

Clinical Pathways Programs: Confusing Choices for Payers and Physicians. Part 1: Selecting the Appropriate Pathways Program

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Managed care payers seek oncology solutions that will reduce both variation and cost. Oncology physicians seek stability in their ability to make decisions in the best interest of their patients and payer contracts that will allow cancer centers and community offices to continue to provide care.



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Both payers and physicians are exploring programs, and the word “pathways” is often raised—but how those pathways are defined and executed makes an enormous difference.

Payers can choose some program management options that don’t address pathways at all, such as drug management, disease management, and oncology management. Most of these programs are imposed from the outside onto practicing oncologists and typically result in very short-term savings, create tension between physicians and payer, and have a difficult time proving a satisfactory return on investment after the first couple of years.

Increasingly, both payers and physicians are exploring the options offered by evidence-based clinical decision-making that lead to clinical pathways programs. However, there is great variation among the current programs, as well as wide variation in satisfaction on both sides with current models. Confusion about the choices and ideal construct for a clinical pathways program abound among both payers and physicians.

In order to decide what model of clinical pathways would work best for a specific payer or physician practice, we must first explore the five key differences, and identify the seven key questions/issues to consider before selecting a course of action.

Distinguishing characteristics of clinical pathways

Clinical source and maintenance. First and foremost, a viable clinical pathways program must be firmly grounded in evidence-based clinical information, based initially upon the clinical parameters found in the National Comprehensive Cancer Network’s published clinical guidelines, and must have undergone rigorous clinical review by an experienced

body of physicians. Periodic review must be planned to ensure the pathways adapt with the ever-changing body of clinical knowledge that defines oncology, yet the program must require sufficient evidence of proof before adoption.

Demand a clear process and timeline for the clinical review of any pathways or guidelines program.

Pathway definition. Clinical guidelines are the accepted standard for appropriate alternatives for treatment of malignancies, yet the range of guideline alternatives for any disease can be compared with an eight- or ten-lane highway. Selection of the highway lane for any given patient is up to the physician, and requires little further consideration of alternatives as long as the chosen treatment is part of the list of those described as part of the clinical guidelines for that disease.

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A true clinical pathway is increasingly clarified as the identification of one preferred treatment for a given state and stage of disease, which has been selected via a rigorous clinical review of the appropriate clinical guideline alternatives and selected based first upon clinical efficacy, then toxicity profile, and, lastly, assuming comparability across the first two criteria, cost of treatment.

A clinical pathways program will always allow physician flexibility to treat with an off-pathway alternative, because there is no one preferred treatment that will be universally applicable to all cancer patients 100% of the time. The rigorous clinical review of alternatives and definition of clinical pathway must be conducted by actively practicing oncologists, with support from

oncology pharmacists, and should be completely free of outside influence into the evaluation process. The scope of a pathway should include not only chemotherapy infusables/injectables, but also orals, biotherapies, supportive care drugs, prognostic testing, and ideally also radiation oncology treatments. Clinical trials should always be considered an on-pathway choice.

Expect a pathways program to list one preferred treatment tailored to individual states and stages of disease. Anything less is still just a guideline, not a pathway.

Point of clinical decision-making. Unless a pathways program is executed at the point of physician medical decision-making (before selection of the patient treatment), it is not part of the decision-making process and becomes an administered treatment-reporting mechanism rather than a clinical pathways program.

Similarly, physician medical decision-making is complex for cancer patients, and involves multiple branches and considerations within a given disease to identify the state and stage of the disease, as well as to think through the many complications of each patient’s health and physical status. This is an interactive process and not well-suited to a static, fixed policy or publication. Therefore, the process that supports the pathways program must allow for rapid evidence-based support of the physician’s thoughts and evaluations and produce an end product that integrates with the practice’s technical and care delivery systems.

Many of the data elements and decision points (including staging of disease) are not collected in traditional practice and payer claims processing systems. Thus, vendor programs that rely on claims-based reporting, by definition, cannot incorporate the scope of decision-making, tracking, and reporting that is essential to a clinical pathways program.

Such programs, thus, default to menus of approved preferred treatments for a general disease, which do not provide physicians or payers the degree of compliance, reporting, or medical decision-making that is expected in a true clinical pathways program.

Require a pathways program to

incorporate front-end medical decision-making, not back-end claims reporting.

Tracking and monitoring. A true clinical pathways program will allow physicians to select treatment options that are off-pathway where appropriate, but track the reasons and causes for such variation as part of the clinical monitoring feedback loop. Reporting and analysis should be available to the physician on a patient and population basis that includes distribution of treatment by disease stage and state, by physician, and by aggregated population; distribution of new patients by state and stage of disease, drug utilization, and market share by class; and distribution of active versus follow-up patients. One also should expect reporting of patient-capture rate, the on-pathway rate, clinical trial-utilization rates, and reasons for going off-pathway. Very few, if any, electronic health record systems can produce reports at these levels of granularity.

Simplistic reporting will not yield results; seek programs that offer a deep granularity of analysis and reporting by state and stage of disease, for all patients, not just a select few.

Documented ease of physician use. A point of clinical decision-making tool is only as good as the number of times it is used by physicians in active clinical practice. A clinical pathways program should be able to document and track the rates at which physicians use it for their entire patient population, or for the population of patients for whom the pathways are being applied.

Most physicians who embrace the selection of pathways decide to apply the pathways process to all their patients, making ease of use on one pathways platform across all patients essential. For this reason, it is unlikely that a physician or physician practice will embrace more than one clinical pathways platform—making it more likely that payer programs will adapt to accept compliance reporting from whatever platform or platforms have been selected by the physicians practicing in the payer’s geographic market.

Allow physicians to select pathways platforms and support platforms that track front-end decision-making, not simply back-end, claims-based reporting.

Key questions to ask

Having defined the distinguishing characteristics of a true clinical pathways program, it is time to identify seven key questions to ask when reviewing possible solutions for payers or physicians:

- Am I looking at a true clinical pathways proposal?
- What is the source of the clinical content, and what is the process for review and maintenance?
- Am I satisfied with the content and depth of compliance rates and reporting for this program?
- Does the proposed program offer doc-

umented evidence of physician satisfaction and ease of use at the point of clinical decision-making for the clinical pathways program, and does the compliance reporting track the rates and reasons for both on- and off-pathway use, as well as accrual to clinical trials, at a bare minimum?

- Who is responsible for the pathways program, and what are their motivating factors?
- Is this program developed directly with the physician and payers, or if there is a third-party vendor involved, what is that party's role

and financial stake in the program—and is that fully transparent to all parties?

- Who stores and controls the data for the program, and what do they do with it?

Conclusion

When done appropriately, clinical pathways programs will decrease costs and variation in the physician's office and across the entire cancer spend for payers. Understanding the distinguishing characteristics of pathways programs and asking these seven questions

will help physicians and payers alike separate true clinical pathways programs from programs that are labeled as pathways programs but focus more on preferred menus of treatments—which is a more tightly controlled way of defining guidelines, but which do not deliver the same depth and detail of care and reporting as fully developed pathways programs. ●

Part 2 of this article will focus on current pathways programs and will appear in the October issue of Journal of Multidisciplinary Cancer Care.