

Moving Toward the “Tipping Point” for Transformation in Cancer Care

Mary Caffrey

WHEN ASKED TO GIVE his title before being interviewed on camera, Andrew Pecora, MD, FACP, CPE, pauses. This might be the toughest question of the day, given the many hats the hematologist/oncologist wears. Pecora is the chief innovation officer and vice president of cancer services at John Theurer Cancer Center, part of Hackensack University Medical Center and an anchor of Regional Cancer Care Associates (RCCA), which has more than 30 locations in New Jersey, Maryland, and Connecticut.¹

He is a professor of medicine at his alma mater, the University of Medicine and Dentistry of New Jersey. He is also the founder and executive chairman of COTA, a company created in 2011 to develop technology that Pecora said is poised to transform cancer care delivery by helping oncologists and other specialists make decisions that will yield the best outcomes in the most cost-effective way, all at the point of care.²

Pecora visited *Evidence-Based Oncology*TM (EBO) recently to discuss COTA's progress, which was presented in a well-received paper that appeared last fall in *JCO Clinical Cancer Informatics*.³ After years of collecting data and building COTA's digital infrastructure, the time for testing is done, Pecora says. COTA is ready for prime time. It will start in RCCA and through a partnership with Horizon Blue Cross Blue Shield of New Jersey, the state's largest payer; Pecora said there were other sites that had not yet been announced.

“We have launched a bundles-based program, where we're going to provide doctors at the point of care insights about outcomes and costs that they've never had before,” he said. Doctors will get information that precisely matches the patient in front of them, and before they make a decision, they will know its downstream consequences—both in how the patient will likely fare and what it will cost the healthcare system.

The big picture is that in the era of population health, each patient can be treated based on a discrete population that mirrors their characteristics, instead of a broad population for which the average treatment “might not be so good,” Pecora said. The idea: “How do we treat every individual as well as we possibly can and [as] efficiently [as] will be allowed, without affecting the outcome?”

“Every person at precision level gets what they need—not more, not less,” he said. “What happens? Clinical outcomes go up for everybody, and total cost of care goes down for everybody.”

The COTA Nodal Address

COTA relies on using a more detailed digital coding system than the current one, the International Classification of Diseases (ICD). The creators of COTA developed a 6-part system that includes prognostic and genomic markers, called the COTA Nodal Address, or CNA.³ As Pecora and his coauthors discuss in their recent paper, the CNA offers a superior classification system that gives physicians and health systems more information that contributes to outcomes and costs, such as cancer stage. The authors say the schema could be hugely useful for payers in developing new payment models or making use of existing ones, such as CMS' Oncology Care Model.

In their paper, the authors discuss how the CNA was applied to the data set in the landmark TAILORx trial, a highlight of the 2018 American Society of Clinical Oncology meeting.⁴ The 10-year study that showed most women with early breast cancer do not need chemotherapy alongside hormone therapy (but it identified which women need both). Although TAILORx is a game-changing trial, “it took 10 years to get the answer,” Pecora said. “COTA took the

same data sets using real-world analytics, and in 6 weeks we got the same answer.” The results were presented at the San Antonio Breast Cancer Symposium in December.⁵

This finding shows how all the data being stored can be unleashed to save time and lives. “The number of valuable questions we can answer by clicking keys instead of waiting months or years is going to transform the pace at which we learn and change behavior,” Pecora said.

EBO asked Pecora if payers could use COTA to predict how much they would save on a given therapy annually if they adopted CNA use across a health system for patients with certain types of cancer. “That's the grand finale,” he said, hinting at a publication to come later this year.

Overcoming Barriers to Change

With the bipartisan outcry over the cost of cancer drugs—spending on cancer reached \$133 billion worldwide in 2017⁶—one would think it would be easy to get the healthcare system to embrace a cost-cutting solution. But Pecora said healthcare moves slowly.

CMS and reimbursement generally are the biggest roadblocks, with the government agency impeded by its design. “Reimbursement will be dragged along by innovation,” Pecora said. But he sees specialists generally and oncologists in particular emerging as stronger players in healthcare, as they embrace how technology can help them deliver care in new ways, with greater efficiency and better results.

Right now, he said, doctors, nurses, and administrators “are at the breaking point,” dragged down with documentation burdens and coding that is both difficult and hugely consequential if not done correctly. “The science of medicine is more complicated because there are so many more treatment choices,” Pecora said.

And along comes COTA, which asks these stressed-out players to toss something brand new into the mix. Pecora does not underestimate the challenge. “[At first] you're going to be thrown out on your ear,” despite the transformative nature of COTA, he said. The biggest hurdle: “overcoming the inertia and resistance to what exists today.”

“And we're doing that now, slowly but surely,” he said. But as healthcare delivery transforms over the next 5 years, the new alliances of payers and pharmacy and technology shake out, and doctors and patients demand something new that costs less, Pecora sees an opening for COTA. “There will be the tipping point where enough people are using it and getting used to it and seeing the results,” he said. “That will pull everyone else in, and I think that will be in the next year or two.” ♦

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