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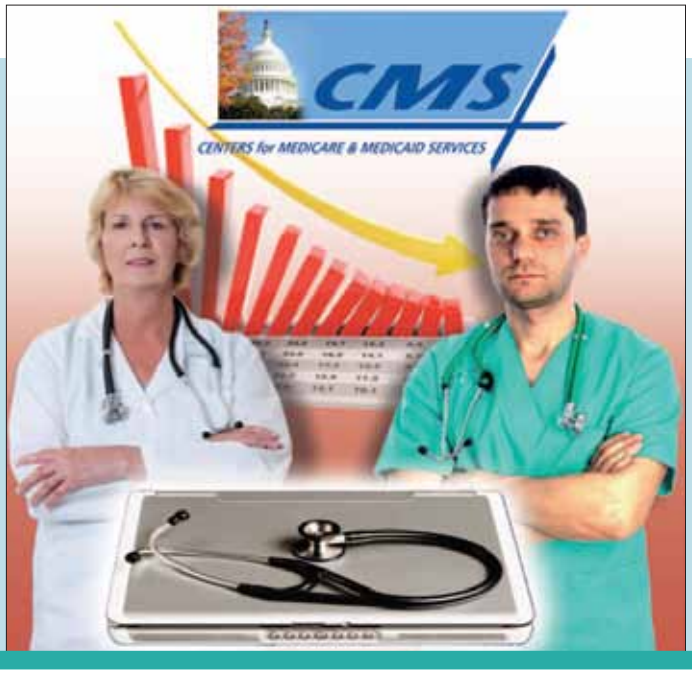

Government Quality Reporting Program Getting Short Shrift from Oncologists

BY LOLA BUTCHER

All signs are that very few oncologists are participating in CMS's PQRI, and fewer still have received any bonus payouts from the voluntary program offering 2% of a physician's total Medicare charges in exchange for successful reporting of certain quality measures. But, said one observer, although it's too early to know if the lack of interest will force modifications or the adoption of an alternative, MDs absolutely need to become proficient at quality reporting—their financial future depends on it.

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ASCO CEO: 3 Things You Probably Don't Know Yet about the Annual Meeting — PLUS: ASCO President's Tips for Blogging! pp.4, 56

AACR '10: (1) Lung Cancer Biomarkers for Drug Decisions; (2) STAR: Tamoxifen, Raloxifene Much Too Underused for Chemoprevention; (3) MicroRNAs & Cancer; and more!

pp.10, 14, 16, 29, 48

[ALSO]

PERIODICALS

Speak Up!

All Pathways Are Not Created Equal

BY PETER G. ELLIS, MD

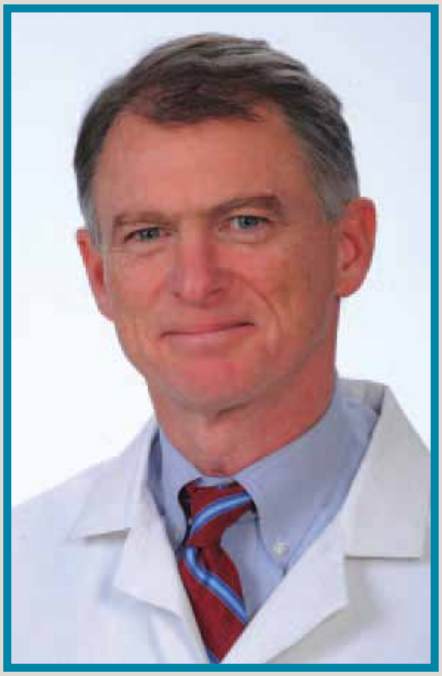
How can we restrain costs so we can afford to expand access? As the health care debate is engaged, more and more attention will be focused on reducing variability in treatments, outcomes, and costs. Oncology is not immune.

The oncology class of drugs is growing three times faster than the overall pharmaceutical market. The expanding range of targeted therapies enables us to more precisely and effectively treat more finite segments of the cancer population. But it is precisely because they target ever smaller segments that these new therapies are so expensive. Off-label uses further increase therapeutic options but also exacerbate variability and push costs up even higher. The average cost per cancer case now tops $80,000.

As oncologists we are in the middle between our patients' hopes for better treatments-encouraged by our own confidence that we can do more and do much better with the advances pharma is delivering—and payers, whose instinctive reaction is to impose access-restraining controls from outside the process of direct patient care.

Oncology groups are adopting clinical pathways to manage the burgeoning volume of information on cancer therapies and to initiate our own solutions to increase treatment consistency, improve quality, and manage costs.

However, all pathways are not created equal. As they consider pathway alternatives,oncology groups ought to ask some serious questions:



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1. Who develops the pathways? Consider the source. Does the organization developing the pathways receive funding from pharmaceutical companies outside of bonafide Phase I-III research? Has it put tangible policies in place to minimize conflicts of interest?

2. How are the pathways developed? Are there permanent disease-specific expert panels that define the critical states and stages of disease for which pathways must be developed? Do they concentrate on Phase III peer-reviewed studies for evidence on survival, disease-free survival, toxicities and other relevant metrics? Do the committees represent both academic and community based oncologists?

3. Do the pathways define one best treatment for each state and stage of disease? Pathways lead to the single best treatment that optimizes outcomes and minimizes toxicities for a given tumor type at a particular stage. If they don't, they are not pathways but only guidelines.

4. Are the pathways comprehensive? Oncology groups need to know the scope of diseases the pathways cover. Do the pathways cover more than just a few diseases? Are they multi-modality? Do they support personalized medicine through prognostic testing?

5. Are the pathways detailed? Pathways must be clinically precise. Real pathways should match the level of granularity in the underlying research studies, stratifying patients based on the

key clinical drivers such as EGFR mutation. They should also include common exceptions and provide options for known toxicities and common contrai dications.

6. Are the pathways regularly updated? If pathways are static, they are useless. The organization developing the pathways should have a process in place for ongoing review and updates, at least twice a year but quarterly is optimal. You should make sure you understand whether and how pathways are updated.

7. Are clinical trials supported by thepathways? Many oncology practices have a strong commitment to accrual to clinical trials, and a good pathways program never penalizes them but, in fact, supports research efforts and treats trial accruals as always on-pathway.

8. Are the pathways available and accessible in real time at the point of care? Oncologists cannot and will not use pathways in three-ring binders or in listings on a website. Oncology groups should look for a robust decision support application that enables oncologists to apply pathways within their workflow.

9. Has the decision support solution been road tested by real oncologists? The software must be easy to use, integrate with other systems such as EMRs, and provide additional value to physicians as a resource and teaching tool.

10. Is results reporting available…and meaningful? Claims data lacks the clinical detail for meaningful data analysis and reporting. Pathways should provide for reporting based on real clinical information.

11. What is the business horizon of the organization developing the pathways? In the health care IT industry, companies come and go as executives and investors plot exit strategies through mergers and acquisitions. That's business. That's the way it is. Oncology groups need to look for a partner that is committed to their success over the long haul.

12. What do your colleagues say? Oncology groups should, of course, check references. You need to know about the experience, good and bad, of oncology practices that have pioneered the adoption of pathways.

It is perilous to predict how health care reform will play out. We feel certain that in oncology the future belongs to those practices that can standardize the adoption of evidence-based therapies, thereby optimizing patient outcomes and efficiently utilizing resources for patients and payers alike. That's why it is so critical to understand that not all pathways are created equal.

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