Nancy M. Lane

From: khoudary@caryurology.com [cary004@nuvox.net]
Sent: Thursday, July 31, 2008 10:24 AM
To: nlane@pda-inc.net
Subject: Fw: Other members of the prostate cancer research team

----- Original Message -----
From: "Howard, Daniel" <howardd@SHAWU.EDU>
To: <khoudary@caryurology.com>
Sent: Thursday, July 31, 2008 9:51 AM
Subject: Other members of the prostate cancer research team

> Louie E. Ross, Ph.D., is a Chronic Disease (Cancer) Epidemiologist at the
> Institute for Health, Social, and Community Research at Shaw University.
> He received his Ph.D. in Sociology from North Carolina State University
> with concentrations in Social Psychology and Family Studies. He has taught
> at several universities including North Carolina Central University and
> Fayetteville State University. Dr. Ross currently serves as an adjunct
> professor at the University of Maryland (Adelphi Campus), and the
> Morehouse School of Medicine in Atlanta, GA. He has taught several courses
> to both undergraduate and graduate students that include the sociology of
> health (medical sociology), SPSS (Statistical Package for the Social
> Scientist), and quantitative research methods.
>
> More recently, he worked as a Research Behavioral Scientist in the
> Epidemiology and Applied Research Branch, Division of Cancer Prevention
> and Control at the Centers for Disease Control and Prevention, Atlanta,
> GA. He has initiated and managed several grants, cooperative agreements,
> and special interest projects. Two of the projects focus on primary care
> physicians' practices related to prostate cancer and screening, and
> attitudes and behaviors of African American and Jamaican men toward
> prostate cancer screening.
>
> Although his research is quite diverse and includes colorectal, breast,
> and cervical cancers, his major focus is prostate cancer. His primary
> research interests are in the areas of social and behavioral influences of
> health and disease (particularly prostate cancer) and health disparities
> research. He has authored and co-authored several publications, working
> papers, decision aids and pamphlets related to prostate and other cancers.
>
>
>
> Mary Anderson is the Associate Director for the Shaw UNC-CH Center for
> Prostate Cancer Research (SUCPCR), the Shaw Johns-Hopkins Center for
> Prostate Cancer Research (SJHCPCR), and the Shaw UNC Undergraduate Program
> for Prostate Cancer Research and Training (SUUPPRT). She is also the
> Executive Director of the Prostate Cancer Coalition of North Carolina
> (PCCNC), a 501(c)3 non-profit organization dedicated to the reduction and
> elimination of prostate cancer deaths in North Carolina.
>
> Ms. Anderson has been involved with various aspects of prostate cancer
> patient care, outreach, education and support since 1996. She aided in the
> formation and development of the PCCNC in 2001 and has expanded its

> statewide network of prostate cancer patient support, reaching into every
> major region of North Carolina. She is a Pilot Site Coordinator for the
> UsToo! International Minority and Underserved Populations Outreach and
> Awareness Program and is directly responsible for the development of the
> PCCNC Prostate Cancer Screening Guidelines, a reference piece for primary
> care medical professionals which captures recommendations for best
> practices prostate screening as defined by North Carolina's leading
> Urologists, and the PCCNC Partners Program, which works closely with
> breast cancer advocates in Western North Carolina to establish community
> and family awareness of both diseases. She is a member of the NC Minority
> Prostate Cancer Awareness Action Team (NCMPCAAT) and is directly
> responsible for the facilitation and expansion of the NCMPCAAT into Rocky
> Mount. She is also critical to establishing the vision and direction for
> the EMPOWER Men's Health Ministry, a pilot program in Rocky Mount, NC.
>
> In 2005 she received the Sword Barer of Excellence Award by NCMPCAAT and
> in 2006 she was awarded the KnowledgeNet award for Family Advocacy and the
> Barbara Pullen-Smith Public Service Award for her work in minority and
> underserved communities.
>
>
>
> Yhenneko J. Taylor is a statistician for The Institute for Health, Social,
> and Community Research (IHSCR) at Shaw University. Currently she serves as
> statistician for the Shaw-UNC Center for Prostate Cancer Research
> (SUCPCR), Shaw-Duke Maternal and Infant Mortality Initiative and Shaw
> University M-RISP Minority Elderly Research (SUMMER) Center. She received
> the Bachelor of Science degree in Chemistry from Shaw University in
> Raleigh, North Carolina (2001) and the Masters of Statistics Degree from
> North Carolina State University (2004). She is trained in both research
> design and analysis methods. Her expertise includes analysis of
> longitudinal data, survival data and survey data analysis utilizing both
> small and large administrative and non-administrative databases. Ms.
> Taylor joined the staff at IHSCR shortly after completing her graduate
> studies and has contributed to several peer-reviewed manuscripts,
> abstracts and presentations.
>
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>

Nancy M. Lane

From: khoudary@caryurology.com [cary004@nuvox.net]
Sent: Thursday, July 31, 2008 10:24 AM
To: nlane@pda-inc.net
Subject: Fw: Organizational information, capability, and capacity

----- Original Message -----
From: "Howard, Daniel" <howardd@SHAWU.EDU>
To: <khoudary@caryurology.com>
Sent: Thursday, July 31, 2008 9:59 AM
Subject: Organizational information, capability, and capacity

> IHSCR Mission
>
>
> The mission of The Institute for Health, Social, and Community Research is
> to become a national leader in the multidisciplinary empirical
> investigation of diverse issues that affect the health and well-being of
> minorities, particularly African Americans, and their families, and the
> communities in which they live. This mission will be accomplished through
> an interdisciplinary approach of intellectual exchange, research,
> education, consultation, technical assistance, and training that focuses
> on the discernment of timely and policy-relevant health issues with the
> goal of disseminating pertinent information to national, state, and local
> policy makers, the community at large, academic institutions, and funding
> agencies.
>
> The Institute
>
> 1) develops a collective of researchers involved in health-related
> areas of interest;
>
> 2) conducts scientifically sound and relevant minority health and
> health disparity research;
>
> 3) enhances collaborations with Research I level universities and other
> institutions; and
>
> 4) provides leadership to Shaw in developing a university focus toward
> public health.
>
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>
> The Center for Survey Research
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> The Center for Survey Research (CSR) within the IHSCR at Shaw
> University was developed from a core of the UNC-Shaw Partnership for the
> Elimination of Health Disparities (Project EXPORT) (grant P60 MD00239)
> funded by NIH NCMHD in 2002. The mission of the CSR is to support the
> IHSCR in its goal to become "a national leader in the multidisciplinary
> empirical investigation of diverse issues that affect the health and well

> being of minorities, particularly African-Americans, and their families,
> and the communities in which they live." The CSR has the capacity to
> design surveys, administer surveys by phone, and mail self-reported
> surveys to potential participants. The CSR uses the Win Cati4.2/Sensus
> software to administer computer-assisted telephone interviews and also has
> the capacity to conduct web-based surveys. The CSR has developed a
> pretesting laboratory for the evaluation of survey instruments for
> reliability and validity. Pre-testing techniques include focus groups,
> behavior coding, and cognitive interviewing.
>
> The CSR is composed of 12 calling stations and will expand to
> 24 calling stations in the new IHSCR facility, making the CSR the largest
> calling room at an HBCU in the nation. Each sound absorbent calling
> station is equipped with a personal computer, NEC Electra Elite IPK
> telephone, and a Plantronics Supra noise-canceling headset. Immediate
> plans include administering virtual surveys. The CSR has dedicated space
> for administrative staff to monitor SUCCEED activities and perform needed
> operations including production, duplication, and assembly of survey
> instruments; assembly and packaging of surveys for mail; receipt, sorting,
> and review of surveys for data entry; and secured storage of documents
> consistent with records retention protocol. University students and local
> community members are hired and trained as professional Interviewers. All
> interview staff participate in a comprehensive training, monitoring, and
> evaluation program.
>
>
>
> The Center for Biostatistics and Data Management
>
> The Center for Biostatistics and Data Management (CBDM) within the IHSCR
> at Shaw University was developed from funding by NIH NCMHD (grant R24
> MD00167) and DHHS AHRQ (grant R24 HS13353) in 2002. The purpose of the
> CBDM is to provide expertise in, data/database management, data quality
> control, statistical analysis, data entry and information technology for
> the IHSCR-funded research projects. The CBDM ensures that the security
> and integrity of the data is maintained throughout the processes of
> collection, managing, and analysis with the utilization of
> state-of-the-art statistical computing and information technology
> solutions. The CBDM provides a wide range of biostatistics support to
> members of the Shaw University community.
>
> The CBDM is comprised of three sub-cores: statistical analysis, data
> management and information technology. These sub-cores provide two levels
> of support to IHSCR investigators - consultation and implementation. The
> consultation level of support provides both general and specific advice to
> the IHSCR investigators on choosing the most appropriate statistical
> techniques for implementing research design, database development and
> management, and data analysis techniques. The implementation level of
> support provides in-depth support for the design of basic research
> studies, database management, analysis of complex data using SAS
> programming, and coordination of innovative web-based solutions to storing
> and disseminating project information.
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Nancy M. Lane

From: khoudary@caryurology.com [cary004@nuvox.net]
Sent: Thursday, July 31, 2008 10:24 AM
To: nlane@pda-inc.net
Subject: Fw: our current prostate cancer research funding

----- Original Message -----
From: "Howard, Daniel" <howardd@SHAWU.EDU>
To: <khoudary@caryurology.com>
Sent: Thursday, July 31, 2008 10:16 AM
Subject: our current prostate cancer research funding

> PC060224 (W81XWH-07-1-0350)Howard and LaVeist (co-PIs)
> 7/1/07-6/30/10 1.2 Calendar Months
>
> U.S. DoD
> $804,631.00
>
> Shaw-Johns Hopkins Center for Prostate Cancer Research (SJHCPCR).
>
> The goal of SJHCPCR is to further establish infrastructure support to Shaw
> University junior-level faculty to conduct prostate cancer research by
> providing training and mentorship through collaborative linkages with
> senior researchers at Shaw and the Johns Hopkins Bloomberg School of
> Public Health (SPH) and School of Medicine (SOM) and the Sidney Kimmel
> Comprehensive Cancer Center (SKCCC) at Johns Hopkins. This infrastructure
> support will allow a strengthened commitment to research aimed at reducing
> and eliminating disparities in prostate cancer, improvements in Shaw
> University's capacity to conduct quality multidisciplinary, and the
> provision of outreach and education regarding prostate cancer. The center
> will focus on prostate cancer research specifically in the fields of
> health services (outcomes) research and epidemiology.
>
> Role: Co-Principal Investigator
>
>
>
> PC061634 (W81XWH-07-1-0274)Godley and Howard (Co-PIs)
> 1/1/07-12/31/09 in kind
>
> U.S. DoD
> $178,600.00
>
> Shaw-UNC-CH Undergraduate Program in Prostate Cancer Research and Training
> (SUUPPRT).
>
> At Shaw University, the training program would add to the critical mass of
> prostate cancer research activity developing in the Shaw-UNC-CH Center for
> Prostate Cancer Research. As Shaw University students matriculate in
> graduate schools, a synergistic effect would come from the presence of
> Shaw University graduates in UNC-CH graduate programs who would both
> generate more interest in prostate cancer research and expand diversity of
> the graduate students at UNC-CH.

>
> Role: Co-Principal Investigator
>
>
>
> PC060396 (W81XWH-07-1-0452) LaVeist (PI)
> 6/1/07-5/31/09 in kind
>
> U.S. DoD
> $419,026.00 (Shaw $89,719.00)
>
> Disparities in Prostate Cancer Treatment Modality and Quality of Life.
>
> The purpose of this project is to examine racial disparities in treatment
> decision-making and quality of life among white and African American
> prostate cancer patients. We will establish a racially diverse cohort of
> men recently diagnosed with prostate cancer. The cohort will be followed
> over a time to examine changes in their status. The baseline data
> collection for the study will be designed to explore factors that
> influence race differences in prostate cancer stage at diagnosis,
> selection of treatment modality, and quality of life. The current proposal
> seeks funding only to develop the cohort and collect the baseline data.
> The specific aims for this phase of the project are: Specific aim 1: to
> develop data collection instruments to conduct a survey of factors that
> influence treatment decision making and quality of life among white and
> African American prostate cancer patients. Specific aim 2: to establish a
> cohort of White and African American men to study factors that influence
> treatment decision making and quality of life among prostate cancer
> patients. Specific aim 3: to administer a questionnaire designed to
> assess factors that effect prostate cancer treatment decision making and
> quality of life as the baseline data collection to the cohort of white and
> African American prostate cancer patients.
>
> Role: Subcontract PI
>
>
>
> PC040907 (W81XWH-05-1-0208)Howard and Godley (Co-PIs)
> 7/1/05-6/30/09 1.2 Calendar Months
>
> U.S. DoD
> $852,263.00
>
> Shaw-UNC Center for Prostate Cancer Research (SUCPCR)
>
> The goal of the proposed Shaw UNC-CH Center for Prostate Cancer Research
> (SUCPCR) is to establish infrastructure support to Shaw University
> junior-level faculty to conduct and sustain prostate cancer research with
> respect to racial disparities among the African Americans by providing
> training, resources, and mentorship opportunities through collaborative
> linkages with senior researchers at Shaw and the UNC-CH SOM, SPH,
> Lineberger and Sheps Centers.
>
> Role: Co-Principal Investigator
>
>
>

Nancy M. Lane

From: khoudary@caryurology.com [cary004@nuvox.net]
Sent: Thursday, July 31, 2008 10:24 AM
To: nlane@pda-inc.net
Subject: Fw: Our current research on prostate cancer - you can pull the articles from our website www.ihscr.org

----- Original Message -----
From: "Howard, Daniel" <howardd@SHAWU.EDU>
To: <khoudary@caryurology.com>
Sent: Thursday, July 31, 2008 10:13 AM
Subject: Our current research on prostate cancer - you can pull the articles from our website www.ihscr.org

> Prostate Cancer specific articles:
>
>
>
> · Use of the Prostate-Specific Antigen Test among U.S. Men:
> Findings from the 2005 National Health Interview Survey Findings from
> the multivariate analyses indicated significantly higher PSA test use
> among younger non-Hispanic Black men than among non-Hispanic White
> men. These findings may indicate that healthcare providers are getting
> and conveying the message of increased risk of prostate cancer among
> African American men. (Cancer Epidemiol Biomarkers Prev
> 2008;17(3):636-44)
>
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> · Physician-Patient Discussions With African American Men About
> Prostate Screening
> Discussions
>
> African American men who were not having discussions with their
> physicians tended to be in fair or poor health, were not getting
> suggestions from their physicians to take the screening test, had not
> had a screening PSA test in the past 2 years, and had health insurance
> coverage. The borderline association between those men not covered
> with health insurance reporting more doctor discussions is somewhat
> surprising. However, this finding reflects a similar but
> non-significant pattern reported when examining men from the general
> population (McFall, 2006). Research by Stroud et al. (2006) reported
> that inasmuch as it is often more difficult for males in general (and
> African American males in particular) to interact with the health care
> system, physicians used "opportunistic counseling" to engage men into
> prostate cancer discussions during unrelated office and other rare
> visits. Possible interventions might focus on these groups to
> increase awareness and knowledge and possibly assist with their
> decision making regarding the PSA screening test. Some of the goals of
> Healthy People 2010 are to decrease risk and mortality for all cancers
> including prostate cancer, whereas an additional goal is to reduce
> health disparities among groups (U.S. Department of Health and Human Services, 2000).

> (American Journal of Men's Health/Vol. 2, No. 2, June 2008)
>
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>
> · Differences in Lower Urinary Tract Symptoms (LUTS) Treatment and
> Mortality among Black and White Elderly Men From 1994 - 1998 there
> were no significant racial differences in treatment by catheter
> insertion, prostate surgery, or drug therapy, for BPH/LUTS.
> However, overall use of the three treatments increased from 1994-1998
> with drug therapy showing the largest increase. Adjusted analyses
> revealed racial differences in prostate surgery only, with African
> American men nearly 40% more likely to receive prostate surgery than
> white men. Men with co-morbid conditions were less likely to receive
> drug therapy, whereas those with poor self-reported health or cancer
> were more likely to receive prostate surgery. Catheter insertion was
> more likely for those who had resided in a nursing home. Men who
> received drug therapy treatment or had regular rectal exams showed decreased risk of
mortality.
> (Pending publication: Journal of the National Medical Association
> (JNMA))
>
>
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>
> · The Effect of Hospital and Surgeon Volume on Racial Differences
> in Recurrence-free Survival Following Radical Prostatectomy High
> hospital and physician volumes were not associated with reduced racial
> differences in recurrence-free survival following prostate cancer
> surgery, contrary to expectation. This study suggests that social and
> behavioral characteristics, and some aspects of access, may play a
> larger role than organizational or systemic characteristics with
> regard to recurrence-free survival for this population.
> (Pending publication: Medical Care)
>
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>
> · Prayer and Self-Reported Health among Cancer Survivors in the
> United States, National Health Interview Survey, 2002 Among men and
> women with a history of cancer, 68.5% reported having prayed for their
> own health and 72% reported good or better health. Among cancer
> survivors, praying for one's own health was associated with several
> socio-demographic variables including being female, non-Hispanic
> black, and never married. Persons who reported a history of breast,
> colorectal, cancers that have short survival times, and other cancers
> prayed more for their health than those persons with a history of skin cancers.
> Respondents who reported good or better health were more likely to be
> female, younger, have higher levels of education and income, and have
> no history of other chronic disease. Overall, praying for one's own
> health was inversely associated with good and better health statuses.
> (Pending publication: Journal of Alternative and Complementary
> Medicine)
>
>
>

> · Trends and Racial Differences in the Utilization of Androgen
> Deprivation Therapy for Metastatic Prostate Cancer African-American
> men were less likely than white men to receive any ADT following
> diagnosis (p<0.001). Differences were noted in the time to receipt of
> ADT, with African-American men having a longer mean time to receipt of
> orchiectomy (time ratio (TR)=1.50, 95% CI=1.03, 2.17) or LHRH agonist
> (TR=1.42, 95% CI=1.06, 1.89) than white men.
> (Under review: Pain)
>
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>
> · Patterns in Prostate-Specific Antigen Test Use and Digital
> Rectal Examinations in the Behavioral Risk Factor Surveillance System,
> 2002-2006
> Overall differences for years 2002-2006 were: a significant increase
> for PSA use only and a marginally significant decrease of PSA and DRE
> combined for years 2002-2006. Having had a recent PSA test (within 2
> years) only, a recent DRE only, or both tests varied by
> sociodemographic and health-related variables including age,
> race/ethnicity, marital status, levels of education and income, body
> mass index (BMI), health insurance status and having a personal doctor or health care
provider.
> (Pending submission/ in clearance with the CDC - will submit to
> American Journal of Preventative Medicine (AJPM))
>
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>
> · Complementary and Alternative Medicine (CAM) use among Men with
> a History of Prostate Cancer
> The most frequently used types of CAM were: biologically-based
> therapies
> (72.6%) and mind-body therapies (70.4%). Within biologically-based
> therapies, use of vitamins accounted for 71.3% of the total and within
> mind-body therapies, prayer for health accounted for 78.0% of the total.
> Use of mind-body therapies did not vary significantly by
> socio-demographic characteristics, however, use of other types of CAM
> was associated with higher levels of education, White race, and being
> a veteran of the armed forces.
>
> (Under review: Oncology Nurses Forum)
>
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> Related articles:
>
> Healthcare Practices among Blacks and Whites with Urinary Tract
> Symptoms Daniel L. Howard, PhD; Bennett G. Edwards, PhD; Kimberly
> Whitehead, PhD; M. Ahinee Amamoo, MS; and Paul A. Godley, MD, PhD, MPP
> Journal of the National Medical Association, VOL. 99, NO. 4, April
> 2007 <http://www.ihscr.org/x/published/JNMA_Article.pdf>

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>
> Quality and Severity of Lower Urinary Tract Symptoms among, African
> American Elders Daniel L. Howard, Bennet G. Edwards, Kimberly
> Whitehead, M. Ahinee Amamoo, and Paul A. Godley Journal of Health
> Disparities, Research and Practice, Volume 1, Number 2, Winter 2007,
> page 73 <http://www.ihscr.org/x/published/JHDRP-V1N2-2007-cs.pdf>
>
>
>

Subject: Corrections to Data in the Proposed 2009 Plan
From: Duncan Yaggy <yaggy001@mc.duke.edu>
Date: Mon, 4 Aug 2008 09:44:53 -0400
To: carol.potter@ncmail.net

Ms. Potter

I write to suggest changes to the data for Duke University Health System facilities included in the Proposed 2009 Plan. All the data are for the year beginning July1, 2006 and ending June 30, 2007.

Duke University Hospital

- MRI Procedures: As reported in our license application, the 5 scanners at the Lenox Baker provided 13,521 procedures, including 6582 with contrast or sedation and 6939 without.
- Adult dx cardiac cath procedures: As reported in our license application, we provided a total of 3887 procedures.
- Pediatric dx cardiac cath procedures: Our total (187) is listed, but the "Hospital" listed in Table 9N is not otherwise identified.

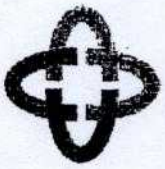
Durham Regional Hospital (DRH)

- PTCA Procedures: As reported in our license application, DRH provided 237 PTCA procedures during FY2007.

Duke Raleigh Hospital (DRaH)

- The data looks fine, but sometimes the Hospital is listed as Duke Health Raleigh Hospital (old name) and sometimes as Duke Raleigh Hospital (new name). Since we changed the name and sometimes use the old name, we are obviously responsible for the confusion !

Duncan Yaggy
Chief Planning Officer, DUHS
3100 Tower Blvd., Box 80
University Tower, 10th Floor
Durham, NC 27707
(919)419-5011 - (office)
(919) 419-5015 - (direct #)
(919)812-3562 (mobile)
(919) 419-5001 (fax)



cary urology

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HENRY A. UNGER, M.D., F.A.C.S.
FRANK L. TORTORA, JR., M.D., F.A.C.S.
KEVIN P. KHOUDARY, M.D., F.A.C.S.
KEVIN P. PERRY, M.D., F.A.C.S.

Miss Carol Potter
NC Division of Health Service Regulation
Medical Facilities Planning Section
2714 Mail Service Center
Raleigh, NC 27699
August 8, 2008

Re: Petition from Parkway Urology

Dear Miss Potter:

I would like to take this opportunity to respond to the well-organized criticisms of my petition received by your office. It was not my intent to place you or your section into the midst of a national turf battle, however here we are. Urologists and radiation oncologists throughout the U.S. are in disagreement as to the delivery of IMRT and who should control what. The American Urological Association and ASTRO will battle this out on the national front. I was hoping my petition, through a co-ownership of all physicians involved (radiation oncologists, urologists, and medical oncologists), would avoid that distraction and permit a focus on optimizing patient care. There is nothing in the state of North Carolina that remotely resembles the facility and level of cooperation across disciplinary lines that I describe in my petition. The multitudes of similar letters, many from a single group with multiple offices describe their radiation centers as multidisciplinary, however no further description is provided. The Triangle's academic centers have glowing descriptions on their web pages and brochures; however my patient's experiences have been disjointed with no apparent interdisciplinary coordination.

It was intuitive to me at the time I first considered a prostate center that a facility focused on a single disease with different professional perspectives on therapeutic options would be optimal for this disease. There is no other disease or cancer like cancer of the prostate. Despite its slow progression and low mortality, a huge prevalence causes prostate cancer to be the second most common cause of cancer death for men. Who to treat and how aggressively are the key questions and a true multidisciplinary approach is perfect for this disease. North Carolina is typically in the top three states when it comes to poor outcomes for prostate cancer. I am a urologist trying to change this. My initial intuition on a disease specific approach is coming to life as recent studies are starting to demonstrate that busier focused facilities have better outcomes for prostate cancer therapy.

Short of Area 20, I did not specify where this center would be located. Cary is a very nice town, however my intent was to place a building in the heart of Raleigh for ease of patient and physician access.

Change can be scary. Many of the letters described potential conflicts with the principles of the CON process. Direct from the 2009 plan:

"Changes in the health care environment require an emphasis on quantification, accountability, and interrelatedness of the basic principles, with particular attention to emerging standardized quality measures. The core values must be retained, but with some adjustment of emphasis: promote high quality health care services as measured by by outcomes and satisfaction, promote equitable access to health care services for all North Carolina's people, and promote high value practices that will maximize the health care benefit gained for resources expended."

These statements and the basic principles of safety and quality, access, and value are by no stretch of the imagination in conflict with my proposal. We have the opportunity to affect change in the demographics of prostate cancer. We need to change how prostate cancer is treated in this state. With outcomes analysis, this demonstration may provide a model for duplication and refinement in all radiation centers.

Thank you for considering my petition.

Yours truly,

Kevin Khoudary

August 7, 2008

State Health Coordinating Council, and
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714
Fax 919-715-4413

Letter in support of Petition Regarding: Change Methodology for Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

Dear Miss Potter:

I am a practicing **radiation oncologist** in Denver, Colorado and I am a partner at The Urology Center of Colorado. We have fifteen urologist and two radiation oncologists and our goal is to provide comprehensive urologic care. I see and treat many men with prostate cancer. Prostate cancer is a complicated disease in that it is very common yet kills the minority affected. Still, it is second only to lung cancer in cancer mortality in men.

Who to treat and how aggressively is one of the most difficult decisions in therapy. Surgery and more recently radiation therapy have become the standard of care. Unfortunately, most patients see only one specialty or the other. That is not the case here at The Urology Center of Colorado. I collaborate closely with my urology colleagues and this has resulted in superior outcomes, better patient satisfaction, and less morbidity. Last year we treated about 430 men with prostate cancer. The breakdown on the treatments was about 180 having radical prostatectomy, 215 having external beam radiation, and about 35 having low dose rate brachytherapy. We also had many patients opt for watchful surveillance. As you can see, our patients get a balanced presentation of the treatment options and are free to make their own choice.

I am board certified in both urology and radiation oncology. This experience has allowed me to see the benefits of both fields for my patients.

Cary Urology's proposed center presents an interesting and well thought out plan. The input of radiation oncology, hematology oncology and urology along with the support staff and outreach appears well integrated. I strongly support this concept since it has worked well here in the Denver area.

Thank you for considering my comments.

Sincerely,

Reginald D. Westmacott, MD
The Urology Center of Colorado
(303)825-8822

August 1, 2008

To: State Health Coordinating Council, and
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Re: Letter in support of Petition Regarding: Change Methodology for Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

One in six men will develop prostate cancer in his lifetime. The death rate from prostate cancer is 18.1/100,000 nationally.[1] Treatment for prostate and male urologic cancers involves varied options including: watchful waiting, androgen hormone therapy, surgery, and radiation therapy.

I am a practicing urologist at Physicians Urology, a center for the treatment of prostate cancer in Akron, Ohio. Along with other urologists, radiation oncologists, radiation therapists and other specialized cancer care providers, we focus on the treatment of prostate cancer. Our center sees improved communication and collaboration among the specialists. Our prostate cancer patients are experiencing better outcomes, more complete recoveries, and fewer and less serious side effects with the use of our multidisplinary process.

Because our physicians specialize in treating prostate cancer, we have seen an increase in efficiency and quality of care through economies of scale and we have developed expertise that benefits our patients.

A Prostate Health Center, with an organized multidisciplinary program focused on total prostate cancer care, will foster excellent and innovative health care in North Carolina, bolstering the State's reputation for providing quality health care.

I encourage you to fully consider the merits of a prostate cancer center and the focused care it will afford the men in your area. Please contact me at the above address if I can be of any assistance or provide you with additional information.

Thank you,

Kevin Spear, M.D.

[1] Gaston, Kris, MD; Pruthi, Raj, MD. "Racial Differences in Prostate Cancer." North Carolina Medical Journal 67.2 (2006): 130-134.

August 7, 2008

State Health Coordinating Council, and
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714
Fax 919-715-4413

Letter in support of Petition Regarding: Change Methodology for Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

Dear Ms. Potter,

This letter is **in support** of Cary Urology's petition for inclusion of a special need for a multidisciplinary prostate health center in Service Area 20 that will offer a full range of services to treat men with urologic and prostate cancer.

It has come to my attention that several respected radiation oncologists have written letters in opposition of this proposal. As a radiation oncologist myself, I must consider the arguments of my colleagues and either agree or disagree. Since I have my own practice specializing in prostate brachytherapy, I do not have any obligations to any one hospital or health system. I hope my view points will at the very least lead to a consideration of other conclusions.

Prostate cancer is quite prevalent, affecting 1 in six to eight men. The treatment options are quite diverse (observation, surgery, EBRT, brachytherapy, cryotherapy, IIIFU, ect) and appear to be growing everyday. No one will argue that prostate cancer is a very important and complex health issue with a number of health dollars at stake. If any disease organ requires special consideration, prostate cancer is one of them.

The most important issue in my mind is whether prostate cancer care improves, worsens, or stays the same if the Cary Urology's petition is approved. I have done much research on the matter and one point is very clear; multidisciplinary management of urologic and prostate cancers is believed to improve patient outcomes. For this reason, major academic centers have comprehensive prostate cancer programs such as at Duke and UNC. Many of the opposition letters reference these two programs as being examples of the quality care that prostate cancer patients have available.

True multidisciplinary management of urologic and prostate cancer is the focal point of the Cary Urology proposal. The question becomes not whether Duke and UNC's prostate programs are sufficient which they are, but whether a better model of multidisciplinary management for Service Area 20 can be created as proposed by Cary Urology and its supporter of over 10 urologists, a program that will offer access to all and complete

integration of services. It is important to note that not one of the opposition letters states that quality will decrease.

We all agree that multidisciplinary management is positive. The Cary Urology proposal is recommending complete integration of all specialties in the management of urologic cancers at levels not currently practiced because it is not compatible with the operations of hospitals, radiation facilities, or urology practices. One must keep in mind that the urologist is the gatekeeper of all prostate cancers. Most practicing radiation oncologists are probably only referred 40-50% of the prostate cancers with the majority already deciding on radiation therapy. Dr. Khoudary and other urologists that I have personally contacted believe that this proposal is creating an outlet for better communication and management in a structure that is feasible for the practice of both specialties.

The Cary Proposal raises some very exciting and stimulating changes in urologic cancer management. Unfortunately, much of their intentions are clouded by issues of self referral and financial gains. When it comes to any designated health service, abuses do and have occurred. There are several urologic specialty cancer centers in the United States and the number is growing. This practice has caused much concern within the radiation community as represented in the ASTRO letter. It can be argued that similar relationships exist with radiologists, medical oncologists, and multispecialty organizations who own radiation therapy practices. These relationships are far more prevalent than the above. It would be impossible for ASTRO to disallow all these practices.

One cannot assume that urologists are a different breed than any other physician in terms of professionalism or motives. I have not heard any substantiated claims from my radiation or urology colleagues that they treat inappropriately because of the ownership arrangements. I have been a partner in a radiation therapy facility, and I can attest that ownership does not influence my medical decision making.

The Cary Urology proposal appears to be sensitive to the financial and self referral issues and is recommending ownership by both urology and oncology, and not an employment situation. Financial reimbursements for treatments are mostly determined by Medicare and medical insurances that are based on a number of variables. Currently, the technical dollars for IMRT are considerable because the technology and implementation on IMRT is very expensive. Physicians do not have control over reimbursement issues. Ownership will have risks since CMS will most likely not repeal the in-office ancillary exception for radiation therapy but instead drastically reduce IMRT payments in the future as the technology becomes more standard. This was very similar to when 3 D conformal radiation therapy became the standard over conventional 2 D therapy.

The concept of a multidisciplinary urologic cancer center has great merit if done correctly. It is creating a model not yet tried in the State of North Carolina, a model that will be transparent and closely studied. The results can help guide the State and other physicians in the future as to the benefits and pitfalls of such a model for this or other

specialties. The Cary Urology proposal appears to have the correct leadership and vision. It would be unfortunate to let fear and mistrust cloud this vision.

Thank you for allowing me the opportunity to express my opinions.

Sincerely,

John Leung, MD
Radiation Oncologist
336-906-5489

August 7, 2008

State Health Coordinating Council, and
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714
Fax 919-715-4413

Letter in support of Petition Regarding: Change Methodology for Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

Dear Miss Potter:

I am a practicing urologist in Statesville, North Carolina. Along with other urologists, I see and treat many men with prostate cancer. Prostate cancer is a complicated disease in that it is very common yet kills the minority affected. Still, it is second only to lung cancer in cancer mortality in men.

Who to treat and how aggressively is one of the most difficult decisions in therapy. Surgery and more recently radiation therapy have become the standard of care. Unfortunately, when I send a patient for radiation, they too often return with preventable injuries – burns to their bladder or rectum, excessive bleeding, erection and voiding issues. These patients, if under the care of urologists and rehabilitation specialists during the course of therapy, may have had their injuries tempered by tailoring the beam and adjusting dosages. This is just not happening anywhere in the state.

Cary Urology's proposed center presents an interesting and well thought out plan. The input of radiation oncology, hematology oncology and urology along with the support staff and outreach may be just what this state needs to alter our dismal prostate mortality rates. I found it particularly wise the proposed center had all physician specialties as co-owners, thus negating self referral issues. I strongly support this concept and if it works, would hopefully have the ability to see such a center in our area. Thank you.

Yours truly,

Mark Makhuli, M.D.

TRIANGLE UROLOGY
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August 7, 2008

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Yours truly,

CHAPEL HILL OFFICE
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Samuel F. Huang

August 7, 2008

State Health Coordinating Council, and
Medical Facilities Planning Section
Division of Health Service Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714
Fax 919-715-4413

Letter in support of Petition Regarding: Change Methodology for Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

Dear Miss Potter:

I am a practicing urologist in Fayetteville, North Carolina. Along with other urologists, I see and treat many men with prostate cancer. Prostate cancer is a complicated disease in that it is very common yet kills the minority affected. Still, it is second only to lung cancer in cancer mortality in men.

Who to treat and how aggressively is one of the most difficult decisions in therapy. Surgery and more recently radiation therapy have become the standard of care. Unfortunately, when I send a patient for radiation, they too often return with preventable injuries – burns to their bladder or rectum, excessive bleeding, erection and voiding issues. These patients, if under the care of urologists and rehabilitation specialists during the course of therapy, may have had their injuries tempered by tailoring the beam and adjusting dosages. This is just not happening anywhere in the state.

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Sincerely,

James Nolan, MD
Fayetteville Urology Associates

North Carolina National Association For The Advancement Of Colored People

Post Office Box 305
Clinton, NC 28329

June 25, 2008

To: State Health Coordinating Council and
Medical Facilities Planning Section
Division of Health Services Regulation
2714 Mail Service Center
Raleigh, North Carolina 27699-2714

Re: Letter in Support of Petition Regarding: Radiation Oncology – Linear Accelerators For the 2009 State Medical Facilities Plan

I am William T. Stokes, the President of the Sampson County NAACP Unit # 5446 and the Executive Committee of this Unit supports your cause. Prostate cancer affects one in six men nationally. We are aware that North Carolina has one of the highest death rates in the country for men, especially indigent African-Americans. We are aware and very concerned about the disease and the underserved populations involved. A prostate cancer center will hopefully help change these demographics. We look forward to working with the prostate center and bringing these gentlemen in for screening and therapy. Please consider this letter of support for a prostate center in our area. Thank you.

Sincerely,
William T. Stokes
William T. Stokes
President