medical decisions…. Rather, they are tools for our member practices. They provide a framework to bring value to the bedside in the context of shared decision-making."

Dr. Mohler described pathways as a sort of "pruning" process that takes into account "familiarity and quality," noting that since pathways reinforce the use of a limited number of approaches, they "should improve the quality" of care delivery.

In response to a question about whether pathways are cost-saving, Dr. Malin said they can be, when the chosen regimen is lower in cost than another equivalent one. However, she added that pathways do not always steer physicians toward bargain drugs. For example, Anthem supports the use of ipilimumab in melanoma. But generally, she said, having lower-cost options allows for more value-based care, which slows the rising cost of cancer care.

Dr. Bach commented that pathways could be viewed as operating much like formularies, in that they offer "tiered treatments." He said this is a "logical response to large variations in the cost of therapies."

Patient Perspective on Treatment Options

Dr. Goodman asked the panel's patient advocate, Linda House, RN, BSN, MSM, of the Cancer Support Community, whether pathways and guidelines align with the information that the patient in the consultation room is seeking.

"Patients are behaving as consumers," Ms. House responded. Unfortunately, she added, patients are often more informed about the purchase of an electronic device than about treatments that affect their lives. She cited a recent Cancer Support Community survey that indicated that although 60% of patients are aware of published guidelines, 50% feel unprepared to make treatment decisions. Most have not heard of pathways. "They don't have a level of understanding and time to make those decisions…. They are unprepared… but they live with the collateral damage of those decisions," she commented.

For example, Ms. House said, patients are frequently unaware of future physical and financial toxicities of their treatment decisions. "In our registry, 37% of patients report making significant alterations to their household budget and 30% go bankrupt paying for cancer care. About 32% of patients reporting financial toxicity do not adhere to treatment. One of our patients commented, 'It's very hard for me to know our family will incur this financial debt, and I am the only one to benefit from it.'"

Dr. Edge concurred, having recently seen a patient reject a biopsy for a breast mass because she did not have $250. Luckily, his institution subsequently found a way to get the woman her biopsy. Dr. Bach remarked, "In the wealthiest country in the world, we are asking patients to make tradeoffs, and we should not be proud of this."

Defining "Value" in Cancer Care

Dr. Edge said, "I have to ask, we're talking about value for whom? For the payer? Shouldn't we be looking for value for our patients?"

Ms. House stated that there is a "huge disconnect" between key stakeholders about what constitutes "value" in cancer care. Patients, doctors, and payers do not conceive of "value" the same way. However, she said, "We cannot *not* include the patient in decision-making. We cannot roll out pathways without considering the end-user, because the patient will 'walk.'"

Dr. Malin pointed out that the current reimbursement model drives practices to select more expensive chemotherapy agents, since practices derive the bulk of their revenue from drug margins. For example, in the case of non-small cell lung cancer, regimens can range from $450 for 4 cycles of carboplatin/paclitaxel to $65,000 for 4 cycles of 3 other agents. Depending on which regimen is chosen, "the difference in revenue to the practice for administering these regimens is enormous," she said. Dr. Malin explained that, to help control the spiraling costs of drugs, Anthem developed its own pathways and an incentive program that rewards physicians $350 per month per patient for pathway compliance. The payment is also supposed to cover care planning and discussion, and distress management. The goal, she said, is to keep oncology practices whole, on average, and make them less dependent on the drug margin from expensive therapies. Anthem is building accountability into its program and will give feedback to its physicians on items such as emergency department visits and hospitalizations.

Ms. House then commented: "I agree we need to make choices, but the challenge is to make choices together. Instead of paying the physician $350 to put the patient on a pathway, let's pay the physician to have a conversation about whether we want treatment to begin with."

Dr. Malin said that the "disconnect" in the healthcare system has reached crisis proportions. Newly approved drugs can cost $15,000 a month, yet patients are rejecting treatments that cost just $250. The average out-of-pocket cost for cancer treatment for an insured patient is now $22,000, yet median family income is only $50,000. At Anthem, she said, the out-of-pocket maximum is capped at around $6,000, "but for many people that's a lifetime of savings."

Cost Considerations in Treatment Decision-Making

Dr. Goodman asked the panelists to consider to what extent cost affects treatment decisions. Dr. Mohler confessed that most physicians are generally unaware of the cost of treatments they recommend, which creates obstacles to discussing value with patients. "We didn't go to medical school to learn accounting," he pointed out. Furthermore, he noted, doctors are being asked to increase volume, which does not allow time to discuss cost issues with patients.

Dr. Edge concurred with the latter point, having stated earlier that he is under pressure to produce more patients and more revenue with less time and resources than he had at a comprehensive cancer center. He also noted that the plethora of insurance products on the market and the number of unique health plans make it unreasonable to expect physicians to be well informed about patients' costs. Nonetheless, he said that even though doctors are not prepared to discuss cost, it "can't be ignored."

But Dr. Bach questioned why information about insurance plans is not "just a click away," describing how his pharmacy determined his copay for a prescription in less than a minute. "We don't have this information at the point of care, and I don't understand why not," he said.

The conversation then turned to some of the reasons for rising health care costs. Dr. Edge noted that when it comes to costs, "payers are not the only villain here. There's plenty of villainous activity to go around!" He said that some blame can be placed on physicians, who sometimes order unnecessary testing and treatment, such as the use of the breast cancer serum marker CA 27-29. "Many of my physicians routinely order these," he indicated. Several panelists also noted that physicians' lack of knowledge about cost also contributes to higher costs, since they might unwittingly select the more costly of equally good treatments.

But patients are not blameless either, according to some panelists. As Dr. Mohler said, "Americans like new things," which are often more costly than existing options. In his view, "the whole system is fundamentally flawed, because we pay doctors to do something to someone, and then we wonder why doctors are doing so much to all these people. Its how the system is set up," he pointed out.

The price of new drugs is another major contributor to cost, the panel agreed. As Dr. Mohler noted, it costs about $1.1 million to die of advanced prostate cancer today, compared to $30,000 before the approval of 5 new drugs. If patients were presented this information in a more personal way, they might participate in value-based decisions about their care, he suggested. "If you put to the patient, 'Would you rather your estate have $1.1 million subtracted from it or $30,000, for adding 3 to 5 months to your life?' I think many people faced with the real costs would make a very different decision."

Dr. Bach alluded to a100-fold increased cost of monthly cancer drug treatment "since the dawn of Medicare in 1965," that has not been accompanied by a 100-fold increase in value. "Healthcare is the only sector that claims to be innovative where there are diminishing returns. It's the product of a completely broken market, a regulatory environment that encourages higher prices."

Conclusions

Assuring that "value" in cancer care equates to "quality" of cancer care remains a work in progress, the panelists concluded. Dr. Malin summed up the challenge: "The idea behind value-based programs is finding a way to come to a soft landing, to encourage value-conscious care in a way that preserves the physician's ability to work with the patient and do shared decision-making. If we can't accomplish that, there will be more difficult choices to be made."

Meet the Panelists

Clifford Goodman, PhD, moderator, Senior Vice President and Principal, The Lewin Group, Falls Church, Virginia.

Peter B. Bach, MD, MAPP, Director, Center for Health Policy and Outcomes, Memorial Sloan Kettering Cancer Center, New York, New York.

Stephen B. Edge, MD, Cancer Center Director, Baptist Cancer Center, Memphis, Tennessee.

Linda House, RN, BSN, MSM, President, Cancer Support Community, Indianapolis, Indiana.

Jennifer Malin, MD, PhD, Medical Director for Oncology Solutions and Innovation, Anthem, Inc, Los Angeles, California.

James L. Mohler, MD, Associate Director for Translational Research and Senior Vice President, Professor of Oncology, Chair of Urology, Roswell Park Cancer Institute, Buffalo, New York.