From the Editor's Desk

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Perhaps the greatest challenge currently facing oncologists in the practice setting is the decision whether to participate in the Competitive Acquisition Program (CAP) to acquire drugs for treatment of Medicare-eligible patients. In this issue of the *Journal of Oncology Practice*, we use a question-and-answer format to focus on CAP. Although CMS has delayed implementation of CAP until July 1, 2006, oncologists will have to elect whether to participate in the program. Participation is a business decision that will depend on individual circumstances. A careful analysis of our article, the primary source document (available at www.cms.hhs.gov/providers/drugs/compbid/), updated and late-breaking information from www.asco.org, and your own financials and projections are in order. I see implementation of this program as cumbersome. The multiple steps involved suggest to me that large, integrated entities—in which the oncologist, the CAP vendor, and the oncologists' front and back office staff all have aligned incentives—are at an advantage to have the process work best for patients.

Charlie McKay of Nashville, Tennessee, is profiled this month in our continuing series of interviews with clinicians who have organized successful clinical organizations. Dr. McKay leads a practice that has an outstanding business execution strategy, a widely recognized clinical trial organization, a flourishing indigent care program, and experience dealing with the notorious TennCare.

On the subject of success, three organizations with excellent minority outreach clinical research programs are featured in our series publicizing ASCO clinical trial participation awardees. Two common themes emerge among these cooperative group award winners—teamwork and supplemental funding. All three winners—a hospital-associated practice in northern Philadelphia, Pennsylvania; a radiology group in St. Louis, Missouri; and a surgical group in Chicago, Illinois—stress the importance of teamwork. All have institutional financial support for their clinical trial team—support not supplied by the National Cancer Institute (NCI)-funded cooperative group. Not only is NCI clinical trial participation a “labor of love” (to use Allen Lichter’s characterization) but it requires subsidization from an external source to be successful. Dr. Monica Morrow, a successful surgical oncology clinical investigator, offers advice on beginning an academic clinical research career.

The National Comprehensive Cancer Network (NCCN), an organization of 19 NCI-designated cancer centers, is featured in our “From Our Partners” series. Most widely known for its series of treatment guidelines, the NCCN also publishes the *Drugs & Biologics Compendium* and holds a series of educational meetings, which focus on its treatment guidelines. (Disclosure: I serve as one of the University of Michigan’s representatives on the NCCN’s Board of Directors.)

Our “Practical Tips” section focuses on infusion pumps reimbursement issues. This is especially topical with the prominence of continuous-infusion fluorouracil-based regimens in the treatment of colorectal cancer. Clinical Practice Committee chair John Cox briefly reviews the history of ASCO’s state affiliate program, and Michigan’s state society (Disclosure again here: I am a member) is profiled in another article. The Michigan society has done a great job of integrating academic and community practice docs, and representing issues of importance to both.

Bob Dillman and colleagues from the Hoag Cancer Center in Orange County, California, review their mortality statistics before and after opening of their community hospital-based cancer center. They compare their mortality for common cancers, especially those cancers that benefit from multidisciplinary care, with mortality from their hospital prior to the center’s opening, and also compare mortality rates to SEER (Surveillance, Epidemiology, and End Results) rates. They advance the thesis that discussion in multidisciplinary educational conferences, a common approach among practitioners, and coordinated medical education offerings improve care. Therese Mulvey, in her editorial, raises the possibility that surveillance and ascertainment biases may influence results, and that historically controlled data is always suspect. Nonetheless, we think these two contributions are provocative and worthy of your attention.

We conclude our series on the use of mid-level providers—physician extenders, nurse practitioners, physician assistants—in an oncology practice. There are important considerations and planning that should be made prior to integrating these valuable personnel into your practice. I have worked with two excellent nurse practitioners. Both are women, and have helped me immensely in both dealing with my female patients, who may be more comfortable initially raising sensitive issues with a woman professional, and also as a reality check for my more outlandish ideas. I was alert to their raised eyebrows and their quizzical facial expressions, and we worked together to enhance our patients’ care.

Our readers and I would love to hear some of your outlandish ideas as well—our collective patients may benefit.

Douglas Blayney