Welcome

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MultiCare Regional Cancer Center
Better Connected

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An Independent Licensee of the Blue Cross Blue Shield Association

Regence
your health, connected.

Seattle Cancer Care Alliance
Fred Hutchinson Cancer Research Center
UW Medicine
Seattle Children's

Virginia Mason

SILVER LEVEL

Group Health

SWEDISH CANCER INSTITUTE

WSMOS
Washington State Medical Oncology Society
National Efforts in Improve Quality and Reduce Costs in Cancer Care: ASCO Quality and Value Initiatives

Gary Lyman, MD, MPH | Hutchinson Institute for Cancer Outcomes Research
Why consider costs of cancer care

• Cost affects access and outcomes
• Out of pocket costs matter to patients, and affect treatment decisions
• Cost matters to payers
• Cost matters to society
US Health Spending is 17.7% of GDP & Rising

Projected US Health Spending 2020 → 20% GDP

Higher Spending Does Not Increase Life Expectancy

Health Care Expenditures and Life Expectancy (2005)

Patients are Bearing More of the Costs

Projected family health insurance premium costs and average household income
Cost of Cancer Care is Rising

→ $125 billion in 2010

→ $175 billion in 2020

Figure LCO2: Estimates of national expenditures for cancer care in 2010 (in billions of dollars) by cancer site and phase of care

Cancer Prevalence and Cost of Care Projections: http://costprojections.cancer.gov/
Cost estimates expressed in 2010 dollars using CMS cost adjusters and adjusted for out-of-pocket expenditures, including co-payments and deductibles.
Estimates for the population younger than 65 were developed using ratios of cost in the younger than 65 and older 65 populations from studies conducted in managed care populations.
Cancer Care Costs Rising Faster than Overall Healthcare

Source: Blue Cross Blue Shield Association
Eight of Top Ten Most Expensive Drugs Covered by Medicare are Cancer Drugs

Monthly and Median Costs of Cancer Drugs at the Time of FDA Approval
1965 - 2013

- Monthly Price of Treatment (2013 Dollars)
- Year of FDA Approval

- Individual Drugs
- Median Monthly Price (per 5 year period)
Eight of Top Ten Most Expensive Drugs Covered by Medicare are Cancer Drugs

Top Ten Medicare Drugs 2012

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Millions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ranibizumab</td>
<td>$1,220</td>
</tr>
<tr>
<td>Rituximab cancer treatment</td>
<td>$876</td>
</tr>
<tr>
<td>Infliximab injection</td>
<td>$704</td>
</tr>
<tr>
<td>Injection pegfilgrastim 6mg</td>
<td>$642</td>
</tr>
<tr>
<td>Bevacizumab injection</td>
<td>$624</td>
</tr>
<tr>
<td>Aflibercept 1 mg</td>
<td>$384</td>
</tr>
<tr>
<td>Denosumab injection</td>
<td>$347</td>
</tr>
<tr>
<td>Oxaliplatin</td>
<td>$309</td>
</tr>
<tr>
<td>Pemetrexed injection</td>
<td>$292</td>
</tr>
<tr>
<td>Bortezomib injection</td>
<td>$278</td>
</tr>
</tbody>
</table>

Source: Moran Company Analysis of Medicare Physician/Supplier Procedure Summary File, 2012. Includes carrier claims only (physician office and DME). Outpatient Prospective Payment System (OPPS) claims are excluded.
Improving Value: Unique Challenges for Oncology

- Sense of urgency as many cancer patients have a poor prognosis and are facing imminent death

- Pressure to use newest technologies/treatments

- Treatments expensive, making appropriate cancer care a hardship or unaffordable

- Treatments can be highly toxic/life-threatening

- Providers often reluctant to switch to best supportive care, even at end of life

Source: 2009 IOM Report: Assessing and Improving the Value in Cancer Care
Challenge: Cost seldom considered by stakeholders

<table>
<thead>
<tr>
<th>STAKEHOLDERS</th>
<th>CONSIDERATION OF COST-EFFECTIVENESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food and Drug Administration</td>
<td>No</td>
</tr>
<tr>
<td>Compendia</td>
<td>No</td>
</tr>
<tr>
<td>Drug product manufacturers</td>
<td>Limited</td>
</tr>
<tr>
<td>Centers for Medicare and Medicaid Services</td>
<td>No</td>
</tr>
<tr>
<td>Private payors</td>
<td>Variable</td>
</tr>
<tr>
<td>Specialty society clinical practice guideline developers</td>
<td>Limited</td>
</tr>
<tr>
<td>Health care/hospital networks</td>
<td>Variable</td>
</tr>
<tr>
<td>Clinicians</td>
<td>Limited</td>
</tr>
<tr>
<td>Patients</td>
<td>No</td>
</tr>
<tr>
<td>Policy makers</td>
<td>Limited</td>
</tr>
</tbody>
</table>
ASCO Quality and Value Initiatives

ASCO GUIDELINES

QOPI® THE QUALITY ONCOLOGY PRACTICE INITIATIVE

ASCO CANCER•LINQ™
Learning Intelligence Network for Quality

Choosing Wisely®
An initiative of the ABIM Foundation

American Society of Clinical Oncology

Value in Cancer Care Task Force
Integrating Cost into ASCO Guidelines: Current Policy and Efforts

• Current Guidelines Policy
  – Optional cost table for recommended drugs for typical course of therapy
  – Commentary on published cost-effectiveness analyses may be included without endorsement

• Pilot Effort: Systematic Review of CEA Studies
  – None met predefined eligibility criteria for the topic chosen
900 Participating Practices
200 Certified Practices

PRACTICE AREAS
- Staffing
- Treatment Planning & Chart Documentation
- Informed Consent
- Chemotherapy Orders
- Drug Preparation
- Chemotherapy Administration
- Patient Monitoring and Assessment
- Preparedness for emergency situations
- Oral Chemotherapy
- Patient Education

QOPI® Certified Practices
A system in which real-time clinical data is captured, analyzed, and used to enhance patient care and drive scientific discovery
Choosing Wisely: Top Five

- Led by ASCO Cost of Cancer Care Task Force
- Based on comprehensive review of published studies and guidelines from ASCO and other organizations
- Input from more than 200 practicing oncologists
- Integration of Top Five List into QOPI
American Society of Clinical Oncology 2013 Top Five List in Oncology

1. Don’t give patients starting on a chemotherapy regimen that has a low or moderate risk of causing nausea and vomiting antiemetic drugs intended for use with a regimen that has a high risk of causing nausea and vomiting.

2. Don’t use combination chemotherapy (multiple drugs) instead of chemotherapy with one drug when treating an individual for metastatic breast cancer unless the patient needs a rapid response to relieve tumor-related symptoms.

3. Avoid using PET or PET-CT scanning as part of routine follow-up care to monitor for a cancer recurrence in asymptomatic patients who have finished initial treatment to eliminate the cancer unless there is high-level evidence that such imaging will change the outcome.

4. Don’t perform PSA testing for prostate cancer screening in men with no symptoms of the disease when they are expected to live less than 10 years.

5. Don’t use a targeted therapy intended for use against a specific genetic aberration unless a patient’s tumor cells have a specific biomarker that predicts an effective response to the targeted therapy.
Increasingly, cancer care will be assessed on VALUE rather than COST

- Transparent, clinically driven, methodologically sound method for defining and assessing relative value of cancer care options that influences treatment choices, insurance benefits, and research priorities.

Value Task Force Charge

- Develop framework for assessing relative value of cancer treatments and interventions based on benefits; harms and costs

Desired Outcomes

- Oncologists: skills and tools to assess/discuss relative value of therapies with patients.
- Patients: understand the relative value of treatment options that meet their unique needs.
- Integrate value discussions into national/international discourse
What can this effort contribute?

• Translate national policy perspective to regional implementation

• Opportunity to develop demonstration projects and scale up

• Opportunity for our state to serve national leadership role in implementation
Setting the Stage

Scott Ramsey MD, PhD | Hutchinson Institute for Cancer Outcomes Research
Defining Value: Perspective Matters

($681,000) \times 25 \times \text{MIL} = ($17.5 \text{ MIL})
Value in Cancer Care: Conceptual basis

Health Outcome Achieved per Dollar Spent

A multidimensional concept of considers returns for expenditure
# Value Domains & Metrics

<table>
<thead>
<tr>
<th>Domains to consider in defining value</th>
<th>Metrics for assessing value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Duration of life</td>
<td>Utilities</td>
</tr>
<tr>
<td>Quality of life</td>
<td>QALYs</td>
</tr>
<tr>
<td>Health status</td>
<td>Cost/QALYs</td>
</tr>
<tr>
<td>Cost</td>
<td>Cost/quality</td>
</tr>
<tr>
<td>Quality of care</td>
<td>Efficiency</td>
</tr>
<tr>
<td>Equity</td>
<td>Effectiveness</td>
</tr>
<tr>
<td>Adverse effects</td>
<td>Necessity</td>
</tr>
<tr>
<td>Compassion</td>
<td>Reasonableness</td>
</tr>
<tr>
<td>Opportunity</td>
<td>Affordability</td>
</tr>
</tbody>
</table>

Abbreviation: QALY, quality-adjusted life year.
Value Metrics

• Hundreds of metrics have been proposed for health and health care
  › Many have nothing to do with value!

• A good value metric ...
  › Considers outcomes and cost
  › Is measurable
  › Is actionable

• A great value metric...
  › Is consistent with organizational goals
  › Is meaningful to multiple stakeholders

• Impossible to capture all aspects of value in a single metric
When Considering Value: Think Incremental, Not Average

• Consider the alternatives
  – What do you get when you spend more?
  – What do you lose when you spend less?
Incremental Costs and Benefits, X vs. Y

- **X More Costly** vs Y
- **X More Effective** vs Y
- **X Less Effective** vs Y
- **X Less Costly** vs Y

- ASCO Choosing Wisely
- Adjuvant trastuzumab HER2+ BrCa
- Radiotherapy after lumpectomy Node+ BrCa
Why now and why here?

- HICOR: neutral facilitator and resource
- World-class expertise in our region
- Collaboration of providers, patients, payers and researchers can engage in a learning and leadership exercise:
  - Show what is happening now in priority oncology areas
  - Identify opportunities for improvement
  - Design targeted interventions & monitor their impact
  - Improve care in our region
Build *consensus*: 3-5 VALUE metrics that are **MEANINGFUL** for the region, **FEASIBLE** and efficient to collect, and **ACTIONABLE**.
Your contribution today

• Share individual and organizational perspective
• Engage: What constitutes value in cancer care?
• Prioritize value measures
• Assess validity and feasibility of collection and reporting
HICOR Contribution

• Open the dialogue
• Listen and facilitate consensus
• Develop a proposal to generate consensus metrics
• Contribute technical and scientific expertise
Challenges

• Unique group with diverse perspectives

• No illusions about how difficult it is to build consensus

• Cancer is complex

THE ASK:
THINK BIG, TAKE RISKS
IMAGINE A NEW MODEL FOR CANCER CARE
VALUE in CANCER CARE SUMMIT

HICOR
Hutchinson Institute for Cancer Outcomes Research

Allied Health Advocates ◊ Centers for Medicare and Medicaid, Region X ◊ Confluence Health ◊ EvergreenHealth
Fred Hutchinson Cancer Research Center ◊ Gilda’s Club ◊ Island Hospital ◊ Northwest Medical Specialties
Overlake Hospital ◊ Providence Regional Cancer Partnership ◊ Washington State Health Care Authority