



CANCER CARE AT THE CROSSROADS

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Cancer Care at the Crossroads 2016
A One-Day International Summit on Innovation, Clinical Benefit and Cost
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WHITE PAPER OVERVIEW AND FINDINGS

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The first Cancer Care at the Crossroads Summit, a one-day international conference on innovation, clinical benefit and cost in cancer care, was held on March 25, 2016 in New York. The Summit convened over 100 C-suite and senior leaders from the United States, Europe, and Canada in a collaborative, discussion-driven meeting designed to facilitate shared understanding and partnership development across the numerous stakeholders/disciplines involved in cancer care – pharma, payors, academic research centers, community oncologists, patient advocacy and survivorship organizations.

This paper will review key challenges in oncology care as identified by panelists and attendees from across the healthcare sector, as well as innovative approaches and techniques that are being utilized and developed to meet these challenges.

We hope you will join us for the second annual CCX Summit, being held March 16, 2017 in New York City. (LINK)

With thanks to our sponsors:



Challenge:

How do we address the unique challenges of transitioning cancer care from a fee-for-service to fee-for-value framework in the US and Europe? How do we measure value – and who benefits from savings down the road? How do we incorporate the development and use of innovative therapies and include all sectors in value-based structures?

Issues raised at CCX:

- Cancer lags behind other areas of healthcare in its incorporation of value-based models – but is reaching a tipping point. Given the longitudinal and increasingly chronic nature of cancer, patient outcomes and total cost of care are the key indicators of success in value-based arrangements.
- Early attempts to place cancer care in value-based structures also struggled due to insufficient data given the complexity of the disease and ability to track outcomes. As a chronic, multidisciplinary disease with multiple lines of therapy, cancer care in a FFS arrangement is not compatible with controlling costs.
- We are seeing a vast increase in the number of value-based programs in the US, and this growth is projected to continue and accelerate. At present, 40% of Aetna contracts have value-based components; by 2020 that number is projected to be 75%. The Blue Cross and Blue Shield Association currently has 704 value-based (patient-centered) programs – triple the number of just two years ago.
- Organization of primary care is key. In parts of Europe, care is organized in primary care centers. General practitioners play a more active role in following patients – particularly in the final stages of life.
- The collection and sharing of data is critical to the success of value-based structures in cancer care – all parties must have a common understanding of the total cost. Employers will drop out of value-based cancer arrangements if they cannot see savings.
- Given that cancer is a longitudinal and increasingly chronic disease, how do you amortize the savings that come down the road? Who benefits from these? Average timeline for a payor is only 3 years, and 5 for CMS.
- Disparate incentives exist across the health spectrum – in order to maximize innovation and patient value, the silos between these sectors need to be broken down with a focus on overall patient outcomes and total cost of care. Innovative treatments are incredibly expensive to develop and purchase – but cost per life year can be lower. How do we place these in an overall value-based structure? All sectors need to be in a value-based relationship where they share responsibility, share in outcomes.
- Payors can be a partner with innovative companies that have new approaches as well as local providers. 40% of spend is through value-based arrangements but is newer in oncology due to a variation in data and treatment.

Cancer care still lags behind other areas of healthcare in moving to value-based structures – but is approaching a tipping point.

Challenge:

The need to provide innovative, evidenced-based cancer care to all patients. With the increasingly rapid speed of change in oncology, how do we rapidly bring innovations to front-line providers – particularly as most patients are better served in the community, closer to home?

Issues raised at CCX:

- It currently takes seven to eight years for innovations in the academic setting to become standard of care in community-based oncology care – there is an acute need to translate innovations to standard of care in the community more rapidly.
- The healthcare sector has not reacted quickly enough to translate basic research into breakthrough treatment – how do we keep track of new discoveries, and apply them to standards or care?
- Community oncologists struggle to keep pace with the rapidity of change in the science of cancer care. How do we educate community oncologists about new clinical trials, progress on current trials and impact daily practice?
- Frontline oncologists have a rapidly developing array of guidelines for patient treatment – how do they decide among various experts (NCCN, ASCO, ESMO, Drug Abacus) to determine what treatment options are best for their patients?
- While patients with rare cancers clearly benefit from having access to a sophisticated center, most patients are better off receiving cancer care in their community. Moreover, the great majority of cancer care can be delivered well in an ambulatory setting – only a small number of patients need to be treated in a quaternary / tertiary facility.
- Collaborations between academic and community providers can bring a unique set of skills from academia to the community setting – but the faster cancer networks expand the harder it is to maintain quality.
- Collaborations should create a two-way learning environment between academic and community physicians.

Partnerships between academic and community providers can bring a unique set of skills from academia to the community setting – but should create a two-way learning environment between community providers and academia.

Challenge:

Cancer patients are faced with an overwhelming array of information – and hype – regarding new treatments, and aggressive marketing by cancer care providers. How can we better manage patient expectations while providing them with the best possible care and outcomes?

Fully-informed patients with a deadly disease should be allowed to choose something other than standard therapy.

In many cases, patients' satisfaction and quality of life is enhanced through palliative care rather than continuing therapy.

Patient-centricity must be at the center of the model.

Issues raised at CCX:

- Patients seeking to make the best choices when faced with a cancer diagnosis are inundated with online information and emotionally-driven marketing by cancer centers – leading to anxiety and “buyers remorse” if treatments are not successful.
- As media – and academic institutions – frequently issue press releases for even the earliest findings in cancer, the public can easily overestimate the progress that has been made in cancer care. However, when patients and their families face a diagnosis, they realize that the progress may not be as substantial as they believed.
- There is a need to manage the hype – and potential backlash – if expectations are not met. How do we communicate to patients and families that in many cases, receiving care in their community is the better option?
- Cancer care is big business – with \$7bn annually spent on mammography alone – and not enough incentive exists to apply high-level evidenced-based decision making to care as a whole.
- The wide application of screening and genomic testing may result in a large group of newly-created patients who never would have had a serious disease – as the vast majority of patients identified as having mutations would not have developed life-threatening cancer. Frequent screenings can also lead to the development of cancer in patients due to exposure to radiation. We must remember that the end game is not technology, but patient benefit.
- Incidence of cancer rises with age regardless of other factors. How much is enough when it comes to cancer treatment? Most drugs only yielding an additional 2-3 months of PFS and interventions can have life-threatening toxicity – yet we have 90 year old patients on 6th and 7th lines of therapy. Europe has controlled pricing / spending in most countries.
- With cancer becoming more chronic, robust survivorship programs are necessary. Survivorship is not “I’m cured” -- it is more all-encompassing and includes living with cancer.
- Fully informed patients with a deadly disease should be allowed to choose something new rather than standard therapy
- Patient centricity must be at the heart of care structures – with the clinical model having primacy, supported by a business model that is then supported by a sustainable regulatory framework.

Challenge:

The need to allocate scarce resources in the healthcare system to maximize patient outcomes and quality of life while investing in new treatments and innovative therapies. How do we address the wide variance in oncology care provided in different geographic areas and socioeconomic groups?

Issues raised at CCX:

- There is a need to re-align incentives to encourage long-term maximization of value and outcomes for patients. Investment in areas that have the potential to offer long-term patient benefit – such as vaccine development, prevention, and pediatric cancers – lags areas that yield a higher financial ROI under current models.
- Studies on prevention are often overlooked because there is little financial incentive for prevention under current healthcare business structures.
- There is evidence that applying advanced genomic sequencing to patients with early-stage cancer could yield a significant benefit in assessing and selecting appropriate treatments – should genomic sequencing be done on all patients with a cancer diagnosis early in their disease?
- Should we treat early stage disease with expensive targeted and immunotherapeutic therapies, where their impact could be greater? How do we pay for this?
- Levels of healthcare spending in the US are far higher than other developed countries – yet the range of spending is distributed unevenly across the US. The biggest predictor of outcome for patients with lung cancer is zip code.
- The wide gap in spending between the US and European systems is cultural as well as structural – the US has “healthcare by aspiration” and in Europe there is “healthcare by decree.” Europe has controlled pricing in most countries. Better care coordination, patient communication and counseling, and end-of-life care can yield increased patient satisfaction and quality of life as well as reduced spend.

Incentives in oncology reward “heroic intervention” in late-stage disease; yet fewer dollars are spent on areas that could yield significant long-term benefit.

In the US healthcare resources are by “aspiration”; in Europe by “decree.”

Challenge:

The need to match patients with the right drugs – and utilize analytics and big data in real time to guide treatment from one patient to the next. How can you effectively scale the use of genomics from individual cases to large populations? How do we encourage collaboration between pharmaceutical companies as combinations of therapies become more important?

Issues raised at CCX:

- With the revolution in genomic medicine comes vastly increased amounts of data being produced and analyzed. How can we utilize this power most effectively to guide treatment and enhance patient outcomes?
- Ineffective care and adverse variance could represent up to 1/3rd of spend in the US.
- Cancer care is facing a sea change – at a crossroads of whether to continue to treat cancer at an anatomic site level or at a molecular level.
- There is a need to use big healthcare data – not only oncology data – to improve patient outcomes.
- There is a need to combine precision medicine with precision informatics to provide patients with the right care and the right place at the right time.
- How do we effectively utilize this data to improve patient outcomes, reduce haphazard care and reduce cost?
- Computational science talent and resources in healthcare are underpowered to deal with the explosive advances in science and medicine – there is heavy and well-funded competition for talent in the sector.
- Payors must partner in these efforts – to meet the need to reduce unnecessary and haphazard care, improve outcomes and lower cost while adopting and developing innovative treatments and drugs. How can payors partner effectively?
- To make headway in advanced disease, we need combinations of drugs that are customized – pharma must collaborate to enable these efforts. Pharma should become more patient-centric – there is a need to go from developing drugs for patients to developing drugs with patients.

Harnessing the potential of genomic data, big healthcare data and analytics has the potential to revolutionize patient treatment selection and reduce ineffective care. However, the challenges are tremendous – and require collaboration between all sectors involved in cancer care.

What is being done to meet challenges and address issues in these areas?

Innovations and examples:

Science

- **Drug efficacy / precision medicine trials**

- NCI Match:
 - <https://www.cancer.gov/about-cancer/treatment/clinical-trials/nci-supported/nci-match>
- ASCO TAPUR Trial:
 - <http://www.tapur.org/>
- WINTHER Trial:
 - <http://www.winconsortium.org/clinical-trial/winther-trial1>
 - <https://www.ncbi.nlm.nih.gov/pubmed/25908602>

Delivery

- **Academic Cancer Center Affiliations with Community Oncologists**

- MD Anderson Cancer Network / Summit Medical Group Affiliation
 - <https://www.mdanderson.org/about-md-anderson/our-locations/md-anderson-cancer-network.html>
 - <https://www.summitmedicalgroup.com/news/smg-news/summit-medical-group-and-md-anderson-cancer-center-officially-launch-partnership/>
- Memorial Sloan Kettering Cancer Alliance
 - <https://www.mskcc.org/about/innovative-collaborations/msk-alliance>
- Dana-Farber Community Cancer Care
 - <http://www.dana-farber.org/About-Us/Satellite-Locations/Dana-Farber-Community-Cancer-Care.aspx>

- **Molecular Tumor Boards – University of California San Diego**

- <http://ascopubs.org/doi/abs/10.1200/jop.2015.004127>

- **Cancer Core Europe**

- <http://www.cancercoreeurope.eu/>

What is being done to meet challenges and address issues in these areas?

Innovations and examples:

Technology

- **Predictive efficacy technologies and tools**
 - ESMO Magnitude of Clinical Benefit Scale (MCBS) -- <http://www.esmo.org/Policy/Magnitude-of-Clinical-Benefit-Scale>
 - COTA: -- <https://www.oncota.com/>
- **Big data and analytics approaches**
 - Blue Cross and Blue Shield AXIS -- <https://www.bcbs.com/about-us/capabilities-initiatives/bcbs-axis>
 - ASCO Cancer Linq -- <https://cancerlinq.org/>
 - Project Datasphere -- <https://www.projectdatasphere.org/projectdatasphere/html/home>

Reimbursement

- **Value-based frameworks**
 - ASCO – www.asco.org
 - ESMO – www.esmo.org (ESMO Magnitude of Clinical Benefit Scale)
 - NCCN – www.nccn.org
 - Drug Abacus – www.drugabacus.org
 - ICER – www.icer-review.org
 - NICE – www.nice.org.uk
- **Value-based and Federated Clinically Integrated Systems of Care**
 - Horizon OMNIA – www.horizonblue.com
 - Banner – Aetna Whole Health – www.bannerhealth.com
 - Canopy Health – www.canopyhealth.com

Public / Patient Perception, Survivorship, and Media

- **Survivorship Resources / Networks**
 - **Pancare**
 - <http://www.pancare.eu/en/>
- **Palliative / Compassionate Care Programs**
 - Aetna Compassionate Care
 - <https://www.aetna.com/individuals-families/member-rights-resources/compassionate-care-program/compassionate-care-description.html>



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CCX 2016 Participation and Feedback

The inaugural Cancer Care at the Crossroads Summit brought together more than 110 leaders from across the United States as well as Europe and Canada. Participants represented stakeholders across the oncology spectrum – academia/research, biotech, pharma, health plans, providers, media, patient advocacy, genomics centers, and others.

The combination of perspectives and backgrounds provided a lively and insightful interaction throughout the day that participants described as one of the day's highlights.

The seniority of participants provided shared insights and perspectives that were valuable across the sectors represented. Nearly 30% of those who attended hold C-Suite titles, and included multiple CEOs of large health systems. An additional 50%+ serve in leadership capacities as Center Directors / Department Heads or hold EVP/ SVP/VP titles.

Interaction with and between senior level decision makers is critical to CCX's goal of facilitating shared solutions, insights and partnerships that lead to more advanced, affordable, and effective cancer care.

The vast majority of attendees surveyed ranked the quality and content of the Summit highly, and stated they would plan to attend a future CCX event.