Cancer Support Services Under Fire

How a redesign plan brought

by Andrea Geshan, RN, MSW

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Cancer support services have had a recognized and formal position at Lehigh Valley Hospital since the mid-1980s. Then in 2000, changes in both the hospital and its cancer program (the John & Dorothy Morgan Cancer Center in Allentown, Pa.) forced staff to examine support services with a critical eye—in a way that had not been done before.

Prior to these changes, the cancer support service team consisted of a clinical nurse specialist and a social worker (both full-time employees) and one part-time patient advocate, who was a cancer survivor. This team provided empathy, support, education, access to resources, and facilitation of several support groups. The practice model—while not formally defined—was essentially reactive, resembling crisis intervention. The target audience consisted of anyone who requested services and was heavily weighted towards the inpatient population.

In 2000 the cancer center's management structure introduced a new vision and philosophy of cancer care that supported "out-of-the-box" thinking. New goals came into play, including the establishment of a satellite cancer center and a push to develop and expand the cancer program's market share. At the same time, drastic reimbursement cuts were negatively affecting the cancer program's bottom line.

By the end of the fiscal year, Lehigh Valley Hospital was performing a hospital-wide analysis of its departments—paying particular attention to service lines that provided added value without bringing in revenue. Hard decisions had to be made as to whether the cancer center could continue to provide support services in the same way.

Answering Some Tough Questions

While Lehigh Valley Hospital understood the important role played by its cancer support services, the economic climate made it impossible for the hospital to continue providing support services as it had for the past two decades. The program would have to become more fiscally responsible. Difficult questions were asked and answered during the evaluation of the cancer support service program, and this process, while painful, brought a number of the program's problems into sharp focus.

The first question asked was whether the cancer support services were reaching the patients who needed them most. While searching for answers to this question, we found that the patient population receiving cancer support services was not clearly defined. Additionally, the support services team was virtually unknown to the outpatient population—the majority of the hospital's patient population. (Due to limited staff resources, expanding the current services to include the outpatient population was deemed unrealistic at that time.)

The second question we looked at was whether the cancer support services team was providing the right level and types of services. If not, would another practice model help? Analyzing the support services program revealed a lack of quantifiable methods for measuring program worth and effectiveness. The "soft" terminology and anecdotal reports from grateful patients did not offer a measurable way to demonstrate changes in patients' quality of life.

We also found that the crisis intervention model was indeed taking a toll on center staff. While the number of cancer patients (and requests for support services) was increasing, the support staff's ability to meet the burgeoning demand was decreasing. The growing number of daily crises was also having a negative impact on job satisfaction for the support staff, and attendance at open facilitation groups was declining.

All these issues led management to question whether a new approach to cancer support was mandated. Discussions on how to restructure the cancer support services to better match the needs of its patients led to questions about the composition of the team itself.

A Funny Thing Happened On the Way to the Redesign

In the midst of this assessment, the hospital's psychiatry department came up with a unique proposition to share the costs associated with providing supportive care to patients with cancer. This partnership would necessitate a complete redesign of the way in which supportive care was provided at Lehigh Valley Hospital. Faced with a hospital-wide goal of shaving 10 percent of expenses from each department's operating budget, it was an offer the cancer center could not refuse.

The first step was to create a redesign team, which initially consisted of the department chair, the department administrator, an outpatient program director of the psychiatry department, the cancer center vice president, and the director of cancer support services. The redesign team adopted a patient-centered model of care that would 1) be in line with the overall philosophy of cancer care, 2) have measurable effects, and 3) be fiscally sound. As the process began, the team soon realized that both the structure and composition of cancer support services would need to be seriously overhauled.

The redesign team developed a support service program that definitely reflected out-of-the-box thinking. The team adopted a behavioral health model of care, which required that a team of mental health professionals provide individual, family, and group therapy based on DSM-IV *(Diagnostic and Statistical Manual of Mental Disorders, 4th edition)* diagnoses as they related to the cancer patient. Staff would need to follow a private practice, fee-for-service model. This shift would require staff to understand and develop referral business.

The redesign team defined the service population as those patients most in need (i.e., those patients experiencing a high level of distress, based on a self-reported measurement tool). To provide psychosocial care to these patients, the cancer support services team had to be comprised of appropriately credentialed staff. The redesign team decided to hire two full-time and one part-time licensed social workers—all with prior experience as therapists. These changes now made it possible for the cancer support services team to bill for its services through the patients' mental health providers.

After identifying a steady revenue stream, the redesign team focused on identifying a program structure that would support the model of care, promote fiscal independence, and permit the support services program to evolve in tandem with cancer program growth. To meet these goals, the psychiatry department and the cancer center would share responsibility for the cancer support services team.

Dollars and Sense

The redesign team set a goal to operate cancer support services from a budget neutral position, and the psychiatry department assumed fiscal management of the program. Psychiatry covered 50 percent of the staff's expense for their "therapy" time. The remaining 50 percent of staff time, spent in additional social work activities, was covered by other means.

In addition to fiscal management, the department of psychiatry also provided the psychotherapeutic framework for services to be delivered at two of its outpatient behavioral health programs. For the convenience of Lehigh Valley Hospital's cancer patients, the redesign team chose to provide behavioral healthcare services directly at the cancer center.

Under the redesign, the cancer center's responsibili-

5 Tips for Assuring the Financial Viability of Your Cancer Support Services Program

1. Identify a program structure that supports your model of care, promotes fiscal independence, and allows the support services program to grow in tandem with the cancer program. Think about adopting a mental health model of care.

2. Consider partnering with another department to share the costs of providing supportive care to your patients with cancer. Your hospital's psychiatric department might be a logical fit and could also provide the psychotherapeutic framework to deliver support services.

3. Operate your cancer support services from a budget neutral position. Switching to a fee-for-service mental healthcare model allows providers to bill for their services through the patients' mental health providers.

4. Understand and prepare for the complexities involved with the billing and credentialing process when making the switch to a fee-for-service mental healthcare model. Consult with a professional familiar with the processes and procedures for mental healthcare services. Having program infrastructure in place and understanding patient flow in advance can help the transition go smoothly.

5. Work with your cancer support services team to grow the program by developing referral business, improving patient scheduling and patient transportation, and establishing annual goals and standards.

ties included support services program design, program growth, integration of services with other cancer center programs, and operations management.

Hospital senior management and cancer center leadership approved the redesign plan, and the redesign team moved on to the next step—implementation.

Facing Challenges Head On

Presenting a new model of care to stakeholders is not easy. The changes to the cancer support services program were especially challenging because they were so widespread. The redesign team met with key players in the cancer center to introduce the new model of care, but initial staff reaction was lukewarm. To get staff on board with the new model of care, old beliefs and assumptions had to be re-examined. Cancer center staff was asked to focus on psychotherapy as an integral part of the interdisciplinary treatment plan, to embrace the changes, and to accept and support the fee-for-service concept.

At the same time, the new cancer services support team faced its own challenges. During this start-up period, a temporary staff member was added to the team. An intern, earning her PsyD degree, was approved to do her final one-year clinical placement in the cancer center. Ultimately, this staff member proved to be a valuable (and permanent) addition to the department. Initially, however, the new position challenged team cohesiveness. In addition, two of the three permanent staff members were new to the team and to the cancer center. They had not worked under either a fee-for-service model or a "matrixed" partnership (i.e., a joint venture between departments). Even though staff were new to the model of care provided by the redesign—they were expected to act as program champions.

The final challenge faced by the redesign team and the new cancer support team was to develop the policies, procedures, and processes necessary to seamlessly conduct psychotherapy at a location separate from the psychiatry outpatient program.

Year One: Outcomes

Despite these hurdles, significant outcomes were realized by the end of the first year:

- Psychotherapy and supportive care were being provided primarily in the outpatient setting.
- The operations of the new cancer support services team were based on psychosocial assessments.
- Individual and structured group therapy were instituted.
- Distress was being measured on a regular basis.
- A psychiatrist "champion" was identified and added to the cancer support team.
- Support services were being provided in a location that was convenient for patients.

Even with this progress, the new cancer services support program needed improvement in several key areas. Establishing an efficient system to bill for services topped the list. This effort involved addressing staff credentialing with our payers; developing single case agreements to assure payment when our therapists were not on a given payer's panel; clarifying and streamlining the pre-certification processes; and identifying and following procedures for collecting co-payments.

In terms of providing seamless service, the redesign team needed to improve the appointment scheduling process and the method for transporting charts back and forth from the psychiatry department to the cancer center.

Cancer support services staff needed help adapting to their new roles and associated performance expectations. Staff members needed to operate as if they were in a private practice, and much of the adjustment process involved helping staff become comfortable and successful with developing a consistent referral base.

To aid with this transition, the redesign team worked with the cancer support team staff to develop

Just the Latest
in a Round of Cuts

Cancer support services have been facing budget cuts for some time. And the latest round of reimbursement cuts are just one more blow in an ongoing progression of cuts in support services that hospitals began facing in the 1980s, said Matt Loscalzo, MSW, associate dean and associate professor at Eastern Virginia Medical School.

Even though support services are considered an integral part of cancer care, reimbursement for these services is virtually non-existent. The result is that many hospitals and physician practices have been forced to scale back or more aggressively manage the budget of their support services program.

Psychosocial consultant Joyce Herschl, MSW, lost her job as a program coordinator for cancer social work services due to hospital budget cuts. Her position was eliminated when support services were restructured. Herschl said the change meant a shift from a social work model of care to a case management model for support services. While support services are still being provided at the hospital where she was employed, the social work contribution is much more limited due to large, often unmanageable caseloads, Herschl said.

Cuts in these services can have a ripple effect. In the past, for example, social workers in Herschl's cancer support services program spent a significant amount of time researching and locating resources for patients and their families. Social workers provided a range of services, including help for caregivers, assistance with transportation, information on home services, access to community programs, and help for patients needing lodging.

"We were focused on the family with the understanding that if you can help the *family* help the patient, you reduce readmissions," Herschl said.

After working more than 20 years in the field, Herschl has noticed that increasingly, oncology social workers are spending time helping patients deal with the financial impact of cancer treatment—for example, how to pay for their cancer medications, loss of income, lack of healthcare coverage.

Herschl is concerned both about the shrinking access to support services for patients and an evaporating job pool for oncology social workers.

Loscalzo notes that often the highest risk groups—the elderly and the poor—are hardest hit. Many elderly cancer patients are socially isolated, living alone, and far from services. "If they don't get the psychosocial support services they need, they may not get treatment," Loscalzo said.

"I think everyone is affected by the reimbursement issues," said Toni Cooley, cancer program administrator with the Providence Cancer Center in Spokane, Wash. "Growing a program that has no revenue connected with it is very difficult," particularly for cancer programs struggling with several years of reimbursement cuts.

Despite the uncertain economic environment, many cancer programs remain committed to offering support services. Comprised of the Sacred Heart Medical Center and Holy Family Medical Center, the Providence Cancer Center support services depend on hospital staff—including nutritionists, nurse coordinators, and therapists—that dedicates a percentage of their hours to the oncology program.

"We feel it's a service we need to provide to our patients with cancer—whether it's revenue producing or not," concluded Cooley.

annual goals and standards, which provided a framework for the support services' daily operations. Identifying achievable, measurable goals also allowed the new cancer support team to be confident in its potential for success. As they developed these standards, the cancer support services team crafted and adopted a central mission. This mission guided their activities, clearly identified team members' roles, and defined a consistent practice model.

Building the Program

During the evaluation process, the redesign team identified additional measures to assure programmatic and fiscal success.

First, the redesign team examined the clinical scope of the program and information gleaned from the distress measurement tool. Looking at the issues that patients identified as "distressful" brought to light a need to expand the therapy program to include specific management of such symptoms as pain, nausea, and sleep disturbances. Expanding the service line in response to patients' needs resulted in increased referrals for support team services and also reminded medical providers of the integral role that the cancer support services team played in medical and pharmacotherapy treatment.

The redesign team wanted to incorporate behavioral health evaluation and psychotherapy into the normal routine of care management. To this end, support service staff began attending daily rounds in treatment areas and case conferences with treatment staff. While these activities helped establish the cancer support team's presence and remind staff of available services, neither activity increased referrals. The redesign team continued to work with the cancer support services staff to develop service volume productivity goals.

As a part of this effort, the redesign team brokered an agreement with a large medical oncology practice to have each new patient see the cancer support team for a brief assessment and introduction to the support services available. This initiative is relatively new, so the success of the program has yet to be determined.

At the end of year two, the fiscal year's financial goals were achieved even though the referral base did not meet projections. Current revenue and expense projections point to the cancer support program ending the

A View from the Inside

by Amanda Patton

Lehigh Valley's Cancer Support Team functions within the Department of Cancer Support Services, which also includes such services as professional and public education, second opinion services, bereavement support, nutrition assessment and counseling, rehabilitation, and community outreach. This dynamic group of employees provides support services to the patients seen at Lehigh Valley Hospital-Cedar Crest, the John & Dorothy Morgan Cancer Center, Lehigh Valley Hospital-Muhlenberg, and the cancer center at Muhlenberg.

How does a four-person cancer support team provide services to this large and diverse patient population? A carefully thought-out team structure allows this small, coordinated unit to function within a schedule that provides both blocks of time for individual and group therapy sessions and the flexibility to respond to on-demand patient support needs.

Lehigh Valley's Cancer Support Team members are Diane Brong, LCSW; Carol Moretz, PsyD; Betsy Klasko, LCSW; and half-time counselor Ulla Martz, LCSW. Mary E. Cohen, MD, a psychiatrist with Muhlenberg Behavioral Health at Lehigh Valley, also provides therapy services one day a week on-site at the cancer center at Cedar Crest.

Each week, the team's schedule follows the same basic pattern. Team members spend about 50 percent of their time providing individual and group therapy for cancer patients. The remainder of their time goes to providing services, including responding to consults on the inpatient cancer units; seeing patients in the infusion center to manage emergencies or to provide support; and seeing patients in the medical oncology practice for brief sessions, during which a team member might do a mental health status assessment and talk with patients about support services. While the bulk of the Cancer Support Team's time is spent with outpatient clients, the team's flexible schedule includes inpatient time and the ability to meet any crises that may arise.

Here is how a typical week's schedule might look: each member spreads a block of 20 hours of therapy time over the five-day work week—allowing for both early morning and late-evening appointments. The therapy block time is arranged so that at least one member of the team is available to respond to inpatient consults, do rounds in the treatment areas, manage crises, and help patients gain access to internal and community resources. Because therapy is provided in the cancer center and staff offices are located in the same building, patient satisfaction and efficiency are enhanced.

"The hours dovetail so that there are always two of us at any one time doing individual therapy and the other person who is not doing therapy is available to do additional team functions," said Moretz. So, for example, one staff member will see therapy patients in the morning and then be available in the afternoon for other staff functions.

Therapy services are offered on-site at the cancer centers, making such services as convenient as possible for patients. Therapists schedule their own patient appointments. This information is then coordinated through the department of psychiatry, which administers all outpatient counseling services and handles all billing.

The Cancer Support Team's goal is to put the patient's needs first. Offering services at the cancer centers—rather than at the behavioral health center—not only streamlines services for cancer patients, but may also help them feel more at ease about seeking support.

In addition to the regular weekly schedule, the Cancer Support Team also facilitates two ongoing support groups. One is a traditional open-ended support group for prostate cancer patients; the second is a bereavement support group. In addition, the staff provides a nine-week structured therapy group, which helps patients and families gain skills needed to cope with the emotional effects of a cancer diagnosis.

Although team members are permanently stationed at the cancer centers and satellite locations, some cross-coverage occurs. Staff arrange their schedules to assure that vacations or staff illnesses are covered and that service to patients is never more than a phone call away. Weekly staff meetings and monthly departmental meetings, as well as e-mail communication, help keep all team members connected.

Amanda Patton is associate editor at the Association of Community Cancer Centers.

year in a budget neutral position, with a fair chance at generating excess revenue.

Looking to the future, the support services team expects to solidify its position within the multidisciplinary cancer treatment program and offer visits to new patients in all cancer treatment areas. Based on patient recommendations and feedback, the support services team is looking to expand the program to include management of sexuality issues associated with cancer and its treatment. The team expects to introduce this modality in the near future, after staff training, supervision, and credentialing is completed.

The redesign of the cancer support services team has put Lehigh Valley Hospital well on the way to having a strong behavioral health program within its cancer center treatment program. Hurdles and challenges were met head on, and vigilance, persistence, a strong partnership with the psychiatry department, and a willingness to be innovative were all key to our early success.

Andrea Geshan, RN, MSW, is director of cancer support services at the John & Dorothy Morgan Cancer Center at the Lehigh Valley Hospital and Health Network, in Allentown, Pa.