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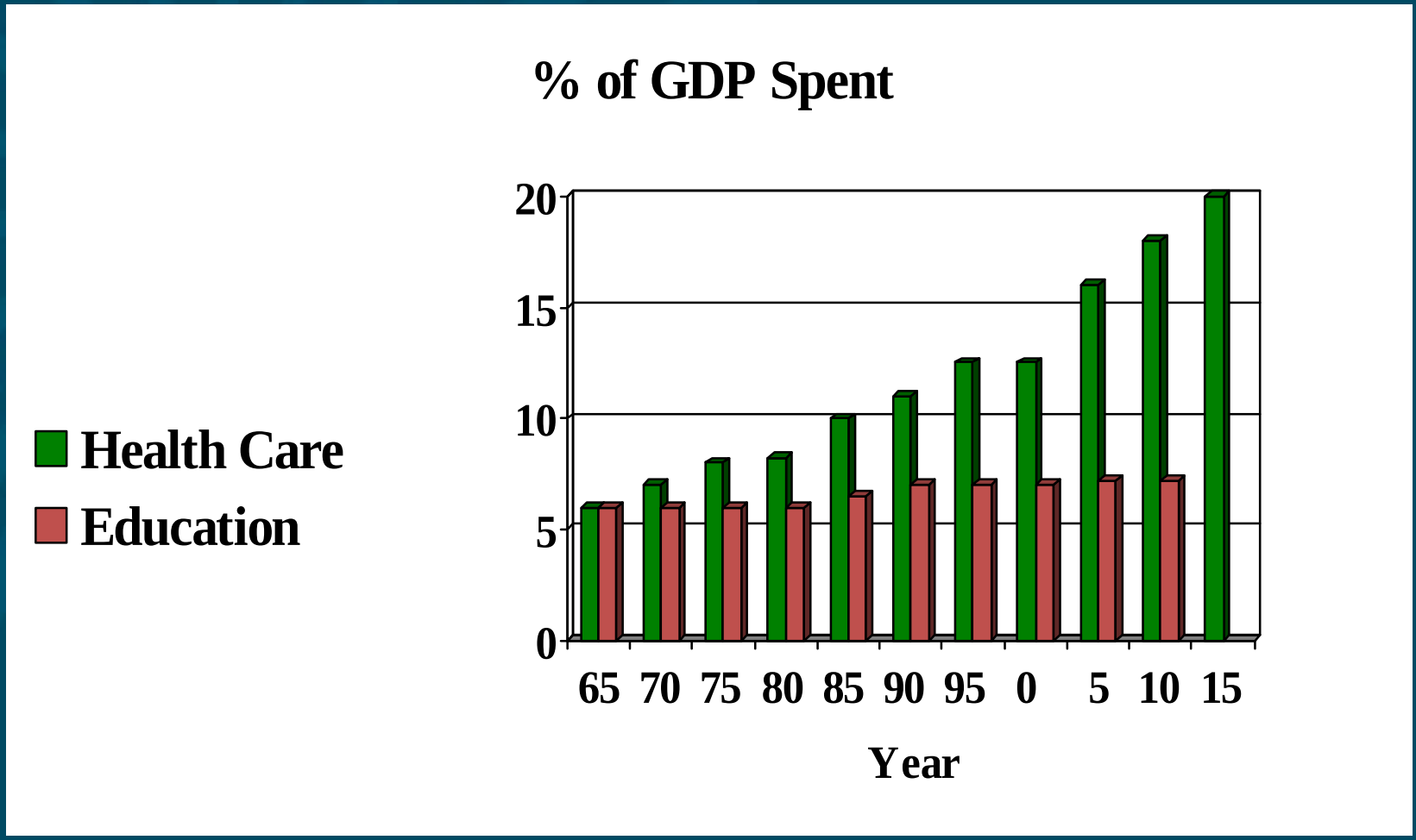
What we spend on health care we cannot spend on other things, like education



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Concrete options and ideas for increasing value in oncology care
The view from the trenches

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Objectives and plan

Problems & Explanations → Suggestions

1. Unrealistic demands for benefit
2. Low reimbursement for cognitive care
3. High reimbursement for chemotherapy or infusions
4. High income expectations of oncology professionals
5. Variable quality of care and little incentive to study it
6. Stress and burnout

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What does this have to do with VALUE in ONCOLOGY?

Currently

- We spend 2x as much any other country for the same results.
- IMPOSSIBLE expectations for success on the oncologist.
- The 'system' rewards trying to meet those impossible demands
- And does not reward explaining why they cannot be met.
  - 16-20% of patients getting chemo within 14 days of death
  - hospice stays of 17 days, 1/3 less than 3 days
  - 25% of Medicare $ in last month of life

Going Forward

- 100+ new drugs in Phase III trial, all will be expensive.
- Continuing the same financial incentives are not sustainable

It is all change-able, just hard to do.

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1. Unrealistic demands for benefit

- Most people are told the goals of care
- Most people commonly not told
  - if they are going to die from their disease.
  - how long they have to live.
  - The anticipated benefit from chemotherapy vs. supportive care
- What is missing
  - There are no decision aids for metastatic disease
  - Tools for balancing benefit, toxicity, and cost when cure is not the goal
- Avoidant Behavior and its Consequences
  - It is easier, and more financially rewarding, to continue giving chemo until the end is near-obvious
  - Despite spending 2-fold more on cancer care per person U.S. survival for patients with advanced cancer is not better (Meropol N, JCO 2007)

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2. Low reimbursement for cognitive care

- At $37/wrRVU an oncologist would have to generate over 16,000+ wRVU to earn the U.S. average oncologist salary
- That would only cover the individual's salary.
- No way to support other elements of the enterprise
  - RNs, staff, social workers, counseling
  - Billing, EMR, Capital Expenses etc.
- Realistic work loads for long hard days based solely on cognitive services would lead to <$200,000 per yr incomes
  - Doing things no one else wants to do.
  - And not pay staff.
- Same compensation as a geriatrician. That has not worked, either.

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3. High reimbursement for chemotherapy or infusions

- No real data.
- ~50 to 75% or more of community oncology practice income from non-cognitive care (unattributable peers)
- Diversified income from interest in imaging and radiation centers.
- Wall Street Level Salaries
  - $358,000 median, $523,000 mean (2006). [90%, $1 mill]
  - Salaries have *doubled* in 10 years
- *All the incentives line up to over-use chemotherapy, supportive care drugs, aggressive care, not refer to hospice until very late in the game.*

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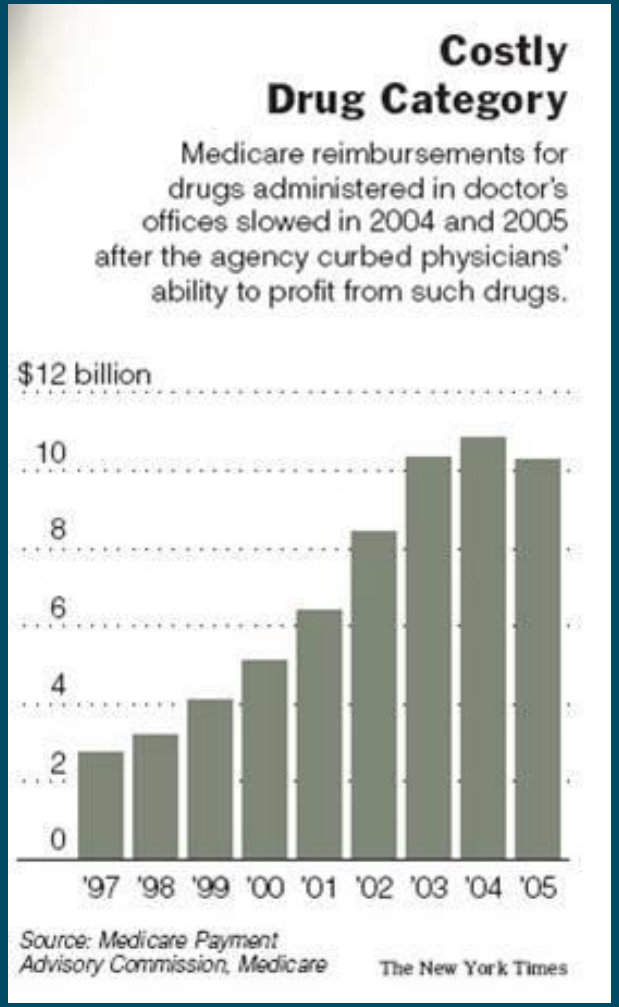
Do we give chemo to make money?

- Reimbursement does not influence the decision to give chemo.
- The more generous the reimbursement the more expensive chemo we use.
- Every $1 increase in reimbursement -> $23 increase in chemo costs.
- Accounts for 4-8% of chemo costs by itself. (Health Affairs 2007)

- Medicare now pays 6% markup, which has reduced chemo use.

- *This may help explain why 16-20% of people get chemo within 2 weeks of their death. (Harrison & Smith, JAMA 2008)*



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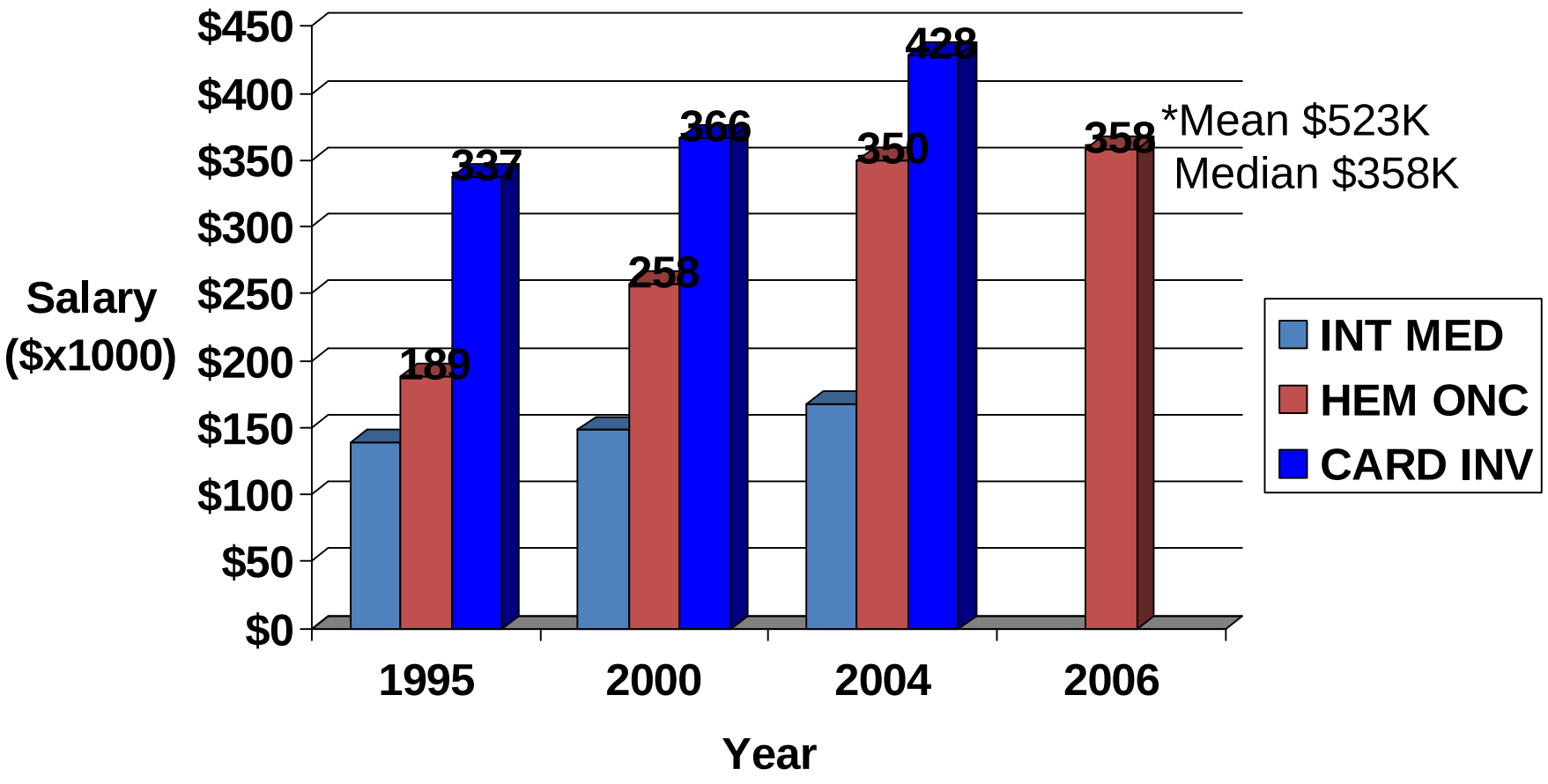
Oncology salaries up 86% in 10 years

the highest of any specialty. Visits only up 12%.



Bodenheimer Ann Intern Med 2007 *Cejka Search firm, 2007.

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4. High income expectations of oncology professionals for very hard work

- For many of us, it's 24/7/365 responsibility
- Far different from most other medical practices.
- We have direct responsibility for outcome with the disease (at least a little bit.) Cf Linkin Park "Easier to run"
- This is not something I would want to do for a low salary. (Geriatrics as example – *dead*.)
- A looming 40% shortage of oncologists, so you can't reduce the salary or change the rules too much.
- What is the reward for having difficult discussions on , withholding chemo ($-1,000) + GCSF ($-600) + MRI ($-600)+ zoledronic acid ($-800), compared to usual care?
- *It's a lot easier, less angst-provoking, to give 4th line chemo.*

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5. Stress and burnout

- It is incredibly hard to take care of sick people.
- Now, society wants us to cut the costs of care, because someone needs to, but no one else will do it.
- So, “they” (CMS and commercial insurers) will systematically lower the reimbursement until we can’t afford to give the drugs that sometimes help at a high cost.
- No one likes to break bad news. Add breaking bad financial news (SPIKE$, JCO 2008)
- There are no successful models for managing all these expectations at the same time that don’t involve major shifts in lifestyle, incentives, income, etc.

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6. Variable quality of care

- Chemo: how many practices give 3, 4th, 5th line chemo, or chemo to people with PS 3 or 4? (See Connor JPSM 2007)
- EOL care: how many practices have model EOL care, with hospice referrals >30 days?
- Under-use of genetic referrals and lack of skills in genetic counseling. (Quillin JPM 2008; ASCO 2009)
- Lack of governmental interest in practical vs. new agents
  - Non-inferiority economic studies are huge, expensive, tough to accrue, and not exciting.
  - We have had extremely limited success getting them done, e.g. monthly zoledronic acid vs. every 3 months for osteolytic bone metastases.

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1. Unrealistic demands for benefit

- Revise the NCI's Cancer .Gov to give prognosis, treatment information.
- Consent form should
  - Document ECOG PS,
  - Document Likely Prognosis,
  - Specify the type of therapy (n-th line)
  - Specify the anticipated benefits and risks
- Chemo based on chance of benefit ("must have at least __% of clinical benefit") and PS
- Requires some limits determined by society
- The Doctor SHOULD NOT be doing this at the bedside

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1. Unrealistic or uneducated demands for benefit

Give truthful information

Treatment Options for Recurrent Pancreatic Cancer

Treatment of recurrent pancreatic cancer may include the following:

- Chemotherapy.
- Palliative surgery or stent placement to bypass blocked areas in ducts or the small intestine.
- Palliative radiation therapy.
- Other palliative medical care to reduce symptoms, such as nerve blocks to relieve pain.
- Clinical trials of chemotherapy, new anticancer therapies, or biologic therapy.

How about honest prognosis (95% dead in one year), mention CONKO 2nd line Rx, suggest hospice and palliative care?

Cancer.Gov, 2.1.09

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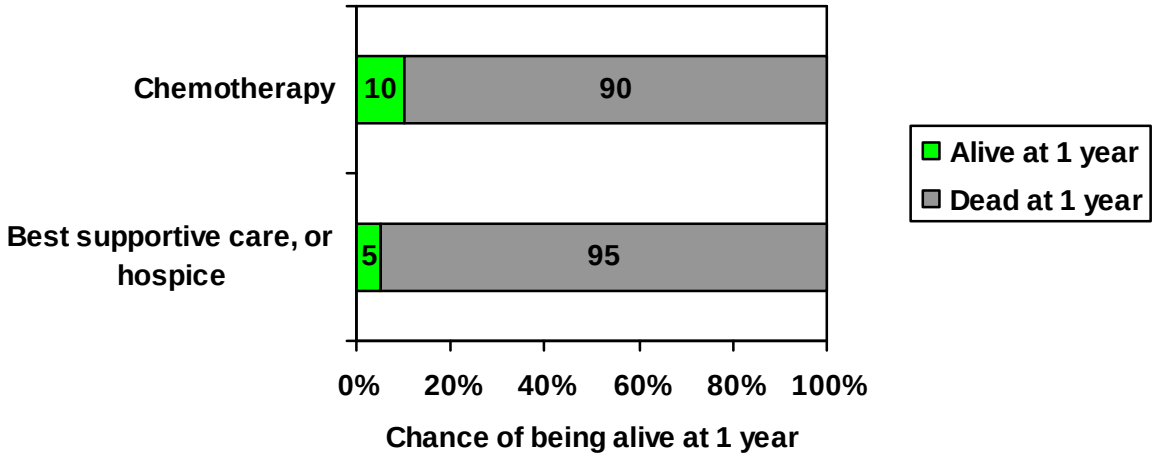
1. Unrealistic or uneducated demands for benefit

Give truthful information

Breast Cancer, fourth line chemotherapy

What is my chance of being alive at one year if I take chemotherapy, or do best supportive care such as hospice? Without chemotherapy, about 5 of 100 women would be alive at one year. With chemotherapy, about 10 of 100 women would be alive at one year. The average woman with breast cancer treated with "fourth line chemotherapy" lived about 5 months. Half will do better, half worse.



What is the chance of my being cured by chemotherapy?

In this setting, there is no chance of cure. The goal may change to controlling the disease and any symptoms for as long as possible. You may want to talk with your doctor about your own chances and goals of therapy.

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1. Unrealistic demands for benefit

Consent form to document benefits, ECOG PS

ASCO. Outcomes of cancer treatment for cancer treatment guidelines. J Clin Oncol 1996;14:671-679.

I, _____ give _____ permission to administer the following chemotherapy drugs to myself.

_____

I understand the risks of chemotherapy and have been provided the following information:

( ) drug specific information ( ) disease specific information.

I (___) do (___) do not want specific information about the benefits of chemotherapy (see below)

The goals of this therapy are (doctor should **P** the appropriate area)

( ) cure

( ) to help me live longer (my disease is not likely to be cured)

( ) to help me feel better

Chemotherapy for my _____ cancer as 1st 2nd 3rd 4th __- line treatment is expected to on average :

- increase my chance of being alive at 1 year from _____% to _____%
- increase my survival compared to no treatment from _____ months to _____months
- prevent my cancer from getting worse (progressing) by _____months
- shrink my cancer in half in ___ of 100 people like me
- shrink my cancer completely in ___ of 100 people like me
- keep my cancer stable for ___ months in ___ of 100 people like me
- improve my cancer symptoms in ___ of 100 people like me

Patient signature: _____

MD signature: _____

MD Documentation of ECOG PS (Circle)
0 no symptoms
1 symptoms but normal activity
2 symptoms but still functioning
3 in bed or chair ≤ 50% of the day
4 in bed or chair ≥ 50% of the day

MD must provide as part of pre-authorization

Could list 4 most common side effects, or
how much money we would make on Rx's,
or co pays (ASCO?)

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Why bother to bring up the “D” word?

People who have a discussion about dying...(and only 37% did)

- No difference in mental health or hope
- Less likely
  - to want heroic measures
  - To undergo ventilation
  - to be admitted to ICU
- More likely
  - To admit being terminally ill
  - Complete DNR
  - To Use hospice
- More family, spiritual, life review opportunities
- $304 MILLION Difference in EOL care expenditures between individuals who had EOL discussions and those who did not
- 50+% savings for dying pts in the hospital on PC vs rest of hospital.

Wright A, JAMA, 2008 Zhang B Arch Int Med 2008,
Smith T, JPM 2003

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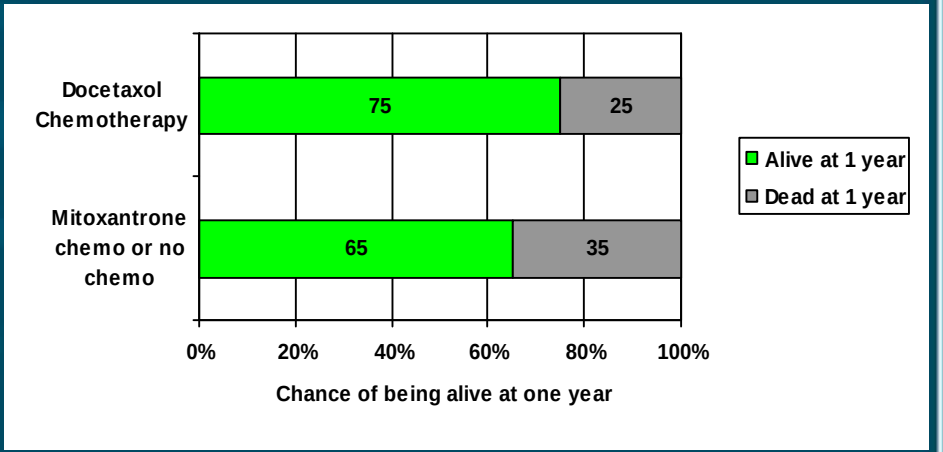
1. Unrealistic demands for benefit

We need NICE or equivalent

There IS a survival and QOL benefit
To Docetaxol (Taxotere) in metastatic Prostate cancer
NHS will pay £33,000/QALY ($64,000)
Impact on NHS
£13-14 million/year



Note: no other drugs have been proven to improve overall survival, and are not available for treatment.
About 15-30% of people will have PSA response.
So, NO second, third, fourth line treatment. There is an appeals process.
Collins R Health Technol Assess. 2007

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2. Low reimbursement for cognitive care

- Will require a substantial revision of the current system.
- It must reward good practice, not unsustainable entrepreneurship.
- Pay all oncologists $50/wRVU for cognitive care
- Pay our practice for RNs (based on duties, infusions given), psychologist, chaplain, social work.
- Reduce chemo to 6% over ASP , all payers. IF the above changes are made.
- Should oncology be a salaried profession?

Peter Eisenberg's letter: http://www.healthbeatblog.org/2009/01/a-very-open-letter-from-an-oncologist.html

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3. High reimbursement for chemotherapy or infusions

Goal: Reduce the incentives to "over use" chemotherapy and supportive agents

- Acknowledge that it will be too complex to 'capitate' or create "illness episode" based payments; too complex.
- Reduce reimbursement for chemotherapy to 6% over ASP .
- Reward us for stopping chemo at NCCN "switch to palliative care" points. [2nd line NSCLC; 3rd line BCA; PS > 2]
- Government purchasing power to reduce the cost of drugs.
- Critically examine the patterns of use of radiology/ancillary services and who owns the service centers.
- Remember there are 100+ new drugs in Phase III trials, some of which will work, all of which will be priced at $3500/month, and people will want. US NICE essential.

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4. High income expectations of oncology professionals

- We say we want to treat people, not disease. These changes all fit that model.
- Oncologists in other countries seem reasonably happy, productive, and appropriately numbered. And survival is the same.
- Reward us for stopping chemotherapy
  - e.g. at NCCN "switch to palliative care" points, 2nd line NSCLC; 3rd line BCA; PS > 2
- More stable salary might balance the lack of a huge "up side" salary. ($523,000 mean salaries has to come from somewhere).

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5. Stress and burnout

- It is incredibly hard to take care of sick people.
- That won't change. As people live longer, with cumulative illness, there is more emotional exposure.
- Don't make it worse.
- Don't ask oncologists to do the work of rationing that government, payers, or society won't do.
- We need reasonable guidance, societal expectations, NICE or equivalent at least for Government payers. (That will reduce the amount of chemo and diagnostics in nth line chemo.)

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6. Variable quality of care

Some things to measure:

- ASCO QOPI: how is pain managed?
- How many practices have nurses who counsel, psychologists, social workers?
- How many practices give 3, 4th, 5th line chemo and for what cancer types?
- Who and % gives chemotherapy if PS is 3 or 4?
- Who and % gives chemotherapy <14 days before death?
- Who and % refer to hospice only <14 days before death?
- PallGenes project: genetic referrals and counseling?
- All of these are do-able, but there is little or no reward for doing them.

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Conclusions

Problems & Explanations → Suggestions

1. Unrealistic demands for benefit: fix. NCI.
2. Low reimbursement for cognitive care: fix. Payers.
3. High reimbursement for chemotherapy: fix. Payers.
4. High income expectations of oncology professionals: ASCO, ACCC.
5. Variable quality of care and little incentive to study it: QOPI, payers, ourselves.
6. Stress and burnout: be mindful that current situation is stressful enough. Ourselves.

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