IOM Workshop:
Achieving Value in Cancer Care:
ASCO's Top 5 and Beyond

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Cancer Center

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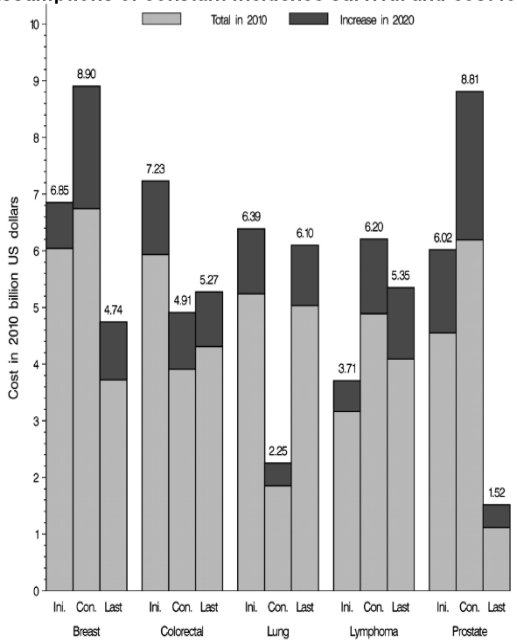
A teaching hospital of Harvard Medical School

Expenditures Cancer Care: 2010

Initial dx, continuing care, last phase

Estimates of the national expenditures for cancer care in 2010 (light gray areas) and the estimated increase in cost in 2020 (dark gray areas) because of the aging and growth of the US population under assumptions of constant incidence survival and cost for the major cancer



Mariotto A B et al. JNCI J Natl Cancer Inst 2011;103:117-128

JNCI

Costs of Cancer Care:

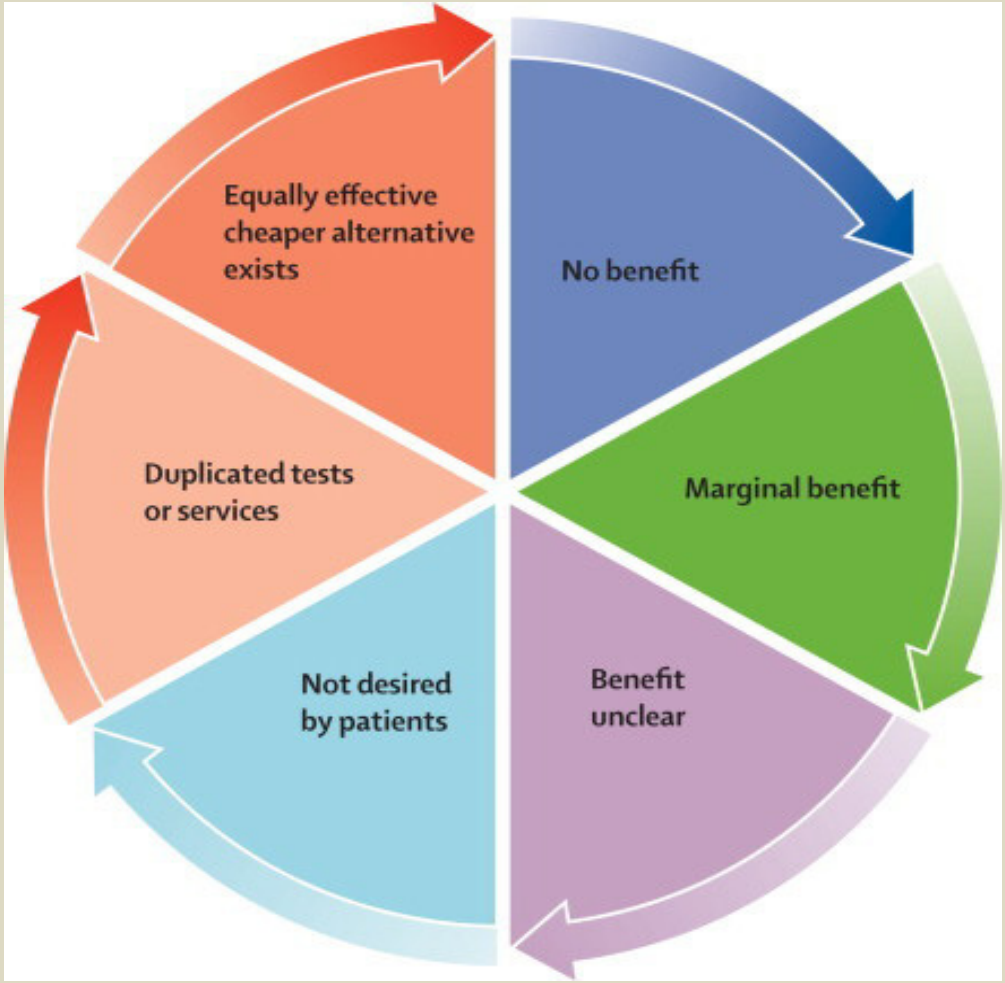
breast, colorectal, lung cancers

- Breast CA as an example: increased use of radiation and chemotherapy: 1991-2002
- Doubling of the cost of chemotherapy ‘91-’02
- Increases in use and cost of imaging
- Difficulty is knowing the downstream impact ($ savings) of these interventions

Reducing Costs Cancer Care:

what is in the physician's control?

Lancet Oncology, 2011



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Top 5 List

H. Brody, NEJM 363:4, 2010

"…the Top Five list would be a prescription for how, within that specialty, the most money could be saved most quickly without depriving any patient of meaningful medical benefit."

Mark Twain said, "Always do right. This will gratify some and astonish the rest."

Physicians-seize the moral high ground!

ASCO's Top 5 List

- For patients with advanced solid-tumor cancers who are unlikely to benefit, do not provide unnecessary anticancer therapy, such as chemotherapy, but instead focus on symptom relief and palliative care.
- Do not use PET, CT and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis.
- Do not use PET, CT and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
- For individuals who have completed curative breast cancer treatment and have no physical symptoms of cancer recurrence, routine blood tests for biomarkers and advanced imaging tests should not be used to screen for cancer recurrences.
- Avoid administering colony stimulating factors (CSFs) to patients undergoing chemotherapy who have less than a 20 percent risk for febrile neutropenia

Identifying the Top 5

- Developed within the Task Force on Cost of Cancer Care
- Vetted through Clinical Practice Committee
- Advocates
- ASCO Executive Committee

200 physicians in all

Do Not Routinely Give Chemotherapy to Patients with Poor Performance Status (PS), ECOG 3 or 4

- Patients with poor PS have more toxicity and markedly less chance of response.
- Not every cancer, but for **most patients with solid tumors**, ASCO and National Comprehensive Cancer Network (NCCN) guidelines call for a switch to palliative (non-chemotherapy) care when the ECOG PS ≥ 3.
  - ECOG 3 is "in bed *or chair* more than 50% of the time."
  - Simple question:
    "Did this person walk unaided into clinic?"

Smith, ASCO Presentation 6/2012

Do Not Routinely Give Chemotherapy to Patients with Poor Performance Status (PS), ECOG 3 or 4

- Exceptions
  - patients with functional limitations caused by other conditions that result in a low performance status (PS) or
  - those with disease characteristics (e.g., mutations) that suggest a high likelihood of response to therapy.

- Changing the focus to symptom control should be accompanied by appropriate palliative and hospice care.

Smith, ASCO Presentation 6/2012

Don’t Perform PET, CT and Bone Scan in Breast Cancer Patients at Low Risk for Metastases

- No evidence of survival improvement.
- No benefit in asymptomatic individuals with newly identified ductal carcinoma in situ (DCIS), or clinical stage I or II breast cancer.
- Can lead to harm through
  - Unnecessary invasive procedure
  - over-treatment,
  - unnecessary radiation exposure, and
  - misdiagnosis.

Blayney, ASCO Nat’l meeting, 6/2012

Do not use PET, CT and radionuclide bone scans in the staging of early prostate cancer at low risk for metastasis

- Low-risk early-stage prostate cancer, defined by PSA < 10 ng/ml and Gleason's score ≤ 6, has a low risk of metastasis.
- Staging tests do not improve outcomes of treatment for this clinical problem.
- Extensive staging is:
  - Unnecessary
  - Expensive
  - Exposes patients to unnecessary radiation.

Raghavan, ASCO Nat'l Meeting, 6/2012

For individuals who have completed curative breast cancer treatment and have no physical symptoms of cancer recurrence, routine blood tests for biomarkers and advanced imaging tests should not be used to screen for cancer recurrences

- Two randomized trials conducted in the 1990's did not find a difference in survival outcomes for women who had routine clinical office visits and mammograms compared to women who had more intensive monitoring with blood work, chest films, scans and ultrasounds.
- Chest and abdominal CT scans or whole-body PET scans have not been evaluated as surveillance strategies for follow-up of early-stage breast cancer.
- With the low prevalence of distant recurrence in early-stage breast cancer, and the high risk of false positive and incidental findings, there is no evidence to support the use of routing imaging tests.

Ganz, ASCO Nat'l Meeting, 6/2012

Guidelines

2006 ASCO Guideline: Use Granulocyte Colony Stimulating Factors (G-CSFs) when the risk of febrile neutropenia is greater than 20%.

"In some situations, primary prophylaxis with CSFs is essential and recommended to alleviate the toxicity of certain 'dose dense' chemotherapy regimens".

Factors that increase risk of FN greater than 20%
Age greater than 65
Poor performance status
Prior episodes of FN
Prior chemotherapy or radiation
Poor nutritional status
Other comorbidities

From Mulvey, ASCO presentation 6/2012

Reactions by Stakeholders

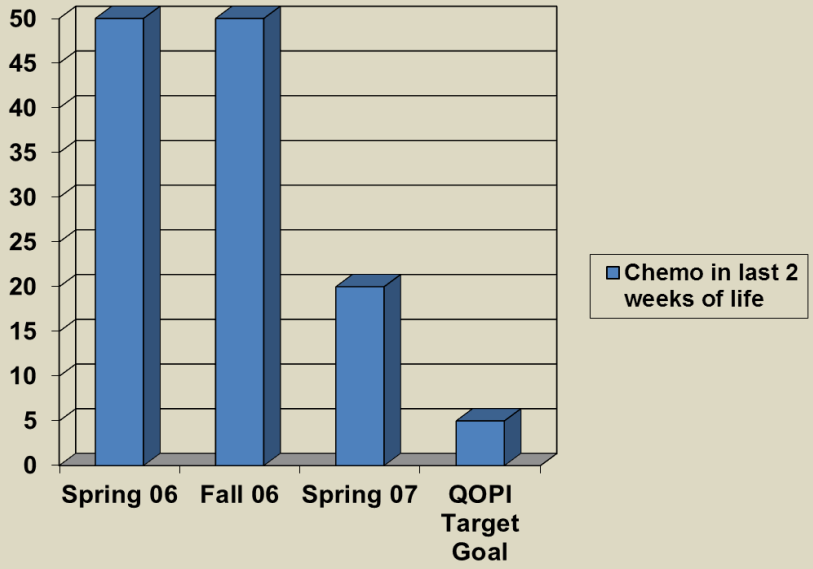
(anecdotal-not necessarily representative)

- Physicians: oncologists quite supportive-"it assists me in the exam room"
- A reporter: "does this mean grandma can't get her last chance?"
- Advocates: skeptical but understanding
- Payers: Supportive but quietly so
- Biotech: do not get in the way of genomic analysis, and accessibility to targeted therapies

Where do we go from here?

Metrics/Accountability-an example:
Documentation>Adherence to Standards

- At U. Michigan, 50% patients received chemotherapy within 2 weeks of death
- Always document ECOG PS.
- When oncologists were given feedback about their own practice patterns, chemotherapy near the end of life dropped from 50% to 20%.



Blayney D, et al. JCO 2009

Where do we go from here?

*Facilitating Accountabi*lity

- Quality Oncology Practice Initiative (QOPI)
  - Integrate the Top 5 into QOPI and start measuring impact of change

- CancerLink-ASCO rapid learning initiative-data in real time

Where do we go from here?

ASCO's Task Force: Current/Future Initiatives

- Broad educational initiatives:
  - Patients: CancerNet
  - Professionals: Journal articles, Commentaries, Educational Programming
  - Physician Advisory Tool
- Develop Top 6-10

Where do we go from here?

moving toward rational payment systems that advocate for new models of compensation

- emphasize quality of care
- emphasize value (optimized health outcomes for lowest cost-eliminating waste)
  - improve techniques to monitor/measure
  - incentives for delivering high value care
- assure practice environments with adequate infrastructure to deliver high value care
  - Oncology “homes”