



How Do We Make Cancer Care Better and Affordable?

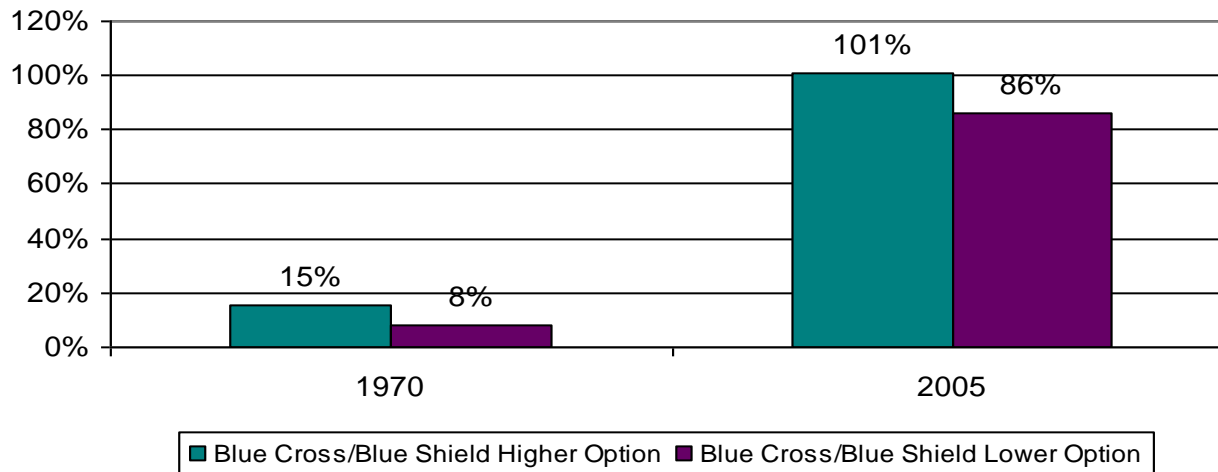
A Partnership Between Community Practices and Payers

Lee N. Newcomer, M.D.

➔ ***Lee Newcomer, M.D.***

- Employment: United Health Group
- Leadership: Chairman, Park Nicollet Health Services
- Non paid advisor: Genentech, Value Advisory Board, 2006-2007
- Disillusioned investor

Total Family Premium for Health Insurance as a Percent of US Minimum Wage Earnings



Source: U.S. Office of Personnel Management; U.S. General Accounting Office Staff Paper, "Information on 1976 Health Insurance Premium Rate Increases for Federal Employees Health Benefits Program," pub. # 094882.

Note: Figures reflect monthly Federal Employees Health Benefits (FEHBP) total premiums for the government-wide Blue Cross/Blue Shield options for non-postal workers and minimum wage earnings for full time work of 173.33 hours per month (2080 hour per year/12) in California.

Courtesy Mark Smith, MD, California HealthCare Foundation

“.. when a person is convinced that her words, thoughts, feelings, or actions will produce and prevent a specific outcome that defies all laws of cause and effect.”

Mark Smith, M.D.

California Healthcare Foundation

➔ ***We just need to get rid of....***

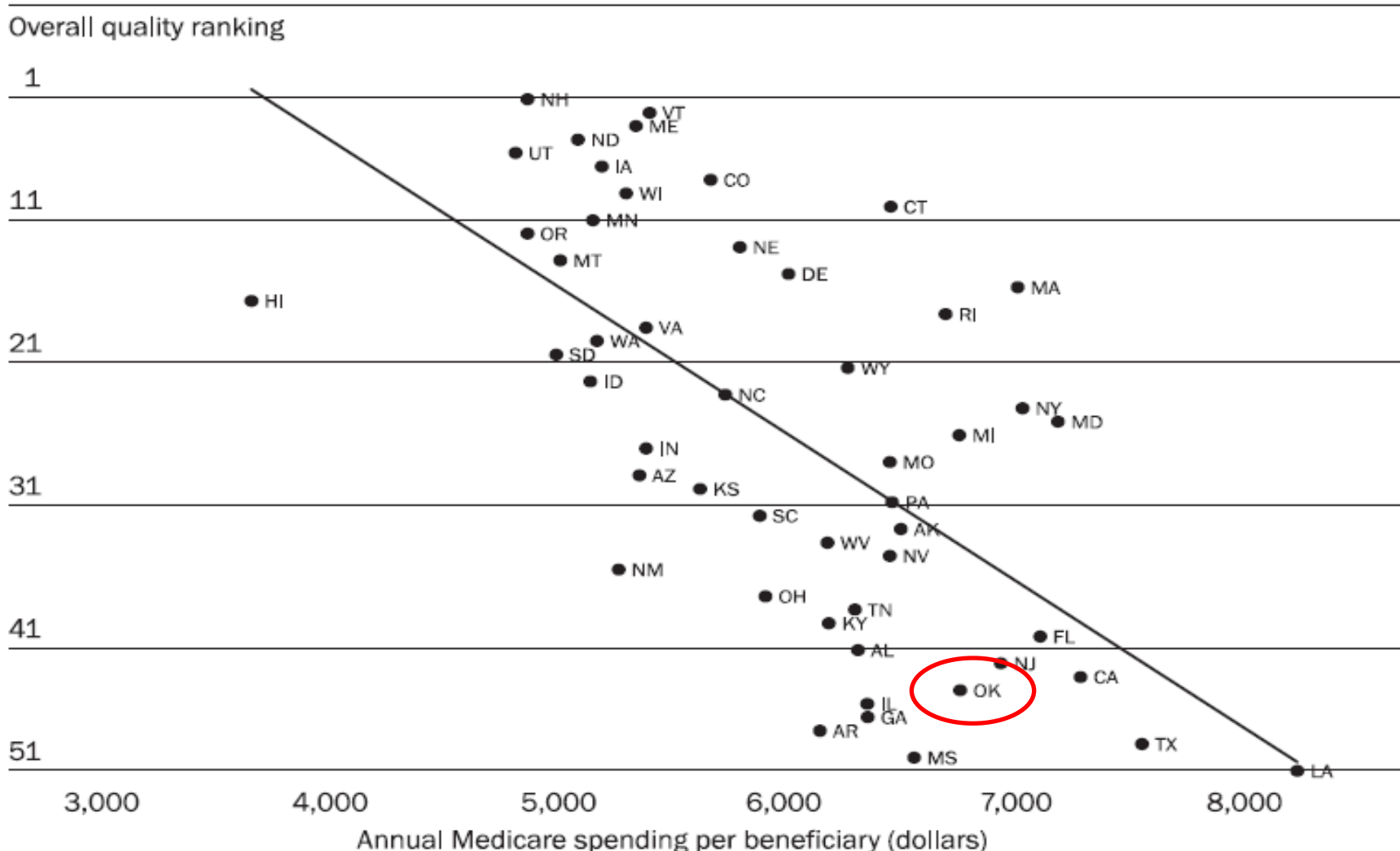
- Conservatives: **Fraud and abuse**
- Liberals: **Insurance overhead**
- Policy Wonks: **Unnecessary care**
- Doctors: **Defensive medicine**
- Benefits Managers: **Frivolous visits**
- Everyone: **Drug company profits**

Courtesy Mark Smith, MD, California HealthCare Foundation

Magical Thinking: Quality Costs More



EXHIBIT 1
Relationship Between Quality And Medicare Spending, As Expressed By Overall Quality Ranking, 2000-2001



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Consistency



Improvement



**Quality,
Affordability**

Variation is Geographic

Figure 11
Days in hospitals during last six months of life among patients who received most of their care in one of 77 “best” U.S. hospitals

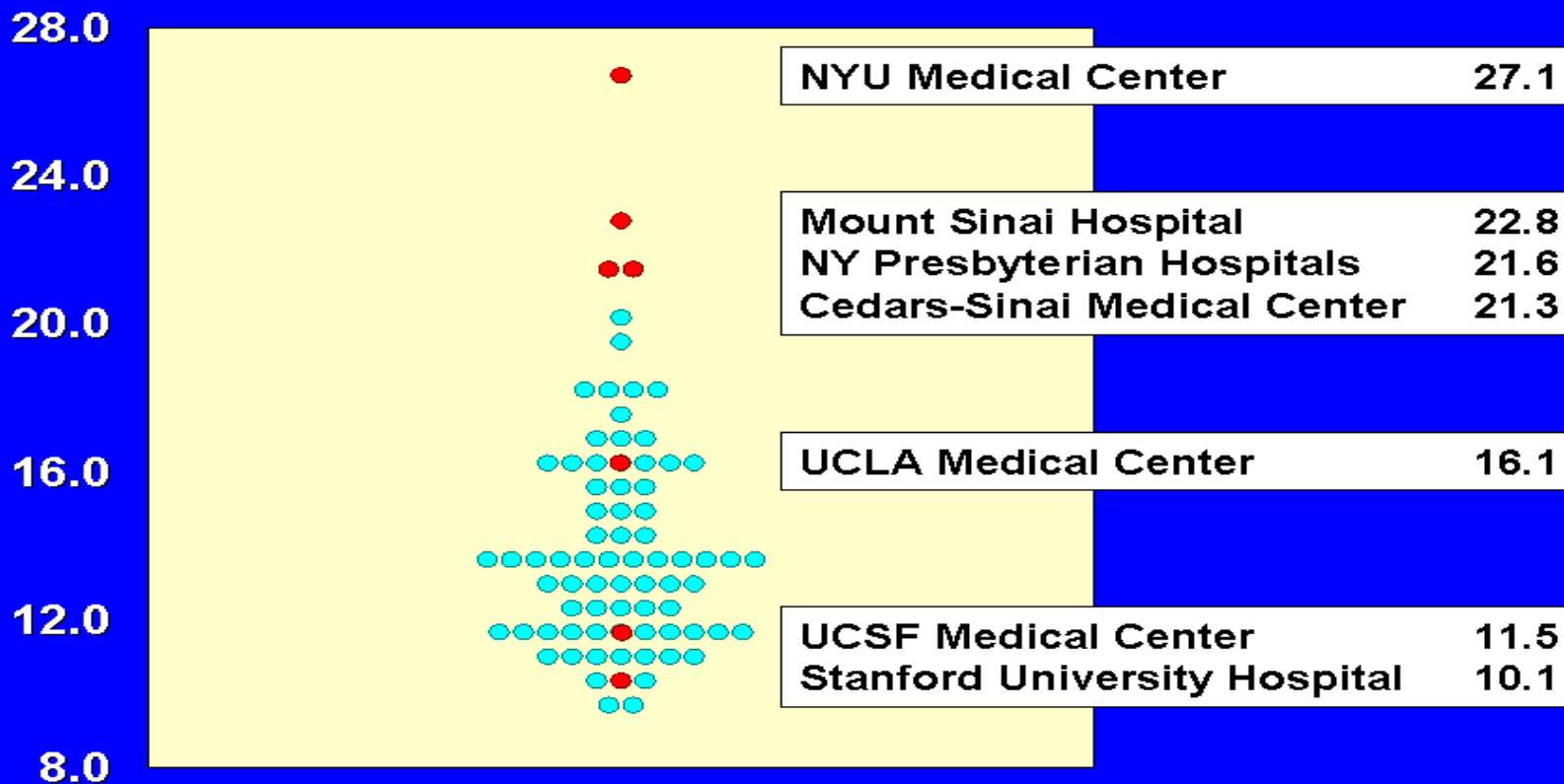


Figure 15
Average number of physician visits per patient during last six months of life who received most of their care in one of 77 “best” US hospitals

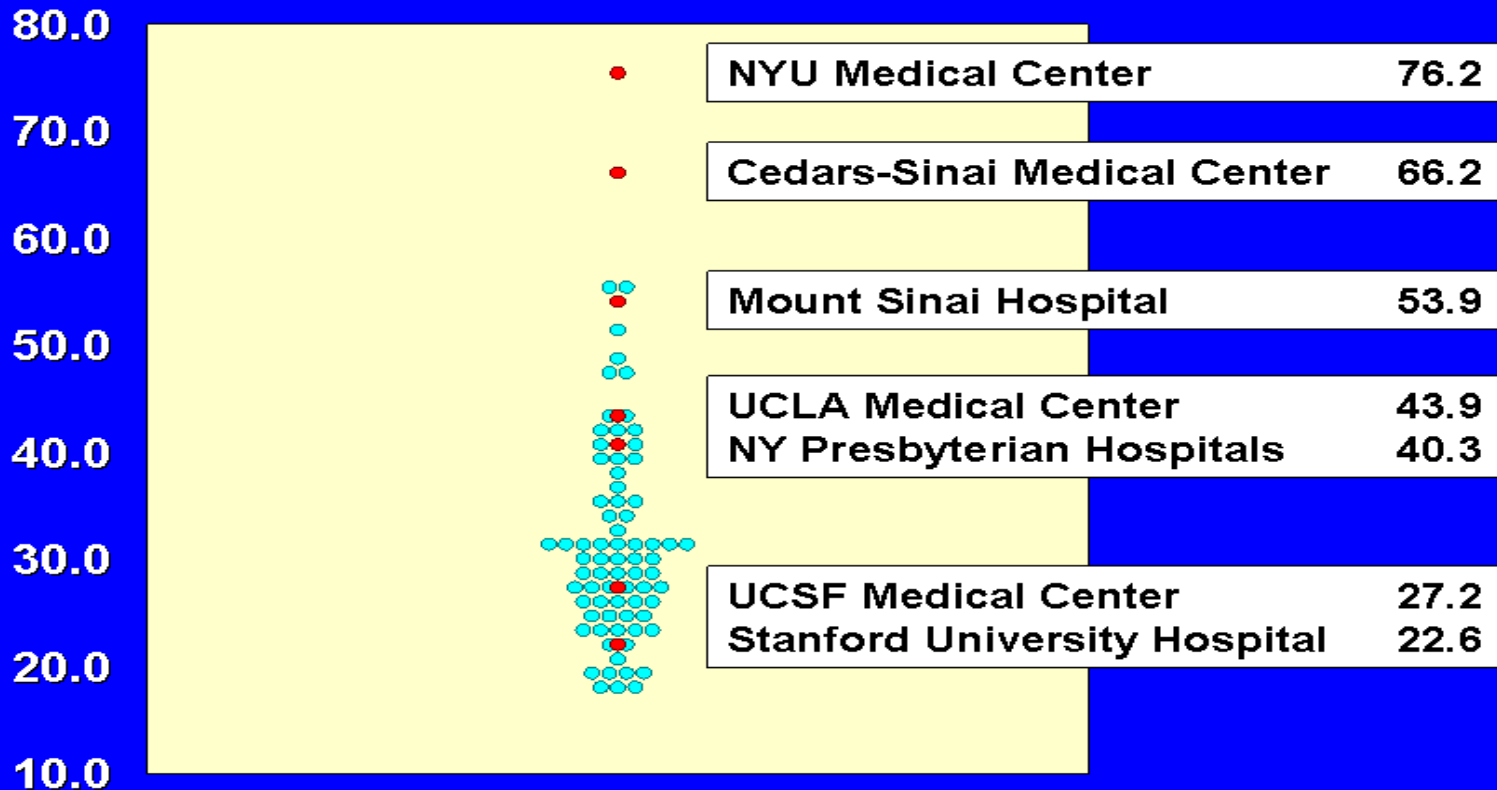
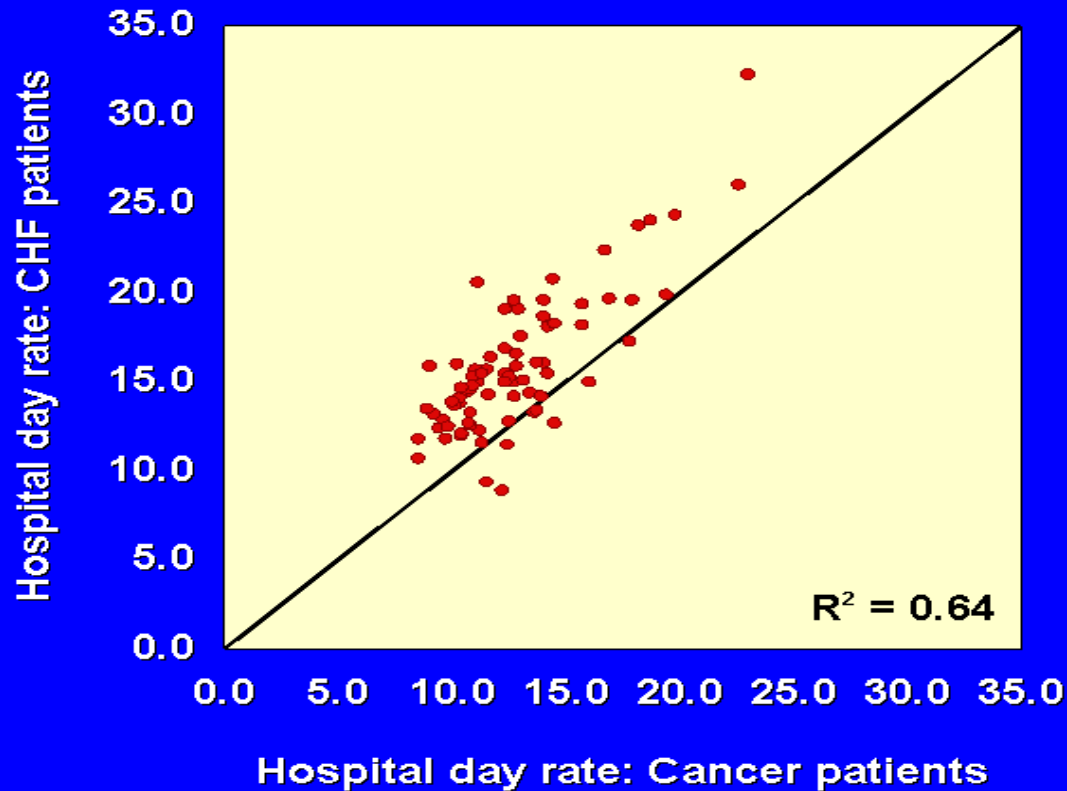


Figure 12
Association between hospital days for cancer and for CHF patients during last six months of life among 77 “best” U.S. hospitals



➔ ***Trastuzumab continued therapy***

“It is **impossible** to decipher...to what extent continued treatment with trastuzumab benefit patients.”

“At least two attempted trials with no trastuzumab in the control arm were attempted, but **failed** to accrue patients.”

Pusztai, Cancer Investigation 2006;24:187-91

Trastuzumab Therapy Examples 3,4

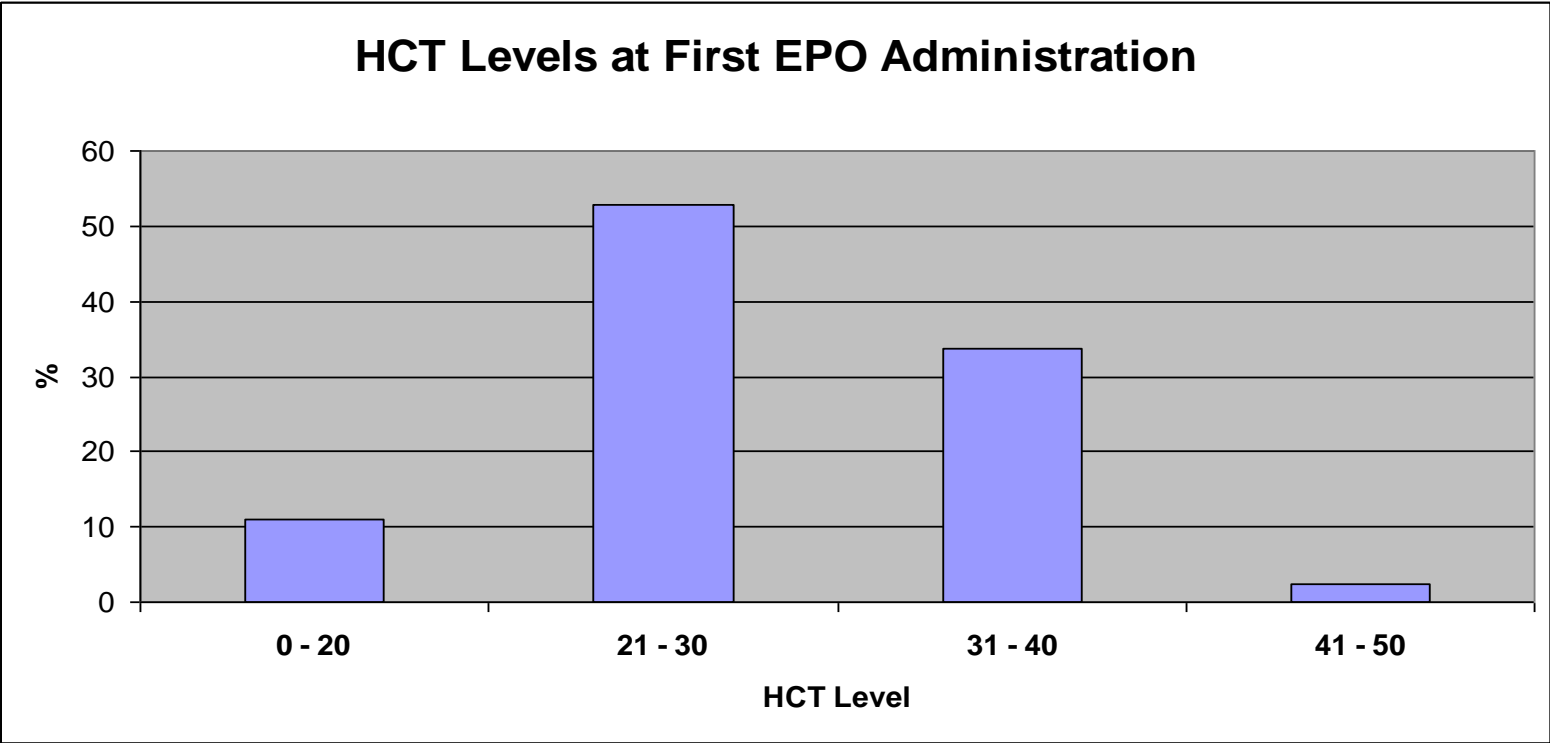
Patient 5																													
CARBOPLATIN																													
DOCETAXEL																													
FULVESTRANT																													
PACLITAXEL																													
TRASTUZUMAB																													
VINOURELBINE																													
Patient 6																													
BEVACIZUMAB																													
CARBOPLATIN																													
CYCLOPHOSPHAMIDE																													
DOCETAXEL																													
DOXDRUBICIN																													
FULVESTRANT																													
PACLITAXEL																													
TRASTUZUMAB																													
VINOURELBINE																													

HER2 Testing in Local vs. Central Labs

Local IHC Testing	Central IHC Testing					Concordance
	0+	1+	2+	3+	Total	
0	76	106	36	6	224	34%
1+	33	101	46	8	188	54%
2+	15	70	48	51	184	26%
3+	9	32	46	290	377	77%
Total	133	309	176	355	973	--

Reddy et al, *Clin Breast Ca*, 2006: 153-157

Variation: Erythropoietin (EPO)



Cetuximab/Panitumab for Metastatic Colon Cancer

Setting	# of treatments	Cost/treatment	Total Cost/Patient
Outpatient (53 patients)	5.3	\$4428	\$23,468
Office (157 patients)	9.0	\$2693	\$24,237

There was no correlation between physician fee schedules and use of the outpatient facility

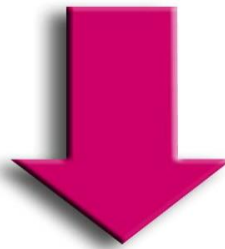
Consistency: It's Not There



**Enforcement with
Coverage Policy**

OR

**Improvement With
Measurement**



**Quality,
Affordability**

It is more important that you do it the same
than that you do it “right”

Why?

You and I will argue for years about the “best”
regimen in the literature and we will both be
“right”.

When you do it the same:

- Error rates fall: less complexity
- You can measure results
- You can apply to the scientific method to systematically improve

Regardless of where you start you will end up with best demonstrated care practices

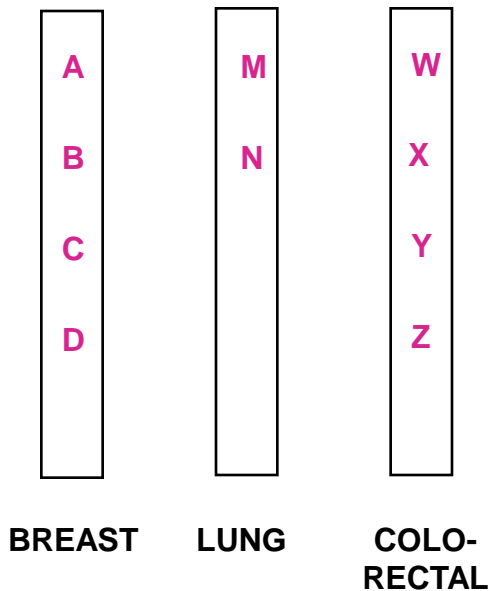
Brent C. James MD, Intermountain Healthcare

- Generate evidence based best practice guideline
- Blend the guideline into the flow of clinical work
- Use the guideline as a shared baseline with clinicians free to vary based on individual patient needs
- Measure, learn from and eliminate variation arising from professionals
- Retain variation arising from patients

Shared Baselines or Current Practice?

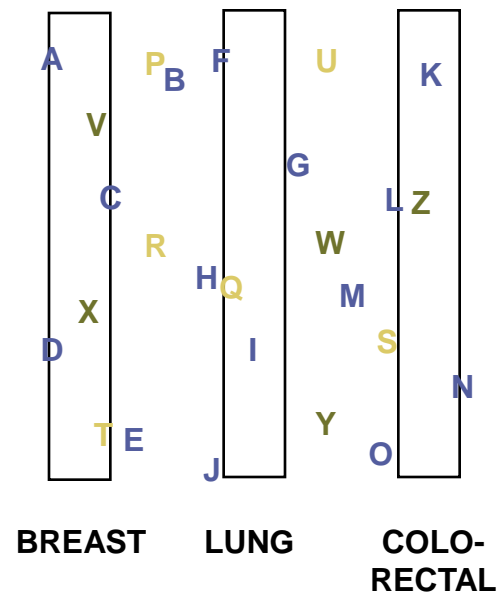


A Consistent Group

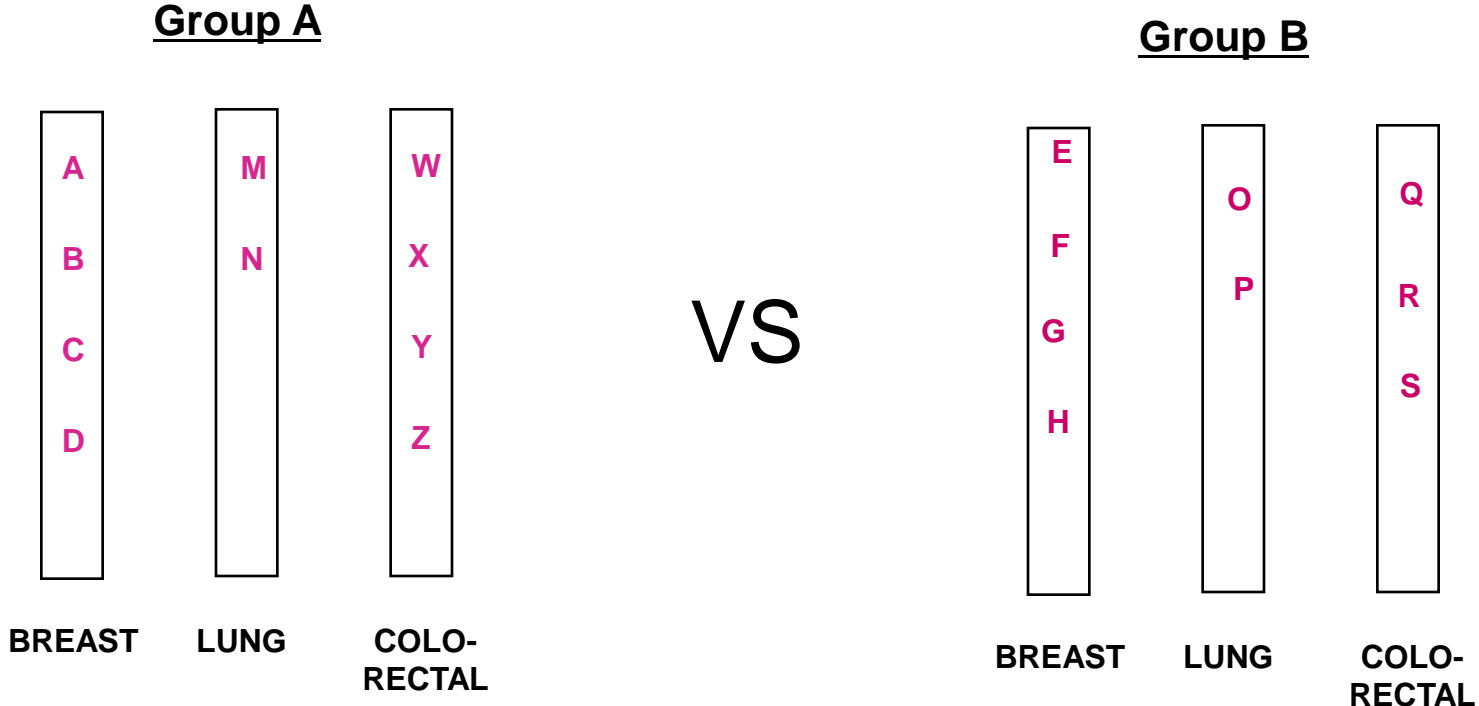


VS

Community

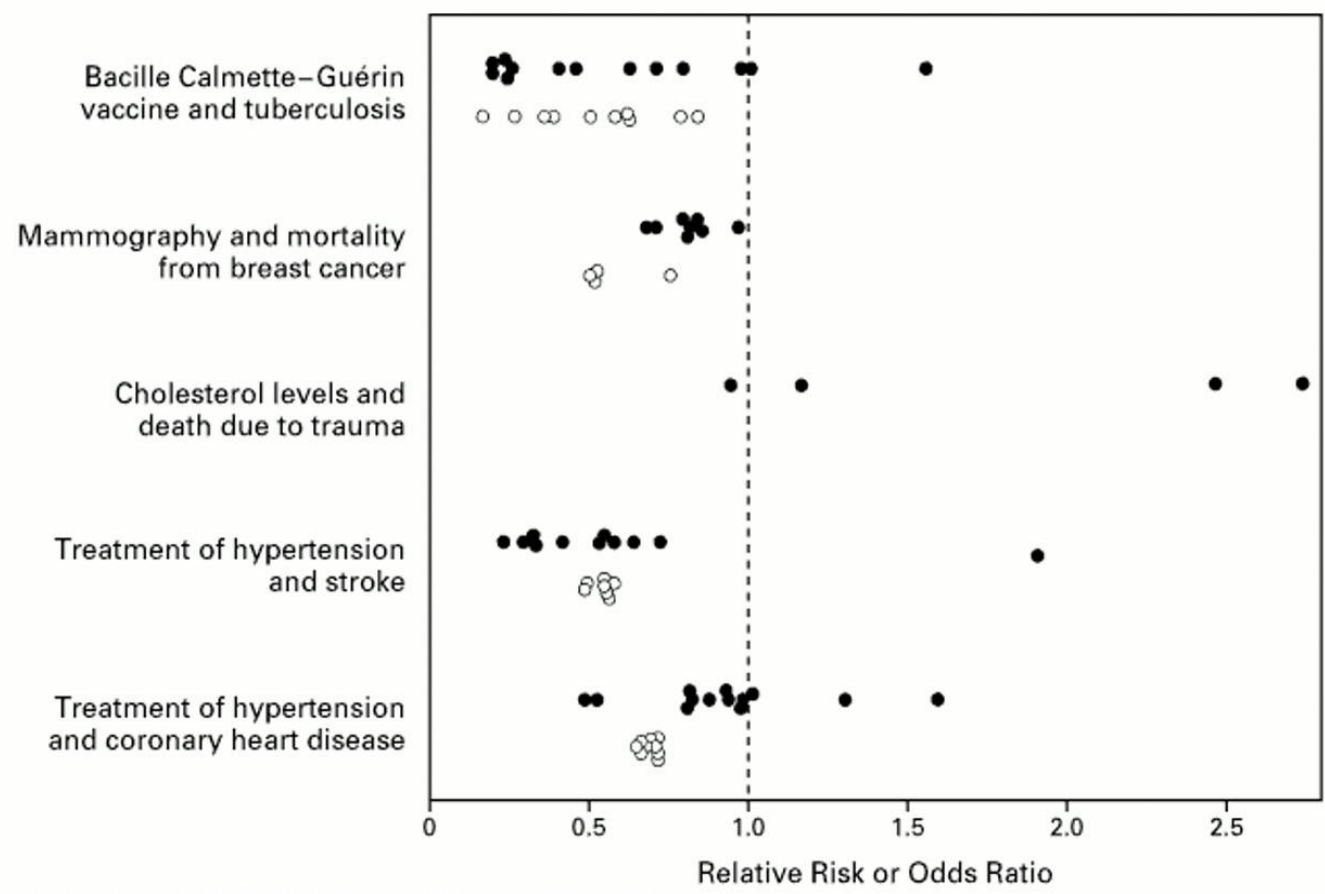


How We Improve with Shared Baselines



Compare performance and adopt the best practices

Observational Comparisons Work



NEJM 2000: 342; 1887

Consistency: It's Not There



**Improvement With
Measurement**



**Quality,
Affordability**

- Erythropoietin up to Hg of 12
- HER2 over-expression for trastuzumab coverage
- National Cancer Center Network guidelines for coverage
- **Build the database with patient stage and status**
 - Stage at diagnosis
 - Current status every 6 months

- KRAS testing for metastatic colon cancer
- Starting dose rules for erythropoietin
- Episode payments
 - Defined by diagnosis, stage and prognostic indicators
 - Independent of drug utilization
- **Shared performance comparisons**
 - **First comparisons in 2009**
 - Search for best practice
 - Eventual basis for reimbursement

➔ ***None of this happens easily***

- Share these slides with your partners
- Schedule a time to begin one shared guideline
- Get consensus on the guideline (1 month from now)
- Measure adherence (3 months)
- Measure performance (6 months)