

Incentives Are Not Improving Care, Expert Says

BY JEFF EVANS
Senior Writer

WASHINGTON — The few studies that have examined the effectiveness of incentivized pay-for-performance programs have found a mix of moderate to no improvement in quality measures, which, in some instances, have led to unintended consequences, Dr. Daniel B. Mark said at the annual meeting of the Heart Failure Society of America.

There are more than 100 reward or incentive programs that have started in the private U.S. health care sector under the control of employer groups or managed care organizations, according to Dr. Mark, but congressionally authorized programs by the Centers for Medicare and Medicaid Services have received the most attention.

It is important to examine the evidence base that pay-for-performance programs actually improve quality because “people are making this association,” said Dr. Mark,

director of the Outcomes Research and Assessment Group at the Duke (University) Clinical Research Institute, Durham, N.C.

During the last 20 years, incentivized performance programs have shown that “what you measure generally improves and what gets measured is generally what’s easiest to measure. But the ease of measurement does not necessarily define the importance of the measurement.” Furthermore, very little, if anything, is known about whether these initiatives are

cost effective for the health care system at large, Dr. Mark said, although he noted that that may be an oversimplification of the outcomes of such programs.

A systematic overview of 17 studies published during 1980-2005 on pay-for-performance programs found that 1 of 2 studies on system-level incentives had a positive result in which all performance measures improved. In nine studies of incentive programs aimed at the provider group level, seven had partially positive or fully positive results but had “quite small” effect sizes. Positive or partially-positive results were seen in five of six programs at the physician level (Ann. Int. Med. 2006;145:265-72).

Nine of the studies were randomized and controlled, but eight had a sample size of fewer than 100 physicians or groups; the other study had fewer than 200 groups. “If these had been clinical trials, they would have all been considered extremely underpowered and preliminary,” Dr. Mark said.

Programs in four studies may have created unintended consequences, including “gaming the baseline level of illness,” avoiding sicker patients, and an improvement in documentation in immunization studies without any actual change in the number of immunizations given or effect on care. The studies did not include information on the optimal duration of these programs or whether or not their effect persisted after the program was ended. Only one study had a preliminary examination of the program’s cost-effectiveness.

Another study compared patients with acute non-ST-elevation myocardial infarction in 57 hospitals that participated in CMS’ Hospital Quality Incentive Demonstration and 113 control hospitals that did not participate in the program to determine if a pay-for-performance strategy produced better quality of care. There was “very little evidence that there was any intervention effect,” according to Dr. Mark. Measures that were not incentivized by CMS also did not appear to change (JAMA 2007;297:2373-80).

In the United Kingdom, family practice physicians participated in a pay-for-performance program in 2004 that focused on 146 quality indicators for 10 chronic diseases as well as measures related to the organization of care and the patient’s experience. The National Health Service substantially increased its deficit that year because the approximately \$3.2 billion that was allocated for the project was eaten by greater than predicted success in achieving the quality indicators. This led to an average increase in the physicians’ pay of about \$40,000 that year (N. Engl. J. Med. 2006;355:375-84).

Other investigators noted that in the 1998-2003 period prior to the NHS project all of the quality indicators had already been improving, “so it’s not clear how much the program’s achievements can actually be attributed to the program itself,” he said (N. Engl. J. Med. 2007;357:181-90).

Another study showed that public reporting of measures alone could improve a set of quality indicators on heart failure and acute myocardial infarction by the same magnitude as a pay-for-performance program that included public reporting (N. Engl. J. Med. 2007;356:486-96).

CUTIVATE® (fluticasone propionate) Lotion, 0.05%

FOR TOPICAL USE ONLY.
NOT FOR OPHTHALMIC, ORAL, OR INTRAVAGINAL USE.

INDICATIONS AND USAGE: CUTIVATE® (fluticasone propionate) Lotion is indicated for the relief of the inflammatory and pruritic manifestations of atopic dermatitis in patients 1 year of age or older. The safety and efficacy of drug use for longer than 4 weeks in this population have not been established. The safety and efficacy of CUTIVATE® Lotion in pediatric patients below 1 year of age have not been established.

CLINICAL PHARMACOLOGY: Like other topical corticosteroids, fluticasone propionate has anti-inflammatory, antipruritic, and vasoconstrictive properties.

Although fluticasone propionate has a weak affinity for the progesterone receptor and virtually no affinity for the mineralocorticoid, estrogen or androgen receptors, the clinical relevance as related to safety is unknown. Fluticasone propionate is lipophilic and has strong affinity for the glucocorticoid receptor. The therapeutic potency of glucocorticoids is related to the half-life of the glucocorticoid receptor complex. The half-life of the fluticasone propionate-glucocorticoid receptor complex is approximately 10 hours.

Pharmacokinetics: Absorption: The extent of percutaneous absorption of topical corticosteroids is determined by many factors, including the vehicle and the integrity of the epidermal barrier. Occlusive dressing enhances penetration. Topical corticosteroids can be absorbed from normal intact skin. Inflammation and/or other disease processes in the skin increase percutaneous absorption.

Special Population (Pediatric): Plasma fluticasone levels were measured in patients 2 years - 6 years of age in an HPA axis suppression study. A total of 13 (62%) of 21 patients tested had measurable fluticasone at the end of 3-4 weeks of treatment. The mean ± SD fluticasone plasma values for patients aged under 3 years was 47.7 ± 31.7 pg/mL and 175.5 ± 243.6 pg/mL. Three patients had fluticasone levels over 300 pg/mL, with one of these having a level of 819.81 pg/mL. No data was obtained for patients < 2 years of age.

CLINICAL STUDIES: CUTIVATE® Lotion applied once daily was superior to vehicle in the treatment of atopic dermatitis in two studies. The two studies enrolled 438 patients with atopic dermatitis aged 3 months and older, of which 169 patients were selected as having clinically significant* signs of erythema, infiltration/papulation and erosion/oozing/crusting at baseline. Table 1 presents the percentage of patients who completely cleared of erythema, infiltration/papulation and erosion/oozing/crusting at Week 4 out of those patients with clinically significant baseline signs.

Table 1: Complete Clearance Rate

	CUTIVATE® Lotion	Vehicle
Study 1	9/45 (20%)	0/37 (0%)
Study 2	7/44 (16%)	1/43 (2%)

*Clinically significant was defined as having moderate or severe involvement for at least two of the three signs (erythema, infiltration/papulation, or erosion/oozing/crusting) in at least 2 body regions. Patients who had moderate to severe disease in a single body region were excluded from the analysis.

CONTRAINDICATIONS: CUTIVATE® Lotion is contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

PRECAUTIONS:

General: Systemic absorption of topical corticosteroids can produce reversible hypothalamic-pituitary-adrenal (HPA) axis suppression with the potential for glucocorticosteroid insufficiency after withdrawal from treatment. Manifestations of Cushing’s syndrome, hyperglycemia, and glucosuria can also be produced in some patients by systemic absorption of topical corticosteroids while on treatment. Patients applying a potent topical steroid to a large surface area or to areas under occlusion should be evaluated periodically for evidence of HPA axis suppression. This may be done by using cosyntropin (ACTH₁₋₂₄) stimulation testing.

Forty-two pediatric patients (4 months to < 6 years of age) with moderate to severe atopic eczema who were treated with CUTIVATE® Lotion for at least 3-4 weeks were assessed for HPA axis suppression and 40 of these subjects applied at least 90% of applications. None of the 40 evaluable patients suppressed, where the sole criterion for HPA axis suppression is a plasma cortisol level of less than or equal to 18 micrograms per deciliter after cosyntropin stimulation. Although HPA axis suppression was observed in 0 of 40 pediatric patients (upper 95% confidence bound is 7.2%), the occurrence of HPA axis suppression in any patient and especially with longer use cannot be ruled out. In other studies with fluticasone propionate topical formulations, adrenal suppression has been observed.

If HPA axis suppression is noted, an attempt should be made to withdraw the drug, to reduce the frequency of application, or to substitute a less potent steroid. Recovery of HPA axis function is generally prompt upon discontinuation of topical corticosteroids. Infrequently, signs and symptoms of glucocorticosteroid insufficiency may occur requiring supplemental systemic corticosteroids. For information on systemic supplementation, see prescribing information for those products.

Pediatric patients may be more susceptible to systemic toxicity from equivalent doses due to their larger skin surface to body mass ratios (see PRECAUTIONS: Pediatric Use).

Fluticasone propionate Lotion, 0.05% may cause local cutaneous adverse reactions (see ADVERSE REACTIONS).

Fluticasone propionate lotion contains the excipient imidurea which releases traces of formaldehyde as a breakdown product. Formaldehyde may cause allergic sensitization or irritation upon contact with the skin.

If irritation develops, CUTIVATE® Lotion should be discontinued and appropriate therapy instituted. Allergic contact dermatitis with corticosteroids is usually diagnosed by observing failure to heal rather than noting a clinical exacerbation as with most topical products not containing corticosteroids. Such an observation should be corroborated with appropriate diagnostic patch testing.

If concomitant skin infections are present or develop, an appropriate antifungal or antibacterial agent should be used. If a favorable response does not occur promptly, use of CUTIVATE® Lotion should be discontinued until the infection has been adequately controlled.

CUTIVATE® Lotion should not be used in the presence of preexisting skin atrophy and should not be used where infection is present at the treatment site. CUTIVATE® Lotion should not be used in the treatment of rosacea and perioral dermatitis.

Laboratory Tests: The cosyntropin (ACTH₁₋₂₄) stimulation test may be helpful in evaluating patients for HPA axis suppression.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: No studies were conducted to determine the photoco-carcinogenic potential of CUTIVATE® Lotion.

In an oral (gavage) mouse carcinogenicity study, doses of 0.1, 0.3 and 1 mg/kg/day fluticasone propionate were administered to mice for 18 months. Fluticasone propionate demonstrated no tumorigenic potential at oral doses up to 1 mg/kg/day (less than the MRHD in adults based on body surface area comparisons) in this study.

In a dermal mouse carcinogenicity study, 0.05% fluticasone propionate ointment (40 µl) was topically administered for 1, 3 or 7 days/week for 80 weeks. Fluticasone propionate demonstrated no tumorigenic potential at dermal doses up to 6.7 µg/kg/day (less than the MRHD in adults based on body surface area comparisons) in this study.

Fluticasone propionate revealed no evidence of mutagenic or clastogenic potential based on the results of five in vitro genotoxicity tests (Ames assay, E. coli fluctuation test, S. cerevisiae gene conversion test, Chinese hamster ovary cell chromosome aberration assay and human lymphocyte chromosome aberration assay) and one in vivo genotoxicity test (mouse micronucleus assay).

No evidence of impairment of fertility or effect on mating performance was observed in a fertility and general reproductive performance study conducted in male and female rats at subcutaneous doses up to 50 µg/kg/day (less than the MRHD in adults based on body surface area comparisons).

Pregnancy: Teratogenic Effects: Pregnancy Category C. Corticosteroids have been shown to be teratogenic in laboratory animals when administered systemically at relatively low dosage levels. Some corticosteroids have been shown to be teratogenic after dermal application in laboratory animals.

Systemic embryofetal development studies were conducted in mice, rats and rabbits. Subcutaneous doses of 15, 45 and 150 µg/kg/day of fluticasone propionate were administered to pregnant female mice from gestation days 6 - 15. A teratogenic effect characteristic of corticosteroids (cleft palate) was noted after administration of 45 and 150 µg/kg/day (less than the MRHD in adults based on body surface area comparisons) in this study. No treatment related effects on embryofetal toxicity or teratogenicity were noted at 15 µg/kg/day (less than the MRHD in adults based on body surface area comparisons).

Subcutaneous doses of 10, 30 and 100 µg/kg/day of fluticasone propionate were administered to pregnant female rats in two embryofetal development studies (one study administered fluticasone propionate from gestation days 6 - 15 and the other study from gestation days 7 - 17). In the presence of maternal toxicity, fetal effects noted at 100 µg/kg/day (less than the MRHD in adults based on body surface area comparisons) included decreased fetal weights, omphalocele, cleft palate, and retarded skeletal ossification. No treatment related effects on embryofetal toxicity or teratogenicity were noted at 10 µg/kg/day (less than the MRHD in adults based on body surface area comparisons).

Subcutaneous doses of 0.08, 0.57 and 4 µg/kg/day of fluticasone propionate were administered to pregnant female rabbits from gestation days 6 - 18. Fetal effects noted at 4 µg/kg/day (less than the MRHD in adults based on body surface area comparisons) included decreased fetal weights, cleft palate and retarded skeletal ossification. No treatment related effects on embryofetal toxicity or teratogenicity were noted at 0.57 µg/kg/day (less than the MRHD in adults based on body surface area comparisons).

Oral doses of 3, 30 and 300 µg/kg/day fluticasone propionate were administered to pregnant female rabbits from gestation days 8 - 20. No fetal or teratogenic effects were noted at oral doses up to 300 µg/kg/day (less than the MRHD in adults based on body surface area comparisons) in this study. However, no fluticasone propionate was detected in the plasma in this study, consistent with the established low bioavailability following oral administration (see CLINICAL PHARMACOLOGY).

Fluticasone propionate crossed the placenta following administration of a subcutaneous or an oral dose of 100 µg/kg tritiated fluticasone propionate to pregnant rats.

PROFESSIONAL BRIEF SUMMARY - See package insert for full prescribing information

Rx Only

There are no adequate and well-controlled studies in pregnant women. During clinical trials of CUTIVATE® Lotion, women of childbearing potential were required to use contraception to avoid pregnancy. Therefore, CUTIVATE® Lotion should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers: Systemically administered corticosteroids appear in human milk and could suppress growth, interfere with endogenous corticosteroid production, or cause other untoward effects. It is not known whether topical administration of corticosteroids could result in sufficient systemic absorption to produce detectable quantities in human milk. Because many drugs are excreted in human milk, caution should be exercised when CUTIVATE® Lotion is administered to a nursing woman.

Pediatric Use: CUTIVATE® Lotion may be used in pediatric patients as young as 1 year of age. The safety and efficacy of CUTIVATE® Lotion in pediatric patients below 1 year of age have not been established.

Forty-two pediatric patients (4 months to < 6 years of age) with moderate to severe atopic eczema who were treated with CUTIVATE® Lotion for at least 3-4 weeks were assessed for HPA axis suppression and 40 of these subjects applied at least 90% of applications. None of the 40 evaluable patients suppressed, where the sole criterion for HPA axis suppression is a plasma cortisol level of less than or equal to 18 micrograms per deciliter after cosyntropin stimulation. Although HPA axis suppression was observed in 0 of 40 pediatric patients (upper 95% confidence bound is 7.2%), the occurrence of HPA axis suppression in any patient and especially with longer use cannot be ruled out.

In other studies with fluticasone propionate topical formulations, adrenal suppression has been observed. CUTIVATE® (fluticasone propionate) Cream, 0.05% caused HPA axis suppression in 2 of 43 pediatric patients, ages 2 and 5 years old, who were treated for 4 weeks covering at least 35% of the body surface area. Follow-up testing 12 days after treatment discontinuation, available for 1 of the 2 patients, demonstrated a normally responsive HPA axis.

HPA axis suppression, Cushing’s syndrome, linear growth retardation, delayed weight gain, and intracranial hypertension have been reported in pediatric patients receiving topical corticosteroids. Manifestations of adrenal suppression in pediatric patients include low plasma cortisol levels to an absence of response to ACTH stimulation. Manifestations of intracranial hypertension include bulging fontanelles, headaches, and bilateral papilloedema.

In addition, local adverse events including cutaneous atrophy, striae, telangiectasia, and pigmentation change have been reported with topical use of corticosteroids in pediatric patients.

Geriatric Use: A limited number of patients above 65 years of age have been treated with CUTIVATE® Lotion in US and non-US clinical trials. Specifically only 8 patients above 65 years of age were treated with CUTIVATE® Lotion in controlled clinical trials. The number of patients is too small to permit separate analyses of efficacy and safety.

ADVERSE REACTIONS: In 2 multicenter vehicle-controlled clinical trials of once-daily application of CUTIVATE Lotion by 196 adult and 242 pediatric patients, the total incidence of adverse reactions considered drug related by investigators was approximately 4%. Events were local cutaneous events, usually mild and self-limiting, and consisted primarily of burning/stinging (2%). All other drug-related events occurred with an incidence of less than 1% and inclusively were contact dermatitis, exacerbation of atopic dermatitis, folliculitis of legs, pruritus, pustules on arm, rash, and skin infection (0 vs. 1%).

Per Table 2, the actual number (per cent) of drug-related events for the CUTIVATE Lotion group (N=221) versus the vehicle group (N=217), respectively, were burning/stinging 4(2%) vs. 3(1%); contact dermatitis 0(0) vs. 1(<1%); exacerbation of atopic dermatitis 0(0) vs. 1(<1%); folliculitis of legs 2(<1%) vs. 0(0); pruritus 1/(<1%) vs. 1/(<1%); pustules on arm 1/(<1%) vs. 0(0); rash 1/(<1%) vs. 2/(<1%); and skin infection 0(0) vs. 3(1%).

The incidence of drug-related events on drug compared to vehicle (4% and 5%, respectively) was similar. Events as per Table 3 were local, cutaneous, and inclusively were dry skin, 3 events (7%); stinging at application sites, 2 events (5%); and excoriation, 1 event (2%).

In an open-label study of 44 pediatric patients applying CUTIVATE® Lotion to at least 35% of body surface area twice daily for 3 or 4 weeks, the overall incidence of drug-related adverse events was 14%. Events as per Table 3 were local, cutaneous, and inclusively were dry skin (7%), stinging at application site (5%), and excoriation, 1 event (2%).

Table 4: Adverse Events Occurring in ≥ 1% of Patients from Either Arm from Controlled Clinical Trials (n=438)

Body System	CUTIVATE® Lotion N = 221	Vehicle Lotion N = 217
Any Adverse Event	77 (35%)	82 (38%)
Skin		
Burning and Stinging	4 (2%)	3 (1%)
Pruritus	3 (1%)	5 (2%)
Rash	2 (<1%)	3 (1%)
Skin Infection	0	3 (1%)
Ear, Nose, Throat		
Common Cold	9 (4%)	5 (2%)
Ear Infection	3 (1%)	3 (1%)
Nasal Sinus Infection	2 (<1%)	4 (2%)
Rhinitis	1 (<1%)	3 (1%)
Upper Respiratory Tract Infection	6 (3%)	7 (3%)
Gastrointestinal		
Normal Tooth Eruption	2 (<1%)	3 (1%)
Diarrhea	3 (1%)	0
Vomiting	3 (1%)	2 (<1%)
Lower Respiratory		
Cough	7 (3%)	6 (3%)
Influenza	5 (2%)	0
Wheeze	0	3 (1%)
Neurology		
Headache	4 (2%)	5 (2%)
Non-Site Specific		
Fever	8 (4%)	8 (4%)
Seasonal Allergy	2 (<1%)	3 (1%)

During the clinical trials, eczema herpeticum occurred in a 33-year-old male patient treated with CUTIVATE® Lotion. Additionally, a 4-month-old patient treated with CUTIVATE® Lotion in the open-label trial had marked elevations of the hepatic enzymes AST and ALT. Reported systemic post-marketing adverse events with CUTIVATE® Cream and CUTIVATE® Ointment have included: immunosuppression/Pneumocystis carinii pneumonia/leukopenia/thrombocytopenia; hyperglycemia/glycosuria; Cushing syndrome; generalized body edema/blurred vision; and acute urticarial reaction (edema, urticaria, pruritus, and throat swelling). A causal role of CUTIVATE® in most cases could not be determined because of the concomitant use of topical corticosteroids, confounding medical conditions, and insufficient clinical information.

The following local adverse reactions have been reported infrequently with topical corticosteroids, and they may occur more frequently with the use of occlusive dressings and higher potency corticosteroids. These reactions are listed in an approximately decreasing order of occurrence: irritation, folliculitis, acneiform eruptions, hypopigmentation, perioral dermatitis, allergic contact dermatitis, secondary infection, skin atrophy, striae, hypertrichosis, and miliaria. Also, there are reports of the development of pustular psoriasis from chronic plaque psoriasis following reduction or discontinuation of potent topical corticosteroid products.

OVERDOSAGE: Topically applied CUTIVATE® Lotion can be absorbed in sufficient amounts to produce systemic effects (see PRECAUTIONS).

DOSAGE AND ADMINISTRATION: CUTIVATE® Lotion may be used in adult and pediatric patients 1 year of age or older. The safety and efficacy of CUTIVATE® Lotion in pediatric patients below 1 year of age have not been established (see PRECAUTIONS: Pediatric Use).

Atopic Dermatitis: Apply a thin film of CUTIVATE® Lotion to the affected skin areas once daily. Rub in gently. As with other corticosteroids, therapy should be discontinued when control is achieved. If no improvement is seen within 2 weeks, reassessment of diagnosis may be necessary. The safety and efficacy of drug use for longer than 4 weeks have not been established. CUTIVATE® Lotion should not be used with occlusive dressings or applied in the diaper area unless directed by a physician.

HOW SUPPLIED: CUTIVATE® Lotion is supplied in:

60mL bottle (NDC 0462-0434-00)

120mL bottle (NDC 0462-0434-04)

Store between 15° and 30°C (59° and 86°F). Do not refrigerate.

Keep the container tightly closed.


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