Value

Outcome / Cost

Relative Value

$RV_1 = O_1 / C_1$

$RV_2 = O_2 / C_2$

Value

Cancer Death Rates US Decreasing

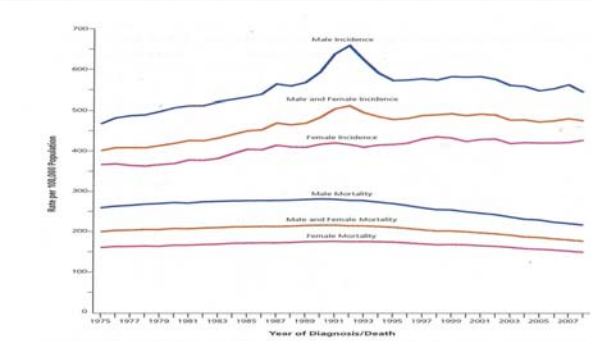
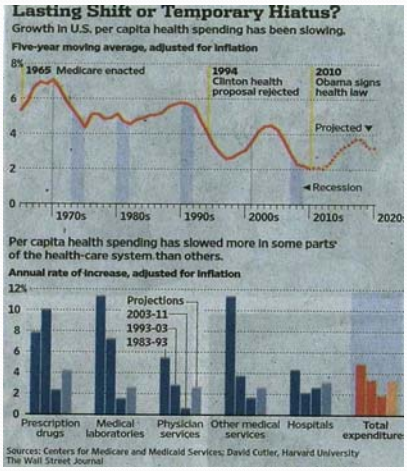


FIGURE 2. Trends in Cancer Incidence and Mortality Rates by Sex, United States, 1975 to 2008.
Rates are age adjusted to the 2000 US standard population. Incidence rates are adjusted for delays in reporting.

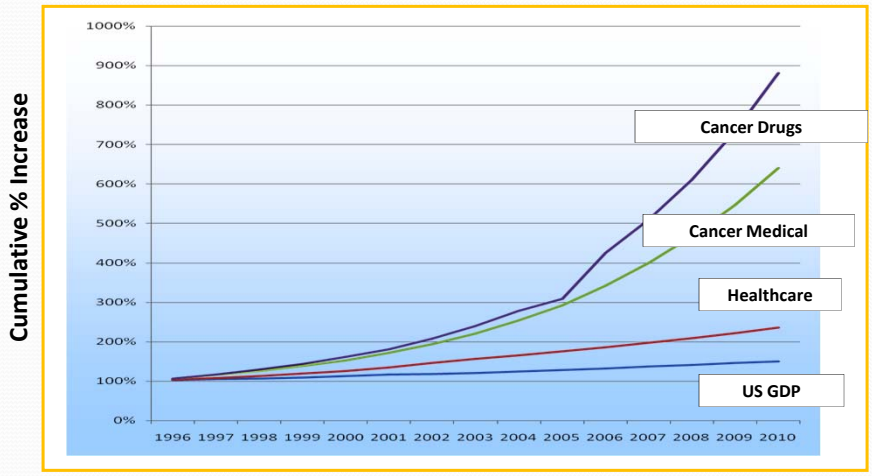
CA Journal

Cost Decreasing?



Wall Street Journal

Costs of Cancer Care Rising Faster than Overall Healthcare



Top Ten Medicare Drugs 2009

	In millions
• Rituximab cancer treatment	$ 674
• Ranibizumab	$ 673
• Bevacizumab injection	$ 610
• Infliximab injection	$ 497
• Injection, pegfilgrastin 6mg	$ 411
• Darbepoetin alfa, non-esrd	$ 361
• Epoetin alfa, non-esrd	$ 284
• Oxaliplatin	$ 258
• Docetaxel	$ 228
• Pemetrexed injection	$ 190

Source: Moran Company Analysis of Medicare Physician/Supplier Procedure Summary File, 2009

Buy and Bill a Success?

3 Eras

- 1991-2003 Stability
- 2004-2006 Adaptation
- 2007-present Squeeze

Practice Response

- Closing
- Merging
- Shifting to hospitals

Results in Increased Costs Reduced Access

Costs to System are Increasing

Drivers –

Technology / Innovation

Duplication

Fragmentation

Payer Response

Reduce Utilization

Aggressive contracting

Case management

Prior authorization

Coverage Policy
(Fail first, tier copay, oral equivalency)

Costs Reduced ,but Outcomes also Reduced and Increased Administrative Burden

Problem with Current System

1. Fee for Service
2. Silo Care
3. Fragmented Care
4. Duplication of Service

Proposed Solution

1. Episode of Care
2. Bundle Payment
3. ACO
4. Medical Home
5. Clinically Integrated Network
6. VBID

Assumptions in New Model

1. System/Population Driven
2. Outcome/Value Driven
3. Evidence Based Standardization
4. Share Information
5. Coordination of Care Across Providers

Barriers

1. Lack of Clear Definition
2. Lack of Organization to Coordinate Care
3. Inadequate Information Technology
4. Physician Independence
5. System/Population Focus

Overall Strategy

- **Oppose cuts to ASP if no concurrent policy change**
- **Monitor/be prepared for ASP to show up again in SGR and budget talks**
- **Pursue policies that move resources from drugs into patient services**
- **Bring payment reform proposals to the table**
- **Understand, anticipate trends**

Be at the table!!

Models in Oncology

1. ACO
2. Medical Home
3. VBID

Role of Organized Medicine

Be *THE* definition
of Value and Quality

Engage Payers: Provider/Payer Initiative (PPI)

- **Constructive dialogue**
- **Innovation**
- **Share issues**
- **Open communication**

Quality Oncology Practice Initiative (QOPI™)

- **Oncologist-led, practice-based quality improvement program**
- **Goal is to promote excellence in cancer care by helping practices create a culture of self-examination and improvement**
- **Includes measurement, feedback and improvement tools for medical oncology practices**
- **More than 600 practices enrolled**

Why is QOPI™ Important?

- **Quality is here to stay**
  - Central to health reform
  - Seen as key to "bending the cost curve"
- **We have a choice**
  - Sit back and allow others to define our quality
  - That will lead to every insurer having a unique program

  OR,
  - Create our own; by colleagues for colleagues
  - Convince insurers to use this single standard

But QOPI Has Shortcomings:

- Retrospective
- Data collected only twice per year
- Data reported on only a sample
- Manual review and entry required
- Intensive resource needs = barrier to adoption

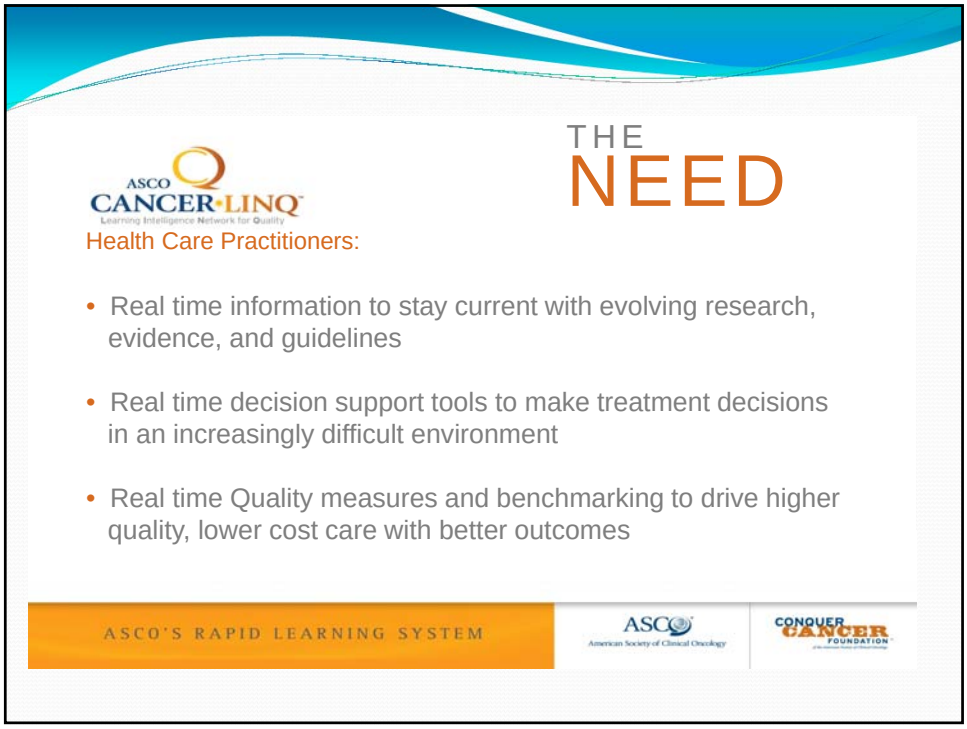
QOPI Needs to Evolve to Become:

- Prospective
- Consecutive
- Longitudinal

Data is King

Rapid Learning System

A system in which real-time clinical data is captured, analyzed and used to enhance patient care and drive scientific discovery.


ASCO CANCER·LINQ
Learning Intelligence Network for Quality
THE NEED
Health Care Practitioners:
• Real time information to stay current with evolving research, evidence, and guidelines
• Real time decision support tools to make treatment decisions in an increasingly difficult environment
• Real time Quality measures and benchmarking to drive higher quality, lower cost care with better outcomes
ASCO'S RAPID LEARNING SYSTEM
ASCO
American Society of Clinical Oncology
CONQUER CANCER FOUNDATION


ASCO CANCER·LINQ
Learning Intelligence Network for Quality
THE NEED
Patients:
• To become more informed decision makers and contributors to their own cancer care
• To have the ability to manage adverse events with evidence based options
• To communicate in real time with caregivers and healthcare providers
ASCO'S RAPID LEARNING SYSTEM
ASCO
American Society of Clinical Oncology
CONQUER CANCER FOUNDATION

ASCO CANCER·LINQ
Learning Intelligence Network for Quality

THE NEED

Payers:

- A way to demonstrate quality and cost-effective care

Researchers:

- To streamline and speed up scientific discovery
- To reduce time to identify key events and make changes

ASCO'S RAPID LEARNING SYSTEM

ASCO American Society of Clinical Oncology

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THE ANSWER

A simple description…

A system in which real-time clinical data is captured, analyzed, and used to enhance patient care and drive scientific discovery

ASCO'S RAPID LEARNING SYSTEM

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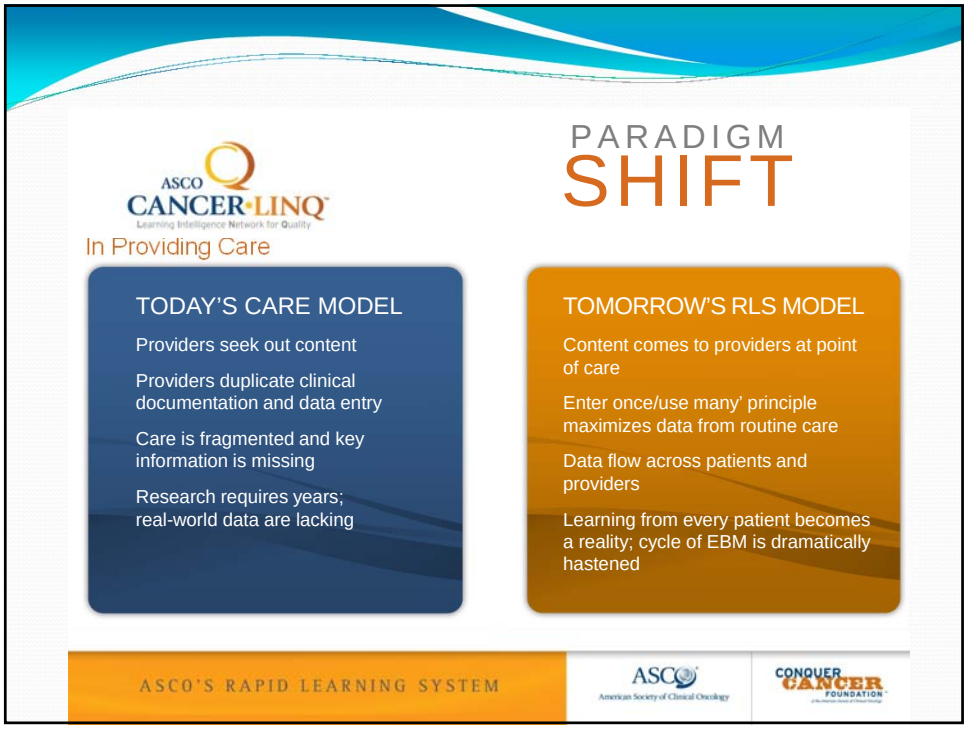
ASCO CANCER·LINQ
Learning Intelligence Network for Quality
In Providing Care
PARADIGM SHIFT
TODAY'S CARE MODEL
Providers seek out content
Providers duplicate clinical documentation and data entry
Care is fragmented and key information is missing
Research requires years; real-world data are lacking
TOMORROW'S RLS MODEL
Content comes to providers at point of care
Enter once/use many' principle maximizes data from routine care
Data flow across patients and providers
Learning from every patient becomes a reality; cycle of EBM is dramatically hastened
ASCO'S RAPID LEARNING SYSTEM
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American Society of Clinical Oncology
CONQUER CANCER FOUNDATION


ASCO CANCER·LINQ
Learning Intelligence Network for Quality
In Technology
PARADIGM SHIFT
TRADITIONAL REGISTRY
Requires Query Writers & Analysts
Form the Query, Get the Data, Use the Data
Structure Data Only
Requires Special Skills
TOMORROW'S RLS MODEL
Ability to Explore Data Freely
Get All Data, Explore the Data, Apply the Data
Structured and Non-Structured Data
Familar Tools Requiring Minimal Training
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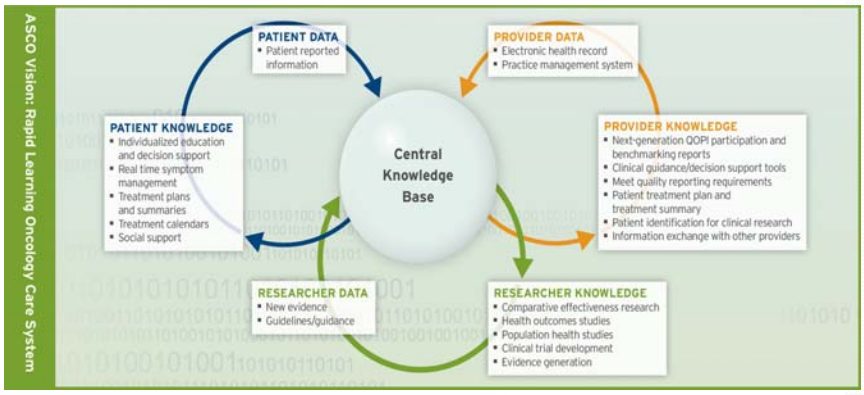
ASCO'S ONCOLOGY

RLS



ASCO'S RAPID LEARNING SYSTEM

WHY

ASCO

- ASCO has been in the "quality" business for at least fifteen years. One could argue that the very founding of the Society in 1964, intended to facilitate the exchange of clinical and scientific information, was designed to improve the quality of cancer care.
- Trusted & respected source for oncologists and oncology information
- QOPI®

ASCO'S RAPID LEARNING SYSTEM

ASCO CANCER•LINQ
Learning Intelligence Network for Quality

GUIDING PRINCIPLES

The ASCO Board of Directors has adopted several guiding principles for RLS:

- Rigorous
- Patient focused
- Transparent
- Independent
- Inclusive
- Streamlined
- Sustainable

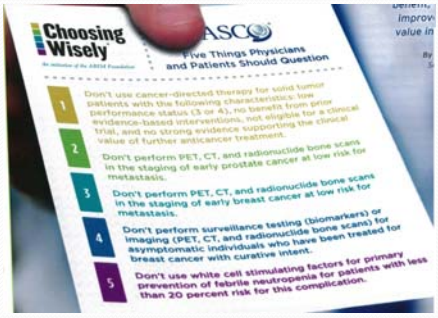
ASCO'S RAPID LEARNING SYSTEM

ASCO American Society of Clinical Oncology

CONQUER CANCER FOUNDATION

ASCO

- **CancerLinQ**
- **Guidelines/Pathways**
- **Five Points**
- **Practice Survey**
- **Advocacy**
- **SAC**



ASCO Connection

The "Choosing Wisely Campaign"

- Proposed by Howard Brody, MD, PhD
  "Medicine's Ethical Responsibility for Health Care Reform — The Top Five List"
  N Engl J Med 2010; 362:283-285
- Challenge to medical specialties: Identify five costly practices that are commonly performed and lacking evidence of efficacy

Choosing Wisely
An initiative of the ABIM Foundation

ASCO Participation

- Led by ASCO Cost of Cancer Care Task Force
  - Multidisciplinary group of oncologists
- Chose treatments based on comprehensive review of published studies, guidelines from ASCO and other organizations
- Input from more than 200 oncologists
  - Practicing oncologists
  - State leaders
  - Patient advocates

Choosing Wisely
An initiative of the ABIM Foundation

"Top 5" List for Oncology

Question these things before doing them:

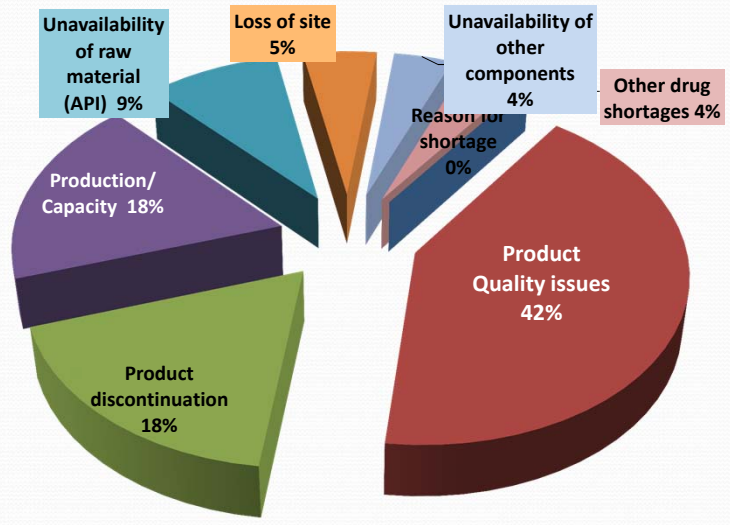
1. Use of chemotherapy for patients with advanced cancers who are unlikely to benefit, and who would gain more from a focus on palliative care and symptom management.
2. For early breast cancer, use of advanced imaging technologies (i.e., CT, PET and radionuclide bone scans) in cancer staging.
3. For early prostate cancer, use of advanced imaging technologies (i.e., CT, PET and radionuclide bone scans) in cancer staging.
4. Routine use of advanced imaging and blood biomarker tests for women treated with curative therapy for breast cancer and who have no symptoms of recurrence.
5. Use of white cell stimulating factors for patients who are at low risk for febrile neutropenia.

Drug Shortages

Shortage Drugs in Oncology (as of March 2012)

- Bleomycin
- Cisplatin
- Cytarabine
- Dacarbazine
- Daunorubicin
- Doxorubicin
- Doxorubicin, liposomal
- Etoposide
- Fludarabine
- Fluorouracil
- Leucovorin
- Mesna
- Methotrexate
- Mitomycin
- Mustargen
- Ondansetron
- Paclitaxel
- Thiotepa
- Vinblastine

Causes of Shortages



Source: FDA Drug Shortages Program

User Fee Act Provisions

- **House and Senate PDUFA provisions address drug shortages**
- **Require manufacturers to provide 6 months notice to the FDA of discontinuance or disruption in "life sustaining drugs" defined as "life-supporting, life-sustaining, or intended for use in prevention of a debilitating disease or condition," with some exceptions.**
- **Authorizes HHS to expedite inspections and reviews based on notifications from manufacturers.**
- **Establishes a task force to mitigate and prevent shortages through intra and interagency coordination working with stakeholders.**
- **Requires that the FDA keep records and report annually to Congress including the number and causes of shortages, the steps HHS has taken to resolve the shortage, and a trend analysis.**
- **Senate bill allows the Secretary of HHS to apply above to biologics through regulation.**

FDA Initiatives

- Draft Guidance on notification to FDA of issues that may result in drug shortage, issued Feb. 21, 2012
- Expedite review of manufacturing sites
- Expedite review of regulatory submissions
- Identify additional sources of supply or alternate manufacturers
- Exercise regulatory discretion on drug importation or expiration dates
- Assist with contingency planning

Competition for Shrinking Resources

"At a time of tight budgets with no possibilities for increases in the near future, along with the enormous costs that other diseases are going to place on our healthcare system in the next decade, **I believe that the NIH needs to revisit its funding priorities.**"

John LaMattina
Retired President of Global R&D
Pfizer

March 13, 2012


Forbes

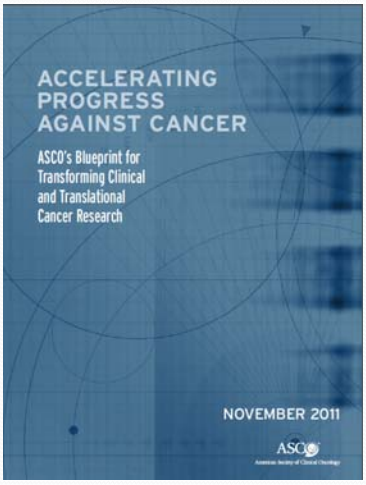
#1 Buffett Stock to Buy Now

It's Time For NIH To Expand Its Focus Beyond Cancer

The National Institutes of Health (NIH) is not a single institution but is made up of over 20 centers, including the National Cancer Institute (NCI), the National Institute of Mental Health (NIMH), and the National Human Genome Research Institute. Its stated mission is: "To seek fundamental knowledge about the nature and behavior of living systems and the application of that knowledge to enhance health, lengthen life, and reduce the burdens of illness and disability." The work both performed and supported by

What ASCO is Doing: Telling Our Story

- Articulating the potential of future research with genomic medicine
- Taking the message to Capitol Hill and regulators with our sister organizations



Equity

Oral Parity

- Patient out of pocket expense for oral chemotherapy often much higher than for IV therapies
- Increasing number of oral drugs in pipeline threatens growing access issue for cancer patients
- Parity bills enacted in 16 states; legislation introduced in 23 states

What is ASCO Doing?

- Preparing a guide for state advocates outlining elements that should be addressed in any bill
- Creating fact sheet and talking points
- Providing model bill language
- Explore inclusion of parity language as part of essential health benefits requirements (which has largely been deferred to states)

State Affiliate Council IMPROVED COMMUNICATION

ASCO STATE/REGIONAL AFFILIATE PROGRAM

Council members are expected to be a conduit from the ASCO Board to their state societies and from society memberships to the Council.

This is not Congress. Recommendations that are, in general, a consensus decision will be helpful to the ASCO Board. A 25-23 majority vote will not be.

- Dedicated Council Board Liaison.
- Issues may come to the Council from grassroots or from ASCO, via the Board.
- What about the CPC?
  - The information from ASCO that State Affiliates are used to receiving through the CPC, will be available at the Council leadership's discretion.

ASCO STATE/REGIONAL AFFILIATE PROGRAM

Working together…

…we will improve care and outcomes for our patients and sustain the practice of oncology for years to come.