Value-based medical care has been the mantra of the Affordable Care Act. Value-based — as opposed to volume-based — reimbursement has gained universal consensus — at least in theory. Indeed, it is impossible to argue against holding treatment outcomes and rates of patient satisfaction as the ultimate determinants of compensation for a medical intervention.

Value is usually defined as quality/cost. In the last 20 years, health care providers and administrators have struggled to operationalize this definition in order to assess value in clinical practice. Such difficulties include evaluating quality and cost. A large component of quality is based on patient preferences at the time of personalized or patient-centered care. The estimate of quality is based on patient preferences at the time of a specific intervention such as hip replacement. The therapists, nutritionists) assessed the benefits and costs of patient satisfaction, and reduced cost. Value-based — as opposed to volume-based — reimbursement has gained universal consensus — at least in theory. Indeed, it is impossible to argue against holding treatment outcomes and rates of patient satisfaction as the ultimate determinants of compensation for a medical intervention.

The implications of this study go well beyond the specialty of radiology and involve health care professionals across all specialties in the new health care environment that is properly “patient centered.” To spend time talking to patients, especially to a patient with a serious condition, is an ethical duty of the clinician, because this conversation allows the patient to exercise his or her autonomy — the first pillar of medical ethics. It is also good practice because clear, convincing information improves treatment adherence and patient satisfaction. Oftentimes, especially for patients who are older, the conversation is not limited to the office visit but includes other contact points by phone or e-mail. The provision of this essential service is hindered by the current medical economic reality. To maintain an adequate income, physicians may feel compelled to transform their clinics into “factory-assembly lines” and reserve 15 minutes or less to each patient. Responsible practitioners may decide to take an income cut and dedicate more time to each patient visit or, alternatively, to extend their working hours by taking patient and family calls after the clinic is closed. The Centers for Medicare & Medicaid Services now compensates physicians for the time they spend with the patient, but the compensation is lower than that for procedures that could have been performed during the same time period and is probably inadequate to support a practice without such procedures.

In this issue of Cancer Control, Collado-Mesa and colleagues describe a novel and important contribution to the assessment of value. At a large academic center, the Sylvester Cancer Center of Miami, Florida, 3 fellowship-trained breast radiologists calculated over 20 days the time they spent engaging in professional activities beyond the actual reading of a mammogram — their only reimbursable task. These activities included preparing for tumor boards (which is an essential function of a comprehensive cancer center), describing findings to patients — the majority of whom requested to see the actual imaging — and performing physical examinations of breasts when indicated. To execute these pertinent, unreimbursed tasks, they committed, on average, 92.1 minutes of their time every day. Because interpreting the findings on a mammogram requires an average of 3 minutes and is reimbursed as 0.7 work- ing work-relative-value units, they concluded that they completed a combined average of uncompensated 52 work-relative-value units every day!
sess value in clinical practice. This matrix, which could be considered germane to other specialties, involves quality, service, utilization management, and professional development. It could very well complement and complete the assessment of value based on adherence to clinical pathways.

Perhaps the main limitation of the article by Collado-Mesa and colleagues is the unilateral assessment of value from the viewpoint of the health care professional. The perspective of the patient should be included to establish the value of some activities, such as interpretation and discussion of the findings on mammography. How much would the patient like to pay for these additional services? Also, how much is an institution willing to pay for these activities if they improve patient satisfaction and increase the demand for the services and the income of the institution?

Collado-Mesa and coauthors highlight and document an aspect of value-based care that has been largely ignored, ie, the time invested by physicians in activities pertinent to their practices but unrelated to the direct delivery of care. These activities are essential for quality and include interacting with patients and participating in multidisciplinary meetings. Although they are recognized as essential, these activities are hindered in the current practice environment, which limits our ability to spend time with patients. Collado-Mesa and colleagues explain that value-based care can only be obtained by accommodating these activities into the busy, daily schedule of the provider. To do so, the perspectives of the clinician, the patient, and the institution should be integrated.

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