Navigation Resources for Survivorship

We wanted to let *Clinical Journal of Oncology Nursing (CJON)* readers know about some survivorship and navigation resources available to them. The George Washington University (GW) Cancer Institute has created several resources on cancer survivorship. The institute's Center for the Advancement of Cancer Survivorship, Navigation, and Policy hosts free monthly webinars on the latest survivorship research and resources, including findings from the Best Practices in Navigation and Survivorship Survey or demonstrations of care planning tools.

The institute also has several training sessions available for healthcare professionals. Through a cooperative agreement with the Centers for Disease Control and Prevention (CDC), the GW Cancer Institute is transitioning its in-person Executive Training on Navigation and Survivorship, a nuts-and-bolts training course for launching a program, to an online format that will be available at no cost through its online academy. As part of the National Cancer Survivorship Resource Center, a collaboration between the American Cancer Society and the GW Cancer Institute funded by the CDC, the institute has developed a free cancer survivorship e-learning series for primary care providers available at www.cancersurvivorshipcentereducation.org. Modules are relevant to oncology and primary care providers, and they cover the current state of survivorship, managing the physical and psychosocial effects of cancer and its treatment, prevention and health promotion, and care coordination. New modules on recovery and rehabilitation as well as guidelines for primary care providers will be added in the next year.

Funded by the Patient Centered Outcomes Research Institute, the GW Cancer Institute also is working on a project to better understand models of survivorship care and their impact on survivor outcomes. The project includes conducting an environmental scan of Commission on Cancer–accredited cancer programs to identify current practices and describe models of care in greater detail as well as perform a comparative effectiveness study on models of care. Those who are interested can sign up to receive updates about the project findings at www.smhs.gwu.edu/gwci/research/evaluating-cancer-survivorship-care-models.

Anne Willis, MA
Director
Division of Cancer Survivorship
Center for the Advancement of Cancer Survivorship, Navigation, and Policy
GW Cancer Institute
Washington, DC

Response to "Incidence and Self-Management of Hand-Foot Syndrome in Patients With Colorectal Cancer"

Forgive me for just getting around to reading Zhao et al.'s (2013) article in the August issue of *CJON*. However, I found it enlightening and disappointing that so many patients reported not having the necessary information to recognize this side effect from their treatment regimen. We can and must do better to educate them. To that end, I wanted to share with you what I now tell my patients and families regarding any skin changes: Have them photograph it with their smartphone.

Benefits are many. The patient and family are involved in the care, a photographic log is created for comparison and reference, and the photo can be emailed or texted to healthcare professionals for review (a practice termed *telederm*), which often can save patients a trip to the clinic or mandate a trip.

Elaine B. Llanos, MSN, RN, OCN®
Ambulatory infusion nurse
Memorial Sloan-Kettering Cancer Center
New York, NY

Reference

Zhao, Y., Ding, Y., Lu, Y., Zhang, J., Gu, J., & Li, M. (2013). Incidence and self-management of hand-foot syndrome in patients with colorectal cancer. *Clinical Journal of Oncology Nursing, 17,* 434–437. doi:10.1188/13.CJON.434-437

Response to "Drug Shortages and the Burden of Access to Care: A Critical Issue Affecting Patients With Cancer"

We fully agree with McKeever, Rosen Bloch, and Bratic (2013) that generic drug shortages have seriously impaired the care given to patients with cancer and countless others. However, their discussion of the causes is seriously flawed, beginning with their characterization of the problem as "multifaceted and complex" (McKeever et al., 2013, p. 490). This explanation also is referred to as the perfect storm theory. Like many other authors, McKeever et al. (2013) cite a laundry list of causes, including raw materials shortages, Medicare reimbursement schedules, hospital inventory methods, manufacturing delays, and so-called gray market distributors.

The notion that the unprecedented drug shortages were the result of a perfect storm is simply false. It was first disseminated in 2011 by the hospital group purchasing organization (GPO) industry (Cherici et al., 2011; Cherici, McGinnis, & Russell, 2011), which controls the purchasing of up to $300 billion in drugs, devices, and supplies each year for some 5,000 private acute care hospitals (Clapp, Rie, & Zweig, 2013; Healthcare Purchasing News, 2012; Litan, Singer, & Birkenbach, 2011; Sethi, 2009). These buying cartels promoted that canard to deflect public attention from their anticompetitive contracting practices, self-dealing, and kickbacks for GPOs, which are the real root cause of this crisis (Earl & Zweig, 2012; Moss, 2012; Woodcock & Wosinska, 2013).

These practices have been documented in four Senate hearings (Hospital Group Purchasing, 2002, 2003, 2004, 2006), numerous media reports (Blake,

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Key words: navigation resources; self-management; telederm; drug shortages

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2010; Bogdanich, 2002; Walsh, 2002; Zweig & Zellner, 1998), government investigations (Blumenthal, 2006; Hospital Group Purchasing, 2003; U.S. Government Accountability Office, 2002), antitrust lawsuits (Lambert, 2007; Smith, 2003), and independent academic studies (Porter & Teisberg, 2006; Sethi, 2009).

In the GPO system, vendors compete for exclusive contracts based on who can pay the largest fees, not who can supply the best product at the best price. The exclusionary contracts and outrageous and undisclosed fees (Blake, 2010; U.S. Government Accountability Office, 2012, 2014; Woodcock & Wosinska, 2013) have reduced the number of vendors to one or two for many drugs and impaired the ability of vendors to maintain quality. GPOs have broken the generic injectable industry by undermining the laws of supply and demand, and they've inflated costs by at least $30 billion annually (Litan et al., 2011).

After years of avoiding public mention of GPOs in connection with the shortages, the U.S. Food and Drug Administration (2013) recently acknowledged their central role (Wosinska, 2013).

McKeever et al.'s (2013) understanding of the impact of the Medicare drug reimbursement formula from the Medicare Modernization Act of 2003 also is inaccurate (U.S. Government Accountability Office, 2014). It has nothing to do with the drug shortages. The average sales price (ASP) plus 6% formula was instituted so that reimbursement would be closer to what providers pay than the previous formula, which was based on the average wholesale price. The ASP uses manufacturers' sales data, so it is not a fixed price ceiling. When prices increase, the ASP increases, and vice versa. The manufacturers' profit margin is built into the negotiated sales price; it is not 6%. This formula enables providers that pay more than the average to be adequately reimbursed.

McKeever et al.'s (2013) suggestion that Medicare reimbursement for chemotherapy drugs should include compensation for staff and facilities expenses is preposterous. In addition, the article confuses causation with correlation in concluding that the formula must have caused the shortages because the number of shortages rose dramatically since 2005 when the new formula took effect. During this same period, the GPOs tightened their grip on the generic injectable market (Earl & Zweig, 2012). Recognizing the GPO role in the supply chain, Obama administration officials correctly rejected calls to amend the formula in 2011 (Wilkerson, 2011).

In addition, McKeever et al. (2013) noted that so-called gray market distributors have contributed to the shortages by charging premium prices, an unfair allegation first leveled by the GPO lobby and later by several lawmakers. These distributors are mostly small to mid-sized firms that have served an important and legitimate function for years by supplying providers with relatively small quantities of drugs, frequently on short notice. Their prices are higher than those charged by major distributors because they are barred by the GPOs from receiving manufacturers' rebates (Earl & Zweig, 2012). What's more, shipments often pass through multiple distributors that are entitled to fair compensation before they reach the providers. Although a few outliers may have engaged in price gouging, the real culprits are the GPOs.

To be effective, advocacy must be focused rather than scattershot. Writing members of Congress and contacting the media about the harmful effects of drug shortages is not enough. Stakeholders, including nurses, physicians, patients and their families, and concerned citizens, must call on President Barack Obama and Congress to repeal the 1987 Medicare antikickback safe harbor, which exempted GPOs from criminal penalties for taking kickbacks from vendors. That misguided legislation created the perverse financial incentives that ultimately gave rise to the travesty of drug shortages.

Phillip L. Zweig, MBA
Executive director
Physicians Against Drug Shortages
New York, NY
Robert A. Campbell, MD
Chairman
Physicians Against Drug Shortages
and Physician
Central PA Anesthesia Partners
Lebanon, PA

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The Author Responds

We greatly appreciate Mr. Zweig and Dr. Campbell's provocative response to our article. We also thank them for forwarding the information about their grassroots organization. We agree that the fact that such drug shortages exist in this century should outrage all in health care, particularly those at the point of care, and we appreciate that they agree that generic pharmaceuticals have affected the care of oncology patients. In response to their comments about the etiology of pharmaceutical drug shortages, the manuscript highlighted a different explanation as to why the United States is experiencing this healthcare problem. This information was based on evidence-based literature cited from peer-reviewed, tiered journals and pointed to different explanations than the ones Mr. Zweig and Dr. Campbell mention in their letter. Because it was not an opinion article, this does not necessarily reflect our opinions on the current state of affairs of pharmaceutical drug shortages.

In addition, the manuscript highlighted challenges that healthcare providers and patients encounter when dealing with drug shortages to demonstrate the negative impact that it has had in the delivery of health care. Because *CJON* is a nursing journal primarily targeting an audience of oncology nurses, the manuscript also provided an action plan for nurses working with oncology patients to manage and address pharmaceutical drug shortages in the workplace. As pointed out in the letter, not all information in health care makes it into scholarly journals. We hope Mr. Zweig and Dr. Campbell's provoking response to our article gets others thinking so that action can be taken to rectify the drug shortages—making sure the American people have access to the drugs they need.

Amy E. McKeever, PhD, CRNP, WHNP-BC
Assistant professor
College of Nursing
Villanova University
Villanova, PA