Clinical Pathways for Oncology: More Rigor Needed When Evaluating Models

TO THE EDITORS:

We read with interest Dawn Holcombe's recent article in *Journal of Oncology Practice/The American Journal of Managed Care* joint issue, entitled "Oncology Managed Programs for Payers and Physicians: Evaluating Current Models and Diagnosing Successful Strategies for Payers and Physicians."[1] As oncologists and others in the industry increasingly turn to *Journal of Oncology Practice* as a source for impartial and accurate information about new approaches to cancer care, we wanted to take the opportunity to offer additional perspective on what we see as some factual inaccuracies in that article.

First, the article identifies nine models for oncology management and generally paints a picture of these nine models as being separate and distinct. From our viewpoint, cancer care pathway concepts are evolving very quickly, and few of the cancer care pathways programs that are currently in operation fall neatly into any one of the nine models outlined in the article. Most of the pathways programs that we lead, for example, are a hybrid of many of the different models identified in the article.

Second, as the article reviewed the approaches of various clinical pathways models, it made a number of incorrect assertions. For example, the article incorrectly stated that the pathways model used by P4 Healthcare (Dublin, OH; acquired by Cardinal Health in June 2010) "does not address any aspect of oncology care other than drugs," "[focuses] solely on the price of drugs," and operates "without direct medical insight into the individual patient's medical situation and disease."[1(pe46s)] The article also incorrectly stated that the P4 pathways model is creating "potential for adverse/unintended consequences that affect patient care or efficacy of the drug combinations" and that "physicians are not involved in this model."[1(pe46s)]

Because we have both personally helped develop P4's approach to pathways development, we can confirm that each of these assertions is untrue. Steering committees composed of physicians within each payer network actually lead the development of the pathways they'll be expected to follow. Every one of our pathways programs also begins with a clear mandate that physicians have ultimate control of treatment decisions at the point of care. To further ensure physician control, neither P4 pathways medical directors nor payer representatives are permitted voting rights when determining pathways. Only steering committee physicians are extended that right.

We believe it's impossible for 100% of patients to be cared for using a limited set of treatment protocols. That's why the P4 pathways model expressly provides room for in-

"The P4 pathways model is, by definition, highly collaborative and intimately involves physicians. Steering committees composed of physicians within each payer network actually lead the development of the pathways they'll be expected to follow."

dividualized medicine and physician discretion. We set compliance goals, but in all cases, the physician has ultimate control of treatment decisions at the point of care.

For example, we generally expect physicians to be pathways compliant at least 70% of the time in year 1 and at least 80% in year 2, recognizing that doctors have the direct medical insight into each patient's medical situation and need flexibility to alter treatment regimens to suit unique patient needs. To date, physician compliance in each of our pathways programs has exceeded these goals, which we view as further evidence that this approach is working for physicians and patients alike.

The article also referenced a relationship between P4 pathways and one of our payer customers as an example of a payer drug cost reduction program that has shown "cracks and problems."[1(pe46s)] On the contrary, the cancer care pathways program to which Ms Holcombe alluded is not only our most mature pathways program, it is also a very successful program. We presented a poster at the 2010 ASCO annual meeting[2] regarding the program's success in improving both patient outcomes and reducing cancer costs, not only through reductions in drug costs, but also through patient quality improvements, such as reduced visits to the emergency room.

Finally, although this article primarily characterized the P4 pathways model as a drug management model, we believe that points made earlier in this letter illustrate that our model is most closely aligned to fit within the disease management model outlined by the author.

In summary, we agree that since P4 Healthcare launched the nation's first cancer care pathways program in 2008, the market has seen a number of new entrants, and new models for leveraging clinical guidelines to improve the quality and costs of cancer care are constantly evolving. As journalists, analysts, and consultants attempt to help practicing oncologists better understand cancer care pathways and the impact these programs can have on patient care, we believe it's important to conduct primary research, directly with the companies that are leading innovations in this field, to ensure that the information shared with clinical audiences is accurate and complete.

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REPLY:

Drs Feinberg and Scott1 write to express concern about the definitions of nine models of oncology management defined in the *Journal of Oncology Practice/The American Journal of Managed Care* joint issue article, "Oncology Management Programs for Payers and Physicians: Evaluating Current Models and Diagnosing Successful Strategies for Payers and Physicians."[2] The definition of the nine models in the original article was not intended to identify characteristics of any specific individual branded program, but rather to clarify the focus and strengths and/or weaknesses of nine identifiable mechanisms of oncology management. As noted by Feinberg and Scott, these mechanisms may be incorporated with other oncology management tools to make up compound branded products. Their comments validate that premise by noting that the programs offered by P4 Healthcare do encompass portions of more than one of the nine oncology management models identified. The original article did draw a distinction between a management approach and a branded program.

I recognize that there are no universal definitions of terms; my use of "drug management model" in the original article refers to a management scheme that encompasses tools such as preferred product pricing that focus solely on the price of drugs with minimal correlation to disease issues. Preferred product pricing is the act of changing the price of a specific drug in relation to the price of another drug—often done when there is a

desire to steer utilization toward the preferred drug. The intent of highlighting programs that use components of these models was simply illustrative. It was not intended to categorize the drug management model as the only aspect of services provided by P4 Healthcare.

I appreciate the description of the P4 pathways program provided by Feinberg and Scott, noting that the program is a compound program that encompasses elements of some of the nine management models identified in the original article. I also appreciate their highlighting a key point made in the manuscript: the importance of broad physician engagement and acceptance of these models by the physicians affected by the programs. Successful implementation of these tools demands attention to effective and transparent governance of the program.

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