

# FOCUSING ON THE FUTURE OF CANCER CARE

## NCCS' Cancer Policy Roundtable Reaches its 20th Year

### SESSION ONE

#### CANCER IN THE NEXT DECADE

**Otis Brawley, MD** | John Hopkins University



Dr. Otis Brawley set the stage for the Cancer Policy Roundtable by providing a detailed overview of the most recent cancer mortality data, showing that from 2016 to 2017 there was the largest single-year decline in cancer mortality ever reported. This improvement is attributed to several important factors including the decline of smoking, as well as breakthroughs in diagnosing and treating lung cancer. In addition, new technologies have been developed to help determine the stage of cancer and its prognosis. An important takeaway from Dr. Brawley's presentation was the biggest factor in reducing cancer deaths is health care access. He explained that the Affordable Care Act has helped cover more Americans and ensured that cancer patients cannot be denied because of their pre-existing condition. However, disparities are still prevalent and cancer outcomes reflect these inequities. Dr Brawley discussed disparities in cancer outcomes and noted that advances in treatments lead to increases in disparities, and disparities are not only related to race, ethnicity, and insurance status. He noted that If all Americans has the prevention, screening, and treatment as college-educated Americans, there would be 22%, or 122,000, fewer cancer deaths, which would be much more powerful than any research or therapy in curbing cancer deaths.

"That's more powerful than any drug that we have," Brawley said. "There's no breakthrough treatment, no breakthrough drug, no breakthrough screening that is as powerful as simply getting to all human beings the technologies, risk reduction, screening, prevention diagnosis and treatment that we already have. Keep in mind some of these risk reductions technologies involve preventing teenagers from smoking, therefore they won't die when they are in their 50's and 60's. Again, this is the 29% decline that we have had over the last 26 years."

### SESSION TWO

#### IMPROVING CANCER CARE QUALITY FOR SEXUAL AND GENDER MINORITIES

**Kimberly Acquaviva, PhD** | University of Virginia School of Nursing

**Blake Farmer** | Nashville Public Radio

**Donna Gentry** | Family Caregiver

**Andrew MacPherson** | Healthspieren, LLC; National Partnership for Hospice Innovation

**Lisa D. T. Rice, SM** | NCCS Board Member and Family Caregiver

Although death is inevitable, few of us know how to find the support we need when we are nearing the end of our lives. This panel presented a unique conversation between patient advocates and health care experts discussing personal experiences with end-of-life care and needed policy changes. The caregivers began the conversation by sharing their powerful stories on what is it like to care for someone at the end of their lives and what barriers existed for them and their loved ones. Lisa Rice, NCCS board member and panelist, shared that the chief lesson she learned in caring for loved ones at the end of the life is that early conversations are so important. "Conversations early on are critical, so that you can make good decisions with them - or in some cases - on behalf of them."



These personal experiences laid the groundwork for a pragmatic conversation about what can be done to improve end-of-life care, Mr. Farmer described his reporting on the heavy burden on caregivers, even with support from hospice care, and the feeling some caregivers had that support from hospice was not sufficient, especially in the final days of their loved ones' lives. A consensus grew from this discussion that was captured in a quote by Dr. Acquaviva: "Regulations should serve patients and families. Patients shouldn't be in service of the regulations."

Feedback from attendees was outstanding for this panel, demonstrating the great need for these conversations on end-of-life care and the gaps that exist for those facing advanced illness and their caregivers.

## SESSION TWO (CONTINUED)

NCCS has a toolbox on end-of-life decisions and discussions that address the many aspects brought up in this panel discussion. Visit <https://www.canceradvocacy.org/resources/cancer-survival-toolbox/special-topics/dying-well/> to access the toolkit.

## SESSION THREE

### CANCER REHABILITATION AS A MODEL OF SURVIVORSHIP CARE

**Michael D. Stubblefield, MD** | Kessler Institute for Rehabilitation, Revital Cancer Rehabilitation

Dr. Stubblefield, an internationally recognized leader in the field of cancer rehabilitation, presented an excellent overview of cancer rehabilitation and how it can aid in managing late- and long-term effects of cancer treatment. Dr. Stubblefield defines cancer rehabilitation as “a process that helps cancer survivors obtain and maintain the maximal possible physical, social, psychological, and vocational functioning within the limits created by cancer and its treatments.” He shared that cancer rehabilitation’s “dirty little secret” is that its foundation is much like general rehabilitation, with the goal of helping patients function to their best possible abilities.

Dr. Stubblefield explained that one very important aspect of cancer rehabilitation is prospective rehabilitation: predicting what is likely to happen to a cancer patient due to treatment and getting in front of those issues. For example, a breast cancer patient who takes an aromatase inhibitor may deal with arthritis as a side effect of this particular treatment. With the introduction of so many new targeted therapies coming out, it is critical that rehabilitation specialists understand the long-term effects of these treatments.

“Why do we need cancer rehabilitation? Frankly, it’s because oncologists have gotten really good at their jobs. Five-year survival rates for almost every cancer has gone up...but the long-term effects from treatments result in numerous types of impairments for patients.”



## SESSION FOUR

### THE ONCOLOGY CARE MODEL AND THE PROPOSED ONCOLOGY CARE FIRST MODEL

**Hillary Cavanagh, MA** | Center for Medicare and Medicaid Innovation

**David Goldstein, MS, OTR/L** | Center for Medicare and Medicaid Innovation

**Ray Page, DO, PhD, FACOI, FASCO** | The Center for Cancer and Blood Disorders

**Kashyap Patel, MD** | Carolina Blood and Cancer Care Associates

In this panel discussion, experts from the Center for Medicare & Medicaid Innovation (CMS) discussed the Oncology Care Model (OCM), a payment model designed to improve the effectiveness and efficiency of cancer care, and the Oncology Care First (OCF) model, which has been proposed as the successor to the OCM. Joining this panel were two providers from OCM practices to give their perspectives on this payment model and how it improves care for cancer patients. Practices participating in OCM commit to providing enhanced services to Medicare beneficiaries such as care coordination, navigation, and adherence to national treatment guidelines for care.

Mr. Goldstein shared experiences and lessons learned from OCM practices on survivorship care planning. Mr. Goldstein says oncologists in OCM practices recognize the benefits of care planning and the other enhanced services required under the model. Some practices have mentioned that incorporating care planning has helped reduce overall expenditures.

## SESSION FOUR (CONTINUED)

Hillary Cavanagh, who is the model lead on the new Oncology Care First (OCF) model, outlined this new proposed model, which aims to build on lessons learned from OCM and incorporate feedback from stakeholders. The OCF, a voluntary five-year model that would run from January 2021 through December 2025, will test an innovative approach to prospectively paying for management and drug administration services with a total cost of care accountability. She explained that the new OCF model would include a broader patient population than the OCM, which is currently limited to beneficiaries who receive chemotherapy. The OCF would include patients receiving hormonal therapy, patients under active surveillance, and cancer survivors still undergoing care management from their oncologist.



Dr. Patel said that the OCM has provided a roadmap for the transformation from fragmented oncology care to truly patient-centered care. He described the changes his practice implemented, including expanded hours, improved triage, and partnerships with local urgent care facilities, that reduced hospitalizations and emergency department visits. He said the model showed that it is possible to improve outcomes, reduce the cost of care, and improve the patient experience.

Dr. Page described the American Society of Clinical Oncology (ASCO) Patient-Centered Oncology Payment (PCOP) model, which moves from fee-for-service payments to a value-based model, while improving quality and lowering costs. Dr. Page said PCOP would be a flexible model which would support getting “the right patient, the right treatment, at the right time.”

The panel also discussed implications of COVID-19 on cancer care, including procedures oncology practices have put in place to ensure patient safety and continuity of care. Dr. Patel explained that they designed a three-tiered structure for patients with acute disease, patients who are stable and getting intravenous therapy, and patients who stable, low-risk patients who could use telehealth as an alternative to in-person visits with their oncologist.

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