OBJECTIVES: The objective of this study was to evaluate the extent to which oncologists would participate and comply with a PQM program employing clinical pathways. METHODS: A PQM program was enacted in five northeastern states, USA, beginning August 1, 2008. Compliance was defined by provision of a drug or regimen not contingent on compliance in year 1. Results: A total of 362 physicians were eligible for participation (174 community based; 34 hospital based; 154 academic based). 49% of all physicians, 88% of community based, 44% of hospital based, and 6% of academic based physicians signed up to participate in the program. Feedback was provided to participants regarding compliance, and increased fee schedules in year 1 were adjusted in year 2 and during the first year of the program. Feedback was provided to participating practices on the quality of care for cancer patients starting a new line of therapy (e.g. overlap of compliance with potential financial advantage of participation). Additional analysis should consider evaluation of alternate definitions of compliance (e.g. errors of omission rather than commission) and reasons for non-participation (e.g. overlap of compliance with potential financial advantage of participation).

RESULTS: Compliance was measured through the claims submitted by participating practices on cancer patients starting a new line of therapy contingent on compliance in year 1. Compliance was measured through the claims submitted by participating practices on cancer patients starting a new line of therapy (e.g. overlap of compliance with potential financial advantage of participation). Additional analysis should consider evaluation of alternate definitions of compliance (e.g. errors of omission rather than commission) and reasons for non-participation (e.g. overlap of compliance with potential financial advantage of participation).

PCN141

ELECTRONIC MEDICAL RECORDS: QUALITY CANCER CARE AND COST-EFFECTIVENESS

Coluisse AD1, Patz G2, Pohl G2, Lu E, Kaye JA1, Khan S2

‘RTI Health Solutions, Research Triangle Park, NC, USA, 1 Eli Lilly and Company, Indianapolis, IN, USA, 2 RTI Health Solutions, Wattham, MA, USA

OBJECTIVES: The objective of this study was to evaluate the extent to which oncologists would participate and comply with a PQM program employing clinical pathways. METHODS: A PQM program was enacted in five northeastern states, USA, beginning August 1, 2008. Compliance was defined by provision of a drug or regimen not contingent on compliance in year 1. Results: A total of 362 physicians were eligible for participation (174 community based; 34 hospital based; 154 academic based). 49% of all physicians, 88% of community based, 44% of hospital based, and 6% of academic based physicians signed up to participate in the program. Feedback was provided to participants regarding compliance, and increased fee schedules in year 1 were adjusted in year 2 and during the first year of the program. Feedback was provided to participating practices on the quality of care for cancer patients starting a new line of therapy (e.g. overlap of compliance with potential financial advantage of participation). Additional analysis should consider evaluation of alternate definitions of compliance (e.g. errors of omission rather than commission) and reasons for non-participation (e.g. overlap of compliance with potential financial advantage of participation).

RESULTS: Compliance was measured through the claims submitted by participating practices on cancer patients starting a new line of therapy contingent on compliance in year 1. Compliance was measured through the claims submitted by participating practices on cancer patients starting a new line of therapy (e.g. overlap of compliance with potential financial advantage of participation). Additional analysis should consider evaluation of alternate definitions of compliance (e.g. errors of omission rather than commission) and reasons for non-participation (e.g. overlap of compliance with potential financial advantage of participation).

PCN149

TRENDS IN USAGE AND UPTAKE OF TARGETED CANCER THERAPIES VERSUS CHEMOTHERAPIES

Appraisal S, Stevens CA

‘PAREXEL Consulting, Bethesda, MD, USA, 2PAREXEL Consulting, Waltham, MA, USA

OBJECTIVES: The oncology market has become one of the major focus areas for pharmaceutical and biotech firms. As of March 2009, 15,752 of 39,747 Phase II, III and III trials listed on clinicaltrials.gov, were related to cancer (approximately 40%). This increase in interest in oncology stems from market success of cancer therapies launched in the past decade and the existence of high unmet need to treat different types of cancers. As the number of FDA approved cancer therapies increases there is a need to understand treatment patterns of these cancer drugs. METHODS: To understand the usage and uptake of therapies we analyzed publicly available prescription) 2005–2008 data for all FDA approved cancer drugs. Drugs were categorized as targeted cancer therapies, chemotherapies, monoclonal antibodies, small molecules, branded and generics. RESULTS: During the past five years the usage of targeted cancer therapies and chemotherapies increased by 66% and 30%, respectively. While the sales of both types of these drugs are expanding, the majority of sales growth is attributed to an increasing uptake of targeted cancer drugs. The sales share of targeted cancer therapies in the US oncology market increased from 36% in 2004 to 56% in 2008. Among targeted cancer therapies, majority (more than 75%) of uptake belongs to monoclonal antibodies. CONCLUSIONS: The usage and sales trends show a significant increase in the use of cancer drugs. The high usage of targeted cancer therapies versus chemotherapies shows the rapidly changing nature of cancer treatment regimens.

PCN151

CLINICAL AND SOCIO-DEMOGRAPHIC DETERMINANTS OF PRIMARY PROPHYLACTIC G-CSF USE IN ELDERLY BREAST CANCER MEDICARE BENEFICIARIES RECEIVING CHEMOTHERAPY

Rajan SS1, Lyman G2

1 University of Houston, Houston, TX, USA, 2Duke University, Durham, NC, USA

OBJECTIVES: Systemic chemotherapy is a vital component of breast cancer management but early-onset toxicities like neutropenia hinder its administration. Primary prophylactic (PP) use of granulocyte-colony stimulating factors (G-CSF) helps prevent neutropenia and ensures successful chemotherapy completion. Nevertheless, lack of specific guidelines for G-CSF administration in the elderly has led to unexplained geographic and racial, and counter-intuitive clinical variations. For example, older individuals with higher co-morbidities (at higher neutropenia risk) have lower probability of G-CSF receipt. This study examined the reasons for these variations and for the first time looked at variations in G-CSF prescription) 2005–2008. RESULTS: A retrospective observational study of newly diagnosed breast cancer patients receiving chemotherapy was performed using the 1994–2003 SEER-Medicare database. Univariate analyses and multivariate logistic regressions were used to explore the determinants of G-CSF administration. METHODS: A retrospective observational study of newly diagnosed breast cancer patients receiving chemotherapy was performed using the 1994–2003 SEER-Medicare database. Univariate analyses and multivariate logistic regressions were used to explore the determinants of G-CSF administration. METHODS: A retrospective observational study of newly diagnosed breast cancer patients receiving chemotherapy was performed using the 1994–2003 SEER-Medicare database. Univariate analyses and multivariate logistic regressions were used to explore the determinants of G-CSF administration. METHODS: A retrospective observational study of newly diagnosed breast cancer patients receiving chemotherapy was performed using the 1994–2003 SEER-Medicare database. Univariate analyses and multivariate logistic regressions were used to explore the determinants of G-CSF administration.

RESULTS: Univariate analyses demonstrated geographic, racial and clinical disparities similar to previous studies. However, multivariate analyses revealed that controlling for chemotherapy characteristics (type and number of drugs and between cycle duration) made the correlation of age and other clinical characteristics with PPG-CSF administration insignificant. Significant geographic and racial disparities existed. Exploration of geographic variations suggested that patients with higher rates of PPG-CSF administration have higher proportion of physicians administering them; none of the physicians using PPG-CSF administered it on a significantly higher proportion of their patients. CONCLUSIONS: Physicians’ decision to administer PPG-CSF is predominantly driven by neutropenia risk associated with pre-planned chemotherapy regimen. Older, sicker women at a higher risk of neutropenia received less intense/toxic chemotherapy thus did not require PPG-CSF. Geographic variations are driven by provider-level variations in PPG-CSF administration with no evidence for overuse among the providers. Racial and geographic disparities have no clinical basis and are a matter of concern.