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*March 4:* Roundtable, "Reimbursement and Payment Policy" (Washington DC)  
*April 1-2:* Health Care Summit, "Delivery of Care: Defining Quality in Value" (Boston)  
*May TBD:* Roundtable, "Diabetes Business Practices" (New York City)

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# Cancer Cornerstones

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By MARK BILLMAYER

**W**hen signing \$787 billion American Recovery and Reinvestment Act into law, President Obama described the occasion as “an unprecedented effort to jumpstart our economy, create or save millions of jobs, and put a down payment on addressing long-neglected challenges so our country can thrive in the 21st century.”

Featuring prominently is health care improvement: \$59 billion in total, of which \$20 billion goes to information technology. But what if some of these big dollars could address key drivers of cancer quality and cost? Would this require us to finally concede that the current system doesn't work?

What actions would be most appropriate in addressing poor care delivery and an inefficient reimbursement system responsible for some \$100 billion in direct annual treatment expenditures?

*Now is the right time for policymakers to drive necessary change in oncology business practices.*

Four areas stand out as logical places to focus energy and resources. Let's call them cancer cornerstones. They impact not only how we research new therapies and select and pay for treatments, but also how

patients manage many aspects of the disease on their own.

Together, they represent significant opportunity for quality improvements and cost savings.

## **One: reduce variation in care; adopt evidence-based medicine**

How many oncologists are tired of payer utilization scrutiny? How many have felt directly the bite of a toothy payer reimbursement policy that today denies payment for what was once covered? Further, how many oncologists feel like payers are somehow calling the shots on clinical practice?

If prior authorization, pre-certification and other utilization management tactics work as a deterrent, now is the time to prospectively drive treatment selection and application via an agreed upon mechanism on which to base payment determination. As long as oncologists leave clinical practice relatively undefined, application of treatments showing little or no supporting clinical evidence of their potential merits risk going unpaid. This places a potentially heavy economic burden on the oncology practice.

Oncologists are in a position to adopt an evidence-based format for treatment selection and application working with payers as leaders in the movement rather than bystanders hoping their clinical practice will go on with “business as usual.”

There are several options available, each with varying specificity, breadth and depth of clinical rigor. They range from broad compendia listings to treatment guidelines to detailed and specific treatment pathways.

The National Comprehensive Cancer Network ("NCCN") is an obvious choice with one of the largest payers using “NCCN compendium in reviewing requests for coverage for chemotherapy drugs administered in an outpatient setting.”

Other options include US Oncology Level I Pathways and the University of Pittsburgh Medical Center (UPMC) Cancer Centers Pathways Program, which are both touted as methodologies for reducing variation based on clinical effectiveness and limited toxicity first with cost secondary consideration.

*Several options are available in evidence-based care*

The American Society of Clinical Oncologists ("ASCO") Quality Oncology Practice Initiative is believed by some to be a “Holy Grail” for clinical oncology practice. Core measures include the presence of pathology reports in the patient chart, explicit statement of staging, a documented plan for chemotherapy before treatment is started, and much more, as part of the standard.

Evidence-based medicine in its present form is only a start and much of this science is focused primarily on the most common cancers in their earliest stages. In the treatment of later stage cancers is where the tough decisions really begin as we weigh head-on the social/cultural aspects of patient-physician choice with the potential for huge cost savings.

### **Two: expand use of information technology: EHRs and EMRs**

Installing basic electronic health record ("EHR") or electronic medical record ("EMR") technologies has many benefits that transcend initial acquisition and implementation investments along with the loss in physician productivity when changing practice workflow.

Depending upon which source you believe, EHR/EMR adoption can range from 10 percent to as high as 40 percent or higher in oncology practices. Regardless, the current rate of adoption is inadequate. Significant hurdles include cost, workflow disruption and interfacing to practice management systems or hospital systems.

Could these costs be mitigated by productivity gains and a coherent, shared data set, which could become a significant source of practice revenue? Further, could collection and submission of these data become a requirement for preferred payment status to drive accelerated adoption? And, what if acquisition costs were

subsidized as an initial step in an overarching agreement to participate in data collection and submission?

**Three: build a uniform data set, a “new world” currency**

The clinical and economic nature of cancer research and care delivery demand inherently complex levels of data and decision support unseen in many other types of medicine. Why do we in the U.S. regulate and invest so heavily in clinical research data and methodology only to abandon similar rigor in community application? Beyond the economic and market share incentives for manufacturers, one answer is that it's cost prohibitive for physicians. Another might be that it's overwhelmingly difficult to alter physician workflow and behavior. And still another suggests that there are inadequate incentives for every physician to invest in the systems, time and disruption to their practices.

Yet on every side of the equation, for all stakeholders, the payoff includes a broader, deeper data set that could be used to inform all facets of the process from clinical research to everyday community application to label expansion and, ultimately, successful treatment delivery and reimbursement.

*Uniform data  
would create a  
huge payoff for  
all stakeholders*

For manufacturers, the promise can be quick, efficient time to market of better therapies developed with better data to deliver unquestionable therapy value. For physicians, it's a certainty that they are providing the best possible clinical care—fairly reimbursed hassle free—derived from a credible clinical body of science in which they help to create. For payers, it's assurance that all treatments at every stage of the disease represent state-of-the-art, cost-effective care.

For patients, it's even simpler. They know that living with cancer in the United States means they don't have to scour the Internet high and low in search of a second opinion beyond the advice and counsel of their trusted physician. For patients, it's merely a given that our system represents the best clinical and economic opportunity to defeat their disease.

**Four: use MTM and patient support services to extend the practice walls**

Caring for cancer patients is a daunting task. Given the many constraints and resource limitations physician practices face, as well as a looming shortage of oncology providers, additional resources focused on helping patients understand and manage their disease seems necessary and appropriate. There are several models emerging which offer new twists to the traditional care delivered inside a clinic or a hospital.

Medication Therapy Management ("MTM") programs, in some cases offered from larger practices with well-developed pharmacy services but also oncology-focused specialty pharmacies can offer tremendous benefits. Beyond basic prescription fulfillment, MTM programs reinforce adherence to often-strict and complex dosing schedules and help patients understand and anticipate potential side effects. In turn, trained oncology pharmacists, nurses and support staff can

mitigate adverse events by ensuring deeper continuity in a patient's therapy regimen.

Similarly, dedicated patient support services programs, often with goals and services akin to MTM programs, help patients to manage the many facets of their disease through deep and specific education, step-by-step care coordination, and planning for advanced care needs if necessary.

One problem with these programs, with the exception of when they exist in the practice, is their frequent disconnection with the physician treatment plan. Almost always delivered from outside the physician practice, some view these programs as intrusive to the physician domain. Others recognize the duplicitous, confusing and nonproductive nature of like services offered in the form of antiquated care management or disease management delivered directly by payers or through a third party.

While many debate the benefits of traditional disease management programs, there is a significant need for empowering patients to own the self-manageable aspects of their disease. To this end, MTM and patient support services programs can drive proactive management in a care setting that requires little more infrastructure than a patient's desire to engage in the program via notebook, telephone or computer. Investing in these programs is one way to increase patient touch, help them remain on their treatment course and keep them out of the hospital. Emerging design models have these services being delivered from the physician practice, connected to the physician's plan of care and supported by call center resources.

*MTM and patient support services can drive proactive care management*

Cancer is expensive. We have to address costs as rigorously as we've funded research and attacked the disease itself. While there are many problems in the system, the good news is that we're advancing in the war on cancer. Survival rates are up and more people are living with cancer but also consuming resources as cancer is now considered a chronic disease.

Key problems include the varied use of treatments after they enter the market for use in the community setting, a lack of pervasive EHR/EMR technology with a common data set that is widely available for furthering research science, and a need for services to help patients stay on therapy.

Creating standards to ensure appropriate use, documenting both on- and off-label application, and then reporting outcomes via a uniform data set will illuminate opportunities for efficacious, extended use. Reaching beyond the physician practice walls to support patients with resources to help them remain on therapy can present positive clinical and cost benefits. But these are only a few of the examples of actionable steps we can take to stimulate change.

In addition to these solution levers, there are other opportunities including multi-disciplinary care that has non-oncologist specialists directly involved in team-

based patient care. Beyond breast surgeons, urologists, and dermatologists, for example, what can be done to promote pulmonologists working more fully alongside medical and radiation oncologists? What other specialists can participate directly in evolving oncology care? Yet another lever is oncology benefit design that assures access to treatments with known clinical merits, and continued service delivery including advanced care options — without breaking patients financially.

Finally, it is recognized that oncologists practice a difficult and complex clinical craft while confronting deep emotional issues with patients and their loved ones. The concepts presented herein represent some of the stepping stones on a shared path to desperately needed transformation.

Indeed, many of these concepts are present in the market today. With this “unprecedented effort to jumpstart our economy, create or save millions of jobs, and put a down payment on addressing long-neglected challenges so our country can thrive in the 21st century,” there Articleshas never been a better time to begin the transformation.

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