

Opinion leaders on quality in cancer: views from the field

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The thought leaders involved with defining and measuring quality in cancer care have weighed in. Their responses to our questions illuminate what is happening on the quality front and what practices can do to better position themselves for the future as these issues become even more pressing.

From these interviews, conducted by phone and e-mail, it's clear that there is a great deal of disparity regarding the definition of quality, and even disagreement on who should be constructing the definition. There are many organizations waiting in the wings to create such definitions should the cancer care provider community fail to do so. The onus is on each oncology physician and practice to collaborate, network, and participate in as many data compilations as possible, to bring some much needed transparency to the discussion of which treatments work in cancer care, and thus, what provides value.

We are in the middle of an evolving process; our greatest constraint is the lack of useable data. Those who are able to assemble and use accurate data on care will be able to drive the next level of quality measures and definition.

Community Oncology: What role does your organization play in defining and clarifying quality and value in oncology care?

Dr. Bailes for ASCO: We have a long-standing and active program developing evidence-based guidelines for which expert teams from diverse specialties and both academic and community practices systematically review the literature. ASCO's practice guidelines help clinicians decide on therapies to provide and avoid, and this promotes both quality and value.

We initiated the Quality Oncology Practice Initiative [QOPI], a practice-based self-assessment program for medical oncologists and hematologists/oncologists. QOPI provides measures, analysis, and comparative data for quality improvement.

Our expert panel

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The QOPI measures are selected by oncologists from diverse practice backgrounds and include evidence-based and consensus quality measures. The program has shown significant variability in care

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for most measures, as well as improvement over time for lowest performing practices. QOPI also provides an important resource for oncologists recertifying with the American Board of Internal Medicine, which recognizes QOPI as a data source for the practice performance requirement for maintenance of certification.

We have developed quality measures in collaboration with the National Comprehensive Cancer Network, the American Society for Therapeutic Radiology and Oncology, the American Medical Association Physician Consortium for Performance Improvement, and the Pennsylvania Cancer Pain Initiative. Some of these measures have been adopted by Medicare and others.

We have also developed practice tools such as patient guides to help oncologists provide high-quality care, as well as chemotherapy treatment plan and summary templates.

Mr. de Brantes for BTE: Bridges To Excellence is continuing to work with members of the cancer care community to create a program that would recognize and reward physicians and practices that deliver good cancer care. As of yet, we don't have a program in place.

Mr. Farber for ACCC: Quality of care is of the utmost importance in oncology, and we support the development and inclusion of quality metrics by the specialty societies.

Dr. McGivney for NCCN: Our guidelines for cancer treatment clearly establish the standards for clinical policy. That is what we will continue to focus on. We address the full continuum of management, illustrating how to achieve high value if care is delivered in accordance with the guidelines. Clinically, there are still many options within the guidelines, but they are all evidence based. Payers are now able to accept these guidelines as effective and high quality for use in developing their own cancer coverage policy. United has now formally recognized in its reimbursement policy use

of the NCCN compendium, derived from our guidelines, and other key payers now correspond with us three to four times a month to update their own policies. They use our guidelines and compendium to influence decisions that affect access to care.

There are 1,564 indications for 196 drugs and biologics in the NCCN Compendium, and only 27 indications are listed as Category 3 indications; 6 of them would be subject to medical review under the United policy. The other 1,558 indications will be paid directly when matched to the correct ICD-9 code on the claim form.

Dr. Newcomer for UnitedHealthcare: The biggest contribution United can make is to use our claims database to describe what happens to patients as they move through the continuum of care. Our collection of clinical stage and patient status, which we started in October, should let us begin comparisons of different approaches to cancer care. Our goal is to provide information to physicians on how these treatment choices compare in the country, the region, and within their own practices.

United is trying to open the big black box of oncology treatment. Collectively, we don't know enough about how, and what we are doing regarding treatment choices and real outcomes for patients. We need to get a better handle on variation in care in adult cancer. For example, recent internal data showed 244 pancreatic patients being treated with 188 different regimens. But there are only six active drugs approved for pancreatic cancer, so the vast majority of those treatments weren't supported by any evidence.

We are using the NCCN compendium to define quality care for chemotherapy drug selection. Any therapy recommended by NCCN will be covered. We are using cancer experts to define the right therapies for cancer patients. The transparent process should be an advantage to UnitedHealthcare and the cancer community.

The NCCN guidelines and com-

pendium cover 87% of all cancer claims that will come through the door. The Category 3 indications that we will not cover automatically, which will go to medical review, constitute only about six drugs, so use of the NCCN Compendium for initial claims review is an advantage to both United and the cancer community.

Dr. Vanderlaan for Aetna: Defining and measuring quality are high priorities for Aetna. We have a number of ongoing initiatives, and we view the professional societies, such as ASCO, as the primary engines driving discussions in this area.

Aetna has been working with ASCO for a number of years and is looking at the QOPI program with great interest. Our goal is to recognize in its provider directory the practices that are participating in QOPI. Down the road, if results of QOPI participation can be shared, potentially we can use this information in a positive way in reimbursement.

QOPI meets the criteria Aetna has set for possible programs and pilots in quality in oncology, which include:

- Externally validated measures that contain the seal of approval by the lead medical association (in this case ASCO);
- Allowing providers to self-report data across their entire practice;
- Moving practices toward quality improvement.

At this point, Aetna has no oncology-related quality pilots in the works other than QOPI. But we have built a number of strong programs with Bridges to Excellence across the country in other disease states.

What do you believe are the key elements of quality and value in oncology that need to be addressed? Are we prepared to address those elements yet? Why or why not?

Dr. Bailes for ASCO: We are still working to ensure that oncologists have the financial resources they need

to deliver comprehensive, high-quality cancer care. A collaborative study between ASCO and the Administrators in Oncology/Hematology Assembly of the Medical Group Management Association demonstrated that a majority of oncology practices provide significant levels of service that are currently unrecognized by payers. Oncologists should be reimbursed adequately for the full range of services they provide, including psychosocial support, nutritional counseling, and prevention. ASCO has also been working with other medical subspecialties to advocate for better recognition by Medicare and other payers of the care coordination provided by physicians who treat complex and chronically ill patients. In addition, ASCO has been supporting legislation to create a new reimbursed service under Medicare for treatment planning and treatment summaries.

Ultimately, oncologists should be able to access data regarding both processes and outcomes of care that are relevant to their practices. Additional process measures are required to provide a comprehensive assessment of quality. Measuring outcomes in oncology is fraught with challenges; however, this is an important next step for outpatient cancer care. Patient-reported outcomes are key in this development.

Mr. de Brantes for BTE: What we're looking for are indicators such as white/red blood cell counts, tumor excisions and/or remissions, and generally good patient outcomes. The argument from the cancer care community has been that outcomes in cancer care can take years to materialize, and that's true. But it is also the case for patients with hypertension or diabetes, and for them there are good measures such as blood pressure and blood sugar that predict their outcomes. We're looking for the same type of intermediate outcomes from the cancer care community, and I don't think there's really any barrier to collecting

or providing those data, except for the will to do it.

Mr. Farber for ACCC: Quality in oncology care may be more difficult to measure than in other specialties, such as emergency room care, or treatments associated with diabetes or heart attack patients. However, treatment planning and preventive measures and visits are vital to ensuring quality in oncology. We are getting better prepared to address these key elements since we have initiated programs such as QOPI and the Physician Quality Reporting Initiative. If we continue in this direction, then hopefully we can address these and other key elements in quality oncology care.

Dr. McGivney for NCCN: More than two years ago, there were several non-oncology organizations starting to develop oncology indicators that weren't official measures. So NCCN collaborated with ASCO to create seven quality measures—three for breast cancer, one each for colon and colorectal cancer, and two addressing rectal cancer (see page 158). The Commission on Cancer of the American College of Surgeons worked with us through the National Quality Forum Cancer Project.

Dr. Newcomer for UnitedHealthcare: Basically, there are two ways to create measures and standards for use by payers. The first way is to take what is out there, like the NCCN guidelines, and measure performance against the standards. The use of erythropoietin-stimulating agents when the hemoglobin count is above 12 g/mL is an example. In our experience, this happens 35% of the time. In cases like that, these are clear boundaries.

The second way is to look at what actually happens in practices and identify ranges of variation in cancer care. Does everyone in a given practice, region, or community of oncologists use aromatase inhibitors in the same way? Physicians need to examine the variation that occurs in their practice—how often does it occur

and why does it occur? Then they can narrow that variation.

ASCO looked at several measures such as the percentage of breast cancer patients receiving postoperative radiotherapy or the percentage of stage III colon cancer patients receiving adjuvant chemotherapy and reported fairly high compliance with the standards. But these were fairly easy measures. We need to look at what is difficult and learn, rather validate what we already know we do well. Practices can't do this alone, because their data don't cover the full continuum of care, so they have to collaborate with tumor boards, payers, and other partners.

What are the differences between NCCN and ASCO guidelines?

Dr. Bailes for ASCO: The fundamental difference relates to how they are developed. ASCO used systematic reviews of the literature, whereas NCCN relied on narrative reviews. Systematic reviews require explicit statements about literature search strategies and study selection criteria and result in graded-evidence tables. ASCO guideline panels confine their recommendations to the evidence gleaned from the systematic review before providing expert opinion or consensus. Narrative reviews are literature based but rely heavily on consensus to derive recommendations.

Dr. McGivney for NCCN: The NCCN guidelines tend to reflect the continuum of care as treatment moves along across all stages of the disease. ASCO guidelines tend to focus more directly on specific interventions in specific circumstances.

Do you feel we have reached any consensus on the definition and clarification of quality and value in oncology, and what do you feel are the most important next steps for 2008 into 2010?

Dr. Bailes for ASCO: The diversity of cancer diagnoses, the complexity of cancer care, and the fast pace of inno-

vation in oncology treatments mean that the discussion on quality and value should be ongoing. It is of utmost importance that oncologists continue to play the leadership role in defining quality patient care.

Mr. de Brantes for BTE: There does not seem to be a consensus on the definition of quality in cancer care. If you ask patients, they'll say it means getting better and/or living better with their illness. If you ask physicians and other health care providers, they'll say it's the microprocess of care, and if you ask payers, they'll say it's adherence to standards. Everyone is right, but ultimately, it's the patient's needs that should be at the center of the measurement framework. We need to focus tightly on the outcomes that matter to the patient, however uncomfortable that might be for the oncology community.

Mr. Farber for ACCC: I think we have more of a consensus on certain quality measures, but we do not have 100% agreement. Part of that is due to the various specialty societies that are represented in oncology, but this should not be viewed as a negative; there are numerous points of view on the definition of quality. As for the next steps, I think expanding programs like the Physician Quality Reporting Initiative [PQRI] and QOPI is a good place to start.

Dr. McGivney for NCCN: There is almost a tower of Babel in organizations rushing to develop measures. It is crucial that the professional medical groups like ASCO and NCCN take the lead to define such measures, or quality in oncology will be a cacophony of miscellaneous targets, rather than a cogent message of what has been proven by evidence to work. That is why NCCN is negotiating agreements with several information systems companies covering several market interests to add consistency of guidelines entered into their systems.

NCCN is also building an outcomes database whose major objective

is to measure concordance of practice. Already the University of Michigan and Michigan Blue Cross Blue Shield have created a program in which community cancer centers can enter their own data into this NCCN database for benchmarking and comparison and receive recompense from the Blues for the cost of the initiative.

Many payers are not sure that any set of measures can adequately demonstrate whether quality care is being delivered. But the more that care can be proved by evidence, the more value we will get out of the care. Comparative effectiveness will require more direct comparison, but that is a delicate process. There are many perspectives on what constitutes effectiveness, cost, value, etc.

NCCN is developing a new user system for guidelines, which will include clickable components for recommendations. Papers and references will pop up for ease of use. This new system is in the process of being created. It requires thousands of pages to be accurately transposed and embedded in the new program.

Dr. Newcomer for UnitedHealthcare: Consensus? Only in a few instances. We are still in a data-gathering stage. We need to get enough information to describe what is going on out there and then we can learn what may work best.

What specific programs have you seen succeed and fail (payer based or other) in the definition, measurement, and clarification of quality and value in oncology care?

Dr. Bailes for ASCO: The success of QOPI has demonstrated oncologists' commitment to self-assessment and quality improvement. Already, more than 350 practices across the country are registered for the program. The recent launch of the QOPI Health Plan Program provides more recognition of oncologists' efforts. With practice opt-in, the QOPI Health Plan Program provides confirmation of participation in QOPI to collaborating

health plans. We have had a very positive response from payers and will be able to assess later this year how payers are using the first wave of participation information.

Historically, quality programs led by payers and others have failed when practicing physicians do not lead their development.

Mr. Farber for ACCC: So far, PQRI has not been the big success that Medicare or Congress hoped it would be. But that may have been due to the uncertainty about the program's future and its funding. Now it appears that Congress and Medicare are committed to continuing this type of program, so hopefully it will be more of a success going forward. The hospital quality demonstration run with Premier, Inc., seems to have very positive results, so possibly more programs like it may be helpful as well.

Dr. McGivney for NCCN: We haven't seen any major successes yet. The question of quality in oncology is still in the embryonic state because of deficiencies of available data. Too often, payers don't know the stage of disease, never mind having consistent stage documentation, or patient status and characteristics. The 2006 demonstration project was the first time that a payer was able to track and become aware of stage and status for patients. UnitedHealthcare now will require that initial stage and patient health status be reported on every patient, with health status updated every 6 months. To evaluate quality of care, claims data can then be matched at the payer level with clinical intervention and drugs.

Dr. Newcomer for UnitedHealthcare: The QOPI program is the strongest we've seen yet. We've decided to recognize practices that ASCO identifies as participating in QOPI in our provider directory. Patients will know that these are "QOPI" practices.

Another very successful program has been the United Herceptin study and policy. Because we learned that

patients were receiving Herceptin even though they did not have the appropriate HER2 levels, we raised awareness and reduced the variation in care just by requiring the lab tests.

We did try a program with MDatacor, Inc. to extract information from MD claims systems so that we could give practices back a mini extraction capability for their own data, but that never really got off the ground.

Because we are now asking for stage and patient status—about 60% of practices are now reporting—United will be able to provide a great depth of information back to the participating practices. Initially, feedback will probably be in hard-copy format. We hope to link treatments to outcomes, toxicity, and other costs. The hope is to bring information to physicians that they wouldn't have already in their records.

Dr. Vanderlaan for Aetna: Beyond QOPI, we are not aware of many other focused programs. But like others, we have been amazed at the explosion of organizations actively developing quality measures. Clearly, there are now well accepted, credible, externally validated measures out there that can begin to be used.

What or who do you think is not being considered at this point and why? What do we need to do before we can add those elements?

Dr. Bailes for ASCO: We can never expect to find the enduring answer to providing the highest quality cancer care. The science of quality improvement, cancer treatments, and the policy environment continue to evolve. They require active, flexible, and forward-thinking leadership from oncology.

Dr. Newcomer for UnitedHealthcare: Physicians seem to feel they have to do it all by themselves. It will take another partnership or even several to tease the information or variation out. What we need to do is become transparent. Bring the data into the light

so that everyone can look at them. Once we have the data, we can find out what we need to attach and start measuring. *Then* we can start worrying about quality measurements.

Dr. Vanderlaan for Aetna: There are no really good measures yet of efficiency in oncology practice, which is understandable: cancer care is complex. But everyone is interested in measuring and improving efficiency.

When discussing quality and value in oncology, how successful do you feel the payers, specialty pharmacy, physicians, organizational providers, patients, and business people have been in communicating with one another? What do we still need to do?

Dr. Bailes for ASCO: We have convened the Cancer Quality Alliance, a multistakeholder group of professional specialty societies, patient advocacy groups, payers, accrediting agencies, and others to promote communication and collaboration on issues important to the quality of oncology care. Membership in this group is growing.

Mr. Farber for ACCC: The initiative is growing and will improve with time. One problem we have now is that many different payers have different quality programs in place, which may be causing some confusion among providers and patients. Perhaps a more standardized program would be beneficial.

Dr. McGivney for NCCN: We need to be more effective on the provider side. Payers are more cohesive in their approach, and with so many provider organizations looking to find their own niche in managing oncology, providers need to speak with a *more unified voice*.

Dr. Vanderlaan for Aetna: We place a very high premium on cross-communication and collaboration. If any practices or networks are interested in exploring oncology-related quality or efficiency pilots, we are always open to

collaborating with them. Practices can contact their area Aetna medical director or direct their inquiry to me.

What challenges, opportunities, obstacles, or barriers do you see looming and how significant will they be in shaping the future of quality and value in oncology?

Dr. Bailes for ASCO: We are devoting significant committee resources to dealing with the challenges and barriers to high-quality cancer care. These efforts include addressing payment systems that are unreliable and at times provide a disincentive for quality care; a serious projected workforce shortage; disparities in care and outcomes based on insurance status, racial and ethnic background, or other characteristics; difficulty defining and measuring quality care in oncology; and ensuring that the quality of patient care remains central to measures of efficiency or value.

Among the opportunities available is the increased adoption of electronic health records (EHRs) in outpatient oncology offices. EHRs hold enormous promise for increasing safety and efficiency, facilitating point-of-service innovations, and automating data assessment for quality improvement. ASCO's EHR Workgroup is challenging EHR vendors to develop products that help meet these goals and create programs and resources for oncology practices.

Dr. McGivney for NCCN: Because the pipeline is replete with innovative but expensive new drugs, oncology would potentially be the first area of the healthcare system to implode. The challenge we have will be to use these drugs effectively, safely, and efficiently. In general, organized medicine wasn't alert enough in the 80s and 90s, so payers standardized and developed policies and processes on their own, which caused a lot of problems. We in the provider community have an obligation to communicate what is appropriate care and to col-

laborate with payers so that good decisions are made, so that the complacency of the past is not repeated.

Pharmacy benefits managers [PBMs] look at oncology as good business. One has to wonder how effective PBMs are, with up to three different entities—a cancer center, managed care company, and PBM specialty pharmacy—all trying to manage the patients. This is a typical example of a healthcare system run amok: the patient is bombarded on all sides, when the conversation should really be between the physician and the patient. The others don't know enough about the patients' characteristics and the treatment complexities to appropriately manage the patient. Often, disease management companies are for-profit groups whose main objective is to generate revenue.

Dr. Vanderlaan for Aetna: Practices are busy and would be burdened by addressing individual programs for different payers. That is why Aetna really supports QOPI, which really should be a practice's first step in pursuing the measurement and improvement of quality.

With respect to oncology management companies, Aetna currently has no relationship with any external vendors. But oncology case management is an integral part of the patient management program internal to Aetna. We also have our own specialty pharmacy and PBM, which makes it easier to coordinate care for our cancer patients.

Aetna also views the multidisciplinary nature of quality cancer care as a significant factor. For example, care for

prostate cancer patients should require more than consultation with a urologist; breast cancer should require more than just a surgeon. We see incredible variation of care across the continuum when it comes to multidisciplinary approaches, and so we try to promote this whenever possible. One way in which we have done this is through a collaboration with the American College of Surgeons Commission on Cancer. We indicate on our Web site those hospitals that have achieved accreditation by this organization, since one aspect of that accreditation is a demonstrated commitment to multidisciplinary care.

We also need to build a platform for more integration of community oncology into the process. That might involve expanded tracking of non-hospital cancer cases by tumor registries. In another arena, we need to raise awareness of the patients regarding care options. There are many good educational resources available to them, such as for symptom or pain management, and we need to see that they are taking advantage of these resources. This is part of our case manager approach.

Aetna sees disease management as another issue for cancer patients, in that cost of care and variations are linked to comorbidity. In Aetna's data, cancer patients with comorbid conditions such as diabetes or heart disease are much more costly to care for than cancer patients without such conditions. We need to make sure that the cancer patient with diabetes or heart failure receives all the necessary treatment for those conditions as well.

This is another area we are exploring with our case managers.

In one sentence, what would you want to add to this discussion on quality and value in oncology?

Dr. Bailes for ASCO: The physician and patient communities need to maintain the leadership role in defining evidence-based, high-quality cancer care. The collaboration of diverse stakeholders is needed to ensure that quality programs focus first and foremost on promoting the best care possible to people with cancer.

Mr. Farber for ACCC: It is important for the entire continuum of oncology care that everyone from the providers to the payers to the patients be involved in the future of defining quality of care in oncology.

Mr. de Brantes for BTE: Focus on outcomes; it's the only thing that matters to the patient.

Dr. McGivney for NCCN: It is critical that physicians and other providers communicate evidence-based recommendations on what constitutes safe, effective, and appropriate cancer care to all constituencies that make decisions affecting access, availability, and delivery.

Dr. Newcomer for UnitedHealthcare: We will all fail if we don't address the questions, 'What are we doing now, and how can we learn from the current variations in care?'

Dr. Vanderlaan for Aetna: I think my answer would be one word: transparency—the need for quality measurement and value definition to be complemented by public disclosure.

Quality measures for breast and colorectal cancers

American Society of Clinical Oncology and National Comprehensive Cancer Network in collaboration with the American College of Surgeons Commission on Cancer

The most current quality measures for breast and colorectal cancers are available in two tables that we have posted on our Web site, with permission, at www.CommunityOncology.net/0503.html.

These measures will be updated regularly to reflect changes in their evidence base. They are being tested in a variety of data sources, including ASCO's Quality Oncology Practice Initiative.

Commentary

A view from the pharmacy world

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Oncology represents a good business opportunity for pharmacy benefit managers (PBMs), specialty pharmacies, and infusion suites. But the picture is complex, as suggested by the following considerations:

Community physicians administering oral and injectable drugs in the office is a business decision, one made increasingly difficult as payments are reduced without adequate recognition of related office-based costs.

Oncology is also a good business opportunity for pharmacy providers, including PBMs, specialty pharmacies, and freestanding infusion suites. These pharmacy providers see opportunity in managing medical benefit drugs administered in the medical office and clinic (oncology, rheumatology, etc), which now are billed to payers using HCPCS J-codes.

The payer would benefit if pharmacy providers would bill, adjudicate, and track these drugs via standardized payment formulas, using National Drug Codes rather than the less specific HCPCS J-codes on CMS-1500s (or similar).

Technically, pharmacy information technology [IT] systems, personnel, and procedures are able to implement payer policies built on

credible clinical guidelines. But pharmacy providers still face the challenge of difficulty accessing necessary clinical data, as well as funding challenges related to monitoring and ensuring quality of care.

There will be increased payer interest in product selection as more specialty pharmaceuticals enter the US market and as increasing numbers of older products lose patent protection. Payers and their PBM contractors have long addressed this through drug formularies, which have not yet had a serious impact in the specialty pharmacy arena.

Incorporating medical benefit drugs in a pharmacy context poses a number of challenges: potentially interrupting the continuity of care; introducing administrative complexity with the Competitive Acquisition Program; and downward pressure on funding of individual funding silos, limiting money for considerations of efficiency or quality across silos.

Separating drug administration from the medical office visit presents potential problems: an oncology patient's drug therapy may be changed just before treatment in response to lab results or other findings, or the office visit may entail other interventions such as nutritional assessment and psychosocial counseling.

As the number of oral self-administered cancer therapies in-

creases, there could potentially be discontinuities in patient care.

Oral drugs are covered under the pharmacy benefit and typically dispensed by community or specialty pharmacies. Although it's beneficial from a continuity-of-care perspective, physician dispensing of old drugs is not well compensated.

Typically, pharmacies are paid for drugs that they dispense, and usually not for "cognitive" services. Disease and side effect management, and pharmacy clinical service are challenging, not only because of the difficulty in accessing non-pharmacy patient-related data on the basis of which these services are rendered. If performance of these services is expected out of (increasingly narrow) pharmacy gross margins associated with the dispensing event, this also creates hurdles.

These issues are challenging but not insurmountable. Pharmacy providers, working together with NCCN, ASCO, payers, oncologists, and others (such as IT companies and entities such as Bridges to Excellence and Integrated Healthcare Association), can find, validate, and implement solutions. In my view, there is little choice: as reimbursement for all concerned continues to ratchet downward, we must work together to find solutions.

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