

ClinicalOncology

Advances in Cancer Care

news

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CLINICAL TRIALS

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EDUCATIONAL REVIEW



Renal Cell Carcinoma: State-of-the-Art Diagnosis and Treatment

by Ronald M. Bukowski, MD and
Laura S. Wood, RN, MSN, OCN

See page 16.

Stem Cell Transplantation Can Be Outpt Procedure

ORLANDO, FLA.—Myeloablative allogeneic stem cell transplantation, a procedure typically associated with a hospitalization lasting between 25 and 30 days, is being successfully performed on an outpatient basis in a program developed in Atlanta.

In fact, it has now been adopted as the standard of care. Except for the in-hospital stem cell transfusion, all other aspects of care, including myeloablative conditioning and supportive care, are planned for outpatient administration. The benefits, according to an evaluation of the first 100

see *OUTPATIENT*, page 20 ►

ADVISORY BOARD EDITORIAL

Evidence-Based Medicine

A Framework For Interpreting Clinical Trials

In science, knowledge is advanced through the processes of observation and experimentation, the results of which are published in tens of thousands of professional journals every year. Clinicians must try to stay current with the literature, appropriately interpret the papers they read, and apply the ever-changing scientific findings to therapeutic decision making. With human knowledge doubling every five to 10 years, this has become an exceedingly daunting task.

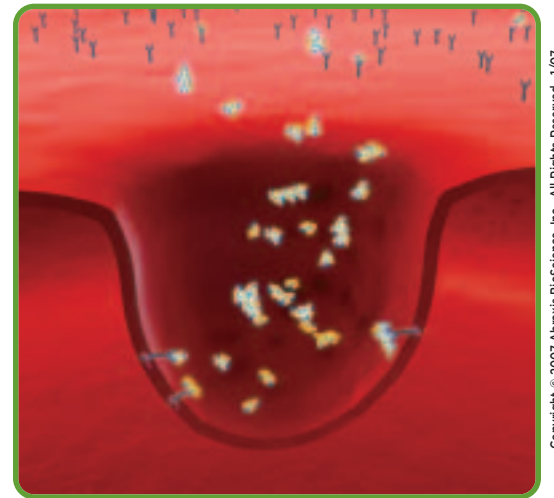
The science of pain management has

see *EBM*, page 24 ►

Nanoparticle Albumin-Bound Paclitaxel Nab-Paclitaxel Tops Docetaxel In 1st-Line Metastatic Breast Ca

SAN ANTONIO—Nanoparticle albumin-bound paclitaxel given weekly was superior to docetaxel given every three weeks in the first-line treatment of metastatic breast cancer.

“Weekly nab-paclitaxel [Nanoparticle albumin-bound paclitaxel; Abraxane, AstraZeneca/Abraxis] used in the first-line metastatic setting increased responses by over 60%, with less toxicity than the FDA-approved dose of docetaxel given every three weeks,” William Gradishar, MD, told *Clinical Oncology News*. Dr. Gradishar, principal investigator of the study, is director of breast medical oncology at the Robert H. Lurie Comprehensive Cancer



Nanoparticle albumin-bound paclitaxel binds with the albumin-specific receptor for delivery of the drug into the tumor cell.

Center, Northwestern University, Chicago. He reported these interim results at

see *PACLITAXEL*, page 4 ►

Tips on Building Provider- Provider Relationships

How To Collaborate and Align Interests

There are several ways for health-care providers to work together to benefit each other, as well as their patients and communities.

Often, providers see each other as enemies rather than as allies who are struggling with similar challenges and problems. These can include insurers

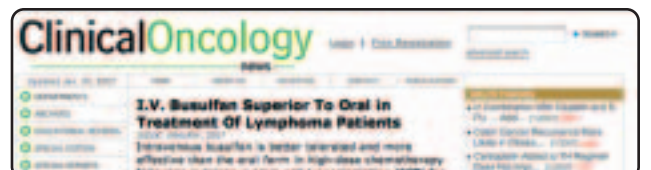
who want rich services at low prices; patients with increasingly poor coverage who lack adequate resources to meet their personal responsibilities; and a national culture in which people believe that every patient—no matter his or her chances of treatment success—

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COLLABORATION

RELATIONSHIPS*continued from page 1 ▼*

deserves heroic measures. After all, we seem to think, someone will pay for it. Right?

This article explores three areas of potential collaboration through which oncologists and hospitals can work to reach the common goal of providing quality care in a given community. Collaboration in these areas becomes especially important because of new Medicare reimbursement initiatives for oncology and the regulatory requirements associated with those initiatives. It is important to carefully assess your options for working with other colleagues and hospitals as regulatory and reimbursement pressures increase in 2007.

We are entering an era where provider payment will be increasingly attached to *proof of quality of care and patient safety*. This will require improved record keeping and patient management by providers—services that are costly to implement and for which there will be no increased compensation. There is, however, one potential resource for physicians.

Electronic Medical Record Systems

In August 2006, a rule was clarified that affects the ability of hospitals to provide physicians with information technology systems. This clarification allows hospitals to assist physicians in the implementation of an electronic medical record (EMR)-keeping system.

Whether providers are located in a one-hospital town or have several hospitals from which to choose,

they typically favor one hospital over another. Determining factors may be the quality of nursing care, the support provided by the hospital's administration or the presence of state-of-the-art facilities. EMRs are now moving up on the list of reasons why physicians choose one hospital over another.

Physicians appreciate the flexibility of being able to view and/or document a patient's progress, test and procedure notes from the office, home or on the hospital's main campus. Hospitals are beginning to understand the value of extending an electronic reach beyond the hospital and providing physicians with the information technology they need in the office and at off-site practices in order to be connected to real-time patient data.

The Social Security Act (SSA) Section 1877(b)(4) Rule 411.375(w), August 8, 2006 created an exception to the physician self-referral prohibition. This rule creates a separate regulatory exception for certain arrangements involving the provision of nonmonetary remuneration in the form of electronic health record (EHR) software or information technology and training services necessary and used predominantly to create, maintain, transmit or receive EHRs.

Software packages may include functions related to administration, such as scheduling, billing and clinical support. The package must include electronic prescribing and comply with the standards provided under Medicare Part D. Physicians receiving hardware, software and information technology support from hospitals are responsible for 15% of the donor's cost toward the purchase of the EHR package.

It is critical to consider investing in a full EMR sys-



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tem for your practice. This improved mode of communication among caregivers will result in better health decisions and improved safety. It will also enhance the quality of care provided for patients. The SSA ruling enables physicians to work with local hospital(s) to obtain or upgrade technology capabilities at a greatly reduced cost.

For more information and greater detail, visit www.cms.hhs.gov/PhysicianSelfReferral/Downloads/CMS-1303-F.pdf for the Federal

see **RELATIONSHIPS**, page 30 ►

COLLABORATION

RELATIONSHIPS

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Register from August 8, 2006.

Infusion Center

Another problem area currently facing oncologists is related to patient insurance coverage and provider reimbursement. As drug costs continue to rise, insurers struggle to decrease spending. At the same time, the incidence—or diagnosis—of many diseases increases, as do patient co-pays. On top of all this, the numbers of uninsured and underinsured individuals grow. Everyone involved in the health care “business” must consider alternatives so that patients are receiving the most cost-effective treatments.

The second concept presented in this article is an evaluation of the benefits of providers aligning interests with local hospitals and creating, for example, an infusion center. The hospital and the providers can work together to secure appropriate funding and to deliver quality oncology treatment and care.

Providers are forced to take a hard look at business operations and to identify ways to continue providing quality care while stabilizing or reducing costs. Strategies such as providing financial counseling and helping patients find available resources, such as state, community and pharmaceutical industry-sponsored programs, are quite worthy of consideration. Additionally, providers should consider the benefits of collaborating with local hospitals.

Many hospitals are faced with the same financial constraints as individual providers. Hospitals and physician practices share the burden of increased regulations. A resolution that would most benefit the local community would be for a provider or provider group to partner with a local hospital.

For example, in considering the regulations and costs associated with providing infusion services, you should also consider working with a hospital that qualifies or could qualify for the 340B drug-discount program. In collaboration with this hospital, you and your group could partner to develop an infusion center.

Acute-care hospitals are eligible for the 340B drug-discount program if the hospital meets the following requirements:

1. The hospital is owned or operated by a unit of state or local government, is a public or private nonprofit hospital that has formally been granted government powers or is a private nonprofit hospital under contract with a state or local government to provide indigent care.
2. The hospital has a Medicare *disproportionate share* adjustment percentage of more than 11.75%.
3. The hospital has certified that it will not obtain covered outpatient drugs through a group purchasing organization or other group purchasing arrangement.

In addition to considering a partnership to create a 340B option for your community, the combination could work to create a cancer foundation with community resources steered to help the underserved patients. The nonprofit status of a hospital can be the catalyst to provide full financial, staffing and other support for a physician practice with which the hospital partners.

By partnering with a community hospital, you and your practice can help build a local oncology program and ensure that cancer patients receive the support and treatment they need. Aligning with a hospital



Key Areas To Consider When Forging New Relationships

Risk: Identify preferences related to risk taking versus risk aversion.

Ask yourself the following questions:

- How much risk am I willing to take?
- Do I want to be an owner?
- Do I want control of day-to-day operations?
- Do I want to maximize my income?
- Which trade-offs am I willing to consider?
- Which is most important?

may also result in substantial savings for you and greater profitability for all parties.

Joint Ventures

A third option to consider is forming a joint-venture relationship with a local hospital. One example would be to work together to provide radiation oncology services. The reality for many communities today is that several physician specialties that manage patients with cancer are exploring the idea of owning radiation oncology centers. Additionally, radiation oncologists can look to a local community hospital as a potential partner, rather than as an employer or competitor.

For sometime, physicians have viewed hospital joint ventures or relationships as an unthinkable option for their practice. Physicians have long preferred to

There are specific legal requirements for joint-venture cancer programs and state laws are often as complicated as federal statutes. For instance, physicians cannot be paid by referral and all payments made as part of a service agreement must be based on fair market value.

either work for the hospital or create a physician entity. The same market forces that have created a renewed interest among surgeons, primarily urologists, and medical oncologists in developing radiation programs have pushed radiation oncologists to reconsider joint-venture options with hospitals.

Hospitals that were once unwilling to share technical revenue and investment opportunity with physicians face a new market reality. Barriers to entry have diminished and physicians have elected to compete as owners. Joint ventures can be extremely helpful in strengthening relationships between physicians and hospitals. Alignment can strengthen and improve the quality of cancer care within a community.

Joint ventures work by aligning parties with common or synergistic economic interests to enhance market position and thereby increase mutual financial success. Joint ventures represent an increasingly important strategy for providers. Successful ventures are based on an integrated approach that aligns long-range strategic, financial and operating plans.

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It is critical for this process that your practice hire a skilled business adviser. It is easy to get caught up in the tactical issues better known as the “details” of the business structure, before actually identifying the parties’ risk tolerance and optimal strategic design structure. Questions regarding the physical facility, insurance, equipment, accounting, information technologies, services, outsourcing and so on, should be discussed after other key questions have been adequately addressed.

Your analysis will raise questions related to structure and control. You will also need to determine your willingness to take risk. The planning process often points out a partner’s strengths and weaknesses and key issues to discuss about operating structure and control matters. Early in the process, you will address all of the key business terms with your potential partner(s) including buy-out, buy-in and noncompete provisions.

—Barbara Constable RN, MBA,
and Rhonda M. Gold RN, MSN

Barbara Constable RN, MBA, and Rhonda M. Gold RN, MSN, are directors of The Pritchard Group. For more information visit thepritchardgroup.net.