

A photograph of four medical professionals (three men and one woman) in a meeting. They are gathered around a table, looking at a laptop. The man in the foreground is wearing a white lab coat over a green shirt. The woman is wearing blue scrubs. The background shows a blurred office setting with a framed picture on the wall.

# Benefits & Limitations of Oncology Guidelines

May 15, 2018

“Oncology High-Value Best Practices” Webinar Series, Webinar #1

# Zoom Tips



- Attendees are automatically MUTED upon entering the webinar
- Type your questions in the **chat box**; we will address them during Q&A at the end of the presentation
- Please refrain from using the hold button
- Message Karen through the **chat box** if you have any technical issues

# Today's Speakers



- Bart Wald, MD
- Medical Director, California Quality Collaborative



- Anthony Ciarolla, MD
- President, Southern California Oncology Associates (SCOA)

# Who is the California Quality Collaborative (CQC)?

CQC is a health care improvement organization dedicated to advancing the quality and efficiency of the health care delivery system in California. CQC creates scalable, measurable improvement in the care delivery system important to patients, purchasers, providers, and health plans.

- Started in 2007
- Multi-stakeholder governance
  - Core funding from health plans sharing a delivery system
  - Administered by the Pacific Business Group on Health
- **Purpose:** Identify and spread best practices across outpatient delivery system in California
  - Trains 2,000 individuals from 250 organizations each year

# CQC Aims 2015 - 2018

## **Aim 1: Manage Total Cost of Care**

Build capacity in provider organizations to manage total cost of care.

## **Aim 2: Practice Transformation**

Improve chronic illness care for populations, especially where scores are lowest. Demonstrate improvement in Commercial, Medicare, and Medi-Cal measures.

## **Aim 3: Medically Complex Patients**

Expand availability of intensive outpatient management for complex patients. Build teams to manage top 15% risk patients.

## **Aim 4: Supporting Independent Practices**

Improve chronic care metrics across independent practices contracted directly with CQC health plans. Test multi-payer outreach support system.

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# Oncology Series Webinar Dates

05/15/18

TBD

- **Benefits & Limitations of Oncology Guidelines**  
(Anthony Ciarolla, MD)
- **TBD** (Joseph Alvarnas, MD)

# High Value Oncology

BENEFITS AND LIMITATIONS OF GUIDELINES



# Topics

- ▶ “High Value” Oncology: What is Value?
- ▶ How and Why Guidelines Can Enhance Value
- ▶ NCCN Guidelines: the Gold Standard?
- ▶ Guidelines 2.0-Adding the Cost Component
- ▶ “Personalized Oncology” -the end of Guidelines?

# Cancer Treatment-How Can Guidelines be Applied?

- ▶ Surgery
- ▶ Radiation
- ▶ Medical Oncology

Cure vs Palliation

# What is Value?

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$Value = Outcomes / Cost$

# Outcomes

- ▶ Cure
- ▶ Survival
- ▶ Quality of Life
- ▶ Side Effects of Treatment-acute and chronic
- ▶ Convenience and Accessibility
- ▶ Family
- ▶ Predictability

# Why Do Outcomes Vary?

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Variability= Factors We in the System Can Control  
+  
Factors We Can't Control

Controllable: MD knowledge, MD Habit, MD Behavior based on  
Payment Model

No Control: Patient population, demographics, cancer heterogeneity,  
resource availability

# Guidelines Current and Future

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## Version 1.0

- ▶ Currently available, in use for many years.
  - ▶ Focus on allowable treatments
- ▶ Usually devised by academic medicine

## Version 2.0

- ▶ Focus on cost
  - ▶ Not widely used or available
  - ▶ Driven by payor community

# Guidelines Version 1.0 are a Tool to Decrease Variability of Treatment

- ▶ Decrease in Variability increases Value
- ▶ Reduce Variability in the MD Component:
  - No more 100 MDs=100 treatments
  - “My experience says” vs “The data says”
  - “I was taught this” vs “The newest information suggests”

# NCCN Guidelines

- ▶ An alliance of 27 academic cancer centers throughout the US.
- ▶ In California members include City of Hope, Stanford, UCSF, and UCSD.
- ▶ NCCN has devised a comprehensive set of guidelines for cancer and supportive care.
- ▶ Guidelines include surgery, radiation, and medical oncology.
- ▶ De facto have become the “gold standard” of cancer guidelines.
- ▶ Easily accessible online.



# NCCN-how do they decide?

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## Different Levels of Recommendation

- ▶ Category 1: “high level” evidence- uniform(85%) consensus intervention is appropriate.
- ▶ Category 2A: “lower level” evidence- <85% consensus intervention is appropriate.
- ▶ Category 2B: “lower level” evidence- at least 55% consensus intervention is appropriate.
- ▶ Category 3: Disagreement that intervention is appropriate.

# NCCN-Pro

- ▶ Guidelines are extensive for virtually all cancer types.
- ▶ Updated frequently.
- ▶ Authoritative-devised by the leading experts in the field.
- ▶ Inexpensive and web accessible
- ▶ Guidelines tend to be “guiderails”, describe treatments that are acceptable to use.

# NCCN Problems

- ▶ “Guidelines” leave extensive room for variability in treatment especially in advanced cancer.
- ▶ Evidence used reflects a select patient population, those in clinical trials.
- ▶ Physicians represent academic medicine.
- ▶ Most have connections to pharma industry.
- ▶ Cost of treatment not considered.
- ▶ Navigation of recommendations may be difficult for non-oncologists.

# NCCN in the Real World

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- ▶ “Guardrails” are so broad in advanced cancer treatment that variability remains.
- ▶ NCCN Guidelines are used as a justification to give more treatment.
- ▶ Pharma industry uses them as proof their treatment is required.
- ▶ Cost must be addressed outside NCCN.

# Guidelines Version 2.0

- ▶ Take NCCN information looked at with **cost** considered.
- ▶ Factor in clinician experience with the treatment.
- ▶ Factor in availability of service and resources in the community.
- ▶ Factor in characteristics of patient population.

# Try it Yourself-1

Stage 4 Nonsmall cell lung cancer-immunotherapy after first line chemotherapy

3 drugs are FDA approved and NCCN Cat 1

- ▶ Pembrolizumab(Keytruda) RR 18% vs chemo 12%, OS 12mo vs 9mo, cost=\$14,877/month
- ▶ Nivolumab(Opdivo) RR 19% vs chemo 12%, OS 12mo vs 9mo, cost=\$15,100/month
- ▶ Atezolizumab (Tecentriq) OS 13.8 mo vs chemo 9.6 mo, cost=\$14,000/month

# Try It Yourself-2

## Metastatic Renal (clear cell) Cancer

### NCCN Cat 1 Preferred Treatments

- Pazopanib \$14,500/mo
- Sunitinib \$15,000/mo
- Yervoy+Opdivo \$50,000x4mo then\$15,000/mo
  - Avastin+Interferon \$20,000/mo
  - Temsirolimus \$8,500/mo

# Constructing Guidelines 2.0

- ▶ Not easy to do
- ▶ Rapid pace of new drugs requires updating monthly? weekly?
- ▶ MD experience with treatments is essential
- ▶ How much is an extra month of life with advanced cancer worth?  
At what quality?
- ▶ Physician buy-in to adhere to Guidelines 2.0 problematic-alternative payment system?
- ▶ Medical Oversight-by another oncologist?



# “Personalized Oncology”

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- ▶ Each cancer undergoes whole genome sequencing or some similar technology to identify specific targets for molecular intervention.
- ▶ Each person’s cancer has a distinctive set of molecular targets depending on accumulation of mutations that activate the cancer process.
- ▶ Therefore each person’s cancer will need a distinctive set of treatments.
- ▶ These treatments will change over time as the cancer mutates over time, so resequencing will be needed after each disease progression.