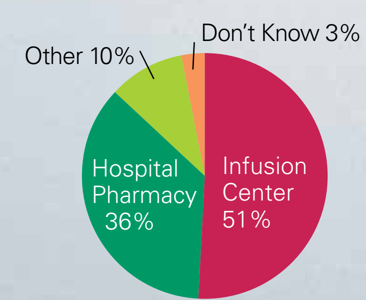
Infusion Centers At-a-Glance

- Mean number of infusion chairs: 17.9 (hospital-owned) and 2.9 (included in the cancer program but not hospital-owned) as compared to 16.4 (hospital-owned) and 3.1 (included in cancer program) in Year 2.
- Average FTE nurse-to-patient ratio in the infusion center is 6:1. No change from Year 2.
- Average number of infusion patients daily per infusion chair is 5.5, up slightly from 5.2 (Year 2).
- In the Year 3 Survey, 78% of programs indicated that infusion of non-chemotherapy fluids is included in the service line. This percentage is up significantly from 52% in Year 2.
- Most programs infuse patients Monday-Friday only. In the Year 3 Survey, 20% of respondents reported treating patients on Saturday, compared to 22% (Year 2) and 33% (Year 1). The number of programs that infuse on Sundays continues to decline 11% (Year 3), 17% (Year 2), and 19% (Year 1).

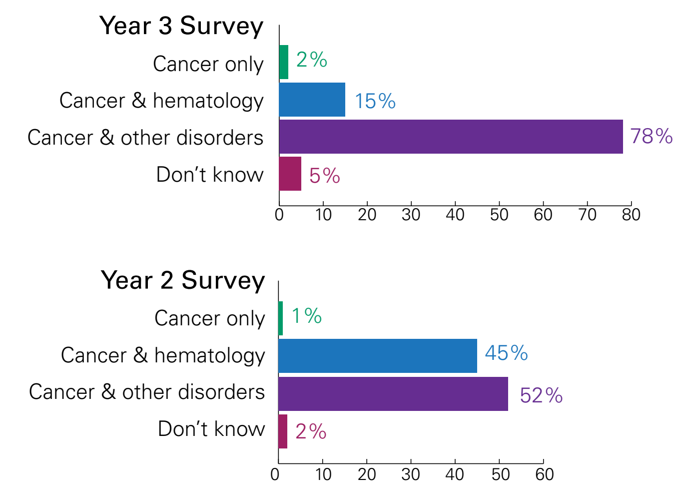
Who Mixes?

And Where?*

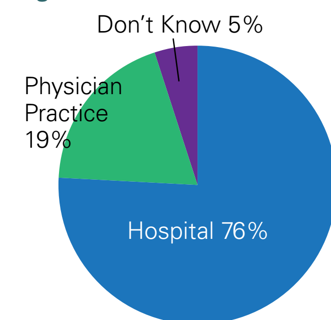


(*Percentages virtually unchanged from Year 2 to Year 3.)

Infusion Center Dedicated to Cancer?



Who Bills for Infused Drugs?



Almost half of cancer programs (46%) plan to expand their infusion center; 20% plan to expand to a satellite facility.

Want to Learn More? Visit *www.accc-cancer.org*

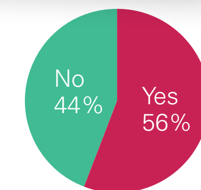
Financial Performance

Most characterized their program's financial status as good or very good for 2010, similar to Year 2. However, more than one-third (34%) of programs do not have sufficient data to track profit and loss (P&L).

While many programs are actively seeking to reduce or control costs without compromising quality and services, several respondents said that their financial strategy is skewed more toward increasing capacity and revenue. Programs boost revenue through a wide range of strategies, with an emphasis on those that increase volume.

Less than one-third (32%) reported hiring freezes compared to 57% (Year 2). Fewer than one in four (24%) reported IT improvement delays compared to 43% (Year 2).

Are You Increasing Coding Reviews to Improve Revenue?



What Respondents Said

Six Sigma helped us increase value added and remove waste.

We improved the way patients flow through the system and reduced drug inventory.

Oncology is a revenue-driven business, not a cost-driven business. It's all about increasing capacity.

We have outreach to physician offices to keep referrals coming to us.

To drive new volume, we are looking at adding oncology rehabilitation, outpatient palliative care, and a survivorship clinic.

We added a financial counselor when the economy took a downturn, and we saw a huge increase in patients needing financial assistance.

Our cancer program started a co-management agreement with physicians to ensure alignment with the oncology service line. Physicians participate in management of the oncology program and receive incentive payments for meeting hospital goals, such as decreased 30-day readmissions, throughput, avoiding delays in treatment, patient satisfaction.

A Survey by the Association of Community Cancer Centers

2012 Cancer Care Trends in Community Cancer Centers

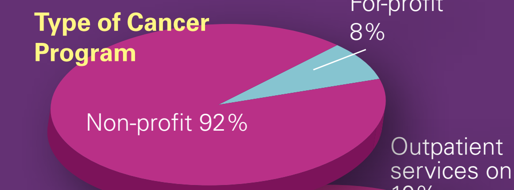
ACCC's annual survey provides insight into how cancer programs are controlling costs, implementing new standards, launching new organizational strategies, and better serving patients. A joint project between ACCC and Eli Lilly, these results are from the Year 3 Survey.

This year, 78% of survey respondents were cancer programs located at community hospitals. While most programs include medical (76%) and radiation oncology (75%) in their cancer service line, 85% said that diagnostic radiology is managed as a separate hospital department.

Fewer programs offer surgical and gynecologic oncology services, a trend away from comprehensive, integrated offerings. In the Year 2 Survey, for example, 43% of respondents indicated surgical oncology was included in the cancer service line, compared to 25% in Year 3. In the Year 2 Survey, 42% said gynecologic oncology was included in the cancer service line, compared to 29% in Year 3.

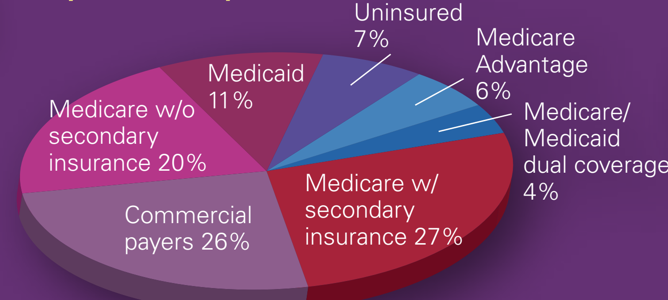
Most, but not all, programs offer the services that are newly required by the CoC, including RN patient navigators (75%), psychological counseling (73%), cancer rehabilitation (69%), genetic counseling (63%), and survivorship (59%).

Type of Cancer Program

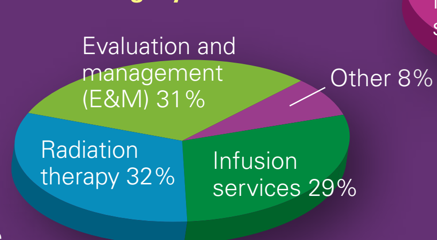


Type of Services Provided

Respondents' Payer Mix



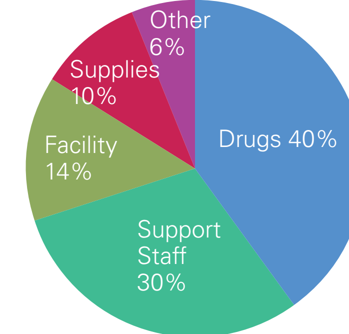
Patient Visits by Service Category



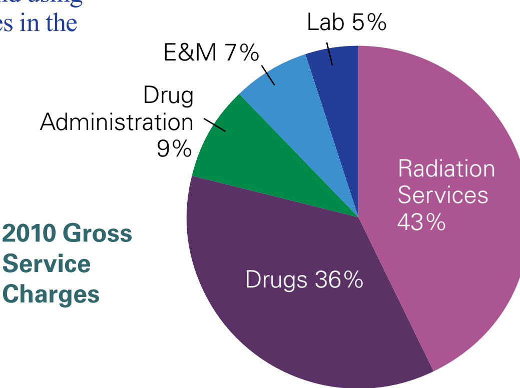
Drugs and Biologicals

Drugs continue to represent a large portion of both charges and expenses. Today, cancer programs must aggressively manage their drug purchasing by reviewing purchasing contracts, using just-in-time inventory, and using less expensive drugs. For 69% of programs, the drug budget resides in the pharmacy, compared to 29% in the oncology program budget.

2010 Expenses



2010 Gross Service Charges

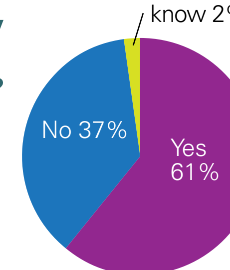


In the Year 3 Survey, 42% of programs report purchasing their drugs through multiple distributors, down from 51% (Year 2) and 46% (Year 1); 31% of programs purchase drugs through a single distributor, compared to 30% (Year 2) and 21% (Year 1).

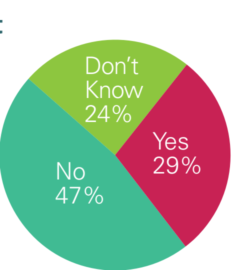
Acquiring injectables from specialty pharmacies increased from 20% (Year 2) to 32% (Year 3). Pressure from payers drives this trend. Why? Specialty pharmacies offer opportunities to manage costs and increase compliance, including utilization management support, simplified and standardized billing, and comprehensive reporting and outcome analysis.

Participation in the 340B Drug Discount Program is on the rise, spurred by loosened eligibility criteria and increased discounts included in the Affordable Care Act. In the Year 3 Survey, 46% of programs participated in the 340B Program, up from 36% (Year 2) and 26% (Year 1).

Dedicated pharmacy in ambulatory outpatient services?



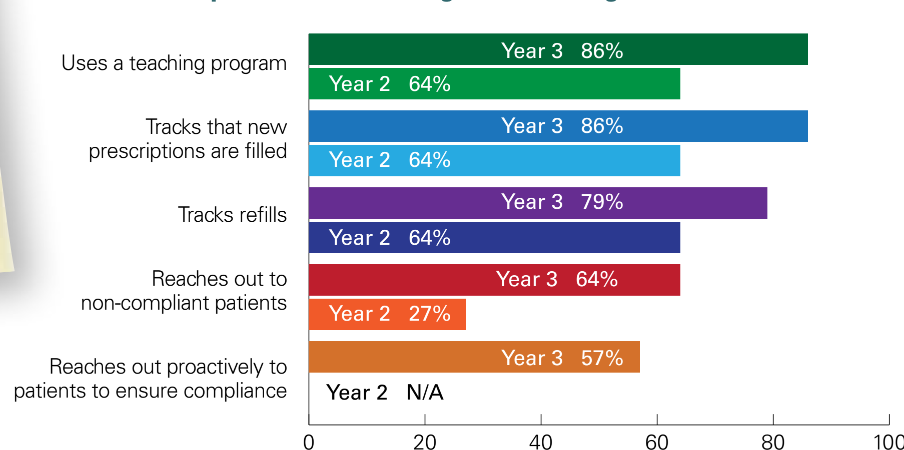
Do you restrict access to any injectables?



Oral Agents

- Only one-third of infusion centers (31%) dispense oral cancer drugs; however, this percentage is up from 24% (Year 2) and 21% (Year 1).
- Of the dispensers, 72% have quality initiatives related to oral agents.
- Only 24% of programs have compliance programs in place.

To Ensure Compliance With Oral Agents Our Program...

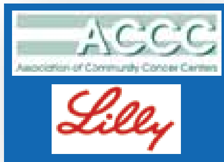


What We Did

For the Year 3 Survey, the Steering Committee again refined the survey instrument. Internet-based data collection was conducted between September 2011 and October 2011. All ACCC Cancer Program members were invited to participate. The consulting firm of Kantar Health collected responses, conducted follow-up interviews in December 2011, and analyzed results. Full survey results are available in the Members-only section of ACCC's website, *www.accc-cancer.org*.

Steering Committee members include: Ernest R. Anderson, Jr., MS, RPh, Steward Health Care; Becky L. DeKay, MBA, Feist-Weiller Cancer Center; Patrick A. Grusenmeyer, ScD, FACHE, Helen F. Graham Cancer Center; and Luana R. Lamkin, RN, MPH, Mountain States Tumor Institute.

In addition, members of the Advisory Committee include: Connie Bollin, MBA, RN, Akron General McDowell Cancer Center; Albert B. Einstein, MD, Swedish Cancer Institute; John Feldmann, MD, Hospice & Palliative Care of Greensboro; Brendan Fitzpatrick, MBA, Alamance Cancer Center; Jennifer Michelson, RN, BSN, Kingsbury Cancer Center; Richard Reiling, MD, FACS, Presbyterian Cancer Center; and Virginia Vaitones, MSW, OSW-C, Pen Bay Medical Center.



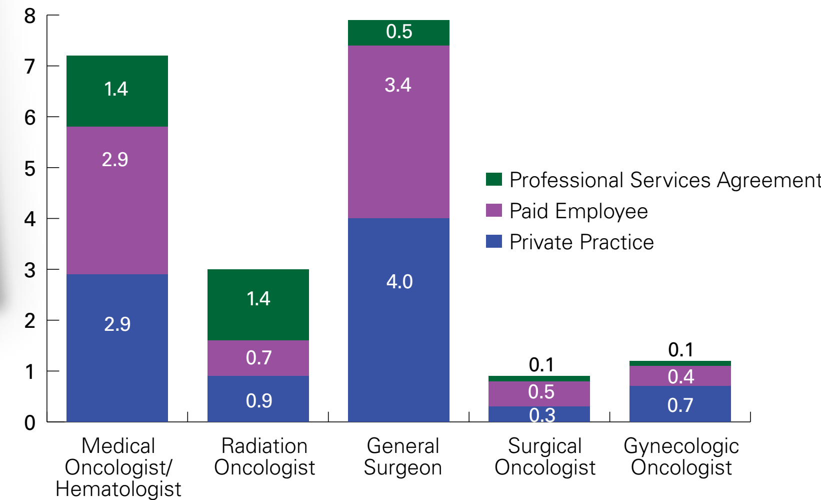
Staffing

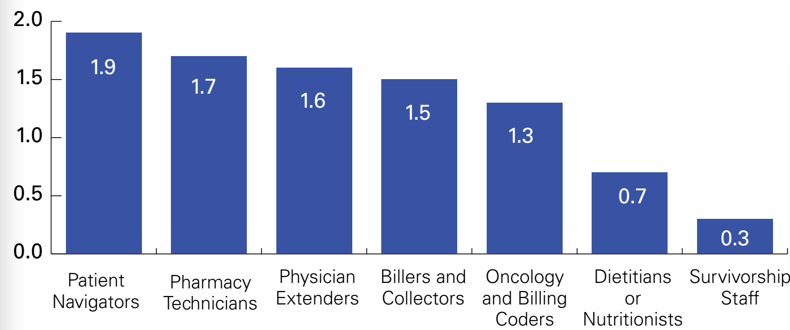
After drug costs, the second highest expenditure is the cost of staff. Nursing accounts for the most FTEs, followed by radiation oncology technicians, administrative staff, and clinical research personnel. The mean number of nurses is 14.6.

Relationships between cancer programs and physicians continue to evolve as oncologists in private practice struggle with declining reimbursements and seek financial stability. Many are opting for employment at hospitals. Professional services agreements between cancer programs and medical and hematological oncologists increased compared to previous years.

Programs rely on their service-line physician groups to network with local physicians who can refer oncology patients. Expanding the number of employed or affiliated physicians may lead to a large volume of "homegrown" physician referrals to support the oncology service line.

The number of patient navigators, pharmacy technicians, physician extenders, and coders varies widely from program to program. Nutrition, genetic, and survivorship FTEs continue to be few in number.





How Are Programs Supporting Community Oncologists?

	Year 3	Year 2
↑ Medical director fees	55%	54%
↑ Clinical research support	51%	39%
↑ Leased space in or adjacent to hospital	45%	39%
↓ Lease employees from the hospital	6%	15%
↔ Increased pay for on-call services to hospital	6%	6%
↓ Partnering on equipment purchases	4%	7%

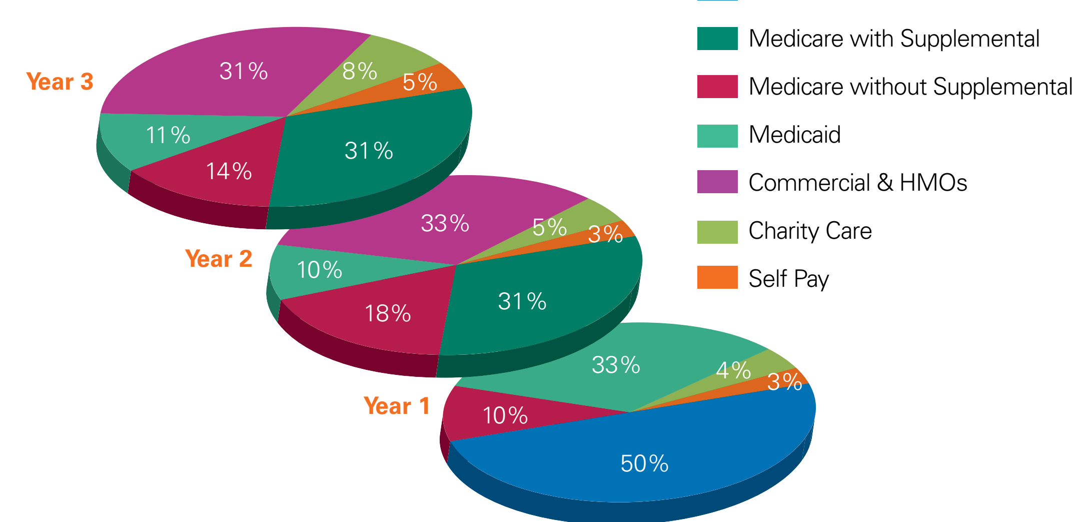
The Marketplace

When asked if there has been consolidation of cancer programs or oncology practices over the last year, 19% reported consolidation through affiliation, 5% through acquisition, and 3% through merger in the past year.

When asked if they anticipate consolidation of cancer programs or oncology practices in the next one or two years, 31% of cancer programs said yes, and 44% of practices said yes.

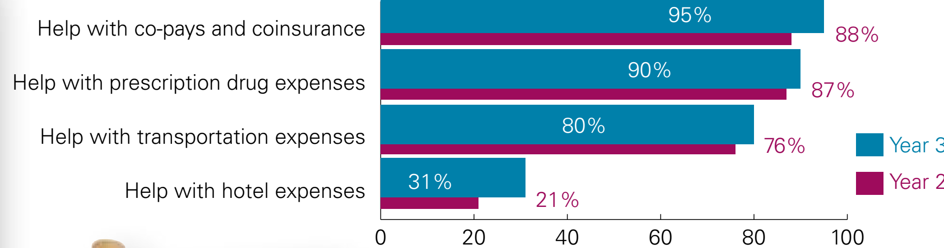
Know Your Competition

The average cancer program competes with 3 programs in its primary service area. This is unchanged from Year 2 to Year 3.

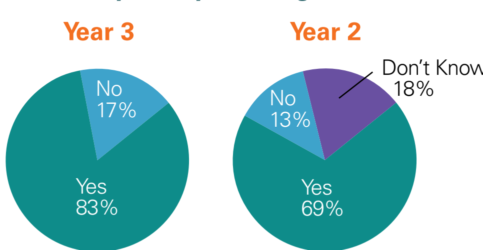


The Economy is Affecting Patients…

In the Year 3 Survey, 95% of programs report seeing more patients without insurance or with inadequate insurance. Cancer programs rely on three primary strategies to accommodate these patients: financial counselors, write-offs or charity care, and drug assistance programs. Looking at patient volume and costs, the percentage of charity care has increased throughout the 3 years of the survey.



Nearly all cancer programs offer financial counseling. Programs have realized substantial benefits from financial specialists who verify coverage, obtain prior authorizations for treatment, and help patients enroll in drug assistance and co-pay programs.



Oncology-Related Services

1 Balancing Cuts & Quality Care! Programs are actively looking to reduce or control costs without compromising quality and services.

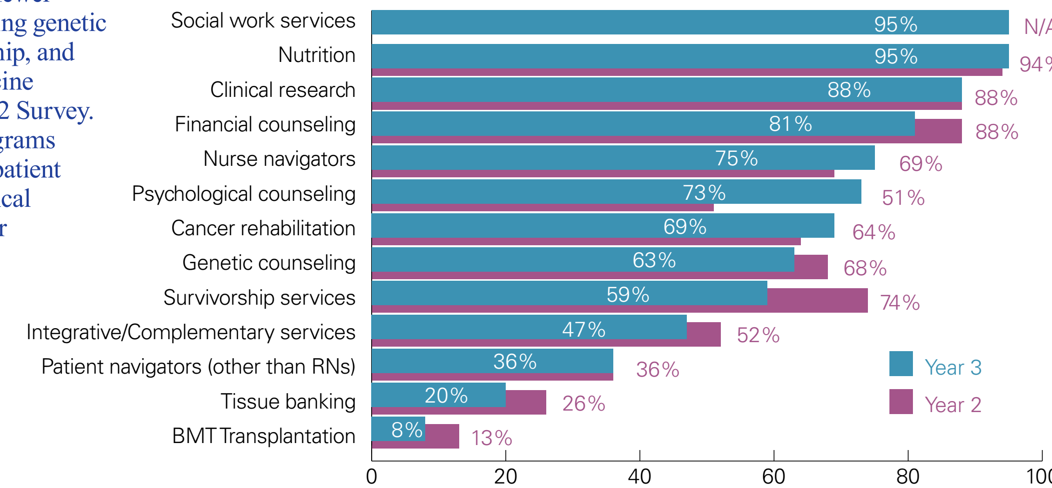
2 Expand or Not? Almost half of programs plan to expand their infusion center, but expansion and replacement plans for clinical technology are limited.

3 Referrals Rule! Programs are increasing affiliations with community oncologists to drive referrals.

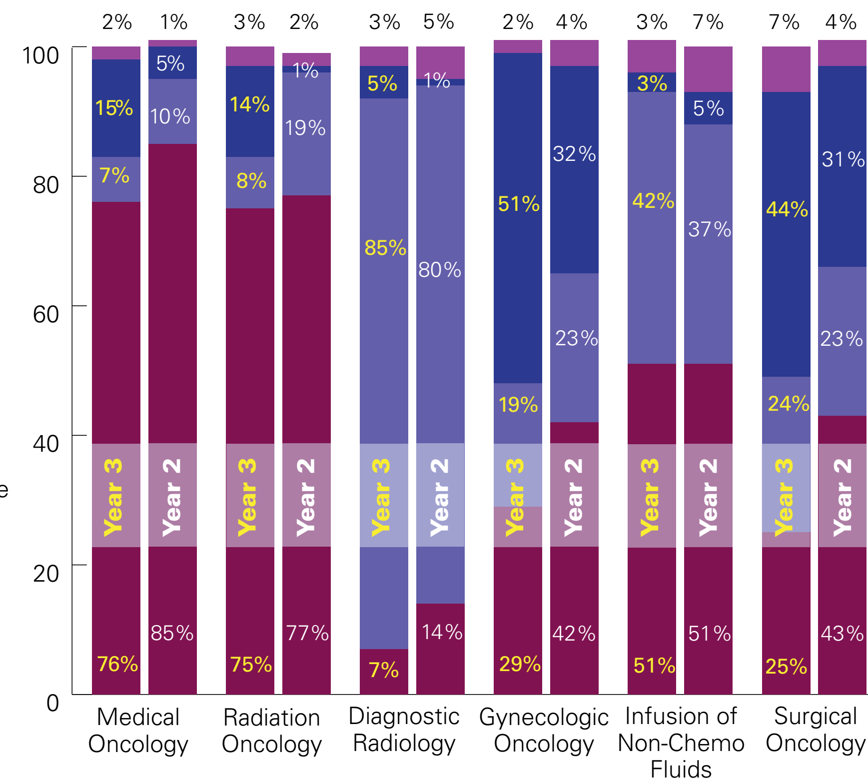
4 Patients Getting Pinched! The number of patients in need of financial assistance continues to rise.

5 Concerns about Specialty Pharmacies! Programs face challenges with regard to operations, reimbursement, patient safety, and institutional liability.

In the Year 3 Survey, fewer programs report offering genetic counseling, survivorship, and complementary medicine compared to the Year 2 Survey. Conversely, more programs report offering nurse patient navigators, psychological counseling, and cancer rehabilitation.



In the Year 2 Survey only 5% of programs responded that they "did not offer" medical oncology services. Our assumption: patients may be seeing medical oncologists in private practices "affiliated" with but "separate" from the hospital. In the Year 3 Survey, 15% of programs said they "did not offer" medical oncology services. Radiation oncology services saw a similar increase in programs that "do not offer" these services from 1% in Year 2 to 14% in Year 3. Why? If the practice is a separate legal entity, then services may not fall under the umbrella of the hospital's cancer service line.



EHRs

The Year 3 Survey saw decreased use of electronic health records (EHRs) with 78% of respondents using EHRs compared to 84% (Year 2) and 65% (Year 1). More than half (59%) of respondents that do use EHRs report using more than one software. Radiation oncology departments frequently need separate EHR systems.

Capital Equipment & Technology

Expansion and replacement plans for clinical technology appear to be limited—continuing the trend from the Year 2 Survey. Across the line, the number of linear accelerators, ultrasound imaging machines, CT scanners, MRI machines, and PET or PET/CT machines budgeted for purchase in the next fiscal year are down, both in the cancer center and on the hospital campus.