POST PROCEEDINGS REPORT

Genentech Oncology Institute 2016
On May 4-5, leading oncology stakeholders joined us at Genentech’s campus in South San Francisco, California for the 2016 Genentech Oncology Institute.

This year’s program focused on the patient journey through prevention, diagnosis, treatment decisions and outcomes. The discussions ranged from a look into the physician/patient dynamic, to understanding healthcare behavioral economics, to a look into major technological disruptors driving change throughout the system.

One thing became clear, the future of care will be patient-centric—and it’s a future that is both promising and challenging. The 2016 Genentech Oncology Institute offered a unique opportunity to examine the issues together and collaborate on solutions. Genentech leads the event to demonstrate continued commitment to managed care for oncology and to help shape the future of cancer care.

**SPEAKERS:**

- **Ian T. Clark**  
  Chief Executive Officer,  
  Head of North American Commercial Operations, Genentech

- **Cliff Goodman, PhD**  
  Senior Vice President and Principal, The Lewin Group

- **Abraham Verghese, MD**  
  Senior Associate Chair, Stanford University School of Medicine

- **Yousuf Zafar, MD, MHS**  
  Associate Professor, Division of Medical Oncology, Duke Cancer Institute

- **Kevin Volpp, MD, PhD**  
  Director, Center for Health Incentives & Behavioral Economics, Leonard Davis Institute of Health Economics

- **Lynn Zonakis**  
  Principal, The Zonakis Group LLC

- **Bruce Gould, MD**  
  Medical Director, Northwest Georgia Oncology Centers

- **Nancy Vitale**  
  Vice President of Human Resources, Genentech

- **Troy Cox**  
  Senior Vice President and Officer, Genentech

- **Kimberly MacPherson, MBA, MPH**  
  Associate Director Health Management, Haas School of Business, Co-Director, Berkeley Center for Health Technology

- **Michael Kolodziej, MD**  
  National Medical Director, Oncology Solutions, Office of the Chief Medical Officer, Aetna

- **Scott St. Germain**  
  Senior Director, Strategic Pricing & Contract Management, Genentech

- **Kerin Adelson, MD**  
  Chief Quality Officer and Deputy Chief Medical Officer, Yale Cancer Center

- **Everett Neville**  
  Senior Vice President, Supply Chain, Express Scripts

- **Jim Kelly**  
  Former NFL Quarterback, Hall of Fame Inductee, Cancer Survivor

- **Roy Beveridge, MD**  
  Senior Vice President and Chief Medical Officer, Humana

- **Bruce Feinberg, DO**  
  Vice President and Chief Medical Officer, Cardinal Health Specialty Solutions

- **Diane Heditsian**  
  Founder and CEO, deClarity Life Sciences

- **Piper Su, JD**  
  Vice President, The Advisory Board Company

- **Marc Watrous**  
  Senior Vice President, Managed Care and Customer Operations, Genentech
THE MISSION OF THE GENENTECH ONCOLOGY INSTITUTE

is to engage healthcare stakeholders with the challenges they will face in the future management of cancer care through an exchange of information and forward-looking visions.

PROGRAM OVERVIEW:
The 2016 Genentech Oncology Institute followed the oncology patient journey through 4 primary “nodes”: Prevention, Diagnosis, Treatment and Outcomes. These topics were examined through the lens of today and with an eye towards the future.

PARTICIPANTS:
The conference drew over 100 managed market executives from across the US, including representatives from national and regional health plans, large employers, hospital systems, distributors, specialty pharmacy, and academic institutions, among others.
DAY ONE: From Prevention to Diagnosis

The tone for the conference was established in an opening keynote address by Dr. Abraham Verghese, who explored The New Next Healthcare Vision in cancer care through his unique, patient centered philosophy of care. His presentation first went back in time to establish the very foundation of diagnostic practice and the imperative of a personalized and “hands-on” approach to diagnosis. Dr. Verghese then brought us forward through the blinding pace of advancement and innovation, to a world that is dominated by the promise and pitfalls of big data and the potential for personalized medicine.

Continuing the discussion, Dr. Yousuf Zafar examined the Physician/Patient dynamic at the point of diagnosis. Through a powerful and engaging role-playing exercise, Dr. Zafar highlighted the complex communication demands placed on physicians as they face the prospect of delivering life-changing news. His presentation validated the need to close the gaps in physician training that leave most unprepared for this very important part of the job.

At this part of the treatment journey patients are faced with a host of confusing and frightening decisions. Dr. Kevin Volpp took a fascinating look at the patient mindset and behavioral economics. By delving into these behavioral triggers Dr. Volpp revealed the very nature of patient decision-making and how the system can evolve to help move patients towards better and more intelligent choices.

The day concluded with a panel discussion that examined: When the Diagnosis is Cancer. With the guidance of moderator Dr. Cliff Goodman, the panel examined the topics of the day and weighed in with insights and perspectives from across the oncology care landscape.

“I am obsessed with the bedside because that’s where the patient is.”

Dr. Abraham Verghese
Day two advanced the patient journey to the topics of treatment and outcomes—focusing the discussions around advances in treatment, innovation, technology and precision medicine as well as examining difficult but critical decisions in late-stage care.

The morning began with a presentation on *Disruptive Change & The Future of Oncology* with a keynote by Kimberly MacPherson. The presentation shifted the focus towards the advance of technology, wearables, limitless information and the empowered consumer. Ms. MacPherson highlighted the cascade of investment into these technologies and the need for evidence and data to begin validating their usefulness and clinical value.

This led to a panel discussion entitled: *Cancer Treatment: A Long and Winding Road*. The panel examined the disruptive trends of innovation and technology and the hot-button topic of precision medicine. Through a lively discussion, the panelists weighed the potential and shortcomings of all things “precision”, as well as examining the costs and real clinical value associated with this bold new world of medicine.

Following the panel, attendees were joined by NFL Hall of Fame Quarterback Jim Kelly. Led by Cliff Goodman, Mr. Kelly relayed his own personal journey through his cancer diagnosis, a long and difficult treatment—and ultimately an inspiring road to survival.

The day concluded with a final panel that focused on a topic that was chosen by the GOI 2016 attendees themselves. Through a unique “crowd-sourcing” activity, attendees chose the topic of: *Value-based Cancer Care*. The panel focused on value frameworks, the very concept of value itself and the need for real world, patient reported outcomes data to inform and benchmark the value of treatment options.

“We need to make sure that the right medicines get to the right people at the right time in an affordable manner.”

*Marc Watrous*
Abraham Verghese, MD
Senior Associate Chair
Stanford University School of Medicine

Abraham Verghese, MD offered a thoughtful and somewhat provocative start to the conference by framing all of our advancements, innovations and scientific learnings through the simple and powerful concept that patient care should always be focused on the patient.

IF WE DON’T UNDERSTAND THE PAST, THEN WE ARE DOOMED TO REPEAT IT.

The keynote began by taking a look back at the relatively short history of modern diagnostic medicine and how the simple concept of “percussion” began the whirlwind of advances that are today leading to a new era of diagnosis and treatment. Within just a few hundred years we have gone from the first diagnostic tool — the stethoscope, and the first real “data point” to advanced molecular analysis and companion diagnostics.

THE FUTURE HINGES ON TWO WORDS: BIG DATA

Dr. Verghese points out that from this one initial data point, we have rapidly progressed to the point where a single patient file can now contain more data than is contained in the entire library of congress. And there’s no sign of slowing down. This is what is powering the New Next, and it is this massive proliferation of data that we must learn to process and integrate into practice if we want to provide personalized care.

PATIENT CARE IS BECOMING PART MEDICINE AND PART I.T. ADMINISTRATION

Dr. Verghese believes that our attention to patients has become distracted by the computer. As a result the patient is in danger of becoming almost secondary to the data.

He illustrated this point by examining how the common practice of “rounds” is transforming from actually visiting and discussing patients at the bedside, to the common practice today of simply examining and discussing patient data in the boardroom. This data empowers decision-making and can lead to precision therapies, but removing the patient from the center of the practice is also leading to other consequences.
THE UNINTENDED CONSEQUENCES OF DATA OVERLOAD

1. PATIENT DISSATISFACTION
A common complaint of today’s patients is how the computer is negatively affecting their interactions with their physicians. The new model may be smarter and more precise, but it is less satisfying to the patient.

2. HEALTH PROFESSIONAL WELLNESS
We are facing an epidemic of physician burnout. 46% experience at least one symptom of burnout.¹ This is a systemic problem that is leading to early retirement, unhappiness and even suicide.

An average ER doctor does 4000 clicks a day.² In fact, something as simple as getting a baby aspirin often requires 6 clicks. Dr. Verghese estimates that 40-50% of the physician’s time is spent on the computer and therefore not with their patients. All the romance of the physician’s training doesn’t prepare for the real job – dealing with the computer.

3. MEDICAL ERROR
Dr. Verghese pointed out that the number of hospital medical errors that result in death every day is equal to the toll we might expect from a jumbo jet crashing. This was the very stimulus for the Electronic Medical Record, and yet these errors continue to occur. Clearly the medical record needs to improve and we need to identify and assess critical data points that can be used to reduce errors. And he believes that a good place to start is with the patient.

4. LOSS OF RITUAL
All of our advances in science, technology and understanding are also affecting the “ritual” of patient care. When patients can look past their quest for a “magic bullet” or “miracle pill” and instead start a partnership for better health with their doctors, it changes the entire process. In this more personal and connected “ritual”, both the physician and the patient have a role.

In the end, Dr. Verghese sees a future that is full of the promise of the advancements in diagnosis and data-driven solutions. But he also believes that if we are to fully succeed, we must not allow the technology of patient care to overtake the care of the patient.

**OF THE 208 REPORTED ERRORS**
that met the inclusion criteria, the error was caused by a **FAILURE TO PERFORM THE PHYSICAL EXAMINATION IN 63%**.³

"MEDICINE at its heart IS A HUMAN-TO-HUMAN INTERACTION.

Dr. Abraham Verghese"
Kevin Volpp, MD, PhD
Director, Center for Health Incentives and Behavioral Economics
Leonard Davis Institute of Health Economics

Even when the communication flow is optimized and even when there is a strong relationship between physician and patient, individual patient behavior is a crucial link in the patient care chain (Figure 1). Understanding what motivates and drives patient actions is essential in everything from healthcare plan design to improving patient outcomes—and this was the focus of a fascinating presentation by Kevin Volpp, MD, PhD.

Dr. Volpp noted that there is great evidence that the current rates of patient adherence to medicines and therapies are shockingly low. So even as the industry pioneers breakthrough new therapies, we struggle to get patients to take these medicines.

INDIVIDUAL BEHAVIOR IS A KEY DRIVER OF POOR OUTCOMES:

There is a huge life expectancy difference based on income mediated behavior.8 This highlights some of the big challenges to the advancement of outcomes. And it also means that the system can do better with the therapies that already exist.

PROPERLY FRAMING PATIENT CHOICES GREATLY IMPACTS THE FINAL DECISION

Dr. Volpp’s research has shown that how we frame choices to patients has a tremendous impact on the choices that they make. One important example is that Opt-in programs are far less effective at motivating positive patient change than Opt-out programs.9

Example: When choosing between brand name and generic prescriptions, when the generic is set as a default (instead of the brand name) generic rate usage rose to almost 100%.10

Remember that from the patient’s standpoint there is often an overwhelming amount of information being presented—and how you present both information and options can have a real effect on what choices the patient makes.

Dr. Kevin Volpp

INDIVIDUAL BEHAVIOR IS A KEY DRIVER OF POOR HEALTH AND HIGH HEALTH COSTS

- Behavioral Problems
- Inadequate Healthcare
- Environmental Causes
- Social Circumstances
- Genetic Predisposition

BEHAVIORAL ECONOMICS: UNDERSTANDING WHAT DRIVES PATIENT DECISIONS (CON’T)

Most patients do not understand all of the complicated options such as co-insurance, deductibles, etc. They have a hard time predicting what things will cost. Additionally, people tend to associate higher cost with higher quality. So when patients aren’t required to foot the bill for their care it is difficult to motivate them to choose lower cost alternatives.

Dr. Volpp added that it’s also not clear that patients want to behave as consumers when they are sick. They want the doctor to tell them what to do and make all of the decisions. This is different from the free market mindset.

MOVING PROVIDER PAYMENT FROM VOLUME TOWARDS VALUE

As a result, Dr. Volpp sees a future that moves away from our current fee for service payments. Simply layering patient and healthcare system incentives on top of fee for service doesn’t help very much in a market dominated by irrational thinking. When the incentives are shared between patients and providers we begin to see lower costs, better compliance and improved results. The new system should focus on rewarding ongoing improvement and not just threshold achievement.
**Panel Discussion: When the Diagnosis is Cancer**

**Moderator:** Cliff Goodman, PhD

**Panelists:**
- Lynn Zonakis, Principal, The Zonakis Group LLC
- Bruce Gould, MD, Medical Director, Northwest Georgia Oncology Centers
- Nancy Vitale, Vice President of Human Resource, Genentech

Day one concluded with a panel discussion around the topics of the day from the unique perspective of a large employer benefits director, a director of a regional oncology organization and a cancer survivor who also happens to be the VP of human resources at Genentech.

**Discussion Topics:**
- The Diagnosis Experience
- Shared Decision-making
- Patient Centricity
- Benefit Design

**The Diagnosis Experience**

Nancy Vitale relayed that once she heard her diagnosis everything else went in one ear and out the other. She missed a lot of that initial conversation and it took her over 3 weeks to even say the word cancer. She recalled that she opted to get her results over the phone, but in hindsight this was a bad decision. She was also dealing with a lot of information and some conflicting advice and details which proved frustrating. But there was a point where the light bulb went off and she realized that she was going to have to own her treatment decision.

**Shared Decision-Making**

Bruce Gould, MD commented that if we really want shared decision-making, then it is vital that all of the physicians and specialties are in constant contact. All of the patient information should be available and constantly updated. And it is also important to have a serious and supportive conversation with the patient and family members that encourages questions and co-decision-making between all of the interested parties.

“I went on the internet. And unfortunately the first site I found was an old site. And all I read was: typical life expectancy = two years. I was thinking of my kids and I’m thinking how do I tell them?”

Glenn
PATIENT CENTRICITY

Bruce Gould, MD noted that there is an emphasis on patient-centered care, this is how we are going to move from fee-for-service to outcomes-based care. Cancer doctors used to say that patient-centric care was a primary care thing. But when it comes to cancer, we are the primary provider for patients.

Nancy Vitale commented that it was screening and early detection that led to her positive outcome. So if we want to be patient-centric, then she believes that promoting prevention and early diagnosis is the most patient-centric thing we can do. Lynn Zonakis explained that cancer care makes up a large part of the health plan/benefits programs for large employers. Employees come to the employer with questions about not just their benefits, but also with questions about how they will be supported at work—or if they will be able to work at all. So a good benefits design should include a host of programs beyond just disease treatment including:

- Absence benefit design to support employees during treatment
- Behavioral health incentives that reward healthy lifestyle choices
- Care management services to support the patient and help them to be a better healthcare consumer
- Balanced benefit design — balancing medical benefits and pharmacy design

THE MOST IMPORTANT THING THEY LEARNED DURING DAY ONE AT GOI 2016

Lynn Zonakis: There are considerable opportunities to realign the plan design with patient and payer incentives.

Bruce Gould, MD: All the science and technology is great, but at the end of the day healthcare is a human endeavor.

Nancy Vitale: Patients need to take charge of their decision-making.
Kimberly MacPherson, MBA, MPH
Associate Director, Health Management
Haas School of Business
Co-Director, Berkeley Center for Health Technology

Day two began with insights on the investment in and advancement of digital health technology and how this investment is laying the groundwork for disruptive change. Kimberly MacPherson provided a look into the future of health-tech and the promises and challenges this future presents.

Ms. MacPherson noted the explosion of investment in health technology from a growing list of respected and high-profile investors and their lofty vision of transforming the healthcare system. Investment in medical technology in and of itself isn’t new or disruptive, but this new wave of investment and technological innovation is aimed at the patient—not the provider. It’s no longer about increasing efficiencies and driving down cost, it’s about empowering patients and providers. The goal is to deliver actionable information and support when and where it is needed (Figure 2).

The keynote pointed out that all of this disruptive innovation offers high potential for better care, but when it comes to health technology there’s also a high bar. Ms. MacPherson reminded the conference that disruption isn’t always good. Today’s healthcare innovators must begin to focus on insuring that all of this technological innovation is providing real, clinical, evidence-based benefits—and not just adding extra burden to the system.

WHERE IS THE NEW INVESTMENT GOING—WHAT IS THE FOCUS?

TOP 3:
1. Healthcare Consumer Engagement
2. Wearables
3. Personal Health Tools and Tracking

We need to be careful that our disruption is positive and not just a burden on the system.

Kimberly MacPherson
Ms. MacPherson pointed out that while there is very sparse evidence that these solutions improve clinical outcomes, there are now innovators who are starting to help digital health companies figure out how to validate their solutions with real evidence and data.

**HOW CAN TECHNOLOGY HELP PROVIDE GREATER PATIENT VALUE:**

- Making Sure the Physician-Patient Interaction is High Quality, Whether In-person or Virtual
- Medication/Therapy Adherence
- Connect Patient Communities

“\[\text{I was afraid of seeming weak. I felt like I needed to be strong for my Mom and for my Step Sister and my Aunt and my Baby. And I did not ever want to feel like I wasn’t in control of my destiny} \text{ and wasn’t in control of getting better.}\.\]”

Jennifer
WE NEED TO BE MORE HONEST

about what we know
and what we don’t know

AND BE OPEN TO SOLUTIONS

"Americans don’t like to give up. If you tell someone there’s a 5 percent chance then they want to go for it.

Everette Neville"

Michael Kolodziej, MD
The morning continued with a lively discussion on the future of cancer treatment from four unique viewpoints. Dr. Cliff Goodman steered the panel through a whirlwind dive into three primary points of interest: Precision Medicine, Provider Stakeholder Decision-making, and Total Cost of Care.

**PRECISION MEDICINE: THE VALIDITY AND VERACITY OF PROVIDER STAKEHOLDER DECISION-MAKING TOTAL COST OF CARE**

Everett Neville noted that precision medicine will hopefully lead to more targeted and personalized treatments. But this will likely lead to higher costs. The closer we get to truly personalized treatments, the higher cost we will see for these treatments. People tend to believe that personalized medicine will lower costs — he believes it will increase costs.

Kerin Adelson, MD offered the strong opinion that we’re living in a time where precision diagnostics is a waste basket of non-actionable mutations and bio information. Patients think it will help target their treatments, but currently it’s not happening most of the time.

Michael Kolodziej, MD summed up the promise of precision medicine by saying that time will tell. Getting to this dream of personalized treatments is a very tall order and requires a massive increase in our knowledge.

**PROVIDER STAKEHOLDER DECISION-MAKING**

Michael Kolodziej, MD – the way the world is today is that access is virtually guaranteed. What we really want though is to promote good value decisions and discourage bad value decisions. How do we get to a world where we value, promote and reward good, value-based decision-making.

Kerin Adelson, MD – we really don’t have the data to discuss value with our patients. We don’t have the cost/value data. What does cost-effective mean to the patients?

Scott St. Germain – the core of the universe in decision-making should be the physician and the patient. There is a system of satellites outside this decision. But the physician and patient should be the ones who make the decision.

**TOTAL COST OF CARE**

Scott St. Germain said the spotlight has been on specialty cancer medicines. But cancer drugs continue to be about 1% of the total healthcare spend. There are so many other variables that need to receive similar focus.

Michael Kolodziej, MD noted we underestimate the complexity of measuring total cost of care. There is a hypothesis that we can lower the cost of care by providing a highly targeted drug.

**WHAT WILL HAVE GONE RIGHT FOR ONCOLOGY CARE BY THE YEAR 2025?**

Everett Neville: The science will have advanced so that we have personalized treatments that work.

Kerin Adelson, MD: We will have an understanding of how these treatments affect total cost of care.

Scott St. Germain: Continued smart aggressive investments in scientific innovations.

Michael Kolodziej, MD: We have treatments that work and we know who to give them to.
KEYNOTE PRESENTATION:
THE TREATMENT JOURNEY

Jim Kelly
NFL Hall of Fame Quarterback, Cancer Survivor

In keeping with the patient journey focus of the 2016 conference, attendees were joined by a cancer patient who also happens to be an NFL Hall of Fame Quarterback. Jim Kelly took the stage at this year’s GOI and had a frank and personal discussion with Dr. Cliff Goodman about his own personal journey through cancer—from diagnosis, through rounds of treatment and disease re-occurrence to survival.

The talk was framed by Mr. Kelly’s experience growing up “Kelly Tough” and by the successes and challenges he faced in both his professional and personal life. His own experience began with a negative diagnosis. But after continuing pain and problems, a second opinion revealed that he had squamous cell carcinoma. Like most patients, the news came as a shock and Mr. Kelly worried not just about himself, but also about how he would break the news to his friends and family.

Mr. Kelly also related that when he first got the news he had no clue about what the diagnosis meant or what his treatment plan would look like. In fact, he didn’t really know what to feel or what to do. In the end, his initial treatment involved surgery and what appeared to be a successful outcome. But a year later his disease returned and what followed was an intensive treatment regimen that included 38 rounds of radiation, 4 rounds of chemotherapy and more surgery.

Now two years cancer free, Mr. Kelly credits his survival to the expert care he received from the healthcare system and to four major “F” factors:

FAITH  FAMILY  FRIENDS  FANS

These crucial factors complimented his medical care and bolstered his “never give up” attitude, leading to survival and triumph.

“When the doctor walks in and asks you to sit down and then he closes the door you know it’s bad news.”

Jim Kelly
make a difference TODAY for someone who is fighting for their TOMORROW

Jim Kelly
CROWD-SOURCED PANEL DISCUSSION:
HOW CAN WE SHAPE THE FUTURE OF CANCER CARE

MODERATOR:
Cliff Goodman, PhD

PANELISTS:
Roy Beveridge, MD
Senior Vice President and Chief Medical Officer
Humana

Bruce Feinberg, DO
Vice President and Chief Medical Officer
Cardinal Health Specialty Solutions

Diane Heditsian
Founder and CEO
deClarity Life Sciences

Piper Su, JD
Vice President
The Advisory Board Company

FOR THE FIRST TIME EVER...
Attendees at GOI 2016 were given the opportunity to help design the conference curriculum. Throughout the two days of the conference, attendees voted on the topic of the final panel discussion:

1. Personalized/Precision Medicine
2. Value-based Cancer Care
3. Community, Government, Stakeholder Responsibilities

The overwhelming choice of attendees was: Value-based Cancer Care. The panel discussed this topic in a wide-ranging discussion that began with an assessment of the slew of recent clinical/economic value frameworks.

“On the other side it just feels so enlightening. And people think that I’m the more fearless person, but there were all these little inner fears that I had. And now I feel like I’m just stomping them out along the way.”

Mia
FINAL CROWD-SOURCED TOPIC: VALUE-BASED CANCER CARE

Bruce Feinberg, DO noted that he is always concerned when discussions miss the Elephant in the room—the fact that recent value frameworks from ASCO, NCCN and others, fail to focus on real world efficacy results. They focus instead on the clinical trial efficacy.

Diane Heditsian explained that patient reported outcomes aren’t routinely reported in the data sets on which these value frameworks are built. The patient voice should be in every aspect of this enterprise, with the doctors, developers, payers, etc.

Piper Su, JD projected good news that there is unprecedented focus on value based care and people recognize the current deficiencies. The fundamental definition of value is: What am I getting and what am I paying for it.

Roy Beveridge, MD highlights that what we are talking about in oncology is not specific to oncology. The lack of real world understanding of drugs and other treatments, and things like telemedicine, point to the universal nature of the problem. The reason that the discussion focuses on oncology is because it is so expensive.

The entire system is moving towards a risk/value driven model. If people are forced to choose their plans and how much they are going to pay, then they start looking very closely at cost.

Bruce Feinberg, DO said if we want to focus on what really determines quality for cancer patients then we need to focus on:

1. Efficacy
2. Toxicity
3. Cost

Roy Beveridge, MD doesn’t think we want CMS to determine what value looks like. But the problem that we have created as providers is that we are not coming together to agree on what value is. We are not presenting them with a single voice. We are showing multiple plans and options. So there is nothing for the government to use.

Piper Su, JD thinks the trick about value-based payment is that it assumes that you are going to have some exclusion and that becomes a very difficult policy discussion.
The 2016 Genentech Oncology Institute was a whirlwind trip through the cancer patient journey, the trials and triumphs of our oncology healthcare system and a forecast for the future. And while the oncology treatment landscape will likely remain a complex and challenging environment—several themes emerged. Insights from across the continuum of care revealed some real consensus looking forward:

- The future of care is more patient-centric.
- The new value equation will rely on real-world data and patient-reported outcomes.
- The future of payment models will likely be collaborative and outcomes-based.

How these changes take effect and who drives this change is still a moving target—and there will undoubtedly be push and pull. Ultimately it’s up to all of the leaders in oncology care to continue to find points of alignment, and to work together to help shape The New Next to the benefit of all. Because the future of oncology care is our future. And we’ll examine it all again in two years at the 2018 Genentech Oncology Institute.

**QUOTE FROM IAN CLARK:**

“If we want to begin working towards solutions that will drive better care, we’ll need to focus on several key initiatives:

- Better patient understanding
- Improving and maintaining access
- Leveraging the science to create better treatment options

*Our goal should be to make Cancer a chronic or curable disease.*

...Our goal should be to make Cancer a chronic or curable disease.

*Ian Clark*