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Oncology...at the Brink

by Cara Egan

The 25th Annual National Meeting of the Association of Community Cancer Centers (ACCC) marked the organization's silver anniversary with the largest attendance of any ACCC event to date. More than 500 interdisciplinary oncology professionals, including representatives of the National Cancer Institute (NCI), the Health Care Financing Administration (HCFA), and the pharmaceutical industry, convened March 24-27, 1999, in Arlington, Va., just outside of Washington, D.C., to celebrate ACCC's quarter century of service to the oncology community.

Attendees were invited to participate in a number of festivities to honor the Association's remarkable past, beginning with a warm tribute honoring ACCC past presidents and their collective and individual contributions to the Association and the oncology community as a whole. Attendees also witnessed the unveiling of ACCC's new logo, followed by an irreverent parody of the Washington political scene by the Capitol Steps, a musical comedy troupe.

ACCC's 25th Annual National Meeting offered attendees both a look back and a look ahead. Opening the meeting, outgoing ACCC president Larry White, M.D., F.A.C.R., stated, "...ACCC's 25th anniversary should be more than a celebration of what we have achieved. Our anniversary is an opportunity to assess the state of what I like to call the "House of Oncology"—the current challenges facing the interdisciplinary oncology team as well as our mission and goals for the future."

Cara Egan is ACCC associate editor. Jeff Matheny, ACCC editorial assistant, contributed to this article.

THE FUTURE BECKONS...AND THREATENS

The consensus among meeting presenters indicated that the House of Oncology is stronger than ever, with widespread support among oncology professionals for interdisciplinary collaboration in treating patients with cancer. New technologies, including innovation in the areas of biotechnologies and cancer genetics, show potential for changing the ways in which cancer is diagnosed and treated. Partnership opportunities among community cancer programs, NCI, and the pharmaceutical industry offer promising advances in improving the quality of life for patients with cancer and their families.

Challenges loom, however, both in the short-term and further into the next century. More immediate threats appear in the form of reduced federal payments to hospitals, as evidenced by Ambulatory Payment Classifications (APCs), which, if enacted as originally written, could force the widespread closing of hospital outpatient oncology infusion units.

Discussion at ACCC's Governmental Affairs Forum included ways to counteract the damaging effect of APCs on oncology. Rep. Gene Green (D-Texas), along with more than twenty co-sponsors, has introduced Bill H.R. 1090, the Medicare Full Access to Cancer Treatment Act of 1999. The bill "carves out" cancer treatment from the outpatient prospective payment system (PPS) and specifically excludes any outpatient drug or biological used "as treatment, supportive care, or both" from APCs.

"The main problem with [the APC proposal] is that it fails to recognize the complexities of cancer treatments and the wide range and individual needs of each patient with cancer," stated Green, addressing meeting attendees. "As a result, the new payment system could threaten the quality and availability of cancer treatment for Medicare beneficiaries."

"ACCC is lending its full support to Rep. Green's bill," said ACCC Executive Director Lee E. Mortenson, D.P.A. ACCC, which was invited to assist in shaping the language used in the bill, is encouraging the oncology community to contact their representatives in Congress to urge support for the Medicare Full Access to Cancer Treatment Act of 1999.

Mortenson also alerted attendees to a recent proposal introduced by Rep. Pete Stark (D-Calif.) that calls for Medicare reimbursement for drugs to be based on the Federal Supply Schedule (the same reimbursement mechanism of Veterans Administration [VA] hospitals). Such a measure would drastically reduce federal payments to hospitals for chemotherapy and supportive care.

According to Mortenson, efforts to reduce drug pricing in this way are taken out of context, without an understanding of oncology drug reimbursement under the Medicare system. Under the VA hospital statutes, reimbursement for the costs of administering a drug is provided separate from payment for the drug itself, Mortenson explained. Medicare provides no discrete mechanism

for reimbursement of overhead costs, such as nursing staff, related to chemotherapy administration. As a result, oncology providers have used drug margins to cover their overhead expenses.

The Stark proposal is just one of many efforts on the part of the federal government to reduce drug pricing. President Clinton introduced in his 1999 budget proposal a provision to reimburse physicians at acquisition cost for the chemotherapy they provide. Mortenson stated that ACCC members can once again expect to be called upon to educate their members of Congress about this and other issues.

Measures to decrease hospital and physician reimbursement are occurring as part of a larger trend to curtail government health care spending as we move toward the millennium. Oddly enough, continued reductions in federal health spending will occur as Medicare beneficiaries become the number-one customers of hospitals and physicians, according to meeting presenter Russell C. Coile, Jr., a noted health futurist and vice president of Superior Consultant Company in Plano, Tex. By 2020, the 65+ population is expected to reach 53 million, comprised of a significant number of baby boomers whose consumer expectations for health care may exceed those of previous generations. This aging demographic will drive increased utilization of hospital care, physician services, and pharmaceuticals. In addition, a host of health care options, including new, minimally invasive technologies, innovative pharmaceuticals, and choice of provider options, will be demanded by the "wired retired," stated Coile, referring to what he expects to be an increasingly techno-savvy senior population.

At the same time, hospitals will be confronted with ever-rising costs associated with meeting these demands. Faced with shrinking investor capital and increased expenses to counteract severe nursing shortages, for example, hospitals will feel what Coile calls "the cut of 1,000 knives." According to Coile, Congress is acting on its belief that there are too many hospital beds in this country. Congress won't pay attention, he said, "until some hospitals bleed."

Coile expects health care providers to respond with powerful regional networks, strategically located solo hospitals, and specialized facilities tailored to specific markets. Hospitals, which are more likely to downsize than close, will create niche markets in search of new sources of revenue. Consolidation will continue as hospitals compete for market dominance. The key, Coile said, is getting there first. "If you're not thinking about how to dominate your market, someone else is."

CLINICAL TRIALS: A COST-EFFECTIVE OPTION

For more than ten years, ACCC has advocated third-party payment for the patient care costs of clinical trials. In the face of restricted federal health care spending, quality outcomes data will be necessary to justify more widespread third-party coverage of clinical trials. "If you truly believe that the best treatment option for the patient with cancer is always, whenever possible, participation in clinical research study, some sort of resolution of this problem [of clinical trials coverage] must be undertaken," stated William P. Peters, M.D., Ph.D., president, director, and chief executive officer of the Barbara Ann Karmanos Cancer Institute in Detroit, Mich. "The alternative to protocol-based research study is not 'no care,' but ineffective, outdated, and costly 'established' care."

The Karmanos Cancer Institute has undertaken a number of financial and patient outcome studies that indicate that the costs of treating patients on bone marrow transplant clinical trials, for example, can be comparable to the costs of treating patients on standard protocols. The studies also indicate that treating patients on BMT trials is less expensive than treating patients off-study, and results in longer regression-free survival.

Peters outlined a Karmanos study that compared two cohorts of patients with breast and lung cancers, respectively, who had relapsed after achieving partial remission. Patients on standard therapy were compared with similar patients undergoing stem cell transplant during remission. Peters presented data showing that median survival rates tend to favor those receiving stem cell treatment as part of the clinical research study. Patients with lung cancer in particular nearly doubled their regression-free survival on the stem cell cohort. Peters also showed that after the first six months of the study, the average cost per patient was actually less for the patient participating in the clinical trial. Costs eventually rose as compared to standard therapy regimens, which Peters attributes to higher death rates (and thus fewer patients) on the standard arm of the study. Overall, however, Peters' data overwhelmingly point to stem cell transplant improving regression-free survival for these patients. Thus, patients treated off-study faced a higher risk of recurrence, which resulted in higher treatment costs.

According to Peters, these numbers make sense. "According to the Congressional Budget Office, 90 percent of trial-related costs are currently covered by private health plans," he stated.

Peters has achieved remarkable financial and patient outcomes for bone marrow transplants, largely as a result of his ability to reduce the greatest cost driver of BMT: inpatient stay. Under Peters' leadership, Karmanos has been able to reduce the average inpatient stay of BMT patients from thirty-seven to just five days.

WILLING RESEARCH PARTNERS

NCI is undergoing a major reorganization that will broaden opportunities for community cancer programs in prevention research, according to Leslie Ford, M.D., associate director for clinical research within the Division of Cancer Prevention at NCI. Up until recently, Ford explained, NCI's Phase II prevention trials had been executed primarily through contracts and grants with NCI's Chemoprevention Branch, which tended to limit physician participation and patient accrual. By opening up a number of these trials to the CCOP network, NCI intends to broaden access to cancer prevention trials. This mechanism

continued on page 30

continued from page 28
would support a pool of Phase II investigators and investigator-initiated grants to which CCOPs have traditionally not been allowed to accrue. According to Ford, it is possible that select CCOPs of the future would have a major focus in prevention, with a minor focus in treatment research.

NCI is also working to encourage increased pharmaceutical participation in prevention research. Ford conceded that the obstacles are formidable. "It is difficult and expensive to prove that a drug prevents something," she stated. "It takes many years, many people, and many dollars to essentially wait for something not to happen." The NCI is collaborating with the Food and Drug Administration to publish guidelines to assist the pharmaceutical industry in bringing a drug to a prevention labeling indication.

According to David Parkinson, M.D., vice president of clinical research with Novartis Pharmaceuticals Corporation in East Hanover, N.J., the pharmaceutical industry is ready and willing to step up its efforts to assist community cancer programs in all aspects of oncology clinical research participation. "Our goals in this area are absolutely identical," Parkinson said. "We want to show benefit with minimal negative aspects."

There are, however, unique pressures related to time, cost, and quality facing the pharmaceutical industry. These forces must contend with a group of shareholders interested in a return on their investment. Execution of a clinical trial then becomes one of risk management, Parkinson said. Processes such as finalizing contracts, obtaining IRB approval, and site review and selection (as well as the lengthy progression of a trial toward often hard-to-achieve clinical endpoints) contribute to added costs and increased risk for pharmaceutical companies.

To the pharmaceutical industry, oncology is a relatively small but complex market, which is itself comprised of multiple segmented markets. Thus, oncology offers special challenges to an industry accustomed to the mass markets of cardiologic, anti-hypertensive, and anti-infective drugs in which clinical trials development is relatively straightforward. "Pharmaceutical companies are used to making big investments in clinical trials programs of agents that aren't very different from the previous agent," Parkinson explained. Oncology is, for many organizations, the "new frontier."

Community cancer programs and their industry partners can work together to ease the time-consuming and costly processes shared by both parties in establishing a clinical research arrangement, recommended Felicia Patterson, R.N., B.S.N., manager of clinical trials for Bristol-Myers Squibb Oncology in Princeton, N.J. Site selection, IRB review, and accrual of patients to trial will proceed more smoothly if both sides are prepared at the outset.

There are a number of criteria that a cancer program must satisfy before qualifying as a trial site. A program's industry partner must be confident that the investigator can operate within a strict timeline that includes execution of the trial, submission of a final report to the FDA, and publication of the results, Patterson said.

Patterson recommended several steps cancer programs can take to reduce unproductive efforts and improve chances for selection as an industry research site. Above all, Patterson stated, a program should know the costs of conducting the trial, taking into account the costs of patient care and fair compensation for staff time. If a program can't perform efficiently, it will lose money, she said. Worse, if the program cuts corners and patient care is compromised, the institution is responsible. Therefore, it is imperative for institutions to weigh the feasibility of any clinical trials arrangement before entering into it.

TECHNO-ONCOLOGY

Oncology is seeking to assume its place in the technological care delivery arena. Peters and the Karmanos Cancer Institute, for example, are now looking to information technologies, including e-mail and video conferencing, to streamline patient care and further reduce costs. Our society is moving, Peters believes, into an "asynchronous decentralized system," i.e., one in which electronic technology permits physician/patient interaction to occur at a distance. Technology allows this interaction to take place after business hours and off-site, at great convenience to the patient and physician.

Karmanos is using video conferencing to monitor outpatient transplant patients and assess potential complications without a trip to the hospital. This type of interaction has the opportunity to substantially change the lives of our patients, Peters said. "If we can manage [patients] 300 yards away, we can manage them at 300 or 3,000 miles."

An informational web site that is easy to navigate can achieve many of the same goals, while also improving a program's market reach. "If you build it, they will come" is the hope of many cancer program administrators, physicians, and other staff members involved with web site development at their institutions. However, turning that hope into referrals, patient and physician services, prestige, and other benefits depends on many factors. According to Peter H. Blitzer, M.D., F.A.C.R., president of the American College of Radiology, the first step is to know your target audience.

A successful site should have content and an appearance that reflect the site's primary viewers. A flashy graphic that attracts the prospective patient, for example, can slow down a busy physician checking his or her schedule. Sites that will likely cater to an audience with conflicting demands are forced to make compromises. Regardless of the audience, Blitzer recommends "keeping a clean site and not getting carried away." He points to the web site for Fox Chase Cancer Center in Philadelphia, Pa., as an example of good layout and design (www.fccc.edu). Above all else, Blitzer believes in three factors for success, "Content, content, and content."

The emphasis on content places most of the workload on physicians and other staff members. "The computer part is easy, content is the hard part," Blitzer asserted. Believing the reverse to be true is a common mistake—and often results in an attractive site that is

of little or no value to patients or physicians. To highlight the simplicity of HTML (the language for web pages), Blitzer claims that without previous knowledge, "you could sit down this afternoon and write a passable-looking page."

A good site requires substantial time commitments from physicians and, to a lesser extent, other staff members as well. Webmasters and programmers should help with posting material to the site and tweaking it a bit, but ultimately the physicians and other staff members should be responsible for all content, Blitzer said.

Y2K IS HERE

Many organizations are implementing their Y2K strategies under the misconception that major malfunctions will occur upon the stroke of midnight of January 1, 1999. In fact, recent studies have indicated that only 8 percent of Y2K problems are expected to occur within the two-week periods before and after January 1, 2000. According to Joel M. Ackerman of Rx2000 Solutions Institute in Edina, Minn., 55 percent of all problems are expected to occur throughout 2000, with 15 to 20 percent occurring in 2001 and beyond. Ackerman is executive director of Rx2000 Solutions Institute, an organization created specifically to help the health care industry prepare for the year 2000.

Perhaps the most troubling statistic of all, 15 percent of all Y2K problems will occur before January 1, which essentially could mean "right now," Ackerman said. Organizations that have not yet begun to explore Y2K's impact on their operations will suffer the most as a result. These organizations are likely experiencing problems such as bad data, but are unaware of it.

Organizations still have time to develop Y2K strategies, but they must act quickly. "At this point in 1999 you're not going to fix everything," Ackerman said. "But you must have a plan in place for dealing with the failures when they occur." He therefore advises groups to focus on contingency plans. "If you have a dollar for Y2K that you could either put toward fixing things or building a contingency plan, I recommend the contingency plan."

An organization can expect its Y2K activities to be scrutinized by regulatory agencies, the media, customers, consumers, shareholders, employees, auditors, and attorneys. From a legal perspective, an organization should assume that it will be sued over some Y2K issues, and that it will likely sue others as a result, according to Ackerman. A hospital's first priority, he advised, is to ensure that patient care failures don't occur, then work with legal counsel to prepare the organization in the event an adverse event does occur.

Despite what many people want to believe, there is no silver bullet or magic fix to this problem. Although many individuals are holding out for federal legislation or assistance from payers to minimize their Y2K risk, "Don't count on it," Ackerman warned.

Hospitals and physicians are also concerned about the ability of the Health Care Financing Administration (HCFA) to process and reimburse Medicare claims in a timely and accurate manner. Joseph Broseker, Jr., Y2K coordinator for HCFA, assured attendees of the agency's commitment to the problem. HCFA has sought the expertise of independent verification and validation contractors to ensure its systems, and those of its contractors, will operate. "We're really all in this together—no matter how well [HCFA is] able to process Medicare claims from January 2000, if we don't receive them, we can't pay them," Broseker said. "If we don't receive them, then we have to be concerned that our beneficiaries are not getting services."

HCFA is spending $200 million on its Y2K efforts, the administration's most expensive systems

Ellen Stovall, executive director of the National Coalition for Cancer Survivorship (NCCS), was honored with ACCC's Annual Achievement Award for Outstanding Contributions to Cancer Care during the Association's 25th Annual National Meeting. "Community oncology is so near and dear to me... and yet it is so undervalued, so under-rated," said Ms. Stovall, noting that all too often large academic medical centers, not community cancer centers, receive media attention. "My hat is off to each and every one of you for the wonderful care you give everyday. I feel that you saved my life."

Ms. Stovall is a twenty-seven-year survivor of cancer. Since 1992, she has served as executive director of NCCS, a national grassroots organization advocating policy issues that affect people with all types of cancer. In 1998, she also concurrently served as founder and president of THE MARCH...Coming Together to Conquer Cancer.

Despite continued regulatory and fiscal threats to patient access to quality cancer care, Ms. Stovall remains optimistic. "As Winston Churchill once said, 'Success is going from failure to failure without a loss of enthusiasm.'"

undertaking since the inception of the Medicare program, Broseker reported. Contrasted with the billions of dollars that HCFA pays out every year—one-third of total expenditures in the health care economy—$200 million is a worthy investment. "We couldn't risk disruption," explained Broseker. "We recognize that if we fail, we could also impact other health care sectors...we can't allow that to happen."

Of course, HCFA's commitment to Y2K meant that other key projects had to be deferred through 2000, a Y2K reality for any organization with limited resources and a pressing deadline, Broseker said. HCFA received congressional approval to delay several pieces of the Balanced Budget Amendment of 1997, for example. "We had to make some painful decisions," Broseker said.

HCFA is organizing a proactive outreach campaign to educate providers about its efforts to ensure smooth operations throughout the next year. Broseker referred attendees to HCFA's 1-800 Y2K helpline (1-800-958-HCFA) and to www.hcfa.gov for updates on its progress.

LIVING IN THE FUTURE

According to Russell C. Coile, "no one can understand the future of health care like the ones who actually practice it." Throughout the continued consolidation and restructuring of health care, improvement of clinical processes will require people with clinical backgrounds, Coile said.

Such was the case with the recent redesign effort of Duke University Health System in Durham, N.C. Duke University Hospital implemented a care management system based on the coordination of clinical business units (CBUs). This service line management model centralizes clinical, financial, and administrative services around particular patient populations. The restructuring, which was created as an alternative to across-the-board programmatic and staffing cuts, was based on the core needs of a particular population and the core value of each discipline serving that population. The issue then became one of allocating resources appropriately across CBUs, according to Kevin Sowers, M.S.N., R.N., senior associate chief operating officer for the Duke University Medical Center and Health System in Durham, N.C. As a result, the contribution of each CBU could be measured in terms of clinical and financial outcomes. Thus, the redesign also introduced a new level of accountability for staff within each CBU, Sowers said.

Encouraging staff to embrace the changes your institution will undergo in the future is not always an easy task. According to Sowers, the journey toward the future involves more than simply leading people to a new place, but "teaching people how to live once they get there."

SIG ROUND-UP

Administrator SIG. Three sessions were offered.

- "Developing Your Cancer Program Web Site" was presented by Peter H. Blitzer, M.D., F.A.C.R., president of the American College of Radiology and partner at Radiation Therapy Services, Inc., in Fort Myers, Fla. He provided an overview of web site development techniques, emphasizing the importance of a targeted audience and the role of physicians in developing content. (See accompanying article for more information.)
- "Redesign of Care Coordination" was led by Kevin W. Sowers, M.S.N., R.N., senior associate chief operating officer and Carolyn Caulfield, M.H.A., strategic services associate, both with Duke University Medical Center and Health System in Durham, N.C. The pair offered advice and techniques for structuring a redesign of care coordination. (See accompanying article for more information.)
- "Practical Tips for Streamlining Your Cancer Program Operations." Ruth L. Lander, F.A.C.M.P.E., administrator with Columbus Oncology Associates, Inc., in Columbus, Ohio, provided insight into how technology can streamline daily operations and facilitate cost efficiencies.

Community Research/CCOP SIG. "Update from the National Cancer Institute" featured the annual "State of the National Cancer Institute Address" by Leslie G. Ford, M.D., associate director of Early Detection and Community Oncology, and Lori Minasian, M.D., chief, Community Oncology & Rehabilitation, both within the Division of Cancer Prevention at NCI, as well as a presentation by David Parkinson, M.D., vice president of clinical research at Novartis Pharmaceuticals Corp., in East Hanover, N.J. (See accompanying article for more information.)

Medical Director SIG. "Improving Your Negotiating Skills" was the topic of this presentation by Paul Cramer, principal and director of the CMI Concord Group in Wellesley, Mass. He discussed the importance of identifying and prioritizing interests, legitimating an offer, and many other elements involved in the delicate art of negotiation.

Radiation Oncology SIG. "Innovative Therapies in Radiation Oncology," was led by R. Alfredo C. Siochi, Ph.D., a medical physicist with Siemens Medical Systems, Inc., in Concord, Calif. Siochi presented the latest equipment and most advanced treatment modalities in radiation oncology.

Nursing SIG. "Legal Issues in Nursing" was presented by Susan B. Fink, R.N., B.S.N., J.D., a nurse attorney with Koskoff, Koskoff & Bieder, PC, in Bridgeport, Conn. She cited recent malpractice cases to illustrate the elements involved in a malpractice suit, the defense tactics commonly employed, and how doctors and nurses can protect themselves from liability.