Episode 23 – Democratizing access to cancer care with AccessHope

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HARLAN LEVINE: Every person with cancer reacts to it differently. Every person with a family member, and I don't mean just an immediate family member, any family member with cancer is touched, impacted and distracted by cancer.

SPEAKER: Welcome to The Cure for the Common Company, a podcast series looking at innovations in the world of employee health and wellbeing. Steve Blumenfield and other experts from Willis Towers Watson's health and benefits practice are talking to entrepreneurs and industry leaders who break ground to meet the needs of today's workforce and deliver benefit solutions that can separate employers from the pack.

STEVE BLUMENFIELD: Harlan, welcome.

HARLAN LEVINE: Hi, Steve. Good to be here.

STEVE BLUMENFIELD: Ron, great to see you.

RON FONTANETTA: Steve, thanks for having me.

STEVE BLUMENFIELD: And welcome, everybody, to The Cure for the Common Co podcast. I'm your host, Steve Blumenfield, from Willis Towers Watson, the Head of Strategy and Innovation for Health and Benefits Business in North America. And I'm joined today by the phenomenal Dr. Harlan Levine, who is one of the founders and the current executive chair of AccessHope, a wholly owned subsidiary of City of Hope. Welcome, again, Harlan.

HARLAN LEVINE: Thanks, Steve. It's great to be here. Thanks for having me.

STEVE BLUMENFIELD: Yeah, love having you here. Thanks so much for being here. And welcome also to Ron Fontanetta. Ron is a brilliant colleague, a thought leader with a passion for and deep experience in the oncology space. And he's worked with Harlan on the cancer topic for many large employers. Ron, welcome again, and thanks.

RON FONTANETTA: Thank you, Steve.

STEVE BLUMENFIELD: All right. So Harlan, we all know that cancer care is highly variable. Cancer itself is highly variable. And the experience that members have and their families have can be variable. And if we were to boil it down to its highest level, just tell me if I've got this about in the ballpark, AccessHope is bringing preeminent cancer care expertise and outcomes to members wherever they may be by coaching the oncologists directly. Is that about right? And if so, can you just tell us a little bit about why and how AccessHope started?

HARLAN LEVINE: Steve, I think you have it right. We do focus a lot on that connection with the treating oncologists, but we also have a program for the cancer member and their family as well. But your question about why we started, I think, is really important in understanding what the program is all about.

The history of City of Hope is actually very rich. We came into being over 100 years ago and we started as just two tents with the mission of helping people who were dying of tuberculosis and dying in the streets. And we thought they needed a place for comfort, care and, quite frankly, to die in dignity. Over the ensuing decades, we've become a leading National Cancer Institute Comprehensive Cancer Center. But the original mission to help people remained consistent. So today our mission has evolved. We want to cure cancer, and we want to improve the outcomes of all cancer patients.

STEVE BLUMENFIELD: That's just beautiful. I mean, to hear such a clear mission against the scourge of our times is just, it's a wonderful thing to hear from an organization.

HARLAN LEVINE: Well, thanks. We take great pride in that. And over the decades, we've actually impacted millions of people through our drug discovery. Our laboratories have discovered the pathway to creating synthetic human insulin, which has changed the world for diabetics. And we've also developed drugs for cancer, the pathway that led to monoclonal antibodies, which are commonly used drugs that people know, like Avastin and Herceptin.

And more recently, we've been involved in licensing our intellectual property in the newest form of cancer treatment in immuno-oncology and cell-based oncology, for example, CAR T-cell therapy. But we asked ourselves about 8, 10 years ago, how can we impact more people in our services as well? So we moved from one site to about 30 sites.

STEVE BLUMENFIELD: Really?

HARLAN LEVINE: Yeah, over the last 8 to 10 years. All in Southern California though. And as most of your audience knows, we're a Center of Excellence. So people can come to us as a Center of Excellence for cancer care, but we know that's not practical for many. So we asked ourselves, how can we take what we do well here at the campus and disseminate it across the country? So our idea was to democratize access to great and leading edge cancer information. And from that notion, AccessHope was born.

STEVE BLUMENFIELD: Nice. Fantastic. So let me just lay out what we often share with our clients, because I think you hinted at this. That when they're thinking about the cancer journey of their members and the care they want to give, they think about essentially four stages. I'm sure there's many more stages. But we break it down into the screening stage, helping get the right people screened and the right type of care for where they are in their diagnosis or pre-diagnosis. The actual diagnosis is the second stage. The third, intervention and treatment support. And the last, in recovery and surveillance.

Roughly those four categories. And we've seen a lot of vendors pop up that focus on some of those areas, like second opinion services to help with that diagnosis or consumer care services or apps that may help put a nurse in your pocket, that type of thing. We've had one of them on the podcast, Helpsy, before. So where do you play in AccessHope relative to that space?

HARLAN LEVINE: So, Steve, we focus on the second and the third, which is the diagnosis and the treatment. But we're also giving advice as the patients move into the fourth stage, which is either recovery or end of life. As we've developed deep partnerships with our employers, we have become advisory in the screening and early detection of cancer.

RON FONTANETTA: So Harlan, the mission is admirable at a time when these issues have become paramount. Our clients are seeing this dramatically in their claims data. The insights about the high variability in quality are coming to the fore. What is your biggest challenge in reaching a large cadre of employees who may be scattered geographically, may come from all sorts of income groups? What are some of the practical lessons that you have learned in terms of expanding your reach to assure that world-class care is reaching the fingertips of anybody that works for an employee, regardless of where they live, their income or their occupation?

HARLAN LEVINE: So I think the opportunity there is to understand three important notions. Number one, for a program to have the reach that you want it to have, it has to be oriented around the patient journey and can't be designed around the hospital view or the health plan view. The second one is to recognize the problem that you're trying to solve, which is that there's a knowledge gap that's created, quite frankly, by how complex and specialized cancer is becoming and how rapidly those changes are happening, largely driven by precision medicine.

And then the third one is, you have to pick a customer. And we chose the employer because we think they represent the segment of the health-care continuum that cares not only about affordability but also about the patient experience, the quality and the outcome. So we designed a program around those three.

So the challenge that the industry finds, particularly when you talk about second-opinion programs, are that you often don't get to the right patients and you get to them too late. So we've designed our program to be able to identify the most complex patients, and we've designed our program to actually work with the health plan as part of health operations so we can intervene early with the right patients and target the patients that are going to be the most complex and have the greatest variability.

STEVE BLUMENFIELD: So what does that mean, Harlan? If I'm an employer and I'm trying to AccessHope on behalf of my people, how do I do that and what is the experience like for me and what is the experience like for my members, for the people I employ and their families?

HARLAN LEVINE: Steve, as I mentioned, we designed this to be incredibly easy for the employer to implement. And what I mean by that is that we work with the existing programs like the TPAs and other health management programs they may have in place. So that's number one.

Number two, we offer three programs, and each of them has a unique feature to them that addresses different problems for the employer. So the signature program is called accountable precision oncology. And at the highest level, what it does is identifies the top 20% of the most complex cancers and identifies them through pre-certification, claims, partnerships with the PBMs, the Pharmacy Benefit Managers, and without the patient having to lift a finger, we collect the information, analyze the case, and then a subspecialist from an NCI-designated cancer center will reach out directly to the treating doctor and see where they can help.

And the secret sauce to that is that it's a collaborative discussion. It's longitudinal, meaning we're there to support over the course of therapy, because cancer is becoming a chronic illness. Our expertise is based on a full-faculty approach. So if it needs a multidisciplinary approach of a surgeon and a radiation therapist, we're able to bring that to the front. And what's particularly nice about that program is that because it's focusing on the highest risk patients, these are the type of patients that many doctors will want assistance in. These are hard cases.

And this is not to say that the community doctor's not doing a good job. But when you have a life threatening illness and the best science is rapidly changing, these doctors are going to have to do a lot of research or refer to an academic center or, quite frankly, worry that they're not doing the best for the patient. And we become like a little tumor board sitting in their ear helping them deliver the care. We're not moving the patient away from the doctor. We're there to support the physician.

So the member gets the best of both worlds. They get the community oncologists. They get to seek and receive care in their community with their family support. But they get the expertise of a National Cancer Institute Comprehensive Cancer Center expert.

RON FONTANETTA: Steve, to underscore the financial dynamic that many of our clients are observing, complex care costs now account for about 1/3 of overall health care spend for the average US employer. And most employers are seeing a variety of cases emerge in that spectrum. Neonatal care, spine care, complex cardiac care, and a host of esoteric diseases to name a few. But by far the number one driver of the precipitous increase in complex care trend is driven by cancer. For many of our clients, we're seeing as much as 40% of their complex care spend being attributable to cancer. Harlan, what would you describe as some of the phenomena that are driving this financial dynamic?

HARLAN LEVINE: Well, what's driving a lot of the trend is the rapidity with which new targeted therapies coming out and the cost of those therapies. If you look across the country, the overall average spend is between 12% and 14%. But the trend is accelerating, and it's headed towards 15%. And specifically, I would suggest that precision medicine, the genomic testing of a cancer, adds a small amount to that, but it makes your treatment that much more targeted and more likely to be effective.

The cost is being driven by the fact that in the past, chemotherapy drugs cost $8,000, $12,000, maybe up to $25,000 or $40,000. But the newer immuno-oncology drugs can cost over $100,000, several hundred thousand dollars, and CAR T-cell therapy, the cells alone will run you $400,000, and the overall treatment can be up to a million. So clearly when you have a case that requires immuno-oncology or CAR T-cell therapy, the cost profile is going to be very different from what was offered just 10 years ago.

RON FONTANETTA: Harlan, you and I have had a chance to work together on several clients, and I know there are some practical operational and execution challenges whenever any employer brings in another partner. And so for employers that are considering the logic of bringing in the level of expertise that you're describing, what advice would you have for them about how we work with other partners in their ecosystem? Health plans, PBMs, disability vendors, et cetera.

HARLAN LEVINE: Yeah, I would start with two perspectives. Number one, the focus and the center, the true north, if you will, has to be the member or the cancer patient going through the journey. So what one wants to do is make sure that the interventions are coordinated and helpful and high value and not creating more disruption for the member. So I would look to the patient experience and then make sure that there's a seamlessness to what you do offer.

The second one is, and all of our customers and partners feel this way, is you have to look at the big picture and understand how to define value. And I know that oftentimes the discussion starts with price. And it should be. Affordability is a key driver. But let me make a few comments about why cancer is different.

So first of all, I think if you're the patient, and the good news is most employers, they look at value as not just price, but they take into account the overall outcome of the patient experience. I think the second issue that an employer should look at is a lot of the traditional methods to control the cost of care just don't work in cancer. Let me give you two or three quick examples. Oftentimes in therapy of high blood pressure or diabetes, and I'm an internist. That's what I did when I practiced medicine.

Step therapy makes a lot of sense. You start with the most cost-effective drug and it doesn't work, you move on to the next one. In cancer therapy, oftentimes your best chance of cure is your first chance of cure. And you want to lead with the best drug. And then secondly, if you lead with the suboptimal drug, you really are delivering low-value care, because it's less likely to work, it's still very expensive, and here's the most important thing to remember: The patient's immune system works better when they're healthy. So the longer you wait to give these targeted therapies, the less effective they're going to be. So you really want to intervene early with the right medication.

STEVE BLUMENFIELD: So Harlan, does that mean for a typical employer, they're going to see, let's say, an increase in a certain item but a decrease overall? Or is it going to be an increase in care? I mean, to put aside the actual survivability, which that's important too, let's hit that next, but what's the difference that the employer will see by virtue of going through that approach you just mentioned?

HARLAN LEVINE: So on a given patient, we're going to do the right thing to get the best outcome for a given patient. Our experience, and we've been up and running for over two years now and over 42 employers and over two million covered lives, our experience is consistently that we're delivering a 3-to-1 return. And where that return comes from is that there's a lot of misuse of treatments and overuse of treatments. And we're able to guide therapy to be more appropriate and more efficient. And that more than offsets the times that we recommend a more expensive therapy.

STEVE BLUMENFIELD: Yeah, so that's really, really critical. And I know, Ron, you're going to jump in here, but I just want to restate what you just said about the value here of starting with the most likely to be effective approach as opposed to the traditional step-therapy approach for other conditions, that it saves

money, it saves heartache, it has a better chance of survival and success for the member and is the right thing to do. That's just the makings of a great solution.

HARLAN LEVINE: It's also a productivity issue for the employer. I mean, the patient may get better faster and return to work. But also just even if it's the employee's family member, just knowing that they have the support. They don't have to go across the country or make many phone calls to find expert care. Knowing they have a built-in expert working behind the scenes to support their doctor often reduces a lot of stress and allows people to be more focused when they do go to work.

RON FONTANETTA: Harlan, I wonder if you could comment on outcomes we're seeing. I know when you and I both have jointly pursued conversations with employers, they were surprised at the amount of disquality or at least uneven quality and outcome results when we present national data. And a significant premise for a focus on cancer strategy generally and your program specifically is the recognition that too often when care gets really difficult and diagnoses are complex, we don't always get it right. Do you have any statistics that you could share with us in terms of what you're finding through your review process?

HARLAN LEVINE: Ron, it's a really good question, and let me address this. So in publications, you can see a up to 20% difference in five-year survival based on the site of care as you move from a nonacademic into an academic into a NCI center into a dedicated cancer center like a City of Hope is.

STEVE BLUMENFIELD: Five-year difference? That's what you just said?

HARLAN LEVINE: 20% in five-year survival.

STEVE BLUMENFIELD: 20% increase in five-year survival rate. That's just amazing. OK.

HARLAN LEVINE: Right. But the problem -- and actually, I want to be clear -- this is not a repudiation of the community oncologist at all; they're well trained, they offer benefits to the overall care of the patient and the family that, quite frankly, an academic center may or may not be able to deliver. Disrupting and having someone travel and removing them from their support system is never a good thing for a cancer patient.

But I do want to make the point that the field is changing so rapidly that it's very hard for an oncologist seeing 20, 30 patients a day and seeing all sorts of cancers, it's very hard for them to remain the expert in colon cancer, the expert in stomach cancer. And then it gets even harder for rare cancers. So that's why we like the combination of the one plus one where you still have the community doctor and then you get the support of the NCI center.

Having said that, let me go back to Ron's question, because it's a really important social issue. We also know that survival and outcomes vary tremendously by demographics and zip code. And there's huge disparities in health care when it comes to underserved and minority populations. And I mean, quite frankly, it should be an embarrassment, and it's a tragedy, a travesty of our society that we allow these disparities in health care to both exist and persist.

So we think of this program that provides NCI-level support and subspecialized support to everybody as the great equalizer as we democratize access to this care. We know everyone can't travel; either they can't afford it or logistically it doesn't work out. So this model focuses on bringing that care directly to the community, directly in partnership with the community oncologists so everyone can get access to that level of insight. And then Ron closed that statistical gap that you were asking about and improve survival and outcomes for everybody.

STEVE BLUMENFIELD: So enabling that local community oncologist to play not just to the top of their license but with the best practices of the top licenses at this specific cancer that they're facing.

HARLAN LEVINE: That's exactly right. And what makes cancer so amenable to this is that the training of the oncologist is through tumor boards and community support. I mean, they're used to seeking out expertise when they need it. And what we do is we just make it easy for the oncologist by proactively reaching out to

them. The patient gets the best of both worlds, and our experience is that the physicians have loved this. We get multiple phone calls from physicians over the course of therapy. When things change, they seek advice. We like to think that we're more accessible than the local university. We also don't threaten to take the patient away. So we're a safe place.

STEVE BLUMENFIELD: Let's talk about that, Harlan, because the rub that certain second opinion-type of programs, which is one of the categories I talked about and we talked about those four categories of the cancer journey that we observe at a high level, when you just have a second opinion step in, at times it can seem almost competitive with the doctor -- not that it should be and not that all doctors would see it that way. But if some of those services work with the member and the member brings it in and you may lose some of that peer-to-peer relationship. What is it about the way AccessHope approaches the relationship with the oncologist that makes them want to learn, want to care? What's that secret sauce?

HARLAN LEVINE: Yeah, that's a great question, because that is among the key differentiators. So first of all, in the program we've discussed so far, accountable precision oncology, we're targeting the most complex cases. So these are cases where the physician already has an academic interest and a personal interest to have exposure to the most leading-edge science. And we bring it to them.

The second part is, and in the reality that's not understood by many, is you can only get so much out of reading a chart. There's so much nuance in actually talking to the doctor that knows the patient and knows the details. So we don't go in there with the attitude of "thou shalt" or "we know better." But rather, we go in there to have a collegial discussion. And we have these, by the way, with community doctors. We also have these with the leading -- with doctors at the leading cancer institutions in the country. So these are not competitive. We're not telling the doctor what to do. And what we find is we're having a tumor board-like exchange of information.

And then I think the third distinguishing feature is we know that cancer is not a one-and-done, that the journey changes over time, and we're there to support the journey throughout. And I'm not implying that the majority of doctors call us five, six times on the same patient. But we do see that. The average is probably one call, but a lot are two to three calls as information comes in.

One specific area that we offer a lot of support is around genomic medicine. There's a lot of data out there that suggests that doctors will self report that four out of five don't feel completely comfortable with interpreting the results of a genomic test.

STEVE BLUMENFIELD: Interesting.

HARLAN LEVINE: So when those tests are done, getting an expert in genomics and in that cancer type can be really helpful in helping the local oncologist decide which treatment is most appropriate. And if you're the employer, think about this: You can misinterpret. Let's say two or three mutations show up on a genetic test and you use a $250,000 drug to target the non-important mutation. You've just delivered low-value care that's pretty expensive for the employer. So that's where the real value hits is when the care gets really complicated, we're able to jump in and help sort out the key clinical questions.

STEVE BLUMENFIELD: And given the proliferation of genetic testing and vendors that have gone direct to employers and used the oncology example, that just really, really hits home.

RON FONTANETTA: Harlan, one other dimension that employers are struggling with contemplates screening strategy. And there has been a whole industry that has grown up around this. Some of it driven by at-home screening capability. Arguably, there is an emerging group of biotech leaders that are looking at early detection capabilities through blood screening. And then to the point that you alluded to, a whole industry that's grown up around genetic screening. I wonder if you could spend a moment talking about how employers should contemplate and view their screening strategies to augment or support some of the efforts that you and City of Hope are performing in terms of more direct care.

HARLAN LEVINE: So let me answer that in -- it's hard when you're being recorded whether it's going to be three categories or four categories.

STEVE BLUMENFIELD: "Several" is always a safe answer, Harlan.

HARLAN LEVINE: Several categories. As I get older, that's more important, by the way, to not try to anticipate how many. So I think there are several, Steve ... well said ... several categories for how to do this.

There's the testing. And I'll focus first on the home testing, Ron. The testing that might fall into the recreational or the "of-interest" category. And in fact, there was a publication in one of the lay journals this week in early February describing how the predictive value and sensitivity of these recreational tests is actually quite low for cancer and you have to be careful and it could be misleading to think that your risk is low because you had a negative test. But in fact, for example, on BRCA1, some of those home testing ones are only testing for a small fraction of those variants. So you can miss them. So the tests are fun. They're informative. But you should not rely on those types of tests for real screening for cancer. So that's one category.

The second category would be a laboratory like a Fulgent that does home screening for risk. But they use a different technique of next-generation sequencing, and they're much more scientifically precise. And it gives you more precise information about your risk of cardiac or cancer disease. So that would be the next step, I would say.

And then you have the first-of-its-kind actual cancer detection home test, which is Cologuard. And I do want to just make a comment that we've licensed two pieces of technology. Actually, we've sold a company and licensed technology to Cologuard's owner, Exact Sciences. But we have nothing to do with Cologuard. But I just want to mention Cologuard is really the first. And for the right population, it has its role and is effective at detecting colon cancer at home that you can send in. So that's a third category, and I suspect you'll see more of those for things like kidney, bladder and prostate cancer over time.

And then the fourth category, Ron, is the one you alluded to, which is the early detection of cancer. And you see a couple leaders emerging in that field. I believe with Exact Sciences being one with Thrive and GRAIL being another. I think you'll see more and more emergence of those detection, detecting cancer before you know you have cancer by doing a blood test. The literature is looking very good. There's some published studies that suggest it can be effective.

But it's early. And I think from an employer point of view, they'll need to decide how early and how leading-edge they want to be. I know from being in the industry several employers are looking at this already and others are waiting for more data and for it to really become more common practice before they jump in. But I think that's more of a choice on the employer part and part of their culture about how much they like to push the envelope and how much they like being on the leading edge of science.

STEVE BLUMENFIELD: Amazing detail there, Harlan. And clearly you can go really, really deep, and this is a topic that deserves that type of depth. Let's pull this back for the member experience that we've been talking about earlier on. How does a member access this if they want to do it themselves and what does that look like?

HARLAN LEVINE: Steve, that's a really good question, because when we started off, we focused on ROI and we created algorithms that allow us to identify the most complex cases. And that's what we heard about so far. But it was the employers themselves that actually pulled us in to a broader view, and they said, "That's great for the top 20% of the cancer patients. But we want to have programs for the other 80%. So what can you do?"

So that led us to do two things. So one is we created an opt-in program for anyone with cancer or any covered member with cancer can just choose to get a second opinion. It sounds like the other programs out there, but I again want to highlight that even in the opt-in program, our focus is multidisciplinary, the full faculty can look at a complex case and we still focus on the treating doctor.

To your point earlier, Steve, these complex issues, we don't believe a patient can negotiate with their treating doctor to say, "Some remote doctor feels A and you're recommending B." This is the most stressful

time of their lives so we still will focus on that relationship with the treating doctor. But of course, the member will trigger it and get the report.

But the third program is entirely different. It is more about the journey. What we recognize is that every person with cancer reacts to it differently. Every person with a family member, and I don't mean just an immediate family member, any family member with cancer is touched, impacted and distracted by cancer. So we've created what we call the cancer support line, which is a team of oncology-trained nurses that are there to support the journey of cancer. Not to give advice on which treatment, but the journey.

And I can't tell you the impact we have on people. It ranges from everything from, "What does it mean to be in a clinical trial? Am I a guinea pig?" to "I have two children about to start chemotherapy. What do I need to do to get prepared?" And honestly, patients don't feel comfortable in the room asking their doctor, "What is radiation therapy? Am I going to glow?" So we get all sorts of questions like that that we really can help with the journey. And when you do the quality-control recordings and listen to the impact you have at a personal level, it's really incredibly moving what we can do for patients.

STEVE BLUMENFIELD: Nice. Nice adds. That sounds like what you've learned from employers, they can always count on that. You have a wonderful idea. You want to make the world better, literally in this case. And then you go to your customer and they say, "Here's how to make it even better for my people."

HARLAN LEVINE: We've seen employers step up in ways that would make the employer community proud. There's one employer that has actually encouraged the managers at their worksites to identify their employees that have cancer and encourage them to call our cancer support line to start the journey. And then from there, they can learn about second-opinion programs or other things. And not only that we offer, but we know what the employer offers in their other programs, whether it's EAP or other support programs. So we're able to connect them to all their needs. But to have direction to the supervisors to look out for their employees with cancer, it was remarkable and heartwarming.

STEVE BLUMENFIELD: This is just such a unique case. Cancer is just one of those things where the community still -- everybody just wants to reach out and help. And it's wonderful to see employers responding in that way.

HARLAN LEVINE: We look at them, the employers, not as customers, but as partners. And we look at their data and we see where the opportunities are. We are also aware of do they have an academic center in the community? In which case, we try to work with them. And for complex cancers, we can offer advice on where might be a good place to have a complex surgery performed or get -- one of the things we really we focus on, which was initially scary in the industry five years ago and 10 years ago but much less so now, is clinical research.

In fact, if I could take a moment, I'd love to talk about the change in the perspective of employers about clinical research. For years, and I've been in the health management business for over 20 years, for years it was kind of a third rail to either talk about cancer or suggest a clinical trial. But now if you think about it, people talk about guideline-based medicine, which is great and has its important role.

But what if the guidelines say you have 8% survival in three years or 10 years? Like metastatic colon cancer or metastatic -- or a few years ago, metastatic lung cancer. Sometimes people want more than just the guidelines. And you don't want to be irresponsible and just try things that are anecdotal. So what we can do is look for curated clinical trials at appropriate centers that can offer real opportunity for an improved outcome for a patient.

And one of the reasons why this is very different now is that standard therapy can cost $200,000, as we mentioned before. Putting someone on a trial is often subsidized. So it's not even a big investment on the part of the employer. They're not doing it to save money, but there's an opportunity to defray costs by putting people on a clinical trial.

I think understanding the impact of that is important. If you go back 10 years, maybe even a little bit less, the average survival of certain metastatic lung cancers was nine months and now it's 89 months.

STEVE BLUMENFIELD: Wow. Wow.

HARLAN LEVINE: And those drugs that are now standard of care were all part of clinical trials five, six years ago.

STEVE BLUMENFIELD: That's amazing.

HARLAN LEVINE: Wouldn't you want your employees to have access to those? Not be forced into a trial, but at least be given the choice.

STEVE BLUMENFIELD: The opportunity.

HARLAN LEVINE: The opportunity. So we talk to the physician that oftentimes doesn't have time to go tracking where the clinical trials are. We talk to the physician and ask, do these seem appropriate for your patient? And again, in partnership, we'll then make that information known to the treating oncologist. And the oncologist and patient can then decide if it's the right thing for the patient.

RON FONTANETTA: Steve, I will offer that one of the key tenets that we are seeing among employers in the marketplace is a resounding and explicit commitment to employee wellbeing. And many employers are looking at ways of standing out and having thoughtful wellbeing programs that are visible and actionable and impactful reinforce their broader brand, both externally and internally for their employers.

And I think as we discuss the topic of cancer care, specifically in complex care more broadly, what I would offer is that this is an incredible opportunity to stand out with a wellbeing proposition that is not commonplace today, even though its uptake is certainly growing, is highly differentiating in terms of its impact and its visibility. And when employers go back and review their own internal data sets and appreciate and realize how significant this plays both qualitatively and quantitatively into their health care experience, it represents, we would argue, a breakthrough moment in a wellbeing strategy and delivery in ways that are really unique today and hopefully become more commonplace, but go above and beyond the way we've looked at physical wellbeing historically.

STEVE BLUMENFIELD: Yeah, Ron, you're absolutely right. Wellbeing is such an enormous area. And you've got the opportunity now to really make an enormous impact on the member, on the member's family, their wellbeing, their emotional wellbeing in addition to their physical wellbeing, extend their lives, and do this and actually save money. It's just such an important topic.

So at the time of this recording, Harlan, Ron, we're still in the heart of the pandemic, and many people just have not sought out the care. And we've heard some terrible stories, some heartbreaking stories about people not getting the cancer care they need for fear of going out or because they legitimately had concerns or the doctors had concerns and weren't even accessible. So how has this affected the way that patients and employers have used AccessHope or how has it impacted what you're seeing? What's been the experience?

HARLAN LEVINE: Well, in terms of using AccessHope, the idea that you can get expert care without having to travel has been a boon for the employee. So the timing of our launch two years ago could not have been more well placed. And we're seeing a lot more remote care. So this is very consistent with what we're seeing with health care overall. So that's been a huge plus from an AccessHope point of view.

But more important than what's good for AccessHope is our grave concern about what's happening in cancer. And it falls into two categories. Category one is, as you mentioned, Steve, the delay in diagnosis. And we're even seeing the delay in treatment once diagnosed. So we as an organization, particularly as the hospitals have become safer or at least more knowledgeable about how to protect cancer patients, we really need to connect with these members, whether through cancer support line or through these expert opinions, and make sure that patients are getting their necessary cancer treatment.

And for those at high risk in particular, that they're getting their screening. There's a lot of publications out there about how we're going to see more advanced cancer over the next five years, which again, will lead to more need for AccessHope services. But that's nothing we really look forward to, to be candid.

The other issue, which is a more complex issue, it is clearly demonstrated now that cancer patients die from COVID at a much higher rate. And that has to do with their impaired immune system. So we really need to make sure that cancer patients during treatment are not afraid to seek out care when they have early symptoms of COVID. They must get care because they're going to do worse than patients with -- significantly worse, by the way, than patients without cancer.

RON FONTANETTA: Steve, just a quick data point. From looking at some of our employer data over the last year, we have seen, as might be predicted, a precipitous decline in screening rates, order of magnitude about 30%. And it does beg the importance as we think about a cancer strategy how to respond to those delayed screenings.

One of the reasons why a rethink about what might be practical and for which types of screenings at home as one answer, but the other is as we come out of the pandemic and we get more regular access, there is an urgency, I'd argue, on the part of employers just to regroup and restate the opportunities that they provide as sponsors for screening capabilities and argues, as Harlan suggests, likely more of an urgency to connect with world-class care if, in fact, we find an increase in later stage or more complex cancers that require the kind of expertise that Harlan has described for us today.

HARLAN LEVINE: Ron, I could not agree with you more. I'm so worried. Employers have spent the last 20 years, as far as I can tell, increasing the uptake of screening through their programs. And I'm afraid this interruption is going to be a setback and kind of a do-over. And to some extent, we should take advantage of that do-over. One of the things that the COVID experience has shown is that there's huge disparities based on race and culture.

And maybe we can learn from this that as we start to do what you said, Ron, to encourage people getting their screening is to understand the importance of culturally sensitive language in doing that. Because we see dramatically different rates of screening by race and culture. And perhaps we can even do a better job after this reset and focus on the type of language and the type of messaging we use. Because we now are all so aware that these differences translate into life-and-death outcomes.

RON FONTANETTA: So Harlan, I know, as you've described, there's a long, rich history of what your organization has done and what it's stood for in terms of not only technical expertise but its commitment to those that don't have ready access to this kind of world-class care. It would be helpful to restate what the vision is today, what, if anything, has evolved as you rolled these programs out in recent years, and how do you think that will evolve in the coming years given your predictions of the future?

HARLAN LEVINE: Thanks, Ron. Our big vision here is that AccessHope becomes the business chassis that connects the country's oncologists to the cancer expertise when needed. I mean, that's sort of the big vision. We started with City of Hope as the first set of experts, but we plan to carefully build a federated network of other NCI centers to join us.

AccessHope members as of today can benefit from the expertise of Northwestern Medicine and the Robert H. Lurie Comprehensive Cancer Center of Northwestern University, which was the first organization to join with City of Hope in helping us partner to achieve this vision. I mean, they've be great to work with, because they share the same commitment we do to really improving care across the country. We're in discussions with other NCI centers in different regions of the country. But to be clear, we already provide national coverage. Our employees are practically in every state across the country today.

And I guess to extend that vision a little bit, we started with employers because we believe, quite frankly, they're the ones that get it. They understand that it's not just about price. It's about value, outcome, patient experience. But we've already been noticed by one large and are engaged with one large regional health plan and engaged with the Health Care Transformation Alliance. And combined, those have about 10 million more members.

STEVE BLUMENFIELD: Well, let's think about where AccessHope might be. Let's say it's five years from now, Harlan, and AccessHope has been wildly successful against the vision that you spoke about earlier. And you're reading your favorite periodical. What do you think that headline would say?

HARLAN LEVINE: I love that question. If this were a human interest article in Atlantic Monthly, I'd love to hear about how AccessHope, working with great centers like City of Hope and Northwestern Medicine, eliminated health care disparities or how we provided the most important employee benefits since the paycheck. That would be a--

STEVE BLUMENFIELD: That would be a long headline.

HARLAN LEVINE: Well, that would be the lead-in to the story. But yeah, that's a long headline. But if you looked at a more traditional business journal like Wall Street Journal, I'd want it to say that AccessHope transformed how cancer patients received care.

STEVE BLUMENFIELD: Outstanding. Both outstanding. In AccessHope's work with oncologists and in some of the products with the patients directly, is there anything you've learned from patients themselves that has been surprising or inspiring or insightful in some way?

HARLAN LEVINE: Well, the patient stories have been the most inspiring part of the whole experience. And they range from everything from a patient about to get a bone marrow transplant who after our review it became clear that they had a rare form of their sarcoma. And with that genetic subtype, eight patients had gotten a bone marrow transplant and all eight had died within a year.

STEVE BLUMENFIELD: Oh my gosh.

HARLAN LEVINE: And to be able to work -- and this was an insightful physician and insightful patient. And to be able to work in collaboration as we brought in multiple experts to review the literature, you just realize that people have this incredible ability to absorb information and make decisions. So that's one type of very clinical story.

But the other stories that we hear are just the heroism of patients as they fight through the journey and their commitment to either still take care of their family members or still perform at work. It's inspiring to our entire team to be able to hear those stories and to be part of their journey in a very supportive way.

STEVE BLUMENFIELD: That's a gift for you and your people as well. Well, you mentioned heroes, and here's one of those more esoteric questions, Harlan, that boy, it's almost awkward to ask on a podcast about cancer. But nonetheless, if AccessHope were a hero or mythological creature of some sort, what would it be?

HARLAN LEVINE: Well, so Steve, I have to have a good answer to this, because my father is a Greek and Latin scholar and professor. So I can feel that he'd roll over in his grave if I didn't have an answer to this one. I think given what we do, I would say Athena, who is the goddess of intelligence and wisdom and helper of heroes on their quest. And we talked about the patient journey. It's a quest. And we see ourselves as playing that role of helping them be the heroes through adding our wisdom and our experience.

STEVE BLUMENFIELD: Very nice. Very nice, thoughtful response and very nice response too. Well, with that, I want to thank you, Harlan. Just outstanding insight, and so glad that AccessHope and City of Hope exist. Thanks so much for joining us and lending your insights to our audience.

HARLAN LEVINE: Well, thanks for having me here today. It's fun to talk about it. It's been great to reunite with both of you.

STEVE BLUMENFIELD: Ron, always a pleasure. You are intelligent and full of the data all the time. Thanks so much for bringing that all here.

RON FONTANETTA: Thanks, Steve. I think we're all very excited about driving some real, great work here.

STEVE BLUMENFIELD: And thanks again mostly to you, our listeners, the audience of Cure for the Common Co. Thanks for joining our podcast, and we look forward to the next time.

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