Oncology Issues

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FROM THE EDITOR

They Just Aren't Interested in CCOPs Anymore

by Lee E. Mortenson, D.P.A.

At the ACCC Board meeting, invited guest, long-time translator, and facilitator Leslie Ford, M.D., was asking us a question: "Where are all the good, new CCOP applicants?" Leslie has been shepherding the Community Clinical Oncology Program (CCOP) for a long time now—probably a decade or more in one way or the other. None of us could tell Leslie where the new crop of CCOPs might be found. Does this mean that community oncologists are less interested in participating in trials or that community hospitals are less interested in developing their cancer programs?

The answer does not appear to be easy to understand. Basically, it has to do with turmoil in the marketplace. Last year I talked with fifteen different hospital groups around the country that were thinking of developing a CCOP program. None of them decided to apply. The reasons varied, but all fall under turmoil. In one city, the medical oncologists split off from the hospital to form a strong, large group that was not affiliated with any institution. In another town, a carve-out bought the physician practice. In many cases, the hospital no longer found that it had the wherewithal to support the part of the program that is not covered by NCI funding. Here is an underlying problem that is going to affect CCOPs and clinical research in many settings: the institutions that participate often put up as many dollars as they receive from the National Cancer Institute in the salaries of individuals necessary to make the program run.

That was okay when programs had a significant margin and were seeking a gold star to attract cancer patient referrals from local physicians. But in these days where managed care—not physicians—refer patients, a CCOP could be an unnecessary problem. After all, we all know that managed care plans are not that excited to see clinical research patients.

So, hospitals are not going to underwrite the development of CCOPs for important logistical reasons. The grant covers only about half the costs of implementation, and physicians in the local neighborhood are more likely to be competitors than partners in helping a hospital develop a program.

This is not good news for Leslie. She knows many of the problems with funding. She has been a valiant supporter of the fact that many existing CCOP programs have significant potential as sites for a number of broad NCI research initiatives. Without her advocacy, NCI might not have understood the potential of CCOPs as sites for prevention and early detection trials.

Is there any relief in sight? Much of the problem is beyond the control and scope of the NCI. Perhaps passage of the Rockefeller-Mack bill might reassure hospitals and physicians that at least patients on trials would not be denied coverage for their care. But fundamental system changes are disruptive in every way. Physicians are busy dealing with business issues and survival. Hospitals have the same set of quandaries: efficiency, partnerships, and fundamental quality care when resources are increasingly scarce and hassles are just increasing. In this milieu, the incentives to be a CCOP—to seek it as a prestigious marker of your institution's accomplishments and fully developed cancer program—are less attractive to many places.

Sorry, Leslie, that's not the answer we wanted to give you.