ACTION ACCC

The Association of Community Cancer Centers'

Prostate Cancer "Best Practices" Project

Phase 2 Update

Phase 2 of ACCC's Prostate Cancer "Best Practices" Project was launched in March 2009. Through an application process, five ACCC-member programs were selected as pilot sites:

- Florida Hospital Cancer Institute, Orlando, Fla.
- Good Samaritan Hospital, San Jose, Calif.
- OncoLogics, Inc., Lafayette, La.
- Saint Joseph's Hospital, Atlanta, Ga.
- Tallahassee Memorial Hospital, Tallahassee, Fla.

Mary Lou Bowers, MBA, of the Pritchard Group, is the facilitator for Phase 2 of the project. To date, all five sites have received onsite education about the process and structures that the "model" community-based prostate-specific programs helped identify in Phase 1 as "best practices" that have helped develop and grow their programs.

As outlined in the *Guide to Best Practices in a Comprehensive Prostate Cancer Program* developed in Phase 1, successful prostate cancer programs range from sophisticated programs—featuring one-stop care with all services and all available treatment options in one location—to simpler programs that focus on education and patient advocacy without providing diagnostic and treatment services. There is no one-size-fits all approach to creating a prostate-specific cancer program. What Phase 1 model programs shared was a common philosophical approach—their primary objectives are both to provide quality care and to empower patients to make educated decisions. (For more, visit the Prostate Cancer "Best Practices" Project on ACCC's website *www.accc-cancer.org/education/education-prostate.asp*.)

In Phase 2, Ms. Bowers has worked with the pilot sites to identify each program's goals. The five sites are in various stages of developing a comprehensive prostate program. Two of the sites are very early in the process, and are trying to develop consensus to move toward creation of a prostate-specific program structured around patient-centered, education-oriented comprehensive care. The three remaining pilot sites are further along in the process. Each has established goals aimed at refining and expanding the services provided through their existing prostate programs.

One learning objective of Phase 2 is to identify common barriers to establishing a model prostate cancer program and to offer solutions to those barriers.

For the two pilot sites attempting to initiate a prostate program drawing on the identified "best practices" components, a major barrier is achieving commitment to the project from multiple parties. At one site, a hospital is struggling to find common ground with community urologists who have already begun to create an independent prostate treatment center outside of the hospital. The challenge for this site is establishing communication channels to explore whether it is possible to bring the parties together on some common goals. Another pilot site is working toward a dialogue with local hospitals to explore the benefits of creating a comprehensive prostate-specific program. For this busy program, a challenge is determining where the prostate project falls in terms of organizational priorities.

Of the three pilot sites with established prostate programs, each faces challenges related to refining and expanding services. At one established prostate program, the challenge is to incorporate a patient advocate/nurse navigator to facilitate patient education and patient decision-making—a "best practice" identified in Phase 1 of ACCC's educational project. Another pilot site has added a patient advocate/navigator position and is working on goals related to patient shared decision-making and patient advocacy and marketing its program. The final pilot site has also hired a patient advocate/navigator and has set goals related to increasing communication and expanding the services of its established prostate program.

All of the pilot sites have benefited from the "best practices" information developed from the model programs identified in Phase 1 of the prostate project. And, in turn, the model programs have served as important resources for the pilot sites. Each of the pilot sites is looking at how to distinguish its prostate program and make it a viable and valuable resource. Each site has embraced the patient education component of "best practice" comprehensive prostate-specific care.

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continued on page 46

18th Annual Oncology Presidents' Retreat

The Association of Community Cancer Centers (ACCC) together with the American Society of Clinical Oncology (ASCO) hosted the 18th Annual Oncology Presidents' Retreat Jan. 14-15, 2010, in Alexandria, Va. The meeting focused on the big picture—how healthcare reform may impact oncology in the near and long-term. Opening remarks by Michael Neuss, MD, chair of ASCO's Clinical Practice Committee (CPC), summed up the meeting's take-home message: "Circumstances of all of our practices are really changing now."

Keynote speaker journalist Juan Williams put the nation's current healthcare reform struggles in historical perspective for attendees. Williams, a political analyst for Fox News and regular contributor to National Public Radio, talked about healthcare reform in the context of President Obama's first year in office, framed by the larger historical context of other presidential reform efforts. When future historians look back on the current U.S. era, "I think history will focus on one issue above all else and that's healthcare," Williams said.

Changes in the country and in the electorate are impacting the current healthcare reform struggle. Our electorate includes both large numbers of people 55 and older and large numbers of people age 18 and under—groups with vastly differing perspectives on healthcare and the reform measures.

While there is tremendous desire on the part of the American people for change, Williams said, at the same time, there is uncertainty that attaches to the specifics of how that change will look. He believes that healthcare reform will happen, but in response to a question he added that the pivotal question is whether healthcare has become the "third rail" in American life. Should current healthcare reform efforts fail, Williams believes we will not see reform efforts again for decades.

The question for Congress, Williams said, is "deciding whether or not you are willing to make history at this moment, even if that history is imperfect."

On Friday, Jan. 15, Cliff Goodman, PhD, of the Lewin Group, facilitated a series of panel discussions focused on the outlook for oncology going forward. Highlights included a panel discussion, chaired by Thomas Ault, MS, of Health Policy Alternatives, on the *Impact on Community Oncology of Health Reform.* Panelist Thomas Whittaker, MD, FACP, described the current practice environment as "horribly uncertain," noting that his community is seeing increasing numbers of uninsured patients as a result of job losses. Panelist Philip Johnson, MS, RPh, FASHP, director of pharmacy, H. Lee Moffitt Cancer Center & Research Institute, was more optimistic, noting that healthcare has constantly been reformed and is constantly evolving. "I'm confident that we will figure out a way to deal with this," he said. However, one trend Johnson mentioned is a shift in cancer care away from the physician office setting toward more care being provided in the hospital setting.

Barbara McAneny, MD, and Al B. Benson III, MD, FACP, participated in a panel discussion with Jeff Allen, PhD, of Friends of Cancer Research, on *Guidelines and Comparative Effectiveness: What the Mammography Debate Foreshadows for Community Oncology.* Dr. McAneny outlined the AMA's 11 principles of comparative effectiveness research (CER), and noted that comparative effectiveness research has the potential to provide the tools to make the best decisions for patients. The nuances of oncology make it imperative that the oncology community is involved in CER discussions, Dr. Benson said. He emphasized the leadership role that oncology has taken in evidence-based medicine.

What impact will CER have on innovation? Comparative effectiveness research has the potential to provide more solid levels of evidence to integrate into guidelines and to inform where evidence is lacking and drive the research agenda. At the same time, Dr. Benson stressed the importance of the investment in getting "a better biological understanding of the disease we all treat."

Attendees also heard discussions on the *Generational Factors Influencing Private Practice* and *Physician Payment Models in Community Oncology.*

The meeting was attended by presidents and representatives from state oncology societies.

ACCC's 5th Annual Hospital Summit: Meeting Wrap-up

On Dec. 11, 2009, almost 100 cancer care professionals gathered in Vienna, Va., for ACCC's 5th Annual Hospital Summit. They met with thought leaders in the oncology field and learned strategies to best chart a path forward under healthcare reform, new Medicare rules, and a difficult economic climate. Here are a few of the presentations attendees heard.

***ACCC's* 2010 Cancer Care Trends in Community Cancer Centers.** "Cancer programs are adapting to the recession," said Lee Blansett, MBA, of Kantar Health, who commented on preliminary results of the 2010 ACCC survey of member cancer programs. He said that 86 percent of respondents report reduced travel and education; 65 percent renegotiated vendor contracts; 61 percent delayed equipment purchases; and 59 delayed construction projects. Close to six in ten made changes to their cancer program as a result of the current economic recession.

The good news for hospitals is that they are positioned for success, said Blansett. Hospitals enjoy more diversified

Presidents' Retreat keynote speaker journalist Juan Williams (on left) said that he believes "…history will focus on one issue [from our times] above all else and that's healthcare." The question before congress, he said is "deciding whether or not you are willing to make history at this moment, even if that history is imperfect."

Presidents' Retreat attendees chat with keynote speaker journalist Juan Williams (on right).

revenue streams and service lines than community practices. And despite the recession, a majority of cancer programs characterize their programs' financial status as good or very good, according to the 2010 ACCC survey.

According to Blansett, hospitals' share of chemotherapy treatment is growing steadily, while oncology practices are seeing their share of chemotherapy decline. Patients referred to hospitals for chemotherapy treatment rose from 11 percent in 2007 to 18 percent in 2009, according to a MattsonJack DaVinci practice managers' survey. "Community practices' referrals to hospitals are rising," said Blansett. "If practices can't afford to treat, they will refer."

At the same time there's a growing trend to hospital-based practice arrangements. "I encourage you to talk to oncology practices. There's an opportunity for you to expand your role in the marketplace," said Blansett.

ACCC's 2010 survey did reveal an unfavorable pattern: Cancer programs have seen a drop in commercial insurance-based patients and an increase in the volume of uninsured and underinsured patients with high co-pays they cannot afford to pay. More patients require help affording their medication and transportation expenses.

Complete ACCC survey results will be published in mid-2010.

The Oncology Roundtable Outlook. Although the indigent and uninsured populations are increasing, patient volume is up across the board. "That should continue forward no matter what happens with the economy," said Allison Cuff Shimooka, MBA, managing director of the Advisory Board's Oncology Roundtable. Twenty-seven percent of programs report increased patient volume up to 5 percent; 28 percent of programs report increases of 5 percent or greater.

There is an "underlying sense of trepidation about the future of oncology," according to Shimooka. Cancer costs are growing exponentially. Costs are high even for insured patients. Insured patients spend an average of $35,000 on cancer treatment throughout their illness. Twenty percent of insured cancer patients spend all their savings on treatment.

Medical oncology practices are in a tighter market than hospital programs, according to Shimooka. Private practice medical oncologists have seen a dramatic decrease in profit per patient. From 2006 to 2007 they saw an 86 percent decrease (from $654 to $89 per patient). At the same time drug margins measured as gross revenue divided by total number of patients decreased from 17 percent to 11 percent in 2007.

Many oncologists are seeking hospital employment; and many hospitals are interested in partnering more closely with physicians. Co-management and joint ventures continue to be the most popular arrangement, but the federal government is chipping away at the models with increased scrutiny and regulatory limitations. "Overall, we are seeing a decrease in partnership activity overall and rising skepticism about them," said Shimooka. More tightly integrated models are becoming more attractive, she said, particularly for radiation and surgical oncologists.

"We are not seeing a wholesale shift among medical oncologists. They like their independence. As a result we are seeing emergence of an alternative: the medical oncology service agreement, by which the financial risk to the oncologist is reduced," said Shimooka, who called the arrangement "incredibly complex." The hospital leases medical oncology office space, becomes the provider of chemotherapy, performs billing and collecting, and provides service fees to physicians equal to the total direct cost, including compensation to the medical oncologist.

Other speakers at ACCC's Hospital Summit explored new opportunities related to healthcare reform, pay for performance from an oncology perspective, innovative solutions to the oncology workforce shortage, making better use of your registry data, and payment reforms.