2021 Oncology State of the Union

Leveraging partnerships to ensure future success
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Thank you!

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Today’s research experts

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Research Analyst
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2021 Oncology State of the Union
Leveraging partnerships to ensure future success
Cancer programs stepped up during Covid-19

Sample strategies cancer programs implemented to reduce patient and staff risk of Covid-19 exposure

- Screening patients before visits
- Implementing rapid triage protocols for suspected cases
- Restricting entry and number of visitors
- Offering onsite “drive-thru” testing and testing tents
- Deploying telehealth
- Rescheduling non-essential visits
- Fast-tracking injections
- Separating lab and infusion visits
- Encouraging appointments during extended hours
- Minimizing patient “touches”
- Designating specific sites to treat Covid-19 patients
- Shifting patients on IV therapies to oral therapies
- Shifting care from inpatient to outpatient
- Shifting care to non-HOPD settings within or outside of your health system
- Shifting infusions to patient home
- Cancelling in-person events, activities, meetings
- Encouraging work from home when possible
- Restricting employee personal travel
- Planning for impending supply shortages

Sample modalities cancer programs used to communicate Covid-19 information and updates to patients

- Creating dedicated cancer program webpages
- Sharing in-the-moment updates through social media
- Making eye-catching in-person signage
Refocusing on the ambition for cancer care

Ideal characteristics of cancer care

Affordable + Personalized + Equitable
Renewed focus on evergreen priorities creates urgency

Current market forces driving industry transformation

1. Increasing purchaser focus on controlling costs
   - Oncology costs projected to continue rising through 2030
   - Increasing price transparency prompted by new CMS policies
   - Biden administration’s health care agenda includes drug pricing reform

2. Accelerating pace of clinical innovation
   - Biden administration has signaled continued commitment to cancer research
   - Increasing media attention on new cancer therapies

3. Growing pressure to prioritize health equity
   - Increased national attention due to Covid-19, leading to changing consumer and health care employee expectations
   - Biden administration has prioritized health equity

“New Year, New CMS Price Transparency Rule For Hospitals”
_Health Affairs_

“A Terrible Price: The Deadly Racial Disparities of Covid-19 in America”
_New York Times_

Still more work to be done to ensure success for most

For each market force, how well positioned for success is your organization moving forward?

2021 Oncology State of the Union Attendee Survey, April 2021

- **Purchaser pressures**
  - 35%: We've got a lot of work to do
  - 63%: Feeling ok, but work to be done
  - 2%: Nailing it, no worries at all
  - n=166 respondents

- **Clinical innovations**
  - 25%: We've got a lot of work to do
  - 69%: Feeling ok, but work to be done
  - 6%: Nailing it, no worries at all
  - n=156 respondents

- **Health equity**
  - 35%: We've got a lot of work to do
  - 60%: Feeling ok, but work to be done
  - 5%: Nailing it, no worries at all
  - n=145 respondents

- 0% to 100%
Many inputs required to respond to each market force

Sample inputs needed to develop effective response strategy for major market forces

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<tr>
<td>• Claims data</td>
<td>• Real-world evidence</td>
<td>• Patient-level clinical data</td>
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<tr>
<td>• Billing data</td>
<td>• Patient safety data</td>
<td>• Patient-level demographic data</td>
</tr>
<tr>
<td>• Total cost of care data</td>
<td>• Data on the cost of innovations</td>
<td>• Community-level demographic data</td>
</tr>
<tr>
<td>• EHR data</td>
<td>• Ability to interpret genomic data, integrate into existing IT platforms</td>
<td>• Data on non-clinical factors impacting health</td>
</tr>
<tr>
<td>• Clinical pathway data</td>
<td>• Funds to invest in innovations</td>
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## Oncology Roundtable has resources to get you started

### Sample Oncology Roundtable resources for effectively responding to major market forces

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<td>Oncology Hospital Operations, Quality, and Finance Benchmark Generator</td>
<td>Cancer Patient Experience Survey Results Portal</td>
<td>Cancer Incidence Estimator</td>
</tr>
<tr>
<td>Claims-based data on financial metrics for individual organizations compared to peers</td>
<td>Survey data about cancer patients’ priorities, including how patients value technology and treatment options when making care decisions</td>
<td>Market-level estimates of new cancer cases, broken out by tumor site, age, and sex</td>
</tr>
<tr>
<td><strong>Resources</strong></td>
<td><strong>Expertise</strong></td>
<td><strong>Resources</strong></td>
</tr>
<tr>
<td>Prior Authorization for Physician-Administered Drugs</td>
<td>Oncology home infusion</td>
<td>Community Advisory Boards</td>
</tr>
<tr>
<td>Best practices for staffing, process improvement, and working with payers to reduce PA requirements</td>
<td>Thought leadership on what it is, why it’s important, and how to decide if you should pursue it</td>
<td>Overview to guide you in developing your own CAB to provide community perspective</td>
</tr>
<tr>
<td><strong>Expertise</strong></td>
<td><strong>Clinical Innovations in Oncology</strong></td>
<td><strong>Expertise</strong></td>
</tr>
<tr>
<td>The precision medicine business plan template</td>
<td>Clinical Innovations in Oncology</td>
<td><strong>Expertise</strong></td>
</tr>
<tr>
<td>Customizable template to develop your own precision medicine business plan to justify investment</td>
<td>Case studies and best practices for integrating oncology innovations into your practice</td>
<td><strong>Expertise</strong></td>
</tr>
<tr>
<td><strong>Health equity</strong></td>
<td><strong>Resources</strong></td>
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<td>Addressing racial health disparities in cancer screening</td>
<td><strong>Resources</strong></td>
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<tr>
<td>Outline of the financial benefits of an equitable screening strategy, to inform the business case</td>
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Don’t have to go it alone, everyone has a stake

1. Advanced practitioners.
Leverage partnerships to respond to major market forces

Current state of cancer care

Ideal state of cancer care: Affordable, Personalized, Equitable

Market forces driving industry transformation:
1. Increasing purchaser focus on controlling costs
2. Accelerating pace of clinical innovation
3. Growing pressure to prioritize health equity

THREE COMMON TYPES OF PARTNERSHIPS

Transactional partnerships
Accountability based on contracts and incentives

Systemic partnerships
Accountability built around outcomes and sustainability

Structural partnerships
Accountability built around authority, equity, and control

Increasing purchaser focus on controlling costs
Purchasers doubling down on cost control tactics

Top purchaser strategies for oncology cost control

**Commercial payers**
- Shifting infusions to lower-cost settings
- Requiring drug sourcing from specialty pharmacies (white bagging)
- Increasing prior authorization requirements

**Employers**
- Narrowing networks to high-value providers
- Steering employees to centers of excellence

**CMS**
- Testing value-based payment models
- Creating regulations to control drug spend

**WHAT TO WATCH**

Biosimilars could become more important part of commercial payers’ and employers’ cost control strategies as wave of biologic patents expires in coming years
Partnerships can promote sustainability under pressure

Common cancer program challenges with purchaser policies, and sample ways partnerships can help

Revenue loss
Partners can mitigate cancer programs’ resource and expertise gaps, and thus reduce investments needed to meet purchaser demands

Difficulty coordinating care
Partners involved in the infusion drug sourcing and administration process can minimize the safety issues and care delays caused by increasingly complex requirements

Patient dissatisfaction
Partners can reduce care delays, site-of-care changes, and other impacts of purchaser pressures that cause patients to be confused or frustrated

Administrative burden
Partners involved in setting or carrying out new requirements can help streamline processes to alleviate the administrative burden associated with purchaser policies
Site-of-care and white bagging policies are increasing

87%
Of health system pharmacy leaders report increase in required use of non-HOPD settings for infusions across 2019 and 2020

84%
Of health system pharmacy leaders report increase in required white bagging for infusions across 2019 and 2020

Select commercial payer oncology site-of-care and white bagging policy changes in 2020

BlueCross BlueShield of TN began a new white bagging policy
Aetna added checkpoint inhibitors to its Site of Care policy
UnitedHealthcare began offering oncology home infusion in FL

Anthem Blue Cross CA announced white bagging for Medicaid HMO beneficiaries
Cigna started requiring white bagging for high-cost oncology drugs administered in the HOPD
Anthem Blue Cross CA expanded white bagging to all PPO plans

Source: "Select oncology medications are being added to the Site of Care management program," Aetna; "Oncology Home Infusion Program," UnitedHealthcare; "Specialty Medical Injectables with Reimbursement Restriction," Cigna; "Anthem PPO added to specialty medication policy," California Medical Association; "7 key facts about our specialty pharmacy changes," BlueCross BlueShield of Tennessee; "Infusion Site of Care Survey, Pharmacy Executive Forum, Advisory Board.

1. Requires the use of non-hospital facilities for infusions administered as monotherapy for maintenance.
2. Advisory Board is a subsidiary of UnitedHealth Group. All Advisory Board research, expert perspectives, and recommendations remain independent.
Purchasers willing to partner to reduce financial burden

OhioHealth worked with commercial payers to keep infusions in HOPD with home-grown algorithm

Clinical algorithm design

- Multidisciplinary team conducted clinical analysis, cost analysis, and medical necessity review
- Designed algorithm to determine clinical appropriateness of infusing drug outside HOPD
- Embedded clinical evidence to support analysis

Payer negotiations

- Managed care team led discussions with payers regarding algorithm
- Worked with payers on resolving technical issues for maintaining billing compliance

Agreement

- OhioHealth patients remain in HOPD
- Payers reimburse OhioHealth at freestanding rates for infusions clinically appropriate to be delivered in a freestanding clinic
- Freestanding rates only enforced when appropriate as determined by OhioHealth’s clinical algorithm

Source: OhioHealth, Columbus, OH.
Partner with specialty pharmacies for coordinated care

Mount Sinai worked with specialty pharmacies to develop processes to better manage white bagging

WHITE BAG INFUSION WORKFLOW

ADMINISTRATIVE COORDINATOR (AC)
- Develops relationships with specialty pharmacies (SPs), including establishing high-level SP contacts

Mount Sinai’s preauthorization team notifies AC when health plan requires white bagging for a patient’s medication

AC notifies SP weekly of new patients or upcoming refills two weeks before next patient appointment

SP concierge team processes patient account and follows up with AC about any missing information (e.g., script, patient consent, copay information)

Therapeutic infusion administration team tracks delivery to ensure drug is shipped and delivered on time

RESULTS
- Close relationships with 10 SPs
- Greater care coordination
- Fewer care delays
- Reduction in lost packages and other errors
- Decline in patient dissatisfaction

Source: Mount Sinai Health System, New York City, NY.
Employer focus on patient steerage jeopardizes volumes

Employer interest in narrow networks and centers of excellence

2020
n=165 U.S. employers

- Steerage within networks
  - Not considering in the next 24 months: 25%
  - Considering in the next 24 months: 29%
  - Currently doing: 47%

- National centers of excellence/episodes of care
  - Not considering in the next 24 months: 28%
  - Considering in the next 24 months: 36%
  - Currently doing: 36%

- Regional centers of excellence/episodes of care
  - Not considering in the next 24 months: 20%
  - Considering in the next 24 months: 39%
  - Currently doing: 40%

“[Employers] are seeing it as their obligation to narrow networks to only high-quality, high-value providers.”

Elizabeth Mitchell, CEO
Purchase Business Group on Health

CHALLENGES FOR CANCER PROGRAMS

- Volume and revenue loss
- Administrative burden

Digital platforms can help capture employer volumes

MSK¹ and Carrum Health aligned visions and capabilities to offer cancer care bundles to employers

FINDING A PARTNER WITH SHARED GOALS

MSK
sought to align financial incentives while doing what's best for patients

Carrum
wanted to offer higher value to the employers they serve

Both organizations
spent the prior 5-6 years working independently on cancer care bundles

DESIGNING SOLUTIONS THAT PROMOTE QUALITY AND VALUE

DETERMINING PRICE

1.5 years spent contracting

MSK had dedicated team studying costs to determine bundle pricing

Carrum provided real-world data to inform cost analyses

DEFINING SERVICES

2-year bundles for non-metastatic breast and thyroid cancer patients

MSK provides cancer care services for a single upfront payment from employers

Carrum
• provides patient with case manager and digital communication platform
• sends MSK all relevant patient records
• coordinates between MSK and local oncologists
• organizes patient travel

1. Memorial Sloan Kettering Cancer Center.

Source: Carrum Health, San Francisco, CA; Memorial Sloan Kettering, New York, NY.

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Finalization of RO Model puts financial viability at risk

Radiation Oncology Model
starts January 1, 2022

- Mandatory for all radiation therapy providers and suppliers within randomly selected Core-Based Statistical Areas
- Prospective, site neutral, episode-based payments will cover radiation therapy services for 16 cancer types
- Model qualifies as an Advanced APM\(^1\) and MIPS APM
- Includes 3D-CRT, IMRT, SRS, SBRT, proton, and IGRT, but not IORT or brachytherapy
- Reporting and performance on quality measures, clinical data, and patient experience are factored into payments

CHALLENGES FOR CANCER PROGRAMS

- Revenue loss
- Difficulty knowing which clinical, operational, and strategic changes to make and committing resources to ensure financial sustainability
- Resource and staffing burden associated with meeting model requirements
- Trouble balancing competing priorities of value-based and fee-for-service payment models

\(^1\) Alternative payment model.

OCM results create uncertainty about future CMS plans

Impact of the Oncology Care Model (OCM) on service utilization and spending during performance periods 1-5

$317.6M overall loss to Medicare during first four performance periods

- $297 reduction in spending per patient episode, with greater reduction among high-risk patients (not including MEOS)¹
- 1.1% decrease in EOL hospitalizations
- More cost-conscious use of Part B non-chemotherapy drugs
- No reduction in ED visits, hospitalizations, or unplanned readmissions
- No improvements in symptom management or adherence to oral chemo
- No changes to chemotherapy drug treatment or radiation therapy

CHALLENGES FOR CANCER PROGRAMS

- Unpredictability of impact on structure of potential Oncology Care First Model proposal
- Lack of understanding about which care practice changes result in meaningful cost savings
- Possibility that future models will require cancer programs to take on greater financial risk

¹ Monthly enhanced oncology services (MEOS). MEOS are payments that Medicare provides OCM practices in addition to Medicare FFS payments to aid in effectively managing and coordinating care.

Partner around value-based care to benefit both parties

US Oncology Network’s participation in value-based contracts

53
50%

OCM PRACTICES ENGAGED IN TWO-SIDED RISK

Two key strategies for incorporating drug costs into value-based contracts

1. Include utilization measures to indicate how you’re lowering costs (i.e., biosimilar conversion, generic utilization, pathways adherence)

2. Measure cost by looking at utilization compared to others in the market and normalize anything above trend to ASP

OCM performance demonstrates potential for impact

100K
$122M

PATIENTS ENROLLED
CUMULATIVE MEDICARE SAVINGS AFTER MEOS AND PERFORMANCE PAYMENTS

Source: The US Oncology Network, The Woodlands, TX.
Considerations for partnering around purchaser pressures

QUESTIONS TO ASK YOURSELF

01 Which purchaser pressures are we experiencing most acutely? Which do we expect to increase in the next 1-3 years?

02 Which purchaser pressure impacts (e.g., revenue loss, disruptions to care coordination, added administrative burden) do we want to prioritize for addressing through partnerships?

03 What opportunities can we leverage to proactively shape purchaser policies?

POTENTIAL PARTNERS

• CMS/CMMI
• Commercial payers
• Freestanding infusion centers
• Home infusion agencies
• Other health systems
• Pharmaceutical manufacturers
• Physician practices
• Specialty pharmacies
• Technology vendors
• Internal health system stakeholders, such as:
  • Billing, contracting, finance, home health, health system executives, other service lines, pharmacy
02

Accelerating pace of clinical innovation
Clinical innovations are transforming cancer care

Sample oncology innovations becoming more widespread

Liquid biopsy for early detection of multiple cancers

1st multi-cancer blood test was launched by StageZero Life Sciences on April 1, 2021

Biomarker testing and targeted therapies

~4x growth in proportion of global oncology trial using biomarkers from 2000 (15%) to 2018 (55%)

Immuno-oncology treatments

3x growth in global immune checkpoint inhibitor clinical trial pipeline over past 3 years

Carbon ion therapy

1st U.S. carbon ion therapy facility will start construction in Q4 2021

Rapid innovation creates need for external partners

Common cancer program challenges with clinical innovations, and sample ways partnerships can help

**Unrealistic patient expectations**
Partners from outside the clinical setting can help manage patient expectations regarding novel technologies and treatments

**Lack of clarity into when and how to translate new research findings into clinical practice**
Partners can set standards for implementing new evidence and assist with incorporation into clinical practice

**Insufficient expertise**
Partners can eliminate the need for in-house expertise on accessing, implementing, and managing every innovation

**Financial liability**
Partners can reduce the financial risk of investing individually and make innovations more affordable for cancer programs and patients

**Inadequate resources or infrastructure for providing patients access to clinical trials**
Partners can enable cancer programs to more easily enroll patients in a wider array of trials

**Difficulty changing clinical workflows**
Partners can help cancer programs establish procedures for using new technologies while reducing bottlenecks and pressure points

Unrealistic patient expectations
Lack of clarity into when and how to translate new research findings into clinical practice
Insufficient expertise
Financial liability
Inadequate resources or infrastructure for providing patients access to clinical trials
Difficulty changing clinical workflows
High cost of innovations hinders access

1. **Insurance coverage for new innovations can be uncertain**

   Carbon ion therapy is not currently reimbursed in the United States due to its experimental and investigational status of cancer patients with commercial insurance had their initial request for proton therapy coverage denied.

2. **Expensive innovations can come without sufficient reimbursement**

   Unadjusted Medicare payment rate for inpatient CAR-T services

   - Recommended by ASCO: $1,963,158
   - Finalized by CMS: $239,929

   “We remain concerned, however, that the reimbursement rate will be insufficient to cover the cost of CAR-T therapy and associated services, which could restrict access to this important treatment.”

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**LEGISLATION TO WATCH**

CMS coverage of FDA-approved multi-cancer early detection tests is dependent on Congressional approval of the Medicare Multi-Cancer Early Detection Screening Coverage Act of 2021 (H.R. 1946)

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Consider competitors as partners for costly innovations

CASE STUDY

New York Proton Center (NYPC)
Proton therapy facility in New York City, NY

Memorial Sloan Kettering Cancer Center, Montefiore Medical Center, and Mount Sinai Health System partnered to open New York’s first proton center in July 2019.

Collaborative partnership structure

- Leaders from each institution are equally represented on both the NYPC Medical Executive Committee and the NYPC Board
- Faculty members from each institution rotate between disease-based teams at NYPC and home institutions

Mutual benefits

- Financial sustainability
- Market differentiation
- Scaled research abilities

Indicators of success

- All partners equally engaged
- Over 1,000 patients treated
- Positive patient feedback

"I think this consortium model can be applied to anything in medicine, even beyond oncology”

Charles Simone, CMO

CONSIDER THIS TYPE OF PARTNERSHIP FOR INNOVATIONS THAT...

- Are expensive
- Have limited demand
- Need high volumes to justify investment

Source: New York Proton Center, New York, NY; Montefiore Health System, Bronx, NY
Cancer programs face barriers to offering clinical trials

75% of Americans would be willing to participate in an oncology clinical trial if they had cancer.

44% of cancer patients have a clinical trial available at their institution.

Top programmatic challenges to offering cancer patients clinical trials

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<tr>
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<th>Percentage</th>
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<td>Program infrastructure¹</td>
<td>58%</td>
</tr>
<tr>
<td>Staff resources and training</td>
<td>55%</td>
</tr>
<tr>
<td>Physician engagement and awareness</td>
<td>46%</td>
</tr>
<tr>
<td>Cost of doing research</td>
<td>40%</td>
</tr>
<tr>
<td>Negotiating adequate reimbursement from payers</td>
<td>23%</td>
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¹ E.g., technology to identify eligible patients and track outcomes.

Virtual trial company can help enroll patients in trials

Components of the Science 37 platform that support completely virtual clinical trials

**Virtual administration systems**
- Patient recruitment and enrollment
- Electronic consent
- Scheduling

**Network of staff**
- In-house telemedicine investigators
- Home health nurses

**Decentralized study methods**
- Video chat
- Door-step study medicine delivery
- Digital self-photography
- Remote monitoring
- Mobile nurse visits
- Questionnaires

**Data capabilities**
- Data collection
- Trial analytics

---

Cancer program role
In some models, patients’ providers participate in study data capture

---

CONSIDER THIS TYPE OF PARTNERSHIP FOR INNOVATIONS THAT...
- Are still in clinical trials
- Patients may have trouble accessing in traditional care setting

Source: Miseta E, “Physicians And The Patient Recruitment Problem,” Clinical Leader, December 18, 2017; Science 37, Los Angeles, CA.
Innovations can alter typical care processes

Sample ways diagnostic testing innovations could impact traditional progression of care

Liquid biopsy testing for early cancer detection by non-traditional providers may impact when and how patients are referred to the cancer program.

**Turnaround time** for receiving biomarker test results can extend timeline for treatment decision, delaying initiation.

Abnormal screening findings or symptoms reported → **Diagnostic testing**

Liquid biopsy test results may necessitate **further testing**

**Diagnosis**

Biomarker test results can trigger **additional assessments**

**Treatment planning**
Biotech and pharma can help implement innovations

GRAIL is partnering with Providence to integrate Galleri test into clinical setting

GRAIL’s Galleri multi-cancer early detection blood test

- Detects cancer in asymptomatic patients by measuring cell-free nucleic acids
- Demonstrated 99.3% specificity across more than 50 cancer types, with 93% accuracy in identifying tissue of origin

Benefits to Providence

- Make innovative technology available to providers and patients in CA, WA, and OR, and eventually the entire health system
- Get GRAIL’s support in implementation, including consultation for providers after results are received

Benefits to GRAIL

- Gain recognition and drive adoption by launching test in notable health system
- Optimize processes for ordering, administration, and interpretation
- Learn about provider utilization and how to best support providers and ensure positive patient experience
- Demonstrate clinical utility to support payer coverage and FDA approval

CONSIDER THIS TYPE OF PARTNERSHIP FOR INNOVATIONS THAT…

- Are the first of their kind
- May change the typical care process

New evidence outpaces ability to change practice

Cancer programs struggle to quickly adjust clinical practices based on new evidence and guidelines

22%

of NSCLC patients received testing for all guideline recommended biomarkers \textit{EGFR, ALK, ROS1, and BRAF}

45%

of NSCLC patients with targetable mutation in \textit{EGFR, ALK, ROS1, or BRAF} received targeted therapy

Industry confusion over treatment efficacy makes it hard to make evidence-based treatment decisions for patients

6

Anti-PD-(L)1 immune checkpoint inhibitor indications voluntarily withdrawn from the market by manufacturers following discussions with the FDA

4

Immune checkpoint inhibitor indications recommended for continued accelerated approval by an FDA panel despite required trials not confirming clinical benefit


Clinical technology vendors can enable data integration

Rush University Medical Center partnered with Tempus and Epic to integrate tumor genomic data into their EHR

The challenge

Patients’ tumor genomic sequencing data, stored in pdfs in the media tab of Rush’s Epic EHR, were unsearchable and hard to use

The solution

Rush worked with Tempus and Epic to design and launch Epic’s genomic module for tumor next generation sequencing results

Rush

*Health system*

- Provided expertise to Tempus and Epic on designing way to receive, parse, and display genomic data elements that would be useful to clinicians
- Created order sets that interfaced to outside reference lab, Tempus
- Created interface to receive Tempus results and display them in EHR
- Produced workflows for clinical decision support and best practices to accompany sequencing results

Tempus

*Technology company and clinical laboratory*

- Designed new interpretive pipeline for exporting genomic data in EHR-compatible format, with quality assurance and feedback from Rush

Epic

*EHR vendor*

- Provided paid consultative services to both organizations throughout the design and implementation process

CONSIDER THIS TYPE OF PARTNERSHIP FOR INNOVATIONS THAT...

- Involve robust collection or interpretation of data
- Can’t be properly documented in typical EHR modules

Source: Rush University Medical Center, Chicago, IL.
Considerations for partnering to keep up with innovation

**QUESTIONS TO ASK YOURSELF**

01. Which innovations has our cancer program struggled to implement? Which innovations would we like to implement in the future?

02. What are the biggest limitations that impede our ability to adopt innovations (e.g., expertise, funding, infrastructure, standardization, tracking changing recommendations)?

03. Which partners can best help us overcome these challenges?

**POTENTIAL PARTNERS**

- Clinical trials startups
- Diagnostic companies
- Labs
- Other health systems
- Pharmaceutical manufacturers
- Professional organizations
- Purchasers
- Technology vendors
- Internal health system stakeholders, such as:
  - Finance, financial navigation, health system executives, IT, pathology, patient navigation, pharmacy, physician champions, pulmonology and other specialties
03
Growing pressure to prioritize health equity
One-off initiatives to tackle disparities aren’t enough

### 2019 Trending Now in Cancer Care Survey

What strategies do you use to address health care disparities and/or access issues?

<table>
<thead>
<tr>
<th>Percentage of respondents</th>
<th>n=120</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use translators or translation software to ensure patients can participate in shared decision making</td>
<td>78%</td>
</tr>
<tr>
<td>Use clinical (e.g., nurse) navigators to help underserved patients</td>
<td>74%</td>
</tr>
<tr>
<td>Partner with community organizations in outreach efforts to underserved populations</td>
<td>73%</td>
</tr>
<tr>
<td>Offer education and resources to patients and caregivers to help improve their health literacy</td>
<td>58%</td>
</tr>
<tr>
<td>Partner with an organization to provide transportation for patients</td>
<td>54%</td>
</tr>
<tr>
<td>Use non-clinical lay navigators or community health workers to help underserved patients</td>
<td>43%</td>
</tr>
<tr>
<td>Open satellite locations so that patients can receive care in their own communities</td>
<td>38%</td>
</tr>
<tr>
<td>Implement a transportation program to ensure patients can get to their treatment visits</td>
<td>38%</td>
</tr>
<tr>
<td>Offer or partner with an organization to provide lodging services for patients traveling for care</td>
<td>38%</td>
</tr>
<tr>
<td>Offer telehealth services for patients in rural location</td>
<td>18%</td>
</tr>
<tr>
<td>We have not implemented any strategies to address disparities and/or access to care issues</td>
<td>2%</td>
</tr>
</tbody>
</table>

Other 4%

Source: “2019 Trending Now in Cancer Care Survey,” Advisory Board.
## Disparities documented across cancer care continuum

**Health disparities or inequities** refer to differences that are socially determined and/or deemed unnecessary, avoidable, or unjust

<table>
<thead>
<tr>
<th>Prevention</th>
<th>Early detection</th>
<th>Diagnosis &amp; treatment</th>
<th>Survivorship &amp; EOL¹ care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.5x △</strong> Higher tobacco and alcohol use in LGBTQ population, creating higher risk for certain cancers</td>
<td><strong>27% ▼</strong> Lower likelihood of getting a screening mammogram for who women who only speak Spanish compared to English speakers</td>
<td><strong>50% ▼</strong> Lower likelihood of receiving chemotherapy for metastatic bladder cancer patients with low socioeconomic status compared to those with high socioeconomic status</td>
<td><strong>40% △</strong> Higher breast cancer mortality rate among Black women compared to white women</td>
</tr>
</tbody>
</table>

### Prevention

- **1.5x** Higher tobacco and alcohol use in LGBTQ population, creating higher risk for certain cancers

### Early detection

- **27% ▼** Lower likelihood of getting a screening mammogram for who women who only speak Spanish compared to English speakers

### Diagnosis & treatment

- **50% ▼** Lower likelihood of receiving chemotherapy for metastatic bladder cancer patients with low socioeconomic status compared to those with high socioeconomic status

### Survivorship & EOL¹ care

- **40% △** Higher breast cancer mortality rate among Black women compared to white women

---

1. End of life care.

---

Non-clinical factors contribute to health disparities

<table>
<thead>
<tr>
<th>Economic stability</th>
<th>Education</th>
<th>Food</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment, income, debt, expenses, medical bills, support</td>
<td>Literacy, language, early childhood education, vocational training, higher education</td>
<td>Hunger, access to healthy options</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Neighborhood and physical environment</th>
<th>Community and social context</th>
<th>Health care system</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing, transportation, safety, parks, playgrounds, walkability, ZIP code/geography</td>
<td>Social integration, support systems, community engagement, discrimination, stress</td>
<td>Health coverage, provider availability, provider linguistic and cultural competency, quality of care</td>
</tr>
</tbody>
</table>

Cancer programs can’t afford to overlook disparities

The business case for cancer programs to prioritize health equity

- Growing cancer program accountability for outcomes and costs, which are affected by disparities, under oncology risk-based payment models
- Existing disparities in patient experience may impact ability to attract and retain cancer patients
- Many oncology accreditation programs have specific standards related to addressing health disparities (e.g., CoC¹, NCI²)
- Attracting and retaining oncology employees may be increasingly dependent on ability to demonstrate commitment to promoting equity
- Grant opportunities for research and community initiatives are increasingly focused on social needs and health equity

Annual cost of cancer disparities in the U.S.

$2.3B
Estimated reduction in national medical costs associated with elimination of racial/ethnic disparities in cancer care

$237M
Estimated reduction in national medical costs associated with elimination of poverty disparities in cancer care

$345M
Estimated reduction in national medical costs associated with elimination of education disparities in cancer care


¹. Commission on Cancer.  
². National Cancer Institute.
# Make health equity a strategic priority for oncology

## Dimensions of a comprehensive health equity strategy

<table>
<thead>
<tr>
<th>Governance</th>
<th>Social needs and community outreach</th>
<th>Data collection</th>
<th>Data analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do we have a leadership structure that can develop a strategy to address health equity?</td>
<td>Are we addressing community-wide SDOH and their root causes?</td>
<td>Do we collect quantitative and qualitative patient data to improve care and support identification of disparities at the population level?</td>
<td>Do we analyze our data to identify health disparities in our patient population?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goals</th>
<th>Staff training</th>
<th>Holistic care</th>
<th>Workforce diversity, equity, and inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do we set measurable goals for reducing disparities?</td>
<td>Do we provide comprehensive skill-building training for our staff?</td>
<td>Do we provide culturally sensitive care to every patient who enters our system?</td>
<td>Do we employ people from our community and build a workforce and organizational culture that reflects our patient population?</td>
</tr>
</tbody>
</table>

Source: “Maturity Model for Reducing Health Disparities,” Advisory Board.
Partnerships can help health equity efforts find footing

Common cancer program challenges with developing and implementing a comprehensive health equity strategy, and sample ways partnerships can help

**Insufficient data**
Partners can supply relevant data and support analysis to identify population-level disparities

**Limited resources**
Partners can provide funding, staff, or other resources to help address community-wide SDOH and their root causes

**Lack of expertise**
Partners can provide insight into community needs, skill-building training for staff, and guidance on how to foster an inclusive organizational culture

**Lack of executive support**
Partners can help cancer programs build a business case for making health equity a strategic priority
Northwestern partners to address health equity challenges

Lurie Cancer Center at Northwestern Memorial Hospital’s approach to address SDOH in community

<table>
<thead>
<tr>
<th>Step 1: Identify neighborhoods with differential outcomes to target</th>
<th>Step 2: Build infrastructure of the Chicago Cancer Initiative (CCI)</th>
<th>Step 3: Understand and prioritize community needs</th>
<th>Step 4: Implement interventions to address highest-priority community needs</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Challenge:</strong> Insufficient data</td>
<td><strong>Challenge:</strong> Limited resources, lack of expertise</td>
<td><strong>Challenge:</strong> Lack of expertise, insufficient data</td>
<td><strong>Challenge:</strong> Limited resources, lack of expertise</td>
</tr>
<tr>
<td><strong>Partners:</strong> No formal partnerships, but relied on publicly available data from many external organizations</td>
<td><strong>Partners:</strong> Pharmaceutical companies, advocacy groups, philanthropic foundations, community organizations, city and state public health departments</td>
<td><strong>Partners:</strong> Community organizations, private sector</td>
<td><strong>Partners:</strong> Community organizations, advocacy groups, schools, health system, local providers</td>
</tr>
</tbody>
</table>

Source: Northwestern Medicine, Chicago, IL
CCI gets off the ground through diverse partnerships

Types of partnerships leveraged to build CCI infrastructure

**Funding**
*Partners provide one-time and ongoing financial support:*
- Pharmaceutical and biotech companies (e.g., Genentech)
- Philanthropic and research foundations (e.g., Pritzker Foundation)

**Non-financial resources**
*Partners provide space for events, access to resources and networks, and connections to community:*
- Community organizations
- Advocacy groups (e.g., Susan G. Komen Chicago)

**Strategic guidance**
*Partners serve on CCI governance board:*
- Apostolic Faith Church
- Chicago Department of Public Health
- FQHC¹ with two locations in Bronzeville
- Mixed-income residential complex in Bronzeville

**KEY STRATEGIES FOR PITCHING THE PARTNERSHIP**
- Focused on the high-level vision for a meaningful and sustainable impact on the community
- Established CCI as a separate entity from the Lurie Cancer Center to allow industry partners to help fund the program
- Dissociated Northwestern’s name from the initiative to demonstrate intentional focus on the community not the hospital

¹ Federally qualified health center.

Source: Northwestern Medicine, Chicago, IL
Considerations for partnering to prioritize health equity

**QUESTIONS TO ASK YOURSELF**

01. Where are our biggest strengths and gaps across the eight dimensions of a comprehensive health equity strategy?

02. Which of the common challenges developing and implementing a comprehensive health equity strategy are most acute for our program?

03. Which partners can best help us overcome our top challenges?

04. Who will be responsible for coordinating with partners?

**POTENTIAL PARTNERS**

- Advocacy groups
- Community organizations (e.g., businesses, faith-based orgs, social service orgs)
- Device manufacturers/IT vendors
- Federal and local government agencies
- Other cancer centers
- Pharmaceutical companies
- Philanthropic organizations
- Public health departments
- Universities/Medical schools
- Internal health system stakeholders, such as:
  - Data analytics team, other service lines, population health department
Leverage partnerships to respond to major market forces

Current state of cancer care

Ideal state of cancer care: Affordable, Personalized, Equitable

Market forces driving industry transformation:
1. Increasing purchaser focus on controlling costs
2. Accelerating pace of clinical innovation
3. Growing pressure to prioritize health equity

In today’s interconnected world, an institution’s survival can hinge on its ability to develop, refine, and manage partnerships.

Got questions? Send them in.

How to ask a question

To ask the presenter, please type your question into the “Questions” box on your GoTo panel and press send.

Minimizing and maximizing your screen

Use the orange and white arrow to minimize and maximize your GoTo panel.
Use the blue and white square to maximize the presentation area.
Has your organization recently implemented an innovative strategy to improve cancer screening? If so, submit it to potentially be featured in the Oncology Roundtable’s first-ever Cancer Screening Innovation Showcase.
Webinar survey

Please take a minute to provide your thoughts on today's presentation.

Thank you!

Please note that the survey does not apply to webconferences viewed on demand.