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Platinum Priority – Editorial

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Now You're Speaking My Language: Getting Patient-reported Outcomes to Talk to One Another

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Countless barriers stand between where we are and where we want to be when it comes to value-based health care, where "value" is the outcomes that matter to patients divided by the cost to achieve those outcomes [1]. This organizing principle has been proposed as the driving force in producing the best outcomes for patients and stands in distinction to name recognition, volume, or process measures that currently dominate discussions of quality in medicine.

Both the numerator and the denominator reflect questions patients bring to their physicians, questions that are currently too often difficult to answer. Direct patient costs represent an increasingly important aspect of cancer care [2]. In prostate cancer, attempts have been made to utilize time-driven activity-based costing [3] to more accurately capture each step in care delivery to understand expenditure. This emphasis on cost rather than charges allows the system to focus on the actual expense of care delivery. There is little doubt that patients will increasingly expect to incorporate the costs of care into their decision-making.

While the cost of care comes into focus as part of the framework in which patients decide on a treatment approach, the outcomes from treatment in prostate cancer already stand front and center. Groups have proposed both methods to determine and actual standard sets of outcomes, including tumor control measures and patient-reported outcomes (PROs), that should be measured for all men following diagnosis [4,5]. Although cancer control measures are relatively well circumscribed, the essential immediate and late effects of prostate cancer treatment that should be measured and reported have proven more difficult to define. This is despite the early recognition in prostate cancer that the patient's experience of outcomes should take precedence over those of his treating physician. Prostate cancer now has a plethora of PRO measures (PROMs) from which physicians and registries must choose [6]. This abundance of riches means that there are now multiple instruments to measure sexual, urinary, and bowel outcomes in this population.

If our goal is to make meaningful comparisons between treatments, centers, and even providers—and it should be—we will need common measures. This has proven easier said than done, as numerous factors influence the decision of which PROM to collect, with institutions arriving logically at very different answers. In this issue of *European Urology*, Singh and colleagues from the Michigan Urological Surgery Improvement Collaborative (MUSIC) and Memorial Sloan Kettering (MSK) Cancer Center [7] present a method for converting the scores of one commonly used PROM to another.

Both groups have been using the MSK-developed questionnaire, and in this study the aim was to create a crosswalk to the Expanded Prostate Cancer Index Composite Short Form (EPIC-26), a tool recommended by an international working group [4]. They utilized data from 1237 concurrently collected instruments from men treated with radical prostatectomy and divided the group into a training set and a test set. They used these data to develop and test crosswalks for the sexual and urinary domains, addressing scenarios both in which the answers to individual questions were known and in which only domain scores were known. Using established cutpoints for sexual function and incontinence, the authors demonstrated 80–93% accuracy for their crosswalk.

Such bidirectional crosswalks are essential in overcoming the practical challenges of making meaningful comparisons

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between populations for which data already collected may come from different instruments. There are already crosswalks for other commonly used prostate PROMs [8] and larger-scale efforts are under way more generally across PROs, as evidenced by work from the Patient-Reported Outcomes Measurement Information System (PROMIS) group's "PRO-setta Stone". A move towards a common instrument is desirable, but in the absence of compelling benefits of one PROM over another, this pragmatic work to create crosswalks will be crucial.

Whether >80% accuracy is adequate for making interpretable distinctions between individuals or centers will depend on the goals, and unstated in this issue is that relatively large samples will be required to detect modest differences given the variability in patient factors impacting outcomes. There are already examples of how well a focus on PROs can result in meaningful feedback and a change in care delivery for surgical [9] and radiation data [10] for prostate cancer, highlighting that this work is actionable. This study took place in the USA among mostly Caucasian men and how the results might differ in other populations is difficult to assess. Regardless, work such as this is necessary, and this paper adds substantially to our capacity to move towards a focus on value and learning health care systems in prostate cancer. While barriers to the delivery of value-based care in prostate cancer remain, they are falling, and we should commit to the next challenge of transparent reporting of our outcomes.

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