THE ISSUE: COLORECTAL CANCER TREATMENT & CLINICAL PATHWAYS

Background: What is a Clinical Pathway?

Clinical pathways are treatment guidelines developed by payers to incentivize the use of predefined treatment regimens which are, in theory, based on available clinical data and provide appropriate care for the majority of patients. They may be referred to as care pathways, critical pathways, integrated care pathways, or care maps. A large systematic review[i] found that pathways can reduce the variability in clinical practice and improve patient outcomes (reduction of complications, shorter hospital stays, lower costs). The majority of clinical pathways are similar to medical guidelines such as those developed by NCCN, ASCO and ASH; however, payer-developed pathways may include decisions based on the cost of care. These pathways are typically developed and reviewed by medical review committees convened by the payer.

The overall incidence of cancer in the United States is projected to increase by 45% in the next two decades from 1.6 million in 2010 to 2.3 million in 2030. Direct medical costs associated with cancer are also projected to increase exponentially from $104 billion in 2006 to more than $173 billion in 2020 as a result of increases in both the cost and quantity of cancer therapies.[1]

Today, many clinical pathways focus on colorectal, breast, and lung cancer. There are increasing concerns about the cost and efficiency of care, and in attempts to control cost, the pathways programs have controversially incorporated financial incentives to practices that participate in the program and meet compliance benchmarks.

Our Position: Guidance to Insurers

Cost control is a major driver in the healthcare industry and is equally important to patients. As leaders of the colorectal cancer community, we feel that it is critical to balance cost control and quality of care in a transparent manner to ensure that patients are fully informed and able to work with their physicians to make choices appropriate to their individual situation.

We recommend that insurers provide:

1. Transparency around the data used to support the treatment pathways, to ensure that all appropriate clinical data is included.
2. Transparency and public disclosure of financial incentives.
3. Transparency around cost-related recommendations, to ensure that cost-driven decisions (eg, the use of one treatment as opposed to a similar treatment) are truly equitable. Incentives to treat on-pathway should not be based solely on cost unless efficacy and toxicity are the same.
4. Transparency around the medical reviewers of the pathways, to ensure that appropriate expertise is at the review table. In addition, we strongly recommend the inclusion of effective and informed research advocates on the review panel, to ensure that patient-specific issues are addressed.
5. Integrate clinical trials as a part of the pathway program, addressing how physicians and patients can participate in trials while being on pathway. Clinical trials are the key to making progress against colorectal cancer, and pathways that are silent on the issue of clinical trials may inadvertently disincentivize participation in clinical trials.

An effective clinical pathway will be:

- Designed and reviewed by experts specific to the disease, including informed research advocates
- Disclosure of financial incentive strategies for clinicians to its members
- Based on all appropriate data
- Evaluated and updated on an ongoing basis

We underscore the need for transparency in each of the above components. Transparency allows those external to the development and implementation of pathways to evaluate the quality of the final product and processes. The transparency of the NCCN guidelines is an excellent example. Members of each committee are included with each guideline, and each guideline cites the data which inform recommendations, including an evaluation of the quality of the data. Importantly, each guideline emphasizes the importance of clinical trials.

We have come together as a colorectal cancer community to inform and guide the discussion on clinical pathways, and to ensure that the best interests of colorectal cancer patients are being met. We collectively agree that each patient's journey is unique to that patient, and while most patients may be well-served through on-pathway treatment, pathways should not incentivize clinicians to provide care which may or may not be in the best interest of an individual.

In conclusion, we applaud efforts to decrease the cost of healthcare, as long as the efforts do not impact the ability of patients and their physicians to make decisions based on the needs of individual patients. Cost is one factor in decision-making, however, it should not be the deciding factor. Transparency in the development, implementation and monitoring of these pathways will increase trust and compliance.

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1. Bruce A. Feinberg, DO, James Lang, PharmD, MBA, James Grzegorczyk, MS, RPh, Donna Stark, RPh, MBA, Thomas Rybarczyk, RN, BSN, Thomas Leyden, MBA, Joseph Cooper, Thomas Ruane, MD, Scott Milligan, PhD, Philip Stella, MD, and Jeffrey A. Scott, MD. J *Implementation of Cancer Clinical Care Pathways: A Successful Model of Collaboration Between Payers and Providers*. Oncol Pract. May 2012; 8(3 Suppl): e38s–e43s

2. Rotter T, Kinsman L, James EL, Mochotta A, Gothe H, Willis J, Snow P, Kugler J. *Clinical Pathways: effects on professional practice, patient outcomes, length of stay and hospital costs*. Cochrane Database of Systematic Reviews 2010, Issue 3

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