ONCOLOGY ISSUES

The Journal of the Association of Community Cancer Centers
March | April 2013

Quality Improvement

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Oncology Issues
March | April 2013
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DEPARTMENTS

ACCC
Association of Community Cancer Centers

ONCOLOGY ISSUES
The Journal of the
Association of Community Cancer Centers

Oncology Issues serves the multidisciplinary specialty of oncology care and cancer program management.

Archived editions of *Oncology Issues* are available to members at: *www.accc-cancer.org*

FROM THE EDITOR

Embrace Your Uniqueness

BY CHRISTIAN DOWNS, JD, MHA

There is only one you for all time.

Fearlessly be yourself.—Anthony Rapp, actor

I have probably visited a few hundred cancer programs over my career. Much like people, each one was a little different and—in some cases—vastly different from the others.

In many conversations I have with providers, I often hear the words: "We are going to launch a program just like (fill in the blank) is doing." Or "I see that there is a national trend to integrate physician practices, we should do that here."

My response usually goes along the line of: "You are a unique provider, meeting the specific needs of *your* community and *your* patients." Of course looking outward to what others are doing is important, even essential, in today's healthcare environment. But for insight and perspective on next steps, looking inward can be equally important.

This edition of *Oncology Issues* is exciting because it highlights a few programs that focused inward, examined their strengths and weaknesses, and developed action plans uniquely-tailored to their specific needs.

For example, quality improvement coordinator Cynthia Jones offers step-by-step suggestions for launching a dedicated quality improvement program and describes the benefits it has brought to Rex Cancer Center in Raleigh, N.C. Her article argues for the importance of continual self-assessment and using data to drive and document quality improvement.

Another great example is the work Ernie Elemento and Vasia Craddick have done at the Southwest Cancer Center in Lubbock, Tex. A 2012 ACCC Innovator Award Winner, Southwest used patient and staff feedback to improve its processes and satisfaction scores.

Now, using patient satisfaction as a tool for change is nothing new. But when was the last time you used that measure as effectively as Southwest Cancer Center? And do you survey the satisfaction of your staff? If so, do you seek to improve staff satisfaction? And when you survey your patients and staff, do you ask specific questions, unique to your cancer program, or do you use the same survey tools as every other cancer program? Asking for feedback from patients and staff is another way of looking inward. The information you gather can be an invaluable tool in assessing your unique community and programmatic needs.

ACCC has a wealth of resources for you at its meetings, on its website, *www.accc-cancer.org,* through its online community on *MyNetwork,* and in its publications and education programs on how other cancer programs are addressing challenges identical to those you are facing. Take advantage of their experiences to improve *your* program. But don't forget: your program is unique—so embrace your uniqueness. OI

PRESIDENT'S MESSAGE

The Practice of Medicine

BY GEORGE KOVACH, MD

The "practice of medicine" is a phrase commonly used to describe a physician's efforts in diagnosing and treating disease. As oncologists we practice in a field in which treatment of a given medical condition is often variable and at times not well-defined in the medical literature.

An added challenge is that the accuracy of medical literature can be questionable, which can adversely affect clinical outcomes. You may be familiar with the saying that "half of medical literature is wrong, and you don't know which half." Unfortunately, this conundrum is something that clinicians deal with on a daily basis.

Without well-designed, accurate clinical trials, defining quality cancer care is dubious at best. Practitioners need concrete information in order to determine the right treatment at the right time for their patients.

Accurate, timely studies are the obvious answer; however, even with excellent peer-review studies, providers may face barriers that result in treatment being delayed or denied. We must and can do better. I believe the appropriate application of pathways and guidelines, in addition to focused clinical trials, offers the best approach to providing the right treatment at the right time to our patients.

Pathways and guidelines, such as those of NCCN, ASCO, and ASH, can reduce the variability in treatment decisions and provide the clinician with up-to-date treatment and management information. However, these approaches must be regularly updated and allow for flexibility in treatment decision making when appropriate.

Of course, the practice of medicine takes place in today's complex and evolving healthcare environment in which cost of care is a priority issue. And if the medical community cannot document the best treatment outcomes for their patients, there is the looming possibility that the metric for coverage may become cost alone—a worst-case scenario.

While the use of guidelines or pathways may or may not help to reduce the cost of appropriate treatment, these should provide quality care with the best outcomes for the patient. In my opinion, cost savings will likely flow from reduction in over utilization and duplication of pre- and post-treatment diagnostic procedures and improvements in palliative care.

My president's theme this year "the right treatment at the right time" aims to ensure that those who practice oncology care on a daily basis will have a voice in shaping the future of cancer care. Its success hinges on your continued engagement and support of ACCC. Get involved by joining ACCC's Grassroots Advocacy Campaign today.

In this, my final "President's Message" column, I want to express my appreciation for the opportunity to have served as ACCC President. It's truly an honor to represent ACCC and its membership. Thank you for your devotion to ACCC and, above all, our patients! OI

Coming in Your 2013 *ONCOLOGY ISSUES*

- Developing a Centralized Process to Review & Track Clinical Studies
- Managing Through Change—A Community Hospital's Acquisition of a Private Oncology Practice
- Developing a Multidisciplinary Thoracic Oncology Clinic in the Community Setting
- A Model Rapid Access Chest & Lung Assessment Program
- Physician-Hospital Alignment: Bringing Together the PSA and MSA
- Survivor PLACE: A Multidisciplinary Approach to Survivorship Care
- A Model Outpatient Palliative Care Program
- Bridging the Psychosocial & Financial Needs of Oncology Patients

more online @ www.accc-cancer.org

New! Financial Assistance Toolkit

TOOL

Tools to assess benefits and estimate treatment costs; sample appeal and collection letters; worksheets to track drug replacement; policies for pre-auths, denials, appeals; and more! Order today at *www.accc-cancer.org/FiLN*.

2013 ACCC Innovator Awards

AWARD

Now in their third year, these awards are sponsored by GE Healthcare and recognize and honor pioneering strategies for the effective delivery of cancer care in the community setting. Innovations should advance the goals of improving access, quality, and/or cost effectiveness of cancer care. Learn more and apply today at *www.accc-cancer.org/innovator*.

Speak Up!

Fixing the SGR formula is a top issue in ACCC's grassroots advocacy effort. Using the script at *www.accc-cancer.org/advocacy/LegislativeAction.asp* call your elected officials to ask them to work toward a reasonable long-term solution. Personalize your calls by explaining how this issue impacts you and your patients.

Strategies for Treating Undocumented Patients

VIDEO

Southwest Cancer Center helps patients return to their country of origin for treatment by paying for transportation and the initial treatment costs. The cancer center also sends a staff member to help with the transition. Watch today at *www.accc-cancer.org/FILN*.

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fast

10 Critical Service Line Strategies Following a Merger, Acquisition, or Affiliation

1. Engage physicians in leading the integrated service line
2. Protect the core business
3. Establish a culture of integration & innovation
4. Consolidate clinical resources to achieve immediate cost savings
5. Optimize the service line's clinical operations
6. Implement aggressive growth initiatives to maximize revenue
7. Develop a growth plan consistent with population health management
8. Use a best in class branding & marketing campaign
9. Establish a physician-led capital plan for the service line
10. Retain & enhance philanthropic support.

Source. The Camden Group. Available online at *www.thecamdengroup.com/top-ten/11012012.php*.

facts

What Are We Spending on Healthcare?

U.S. healthcare spending rose **3.9%** in 2011 (the same rate as in 2010 and 2009) as continued economic weakness depressed demand for healthcare services & increased the ranks of the uninsured.

Healthcare spending totaled **$2.7** trillion in 2011, making up almost **18%** of the gross domestic product.

Healthcare spending in 2011 equaled **$8,680** per person.

Source. Hartman M, et al. National health spending in 2011: overall growth remains low, but some payers and services show signs of acceleration. *Health Aff.* 2013;32(1):87-99.

PATIENT NAME:
ADDRESS:

Rx

Pharmacist Survey Says...

- 62% said the high cost of drugs is currently the biggest cause of non-adherence for patients
- 91% said cost-efficient alternatives to more expensive therapies improve medication adherence
- 89% believed counseling their patients is as important as filling their prescriptions
- 89% said patients welcome being offered generic substitutions as a cost-savings measure
- 88% said patients who pick up their medications and receive first-hand counseling from their pharmacist were more likely to be adherent.

Source. CVS Caremark. Survey of CVS Retail Pharmacists. *http://info.cvscaremark.com.*

DATE:

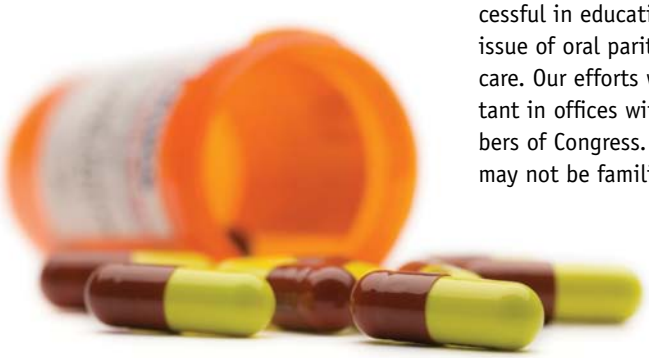
SIGNATURE:

Congress Goes Back to School

BY MATT FARBER, MA

This year, Congress has been busy dealing with issues that will significantly impact the future of the United States. Some of these issues are government spending, military readiness, immigration reform, and gun control. While you will note healthcare is not on that immediate list, rest assured that lawmakers are not ignoring the issue. This means that organizations, such as ACCC, cannot afford to ignore the issue either.

For example, there is an effort to introduce legislation related to oral parity on the federal level. (In brief, oral parity legislation requires payers that cover chemotherapy treatment to provide coverage for oral anti-cancer drugs on terms that are no less favorable than the coverage provided for IV medication.) Many readers know that 21 states* and Washington, D.C., have successfully enacted oral parity legislation. ACCC and many oncology state societies supported this legislation and other laws protecting patients' access to care.



That said, these state initiatives only regulate certain insurance plans within the state. Further, oral parity laws differ across the states. If oral parity is enacted as a federal law, patients will be afforded the same protection across all states. To help further this cause, ACCC joined a coalition effort that has been advocating for a federal oral parity law—Patient Equal Access Coalition (PEAC).

In 2012 the House of Representatives introduced an oral parity bill that more than 50 bi-partisan representatives signed on to support. Unfortunately, last year's political climate hindered the bill's progress. With a new Congress in place, PEAC is working to have the bill reintroduced in the House. In addition, the coalition is also working to have a Senate companion bill introduced. Running companion bills in the House and Senate underscores the importance of the issue and will ultimately speed the approval process.

In February, ACCC joined other PEAC coalition members in visiting numerous Senate offices. Our meetings were successful in educating staff members on the issue of oral parity and patient access to care. Our efforts were especially important in offices with newly-elected members of Congress. Because these members may not be familiar with the issue of oral parity, we were able to educate them in our own words and using the powerful stories of our members.

The importance of educating congressional representatives cannot be overstated. Even if our efforts do not result in a Senate co-sponsor, PEAC members were still able to introduce this issue to members of Congress. Now, when the issue of oral parity comes up again, staff members will remember our meetings, and perhaps even call on a member of the coalition to provide further information.

This advocacy effort is an example of the type of efforts we are asking you—our ACCC members—to get involved in through ACCC's Grassroots Advocacy Campaign. If you are interested in helping to educate Congress on the issues affecting your cancer program and your cancer patients, visit *www.accc-cancer.org/advocacy/QualityCare.asp*. Here, you will learn more about the issues impacting cancer care, along with easy avenues to reach out to your elected officials. There are many ways for your practice or cancer center to participate in grassroots advocacy; some efforts take as little as five minutes. To learn more or to get involved today, contact *mfarber@accc-cancer.org*. OI

*Colorado, Connecticut, Delaware, Hawaii, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Maryland, Minnesota, Nebraska, New Jersey, New Mexico, New York, Oregon, Texas, Vermont, Virginia, Washington

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DIRECTOR, ONCOLOGY SERVICES
Omaha, Nebraska

Job Summary
Develops and directs effective systems for cancer patient populations to ensure optimal customer outcomes, enhance service delivery goals, and meet or exceed financial margins. Leads, coaches, and develops teams of people to achieve high performance standards and strategic objectives. Administer 24-hour accountability for patient care delivery, human resources management, and compliance with regulations.

Essential Requirements
Bachelor's degree in nursing or related healthcare field required; bachelor's degree in nursing preferred. Master's degree preferred. Minimum of 10 years of nursing experience required. Minimum of 5 years leadership experience in healthcare operations required. Current RN license in the State of Nebraska strongly preferred. Also required:

- Effective verbal and written communication skills
- Lead others through development and empowerment
- Perform in a complex, changing environment
- Complex problem solving
- Effective analytical, business & marketing skills.

Apply online at *www.Nebraskamed.com*.

EXECUTIVE DIRECTOR
Community Cancer Center

Job Summary
Executive Director to lead the Community Cancer Center, an established joint-venture between Advocate Bromenn Medical Center and OSF St. Joseph Medical Center.

Essential Requirements
The Executive Director will be accountable for the organization's P&L and will direct strategic planning, operations, metrics improvement, contracting, business development, financial performance, and ensure service excellence. The ideal candidate shall offer:

- Senior level leadership experience, including responsibility for budgeting, marketing, physician relations/joint ventures, and program development experience.
- Substantial track record of developing and managing relationships with physician partners and implementing organizational change.
- Proven ability to manage expansion, new construction initiatives, and accompanying process redesign.
- Masters preferred. Excellent communication and problem-solving skills required.

Submit resumes to: Page Ettle, Senior Consultant, Grant Cooper HealthCare, Phone: 800.886.4690, x104; Email: *page@grantcooper.com*.

DIRECTOR, REGIONAL CANCER CENTER
Wisconsin

Job Summary
Challenging full-time leadership opportunity available to provide overall operational management to the CoC-accredited programs of St. Vincent Regional Cancer Center in Green Bay, Wis. and St. Nicholas Hospital Cancer Program in Sheboygan, Wis.

Essential Responsibilities
Areas of direct responsibility include radiation oncology, GYN oncology, and cancer registry, as well as radiation oncology satellite centers. Operations span five locations throughout a regional network in Northeastern Wisconsin. Position is responsible for leading operations to maintain accreditations and implementing innovative solutions to enhance quality, service, and operational efficiency.

Essential Requirements
Bachelor's degree, 5 years experience in a clinical healthcare role, 5 years experience in a management role, and extensive experience in health organization including supervision, budgeting, planning, and administrative reporting required. Master's degree and experience in oncology preferred. EOE.

Apply online at *www.stvincenthospital.org*.

ONCOLOGY PHARMACIST COORDINATOR
Stamford, Connecticut

Job Summary
Provides quality patient care in relation to the patient's oncologic diagnosis, prescribed treatment, age group, and other identified needs. Provides comprehensive pharmaceutical care to oncology patients to assure safe and effective drug therapy. Requires independent decision-making, clinical judgment, and an in-depth knowledge of oncology and therapeutics. Coordinates the drug therapy process for oncology patient population.

Essential Requirements

- PharmD required.
- Current licensure to practice pharmacy in CT required.
- BPS certification in oncology highly preferred.
- Residency in oncology or equivalent experience as clinical pharmacist in oncology practice setting.
- Vaccine administration certification in CT required.
- Oversees pharmacy students, pharmacy residents, clinical pharmacists, pharmacists, and pharmacy techs.
- Ensures that all activities are within legal limits, regulatory requirements, and patient-safe.

Submit resumes to: Amanda Sawicki, Human Resources Partner, Email: *asawicki@stamhealth.org;* Phone: 203.276.7588.

HEMATOLOGY & ONCOLOGY MANAGER
Whittier, California

As an Integrated Delivery System (IDS), PIH Health provides a range of healthcare services to better serve its community. We are currently seeking a Hematology & Oncology Manager.

Essential Responsibilities

Ideal candidates will oversee the day-to-day operations of the Hematology and Oncology Office, ensuring efficient and effective office operations, hold staff accountable to a patient-centered culture, and ensure that organizational goals and objectives are met. This position involves participating in budgeting, growth, and development efforts as required.

Essential Requirements

- Bachelor's degree in Healthcare, Business Management, or other related area is required; Master's degree preferred.
- 2 years of management experience in a medical group, hospital, IPA, or HMO setting.
- Clinical Oncology practice management experience preferred.
- Current California RN license strongly desired.
- Strong understanding of ICD-9 and CPT coding.
- Lean training or process improvement training and certification preferred.

To apply, contact our recruiter at *Monique.Tafurt@pihhealth.org* or visit *www.pih.net*. EOE.

NURSE PRACTITIONER
Goshen, Indiana

The NP may be primarily assigned to one of three clinical disciplines: Surgical Oncology, Radiation Oncology, Medical Oncology, while operating comfortably within a combination of the three. The NP works with a physician to manage patient caseloads in both the inpatient and outpatient setting. NP will assist in the evaluation, observation, and treatment of patients presenting a variety of medical problems related to oncology care, ranging from chronic disease, acute illnesses, episodic disorders, symptom management, palliative care, healthcare maintenance and/or survivorship.

The NP receives professional medical direction from physicians. NP proceeds independently in the care and treatment of patients within the scope of practice defined and agreed to by medicine, nursing, and administration. NP seeks the expert opinion of a physician whenever a case falls outside the scope authorized by the board of nursing, policies, and/or protocol.

Requirements: At least two years of oncology practice, as either an RN, NP, or PA. Inpatient experience is preferred. A license to practice as a RN and a certificate to practice as a NP issued by the State Board of Registered Nursing. PAs will be considered, but are not ideal.

Contact Sondra Patton, Recruiter *spatton5@iuhealth.org* or apply online at *www.iuhealth.org/goshen*.

HEMATOLOGY & ONCOLOGY MEDICAL DIRECTOR
Bristol, Connecticut

Leadership opportunity for hematologist/oncologist to provide vision as Medical Director of Bristol Hospital's Cancer Care Center. As program champion, you'll provide medical directorship and direct patient care services. The Medical Director will provide medical oversight and coverage of both the inpatient and outpatient cancer programs along with three other hematologists/oncologists and assist in the performance improvement initiatives and development of clinical protocols.

We are affiliated with the Yale-New Haven Cancer Network, as well as the Yale University Cancer Center. Bristol Hospital is a progressive community hospital located in a family-oriented community with unmet demand, home to ESPN with nearby desirable suburban communities; top-rated public and private schools, close proximity to professional sporting events, concerts, theatres, skiing, and coastline. We are located two hours from NYC and Boston.

For more information about this opportunity, contact Bristol Hospital's Physician Recruitment Department at 800.892.3846.

REGISTERED NURSE, ONCOLOGY
Eau Claire, Wisconsin

Sacred Heart Hospital Cancer Care Services' goal is to deliver high quality, compassionate care and to uphold the pledge to our patients that is boldly engraved above our front door: "There is hope here." Join a group of extraordinary cancer care professionals in the assessment, planning, evaluation, and implementation of the care of our patients on our 12-bed dedicated Oncology unit specializing in providing outstanding care to our cancer patients. We foster a collaborative team approach to patient and family-centered care. Multiple Shift configurations available FT/PT/Weekend Option. EOE operating under an Affirmative Action Plan.

Experience

- Valid WI RN license and BLS are required.
- Minimum 2 years of oncology experience preferred.
- Chemotherapy Biotherapy Administration Provider and/or OCN certification from ONS a plus.

If you would like to serve in an atmosphere where you are valued as an individual and given opportunities for professional and personal growth, we would be excited to hear from you.

Submit your resume to *careers@shec.hshs.org;* Fax: 715.717.4976; or link directly to the job posting at *www.sacredhearteauclaire.org/contentmgr/showdetails.php/id/2084*.

The ABCs of Billing MNT

BY CINDY PARMAN, CPC, CPC-H, RCC

Medical nutrition therapy (MNT) includes nutritional diagnostic therapy and counseling services provided by qualified personnel for the purpose of managing an acute or chronic condition or disease.[1] The intent is to help individuals optimize nutritional status and maintain or improve health. The licensure laws of some states specifically include medical nutrition therapy as a service provided by licensed dietitians or nutrition professionals.

MNT occurs over a series of patient encounters; the typical MNT service includes an initial assessment and intervention followed by multiple re-assessment and intervention visits.

Medical Nutrition Therapy Codes

The *CPT® Manual* includes three codes for medical nutrition therapy, which are distinguished from each other based on individual versus group assessment. In addition, there are initial and subsequent individual assessment and intervention codes. These codes are reported for patients in all age groups and in all care sites. Although medical nutrition therapy is primarily provided by physicians and by registered dietitians, a cross-reference following these codes instructs physicians to use the Evaluation and Management (E/M) or Preventive Medicine codes for reporting this service. The codes used to report MNT include:

Code 97802. Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes. This service includes, but may not be limited to:

- A thorough review of the patient's medical record for medical diagnosis, past medical history, and history of present illness.
- Order and review pertinent laboratory testing.
- Nutrition history is taken from the patient, including a thorough evaluation of nutrient intake, use of nutrition supplements, and identification of nutrition problems.
- Calculations related to body size and physical measurements of the patient are obtained.
- An intensive nutrition assessment is performed to evaluate nutrient requirements, appropriateness of weight in relation to desirable body weight and goal weight, adequacy of present diet, potential drug-nutrient interactions, exercise patterns, psychosocial food patterns, and patient's knowledge of and willingness to implement nutrition interventions.
- Review of clinical data and evaluation of patient's ability to perform self-monitoring.
- Formulation of a complex nutrition prescription specific to the patient's diagnosis, translation of nutrition prescription into an individualized meal plan, and completion of menu guidelines.
- Therapy includes self-management training, review of techniques for self-monitoring, identification of self-management goals, identification of barriers to adherence and strategies to overcome barriers, and scheduling of follow-up appointment(s).
- Documentation of nutrition assessment, nutrition prescription, self-management training provided in the patient's medical record, with notation of communication with other health-care providers and necessary referrals are also performed.
- The length of a typical initial individual MNT visit is 60 minutes (four 15-minute units).

Code 97803. Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes. For this re-assessment, services include but may not be limited to:

- The patient's medical record is reviewed and an intensive nutrition history is again obtained from the patient, with identification of changes in the physician orders and identification of nutrition problems.
- An intensive nutrition assessment is again performed to evaluate the patient's adherence to the nutrition prescription and meal plan, barriers to adherence, medication schedule and laboratory data, effectiveness of dietary modifications in medical management of diagnoses, changes in weight status, and need for additional nutrition interventions.
- The therapy includes reinforcement of self-management training on nutrition prescription, menu guidelines, and self-monitoring procedures and a schedule is defined for follow-up.
- The service concludes with documentation of nutrition history, nutrition

assessment, provision of reinforcement instructions, collaboration with other healthcare providers, and necessary referrals made in the patient's medical record.
- The length of a typical re-assessment MNT visit is 30 minutes (two 15-minute units).

Code 97804. Medical nutrition therapy; group (two or more individuals), each 30 minutes. As listed in the code descriptor, group therapy includes a minimum of two individuals, and includes but may not be limited to:
- Each patient's medical record is reviewed and a nutrition history is taken from each patient, with identification of changes in physician orders and identification of nutrition problems.
- A nutrition assessment is taken to evaluate each patient's adherence to the nutrition prescription and meal plan and the effectiveness of dietary modifications in medical management of diagnosis, changes in weight status, and need for additional nutrition interventions.
- The therapy includes skill development and self-management training in a small group setting on nutrition prescription, menu guidelines, and self-monitoring procedures. The service concludes with definition of the schedule for follow-up, documentation of nutrition history, nutrition assessment, and instructions provided in each patient's medical record.
- Group MNT visits are typically 60 to 90 minutes (two to three 30-minute units).

Medicare Coverage

For covered medical nutrition therapy services provided to Medicare patients, there are two unique HCPCS Level II codes for MNT re-assessment and intervention:
- **G0270.** Medical nutrition therapy; re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes.
- **G0271.** Medical nutrition therapy, re-assessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen (including additional hours needed for renal disease), group (two or more individuals), each 30 minutes.

CMS (Centers for Medicare & Medicaid Services) states that these HCPCS codes should be used when additional hours of MNT services are performed beyond the number of hours typically covered (three hours in the initial calendar year and two follow-up hours in subsequent years with a physician referral) when the treating physician determines there is a change of diagnosis or medical condition that makes a change in diet necessary. According to the *Federal Register,* August 2, 2001:[2]

We are proposing that the services covered will consist of nutritional assessment, interventions, reassessment, and follow-up interventions. We chose not to define the specific components of the benefit in more detail because we anticipate that registered dietitians and nutritionists will use nationally recognized protocols, such as those developed by the American Dietetic Association (ADA), as they normally would in their business practice. We also chose not to specify the number of hours of MNT that will be covered. Rather, we will develop these frequency limits using the NCD [National Coverage Determination] process. After we complete a literature review, we will solicit input from interested parties as part of the NCD process.

National CMS guidelines for MNT are located in Chapter 1, Part 3, Section 180 of the *Medicare National Coverage Determinations Manual.*[3] NCDs differ from local coverage determinations (LCDs) in that they apply uniformly to the entire Medicare patient population, rather than only to a small local area. Excerpts from this document include:

Section 1861(s)(2)(V) of the [Social Security] Act authorizes Medicare part B coverage of medical nutrition therapy services (MNT) for certain beneficiaries who have diabetes or a renal disease.

Effective October 1, 2002, basic coverage of MNT for the first year a beneficiary receives MNT, with either a diagnosis of renal disease or diabetes as defined at 42 CFR 410.130 is three hours of administration. Also, effective October 1, 2002, basic coverage in subsequent years for renal disease or diabetes is two hours.

The dietician or nutritionist may choose how many units are administered per day as long as all of the other requirements in this NCD and 42 CFR 410.130 – 410.134 are met.

Pursuant to the exception at 42 CFR 410.132(b)(5), additional hours are considered to be medically necessary and covered if the treating physician determines that there is a change in medical condition, diagnosis, or treatment regimen that requires a change in MNT and orders additional hours during that episode of care.

Remember that Medicare Advantage may not have the same diagnosis restrictions as Original Medicare; for example, the Highmark Medicare Advantage policy states:[4]

Medical nutrition therapy services (diagnostic, therapeutic, and counseling) when provided by a registered dietician or nutrition professional for medical necessary reasons will be reimbursed according to the applicable network rules.

Payment for a registered dietitian or nutrition professional services is made at the lesser of the actual charge or 85 percent of the physician fee schedule.

Other Insurers

In addition to the use of the MNT codes for disease management, other third-party payers may use the MNT codes for licensed nutrition professionals who provide other services, such as nutrition services provided within complementary alternative medicine programs. According to Mountain State Blue Cross Blue Shield:[5]

When reported separately, charges

for medical nutrition therapy (97802, 97803, 97804, G0270, G0271) should be combined with and processed under the appropriate medical visit procedure codes. If MNT is the only service performed, it will be reimbursed in accordance with the member's medical care benefits.

According to Aetna:[6]

Medical nutrition therapy provided by a registered dietitian involves the assessment of the person's overall nutritional status followed by the assignment of individualized diet, counseling, and/or specialized nutrition therapies to treat a chronic illness or condition. Medical nutrition therapy has been integrated into the treatment guidelines for a number of chronic diseases, including (i) cardiovascular disease, (ii) diabetes mellitus, (iii) hypertension, (iv) kidney disease, (v) eating disorders, (vi) gastrointestinal disorders, (vii) seizures (i.e., ketogenic diet), and other conditions (e.g., chronic obstructive pulmonary disease) based on the efficacy of diet and lifestyle on the treatment of these diseased states. Registered dietitians, working in a coordinated, multidisciplinary team effort with the primary care physician, take into account a person's food intake, physical activity, course of any medical therapy including medications and other treatments, individual preferences, and other factors.

***Note:** In all circumstances, the intent of this policy is to permit the nutritional counselor to function as a consultant to evaluate the member and coordinate ongoing care with the referring physician.*

While CIGNA includes caveats relating to coverage guidelines that apply to individual plans, the general policy statement includes coverage for dietary issues associated with the treatment of malignant neoplasms and states:[7]

CIGNA covers individualized nutritional evaluation and counseling as medically necessary for the management of any medical condition for which appropriate diet and eating habits are essential to the overall treatment program when prescribed by a physician or physician extender and provided by a licensed healthcare professional (e.g., a registered dietician) covered under the plan.

While nutrition associated with neoplasm treatment is not specifically listed in the coverage policy, United HealthCare states:[8]

Nutritional counseling services provided by a dietician (a licensed health professional) to develop a dietary treatment plan to treat and/or manage conditions such as diabetes, heart failure, kidney failure, high cholesterol, anorexia, bulimia, etc. are Covered Heath Services when both of the following are true:

1. Nutritional education is required for a disease in which patient self-management is an important component of treatment.

2. There exists a knowledge deficit regarding the disease which requires the intervention of a trained health professional.

It is also essential to keep in mind that some insurers, such as Blue Cross Blue Shield plans, will reimburse for MNT only if the proper HCPCS Level II code is reported:

- **S9452:** Nutrition classes, non-physician provider, per session
- **S9470:** Nutritional counseling, dietitian visit.

Documentation

Medical record documentation to support the need for nutritional assessment and intervention includes, but may not be limited to:

- Documentation to support recent appetite changes with significant weight gain or loss, or other evidence of nutritional compromise.
- Diagnosis statement supporting a serious physical condition such as diabetes, kidney disease, liver disease, gastrointestinal disease, cancer, or other neurological or psychogenic compromise that would benefit from assistance with diet modifications.
- Documentation of ongoing problems with chewing, swallowing, nausea, vomiting, diarrhea, or constipation.
- Documentation that the patient requires assistance following a modified diet or management of a feeding tube.
- Development of a plan that identifies interventions to improve the health of the patient through proper nutrition, and/or coordination of diet with concurrent medical conditions and medications.

Remember that reimbursement for MNT varies based on the insurance payer and the patient's documented need for this service. Individual payer guidelines should be consulted in all billing situations, preauthorization obtained where possible, and denials investigated when services are documented as reasonable and necessary. OI

—Cindy Parman, CPC, CPC-H, RCC, is a principal at Coding Strategies, Inc., in Powder Springs, Ga.

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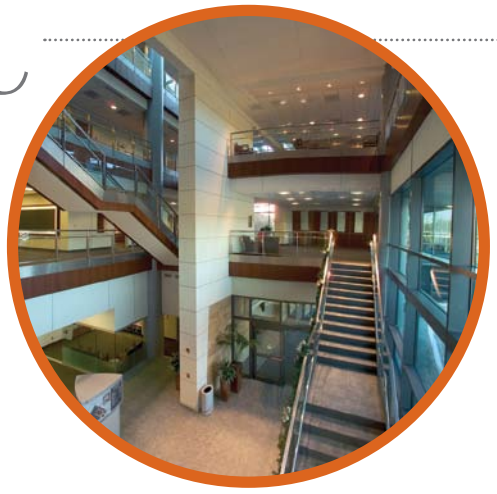

The Comprehensive Cancer Center at Wake Forest Baptist Medical Center

Consolidating cutting-edge care

The Comprehensive Cancer Center at Wake Forest Baptist Medical Center, part of the Wake Forest Baptist Health system, has held continuous NCI-designation since 1974, and this designation was recently renewed for another five-year period through 2017. Additionally, the cancer center holds accreditations from NAPBC, the American College of Radiology (ACR), and ACoS. Located in Winston-Salem, N.C., the Comprehensive Cancer Center serves as the primary tertiary referral center for patients in a geographic region encompassing nearly nine million people.

Consolidating Care

A significant commitment to streamlining care and services is the $125 million expansion of the cancer center. This expansion will create 280,000 square feet of new space and bring all inpatient and outpatient cancer services under one roof. Part of the expansion planning process involved administrators, faculty, physicians, and management. Once the North Carolina Certificate of Need process was successfully completed, the plan for consolidating services was underway.

The construction, scheduled for completion in late 2013, will add four inpatient floors and a day hospital floor to the existing four-story outpatient cancer center; plus a conference center floor and an administrative floor. The new building will total 530,600 square feet when completed, accommodating current and projected cancer-related inpatient volumes (the number of inpatient beds will increase from 113 to 148 acute care and 44 observation beds, day hospital, observation, and infusion beds). The expansion will include a dedicated oncology intensive care unit, and will free up space on the main campus for other services.

Outpatient services include:

- Radiation Oncology, including Gamma Knife Center
- Hematology and Oncology Clinics
- Thoracic Oncology Program
- Clinical Research Management Program
- Outpatient Radiology
- Breast Care Center
- Multispecialty and Surgical Oncology clinics.

As the opening approaches, the cancer center is seeking patient input on furniture design, artwork, and the gardens.

Cutting-Edge Multidisciplinary Treatment

The cancer center provides care with the latest technology, treatments, and research, including cytoreductive surgery and hyperthermic intraperitoneal chemotherapy (HIPEC) for malignancies that have spread throughout the peritoneal cavity. The cancer center performs about 100 cases annually. The HIPEC program continues to draw patients from around the country and is linked to a variety of research initiatives, including the largest quality of life study for HIPEC patients worldwide.

Wake Forest has been performing Gamma Knife radiosurgery since 1999 and has one of the most active Gamma Knife centers in the U.S. The current Leksell Gamma Knife® Perfexion™ machine is the most accurate and advanced radiosurgery technology available.

Wake Forest also offers breast tomosynthesis, a highly accurate diagnostic tool recently approved by the FDA. This technology converts digital breast images into a stack of thin slices that are used to create a 3D mammogram. Used in conjunction with 2D mammography, 3D mammography improves visibility by reducing tissue superimposition that can hide or mimic pathology in 2D mammography.

Hematology and Oncology provides services on four inpatient units and a BMT unit, as well as one onsite outpatient unit that includes a 35 chair and bed infusion area at Wake Forest Baptist Medical Center.

The infusion pharmacy serves more than 150 patients per day. A staff of three pharmacists and three pharmacy technicians provide distribution expertise in the infusion area. Recently, the infusion pharmacy was renovated to include a state-of-the-art clean room that is home to an Apoteca machine, one of two operational chemotherapy-mixing robots in the nation.

Surgical Oncology is extensively involved in multimodality consultations for the care of patients with melanoma, sarcoma, endocrine tumors, and diseases of the breast, as well as the full spectrum of gastrointestinal malignancy. The clinical service includes seven fellowship-trained surgical oncologists, surgical oncology fellows, four surgical house officers, two to three medical students, three advanced practitioners, and three nurses. Surgical Oncology provides

Number of analytic cases in 2011: 3,673
Select Support Services:

- Counseling and Social Work
- Support Meetings
- Nutrition Services
- Therapeutic Programs
- Integrative Medicine
- Resources Centers
- Activities and Education
- Financial Services
- Palliative Care
- Pastoral Care

services on one inpatient unit and one onsite outpatient unit.

Outpatient radiology at the cancer center performs diagnostic X-ray, CT, ultrasound, and mammography services. Accredited by the ACR as a Breast Imaging Center of Excellence, outpatient radiology also performs mammographic interventional procedures, such as stereotactic biopsies and needle localization. MRI services will be provided in the cancer center beginning in July of 2013.

Interventional Radiology offers a full complement of diagnostic and therapeutic procedures such as advanced loco-regional liver directed therapies, including transcatheter arterial chemoembolization (TACE), Yttrium-90 radioembolization, radiofrequency ablation (RFA), and portal vein embolization.

The cancer center also has a unique integration of psychosocial support and counseling services. Such an integrative model allows for interdisciplinary collaboration and the delivery of mental health services in conjunction with medical care.

In 2012 the cancer center enrolled more than 1,200 patients from the region to clinical trials, including Phase I, II, and III cooperative group, investigator-initiated, and industry-sponsored trials. The cancer center accrues approximately 30 percent of patients to clinical trials annually.

Unique Support Services

Wake Forest currently provides navigation and coordination services in Breast Health, Thoracic Oncology, Pediatric Oncology, GI Oncology, Melanoma/Immunotherapy, and NeuroOncology. The navigation programs function as a concierge-type service, with navigators serving as a touch-point for patients from their initial diagnosis all the way through survivorship.

According to Kerry Snyder Husted RT, RTT, MBA, administrative director, Cancer Center of Excellence & Oncology Service Line, the role of the navigator spans, "from social work to psychosocial work, to counseling, nutrition, patient advocacy, clinician connections; basically everything from A to Z that a patient would need or want, and then that transitions into survivorship."

For breast cancer patients, the cancer center sends out a patient satisfaction survey specific to those patients. This is in addition to the satisfaction survey sent out by the medical center. The navigation program continually scores above 98 percent in satisfaction by patients.

Survivorship services include an orientation hour using a patient self-assessment with a survivorship worksheet and distress thermometer and Seasons of Survival (SOS) educational group meetings.

A unique music therapy program offered by the cancer center is the Healing Harps program. What began a few years ago as one harpist playing in inpatient area hallways and the outpatient clinic has expanded into a full-blown therapeutic program. The cancer center is now a national site for the training and certification of therapeutic harpists. The therapeutic harp practitioner and other harpists play soothing music in the outpatient clinic on various days of the week. This service helps settle patients and family members waiting for appointments. Patients can also request one-on-one time with the harpist.

Other support services include valet parking for patients, an appearance boutique with wig fittings and prostheses, and Healing Touch therapy. Nurses can complete an education and certification process for Healing Touch to be able to provide it for any patient.

Patients and family members can also take advantage of the cancer center's alternative to waiting rooms. "Hospitality rooms" are available in the outpatient cancer center; one on the first floor in the Radiation Therapy Department and the other on the third floor in the Hematology and Oncology Clinic. These rooms function as an informal meeting space where people can go in and talk to other families and patients. Snacks, coffee, and trained volunteers are always on hand.

"Patients and especially families do like to linger in there as it gives them a very therapeutic location to be able to share information with each other," said Marcy Poletti, RN, MSN, program administrator for Wake Forest Baptist Health. She noted that these rooms end up as little personal support groups without the formality of an established support group.

Outreach & Affiliation

The Cancer Prevention and Control Program has close to 40 funded cancer control projects with more than $10 million on breast, prostate, and colon cancer currently under way. These projects focus on molecular epidemiology and genetics, cancer prevention, rural and minority health, tobacco control, survivorship, and access to care.

The cancer center actively partners with the Maya Angelou Center for Health Equity at Wake Forest School of Medicine. The Angelou Center works to address health disparities across the region and the nation.

tools

Approved Drugs

- The U.S. Food and Drug Administration (FDA) has approved Celgene Corporation's *(www.celgene.com)* **Abraxane® for Injectable Suspension (paclitaxel protein-bound particles for injectable suspension)** for first-line treatment of non-small cell lung cancer (NSCLC) in patients who are not candidates for curative surgery or radiation therapy.

- Genentech *(www.gene.com)* announced that the FDA approved a new use of **Avastin® (bevacizumab)** in combination with fluoropyrimidine-based irinotecan or oxaliplatin chemotherapy for people with metastatic colorectal cancer (mCRC). The new indication will allow people who received Avastin plus an irinotecan or oxaliplatin containing chemotherapy as an initial first treatment for mCRC to continue to receive Avastin plus a different irinotecan or oxaliplatin containing chemotherapy after their cancer worsens. The approval is based on positive results from the Phase III ML18147 study, which showed that people who continued to receive an Avastin-based regimen after their cancer worsened lived longer than people who switched to chemotherapy alone.

FDA Approves Generic Version of Doxil®

On Feb. 5, the FDA approved the first generic version of the cancer drug **Doxil (doxorubicin hydrochloride liposome injection)**. The drug is currently on the FDA's drug shortage list. For products on the shortage list, the FDA's Office of Generic Drugs is using a priority review system to expedite the review of generic applications to help alleviate shortages. The generic is made by Sun Pharma Global FZE and will be available in 20 mg and 50 mg vials.

- Celgene Corporation *(www.celgene.com)* announced the FDA has approved **Pomalyst® (pomalidomide)** for patients with multiple myeloma who have received at least two prior therapies including lenalidomide and bortezomib and have demonstrated disease progression on or within 60 days of completion of the last therapy.

Drugs in the News

- The FDA has granted priority review to Boehringer Ingelheim Pharmaceuticals' *(http://us.boehringer-ingelheim.com)* new drug application (NDA) for its investigational oncology compound **afatinib**. The NDA for afatinib is currently under review for the treatment of patients with locally advanced or metastatic non-small cell lung cancer with an epidermal growth factor receptor (EGFR) mutation as detected by an FDA-approved test. Recently, afatinib was also granted orphan drug designation.

- Astellas Pharma US, Inc. *(www.astellas.us)* announced that the FDA accepted a filing and granted priority review for a supplemental NDA for **Tarceva® (erlotinib)** for first-line use in people with locally advanced or NSCLC whose tumors have EGFR activating mutations.

- Bayer HealthCare *(www.bayer.com)* announced their NDA submission to the FDA seeking approval for **radium Ra223 dichloride (radium-223)**, an investigational compound for the treatment of castration-resistant prostate cancer patients with bone metastases.

Approved Devices

- The FDA has cleared BD Medical's *(www.bd.com)* **BD PhaSeal™ Closed System Transfer Device (CSTD)** under the newly created ONB code. The BD PhaSeal System is a device that reduces healthcare workers' exposure to hazardous, parenteral medications from preparation in the pharmacy to administration with the patient. The system is an airtight leak-proof CSTD that mechanically prohibits the transfer of environmental contaminants into the system and the escape of drug or vapor concentrations outside the system, thereby minimizing individual and environmental exposure to drug vapor aerosols and spills. This system also prevents microbial ingress.

- Varian Medical Systems *(www.varian.com)* has received FDA 510(k) clearance for the company's **Edge™ radiosurgery suite**, a new dedicated system for performing advanced radiosurgery using real-time tumor tracking and motion management technologies. Recent FDA 510(k) clearances cover the following technologies that are integrated into the Edge radiosurgery suite: The PerfectPitch™ couch, The Advanced Motion & Image-Guided Radiotherapy (IGRT) package, the Intracranial radiosurgery package, and the Calypson system.

- The FDA has given 510(k) clearance to Neusoft Medical Systems' *(www.neusoft.com/en)* **NeuViz 64 multi-slice CT scanner**. The NeuViz 64 design delivers low-dose scanning, high patient throughput, and ease of use; performs advanced cardiac imaging; and provides a wide variety of clinically-relevant post processing and diagnostic techniques.

- Varian Medical Systems *(www.varian.com)* has received FDA 510(k) clearance for the latest version of its **Vitesse™ real time planning** for HDR brachytherapy which is used to plan and perform high-dose-rate (HDR), ultrasound-guided brachytherapy treatments for prostate cancer. OI

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Jamie Harness
Program Coordinator,
Cancer Services, OhioHealth - Grant Medical Center

"The national recognition helped support continued efforts to promote the program. Even though our program is not a money maker, its recognition through this award has helped keep our supportive care clinics in the spotlight as something requiring continual improvement vs. something to be tossed aside."

Robert Mancini, PharmD, BCOP
Oncology Pharmacist, St. Luke's Mountain States Tumor Institute

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- ★ Outreach

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All entries will be peer reviewed. Applicants must be affiliated with ACCC as Cancer Program Members.

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BY CYNTHIA L. JONES, BSHA, CPHQ

Are You as Good as You Think You Are?

Developing a dedicated quality improvement program

Radiation oncology staff at Rex Cancer Center includes (bottom row, left to right) Kelly Hogan, RT(T)(T), Terri Saunders, RT(T)(T), Martha Jubera, RT(T)(T), Cindy Sadler, RT(T)(T) (top row, left to right) Lynn Coleman, RT(T)(T), Susan Litzsinger, RT(T)(T), Amy Luetgenau, RT(T)(T) and Matt Keefe, RT(T)(T).

At hospitals, traditionally most quality and safety programs are stretched thin supporting the critical needs of inpatient operations. This often leaves other service lines—including outpatient cancer care—to find their own way to address needs in the ambulatory care environment. While clinical managers address quality needs within their respective service lines, they typically are busy running the business and clinical operations with little room for handling additional needs that may arise as services grow. As a result, programs may use a reactive or "just in time" approach to problem-solving characterized by quick-fix responses and "putting out fires." Further, while managers have vast areas of expertise, they are not necessarily experts in the areas of data analysis, process design, and development of improvement strategies—all key elements of progressive quality improvement programs.

In recent years, the healthcare community, especially acute care, has shifted from a traditional quality assurance approach to more robust quality improvement methodologies. This change is reflected in the new CoC Standards for 2012 and 2015.

Rex Cancer Center, Raleigh, N.C., is a thriving program that has earned multiple commendations and accreditations (see box, page 23).

Despite these accomplishments, expanding services, increasing volumes, and the hiring of additional staff—coupled with growing accreditation, regulatory, and safety needs—made it clear that Rex Cancer Center needed to devote more resources to meet the quality and regulatory needs of its complex oncology service line.

Accordingly, program director, Vickie Byler, RN, MSN, set out to discover what else needed to be done in the center's quest for quality care. Here are step-by-step suggestions for launching a dedicated quality improvement (QI) program based on the Rex Cancer Center experience.

STEP 1—Recognizing Best Practices

A key starting point for any program looking at QI strategies is to recognize your best practices. What is your cancer program doing really well right now? This perspective provides insight on some important elements that are often overlooked. Start by asking these questions:

- What does the oncology service line do that is exceptional or that might be considered "best practice?" What measures validate or what evidence supports this finding?
- How is the best practice communicated and shared in the service line or healthcare system?
- What are the values associated with the best practice?

The answers to these questions reveal the key strengths and culture already at work in your cancer service line. Spend some time understanding what your team does well, their skill set, and what the work culture is like at your cancer program.

For example, at Rex Cancer Center, we are very strong in the areas of service excellence, patient perception of care, and co-worker loyalty. These core values of Rex Healthcare are part of the teaching and orientation for all employees. Rex Healthcare is recognized within our community and beyond.

Validating measures and supporting evidence include:

- Professional Research Consultants (PRC) Five-Star Award & Top Performer (2008, 2009, and 2012)
- Association for Healthcare Foodservice 2012 Culinary Competition (Gold Medal 2012)
- Modern Healthcare's Best Places to Work List 2011 (N.C. hospital)
- Becker's Hospital Review Top 50 Best Hospitals in the Nation 2011
- National Research Corporation (NRC) Consumer Choice Award 2009
- Thomson Reuters Top 100 Hospitals National Award Winner 2008
- Magnet Recognition by ANCC (American Nurses Credentialing Center) in 2008 (first in the region)
- North Carolina Governor's Award for Excellence for its Workplace Wellness (1995–1999).

These rewards and accolades are communicated and tracked from senior leadership to the management level and on to the entire staff.

STEP 2—Assessing Needs & Opportunities

The next step is to work with your cancer care team to address areas of need.

In 2011, with a new QI coordinator in place, Rex Cancer Center faced significant work with three accreditation surveys due within 18 months: The Joint Commission survey, followed by the CoC accreditation survey, and finally the cancer center's first NAPBC re-accreditation. With these surveys in mind, our team worked to address areas of need and areas of opportunities.

We began by asking a question: What is "high-risk" and what is "high-volume?" On the inpatient side, high-risk and high-volume areas have commonly been a safety and quality focus of The Joint Commission. These key areas are where you are likely to find gaps, the potential for harm, and opportunities to intervene.

To assess these areas in the ambulatory cancer care environment, we started looking at chemotherapy and blood product transfusions. These services are a part of daily life in the cancer center, but they are also high-risk. A quantitative review found that, on average, our cancer center has 1,000 chemotherapy mixes and 200 transfused blood products per month.

Next, we took this quantitative measure and looked for more details to form a qualitative assessment from a regulatory or quality perspective. For example, if our cancer center has 1,000 chemotherapies mixes per month:

- How many adverse drug reactions are identified? Is identification timely and addressed by cancer program staff? How are these events reported and communicated? Are any preventable issues identified?
- How many medication errors occur? Is identification timely and addressed by cancer program staff? How are these events reported and communicated? Are any preventable issues identified?

We looked to our data to answer these questions. Most health systems and hospitals use some type of error or variance reporting system based on self-reporting of issues that occur, such as medication errors or reactions. Rex Cancer Center uses a staff-friendly, web-based program to support such reporting, and even allows anonymous reporting of any event. Data analysis showed a total of 18 events reported, including only one transfusion reaction and 10 medication events (see Table 1, right). Given our volume, we were concerned that staff might be under-reporting these events.

To test this hypothesis, we shared the data with cancer program leadership and staff and began to implement a culture of change.

STEP 3—Communicating the Need to Support Cultural Change

Care must be taken when trying to effect a change in culture. At Rex Cancer Center our experienced staff delivers excellent care. With this understanding in mind, our QI coordinator worked with management to make "quality" a standing agenda item at the monthly manager's meeting. Each month, the QI coordinator would present data on adverse events and medication errors.

After presenting the 2010 adverse event report, the QI coordinator asked the management team about their thoughts on the data. Again, based on the large volume and the very low rate of adverse events, the general consensus seemed to indicate that staff might be under-reporting. We were then able to initiate an open discussion on the value of variance reporting, non-punitive communication of issues in our workplace, and the future of our organized efforts to improve identified areas of need. With management and leadership buy-in, the next step was getting the full staff on board.

We initiated open forums on event reporting and began to collect the data we needed to identify areas where Rex Cancer Center had issues or unmet needs.

Changing to a non-punitive culture took time, open discussion, and mentoring. In the end, we were able to effect change (see Table 2, right). By the third quarter of 2011, the way Rex Cancer Center practiced medicine was shifting, encouraging the reporting of events, errors, or even "great catches" (i.e., issues that are caught before they occur). We

Table 1. Voluntary Reporting Variances, Jan. 2010 to Dec. 2010

EVENTS REPORTED: JAN. TO DEC. 2010	1ST QTR.	2ND QTR.	3RD QTR.	4TH QTR.	Total
Adverse drug reaction	0	1	5	1	**7**
Blood or blood product event	1	0	0	0	**1**
Medication event	4	1	3	2	**10**
Total	**5**	**2**	**8**	**3**	**18**

Table 2. Voluntary Reporting Variance, Jan. 2011 to Dec. 2011

EVENTS REPORTED: JAN. TO DEC. 2011	1ST QTR.	2ND QTR.	3RD QTR.	4TH QTR.	Total
Adverse drug reaction	1	5	15	5	**26**
Blood or blood product event	0	5	3	2	**10**
Medication event	12	9	34	22	**77**
Total	**13**	**19**	**52**	**29**	**113**

Table 3. Dosimetry Treatment Patient Delays, Sept. 2010 to Feb. 2011

RADIATION ONCOLOGY PERFORMANCE IMPROVEMENT	SEPT. 2010	OCT. 2010	NOV. 2010	DEC. 2010	JAN. 2011	FEB. 2011	Total
No. of dosimetry patient delays	2	10	4	3	14	10	**43**

Table 4. Reasons for Dosimetry Treatment Patient Delays, Sept. 2010 to Feb. 2011

REASON FOR DOSIMTERY DELAY	SEPT. 2010	OCT. 2010	NOV. 2010	DEC. 2010	JAN. 2011	FEB. 2011	Total
Not ready for treatment planning	1	4	3	0	5	3	**16**
Plan not approved in ADAC	1	2	0	0	3	3	**9**
Additional information needed by physician	0	0	0	1	4	1	**6**
Change in treatment planning volume	0	2	1	1	0	0	**4**
Physician on vacation or out of office	0	2	0	0	1	1	**4**
Plan not approved in IMPAC	0	0	0	0	1	2	**3**
Other	0	0	0	1	0	0	**1**
Total	**2**	**10**	**4**	**3**	**14**	**10**	**43**

Table 5. Dosimetry Treatment Patient Delays, Jan. 11 to Dec. 11

RADIATION ONCOLOGY PERFORMANCE IMPROVEMENT	JAN. 2011	FEB. 2011	MAR. 2011	APR. 2011	MAY 2011	JUNE 2011	JULY 2011	AUG. 2011	SEPT. 2011	OCT. 2011	NOV. 2011	DEC. 2011	Total
No. of dosimetry patient delays	14	10	2	3	2	0	0	3	0	1	3	1	**39**

Table 6. CQI Measures for Chemo Waste & Potential Chemo Waste

BY CONTRIBUTING ISSUE

	JAN. 2012	FEB. 2012	MAR. 2012	APR. 2012	MAY 2012	JUNE 2012	JULY 2012	AUG. 2012	SEPT. 2012	OCT. 2012	NOV. 2012	DEC. 2012	Total
Lab values not assessed	4	8	7	2	4	4	4	3	2	4	3	3	**48**
Other	4		1			1			2	1	2	1	**12**
Intended or ordered for later	1												**1**
Total	**9**	**8**	**8**	**2**	**4**	**5**	**4**	**3**	**4**	**5**	**5**	**4**	**61**

BY MEDICATION STATUS

	JAN. 2012	FEB. 2012	MAR. 2012	APR. 2012	MAY 2012	JUNE 2012	JULY 2012	AUG. 2012	SEPT. 2012	OCT. 2012	NOV. 2012	DEC. 2012	Total
Mixed & discarded as waste	1												**1**
Mixed & medication salvaged			1										**1**
Medication not mixed	8	8	7	2	4	5	4	3	3	5	4	3	**56**
Other									1		1	1	**3**
Total	**9**	**8**	**8**	**2**	**4**	**5**	**4**	**3**	**4**	**5**	**5**	**4**	**61**

BY COST

	JAN. 2012	FEB. 2012	MAR. 2012	APR. 2012	MAY 2012	JUNE 2012	JULY 2012	AUG. 2012	SEPT. 2012	OCT. 2012	NOV. 2012	DEC. 2012	Total
Mixed & discarded as waste	$1,177												**$1,177**
Mixed & medication salvaged			$127										**$127**
Medication not mixed	$10,632	$9,515.00	$6,171.00	$1,967.00	$10,888.00	$4,751.00	$3,649.00	$4,789.00	$15,350.00	$20,495.00	$10,099.00	$9,231.00	**$107,537**
Total	**$11,809**	**$9,515.00**	**$6,298.00**	**$1,967.00**	**$10,888.00**	**$4,751.00**	**$3,649.00**	**$4,789.00**	**$15,350.00**	**$20,495.00**	**$10,099.00**	**$9,231.00**	**$108,841**

began to formally recognize staff for "great catches" and reporting issues that—although caught early—had potential for significant errors if they had remained unidentified. Our goal: to perform system-level fixes and strategic process improvements with a stable and robust mindset, greater reliability, and precision. We wanted to make improvements that would truly reduce variances and prevent future events.

STEP 4—Using Your Data to Make a Difference

In 2011 our QI coordinator joined the existing Radiation Oncology Performance Improvement Committee. At that time, the radiation oncology team had the only established PI committee in Rex Cancer Center. The committee measured safety elements and provided a forum for the various disciplines supporting the service line.

One measure that staff was openly vocal about improving was dosimetry delays (see Table 3, page 21). Each month, the committee tracked the number of dosimetry delays. Our threshold or expectation was two or less delays per month. Problems soon became evident. In January 2011, we saw a significant increase to 14 patients experiencing delays; 10 patients experienced delays in February 2011. Over the previous six months, 43 delays resulted in patients having to be rescheduled. These delays created backlogs in scheduling, increased stress among the radiation oncology team (from dosimetry, physics, physicians, and therapists), and was a source of significant dissatisfaction among patients. From a quality perspective, it is important to listen to these types of complaints and issues with an unbiased approach.

Now that we had identified a problem, our next concern was how to help the team get to the underlying issues. In other words, we had the "quantity" piece of our problem, but we

needed additional information to get to qualitative data. The team used a working list in an Excel spreadsheet to track all delays, including general comments about each delay. Using these data, we began to drill down into the reported events and identify reasons for the delays (see Table 4, page 21).

Our first step was to address the "quick fixes," those delays that just should not happen. For example, improving staff communication would resolve delays caused by the physician being on vacation or out of the office. With their dedication to customer service, our schedulers and front office staff agreed that these delays were a "never should occur" event.

We then moved on to more complex issues. Further analysis showed that 50 percent of the delays occurred in GU, breast, and head and neck cases. Once again, communication was identified as a key factor in these delays (communication is most often the main component in breakdowns and delays, especially in healthcare.) To improve staff communication we began to review our policies and procedures, standardize documentation across sites, and ensure staff was educated about these practices. We recognized that our head and neck patients were the most time intensive, so we allotted additional planning time to ensure the best treatment for these patients.

Our team's collaborative efforts quickly paid off. As shown in Table 5, page 21, we were back within the threshold of two delays or less by March 2011, and we were able to maintain those low incidence rates for the rest of the year. Going forward, we developed a more robust qualitative tracking tool for the dosimetry team to log any delays and identify the reason for the delay, as well as patient diagnosis. This process continues to be a strong part of the Radiation Oncology Performance Improvement Committee metrics, and an example of best practice and quality efforts for Rex Cancer Center. We are now going a step further to evaluate timing for the service sites by disease and diagnosis to see if additional improvement efforts are needed.

STEP 5—Telling & Retelling the Story

With some success under our belt and momentum with staff and management engagement, needs and opportunities continued to present themselves. Based on the success of the Radiation Oncology Performance Improvement Committee, leadership decided to establish a similar forum in medical oncology services.

Our early efforts engaged nursing, support staff, pharmacy, and research to help develop core measures, including regulatory requirements and National Patient Safety Goals. We measured and were able to improve infection control, hand hygiene, medication safety, laboratory turn-around times, and documentation of critical lab values.

OUR PROGRAM AT-A-GLANCE

Since 1987, Rex Cancer Center has been an integral service of Rex Healthcare, which is affiliated with the University of North Carolina Health Care System. Over the years, the cancer center has expanded to better service the community, including a satellite center that opened in 2009. Today, Rex Cancer Center has four satellite locations.

Rex Cancer Center recognizes the importance of quality care through established and recommended practices. Accredited as a Comprehensive Community Cancer Center by the American College of Surgeons Commission on Cancer (CoC) since 1991, Rex Cancer Center received the CoC's Outstanding Achievement Award in 2011, inaugural NAPBC accreditation in 2009, and re-accreditation in 2011.

The medical oncology service is led by a team of six medical oncologists, along with nurse practitioners and physician assistants, and offers a robust clinical trial and research program. The radiation oncology service line includes seven radiation oncologists, a nurse practitioner, and a team of radiation therapists, dosimetrists, and medical physicists—all using evidence-based practices, treatments, and technologies.

The multidisciplinary team providing comprehensive care includes five disease-specific nurse navigators, three clinical social workers, and dietitians. Services include spiritual care support, rehabilitation services, genetic counseling, a breast center, and a multidisciplinary care clinic.

Changing the process and gaining a better understanding of each employee's role along the [drug] supply chain helped us improve our service delivery and our bottom line.

One area of concern to the manager and the pharmacy team was chemotherapy waste. Our team began working with a list, compiled by the pharmacy, of chemotherapies that were mixed but not used. Further investigation and additional research revealed valuable qualitative issues behind the medication waste. Specifically, we reviewed 38 chemotherapies that were mixed and not used for the patient intended, and identified the reasons behind each event (see Table 6, page 22). We then assigned these events to categories based on the contributing issues, for example, "lab values not assessed."

With this additional information, our team addressed any event believed to be "preventable." As seen in Table 6, the largest category of potential waste (60 percent) was what we defined as "lab values not assessed" before mixing. Our process requires physicians to write the hold for parameters and for nurses to check the order prior to dropping the order off at pharmacy and before administering the medications. Sometimes the check occurred after pharmacy mixed the order. To alleviate or reduce these events, our pharmacists agreed to be another crucial check-point in assessing lab values before any mixing occurs.

Next, we looked at events related to IV or port site access. Dedicated to patient satisfaction and perception of care, our nursing team wanted to prevent any delays for their patients. With that goal in mind, our nurses would send the order to mix the chemotherapy to the pharmacy before the IV or port site was assessed or accessed. Although timely for the patient, this practice was not sound due to potential issues with IV or port site access. Our nursing team realized that what it perceived to be a good practice was actually time-consuming and costly—not only fiscally, but also in terms of preventing waste of drug supplies. Now nursing staff does not send any orders to the pharmacy until the IV or port is ready for infusion.

Changing the process and gaining a better understanding of each employee's role along the supply chain helped us improve our service delivery and our bottom line. By focusing on "preventable breakdowns" in our processes, we ensured that patients received only treatments that were within their lab values as prescribed. We also prevented loss of medication—some of which was often in reduced or short supply. Lastly, we realized substantial cost savings by preventing the waste of more than $55,000 in medication that may have been wasted prior to implementing these optimal practices (this cumulative effort prevented $100,000 in loss for calendar year 2012.)

Our next focus: orders intended for future dates and how our team might optimize communication and hand-offs in this area.

Patience & Persistence Make a Difference

The specific program improvements discussed in this article are representative of similar ongoing efforts within Rex Cancer Center. Additional QI successes include:

- ***Comprehensive metrics for social work and support services.*** These measures help us monitor the needs of our patients, acuity, and scope.
- ***Medication safety performance improvements.*** These measures assess ordering, preparation, dispensing, and administration. We have also established a Chemotherapy Improvement Team.
- ***Case review and performance improvement for medical staff services.*** Based on QOPI core measures, we are targeting the needs identified, for example, status post (s/p) narcotic constipation.
- ***Radiation oncology service practices.*** We have improved laterality practices, including communication and supporting documentation. We have also improved hand-offs between radiation oncology and medical oncology services. Treatment set-up communication and documentation have also been improved. We implemented an interdisciplinary Service Excellent Council where staff is tasked with addressing and improving patient and co-worker satisfaction.

Of course, with any QI effort, push-backs and challenges are expected. The difference is often how these are heard by leadership and what leadership does with the information presented. Most often, a complaint has elements of fact that provide insight to the culture and operations of a community cancer center.

We suggest taking an unbiased approach in listening to what is being said or not being said. Get to the root of the problem by peeling away the layers of breakdown and resistance. Only then can you build trust and accountability; two crucial elements when leading cancer centers from being *as good as they are to being as great as they can and should be.*

On the quest to quality, keep in mind that it is not about us as individuals, but it is about our patients, physicians, customers, and staff.

The words of revered coach John Wooden apply just as much to coaching cancer centers as they do to coaching a basketball team: "If you don't have time to do it right, when will you have time to do it over?" OI

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Molecular Genetics

in the Community Setting
Positioning your cancer program for success

BY JESSICA EVERETT, MS, CGC, AND LEIGHA SENTER, MS, CGC

Molecular testing is a broad term that in the clinical setting describes any diagnostic test involving analysis of DNA or RNA. Molecular tests can be broadly divided into four major categories of use:[1]

1. Diagnosis and management of classical genetic disorders
2. Prediction of susceptibility to common complex diseases
3. Modulation of drug therapy (pharmacogenomics)
4. Development of prognostic indicators and targeted therapies for cancer (and other diseases).

In the oncology setting, molecular testing is routinely used in categories 1 and 4—identifying patients and families at increased risk of cancer due to hereditary factors and identifying specific molecular markers within tumors to make decisions about treatment. In this article, we outline current and future uses of molecular testing in oncology care, and the role genetic counselors can play in incorporating these tests into care in the community setting.

The number of molecular tests available for clinical use has exploded over the past 10 years. UnitedHealth Center for Health Reform and Modernization recently published a working paper reporting that nearly $500 million was spent in 2010 on genetic and molecular diagnostic testing for UnitedHealthcare (UHC) members alone, with 16 percent of this (roughly $80 million) spent on cancer-related testing.[2] Combined with data from Medicare and Medicaid, UHC further estimates that $5 billion was spent on molecular tests nationwide and growth trajectories estimate that this number could rise as high as $15 to $25 billion by 2021.[2]

Increased use of molecular testing is likely to contribute to increased overall healthcare spending, but *appropriate* use of testing could also improve health outcomes, including outcomes in the oncology setting, which could have an opposite effect on healthcare costs.

Molecular Testing & Cancer Treatment

The National Cancer Institute defines cancer as "a term used for diseases in which abnormal cells divide without control and are able to invade other tissues." The abnormal behaviors of cancer cells result from changes (or mutations) in genes that control the processes of cell division, growth, and death. These mutations are usually not inherited, but can occur as a result of environmental insult (e.g., UV light) or randomly during the normal process of copying DNA before cell division (see Figure 1, page 28).

Historically, most standard chemotherapeutic agents worked by killing rapidly dividing cells, including not only cancer cells but also healthy cells that divide rapidly under normal circumstances—in the hair follicles, bone marrow, and the lining of the digestive tract for example. Indiscriminate killing of rapidly dividing cells leads to side effects, including hair loss, decreased blood cell counts, and GI symptoms. The goal of

Figure 1. Loss of Normal Growth Control

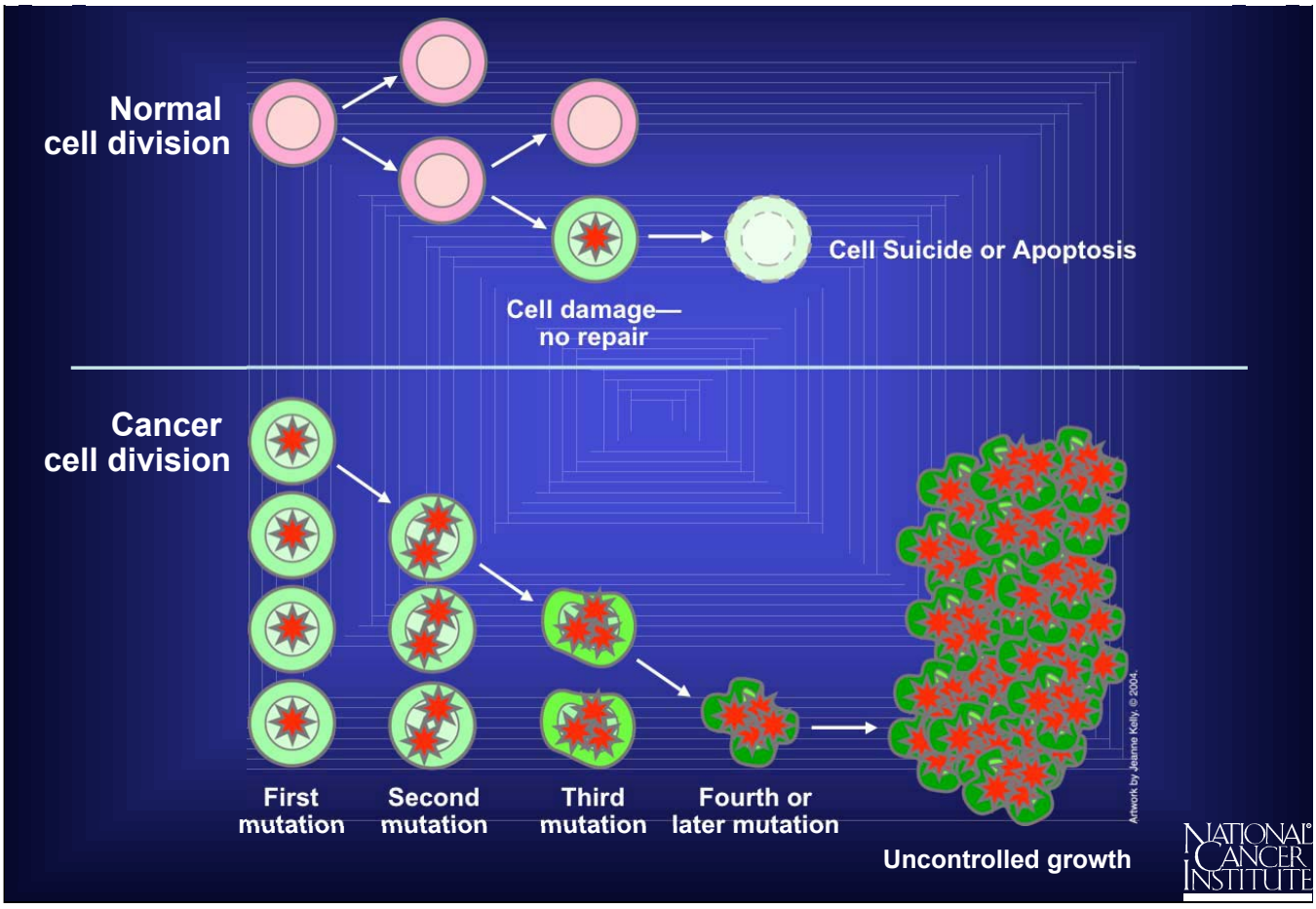


Figure 1. Accumulated mutations lead to uncontrolled growth and invasion. Molecular testing can be used to identify the mutations in cancer cells, with the goal of targeting specific therapies to treat cancers with different types of mutations. Source: National Cancer Institute, *www.cancer.gov.*

molecular testing is to identify specific behaviors of cancer cells and underlying genetic changes that are *not present* in most normal cells. Therapies can then be chosen that *target* the genetic changes and unique behaviors of cancer cells with the hope of increasing efficacy and decreasing side effects, a strategy often referred to as "personalized" care.

There are several well-established examples of genetic aberrations identifiable through molecular testing that are already used to guide treatment decisions, and a growing number of targeted therapies that are FDA approved and in clinical trials.[3] Large research consortia, including The Cancer Genome Atlas[4] and the Cancer Genome Project,[5] are working on sequencing cancer genomes for many different types of cancer to better characterize and catalog all genetic mutations in order to improve our understanding of how and why tumors behave as they do. There is hope that this research could also lead to strategies for earlier detection and even cancer prevention. As a result of this work with cancer genomes, the number of targets and related therapies is likely to expand dramatically over time.

Molecular Testing & Hereditary Risk

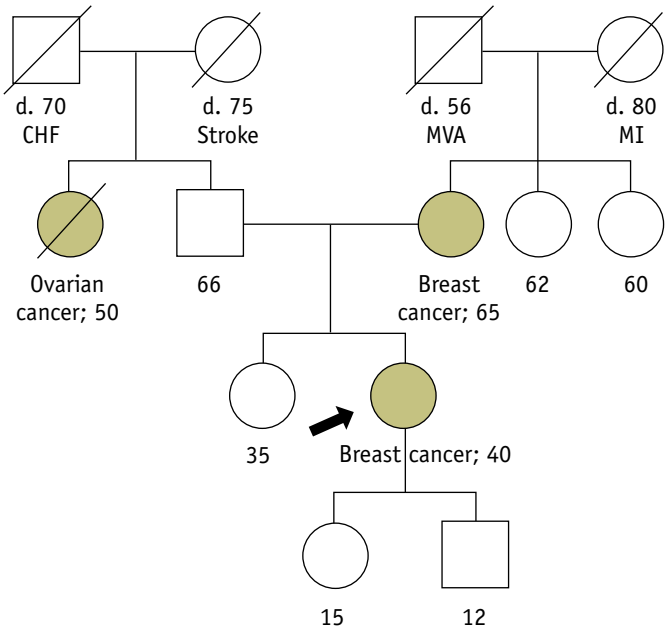
Through July 2012, the Cancer Genome Project had reported 488 genes important in cancer development and progression.[5] Of these, 90 percent have an impact when a mutation occurs in cancer cells, and 20 percent are important in causing hereditary risk (10 percent have a role at both levels).[6] Thus, in the oncology setting, molecular testing has an important role in identifying patients and families at risk for hereditary cancer susceptibility.

Testing for mutations in the *BRCA1* and *BRCA2* genes has been clinically available since 1996, and is considered to be standard of care for women diagnosed with breast cancer under age 45, women with triple negative (ER-, PR-, HER2-) breast cancers under age 60, and women with family history of breast and/or ovarian cancer.[7] Similarly, 2 to 4 percent of all colon cancer diagnoses are caused by Lynch syndrome, and identification of these patients and families through molecular testing is critical to their care.[8]

Advances in Molecular Testing

Until recently, molecular testing typically involved selecting one or a few very specific tests for specific patients based on

Figure 2. Impact of Molecular Testing on Cancer Care



SQUARES: Denote male family members
CIRCLES: Denote female family members
CHF: Congestive heart failure
MVA: Motor vehicle accident
MI: Myocardial infarction

In this example, patient presents with breast cancer at age 40.

Molecular testing initiated at diagnosis:
- Analysis of ER/PR/HER2-Neu status
- If ER positive: gene signature panel for recurrence risk and chemotherapy decision
- Referral to genetics for *BRCA1/BRCA2* gene testing

Genetic Counseling Issues

Before additional testing ordered:
- Interpretation of molecular testing thus far
- Timing of testing: to be used for surgical decisions or better to wait until patient has had time to deal emotionally with diagnosis?
- Screening recommendations for at-risk family members with or without genetic test results as they are likely to still have moderately increased risk.

After test results are available:
- If *BRCA* mutation positive, discussion of prophylactic bilateral salpingo-oophorectomy
- Implications for family:
  - Not entirely clear which side of the family a *BRCA* mutation came from. Test parents.
  - Patient worried about daughter, but typically not necessary to test minors for *BRCA* mutation
  - Educate about cancer risks for males
- If no mutation identified, provide risk assessment based on family history.

clinical criteria. For example, testing for *BRCA1/BRCA2* mutations in a woman diagnosed with breast cancer at age 35 and with a family history of breast cancer, or testing for *EGFR* mutations in metastatic non-small cell lung cancer (NSCLC) for treatment planning. With the rapid advances in next generation sequencing technology, it is becoming technically easier and less expensive to order panels of molecular tests that include multiple genes.

Existing clinically available tumor panels can test for up to 739 specific mutations in 46 different cancer genes with potential to impact treatment decisions. Next-generation panels for hereditary risk are also available, and currently existing panels offer testing for mutations in up to 23 different genes implicated in cancer risk on a single blood sample. While there are clear advantages to this type of testing, it also leads to more possibilities for unexpected results or findings that may be difficult to interpret.[9] For example, you may find a mutation in an unexpected tumor type where there is not yet data to support a related treatment, or you may find a mutation for hereditary risk in a family that does not have any suggestive history. With this in mind, tests should be ordered in a responsible manner and with careful attention to impact on patient care. Further, tests should be clinically validated, warranted for the specific patient, and interpreted properly.

UHC surveyed 1,254 physicians of varying backgrounds and specialties in early 2012 and found that almost 75 percent of them responded that they have patients in their practices that have not had genetic testing, but who would benefit from doing so. UHC also found that the most frequently ordered tests are oncology-related (64 percent) but that only 28 percent of physicians surveyed felt comfortable interpreting results of oncology tests.[2] Given the rapid changes in genomic medicine, providers will be challenged to build and maintain satisfactory genetics knowledge when other aspects of oncology diagnosis and treatment are also constantly evolving. In 2011 a perspective piece in *Nature* suggested that "all healthcare providers must acquire competency in genomics to provide services appropriate for the scope of practice."[10]

Many professional organizations have convened special interest groups and developed educational materials for the purpose of filling genetics and genomics knowledge gaps for their members. Community cancer centers can help clinicians remain up-to-date by providing genetics-focused CME events. With the help of genetics specialists, programs can focus on topics that are of broad interest to staff and have the potential to alter clinical care in a positive way. Inclusion of genetic counselors in multidisciplinary care teams can also help to meet this need, given their special expertise in understanding implications of genetic testing and in conveying these ideas to patients.

The Genetic Counselor Role in Multidisciplinary Cancer Programs

Most community cancer centers now provide multidisciplinary care in oncology. Some institutions have implemented truly multidisciplinary clinics in which patients meet with multiple providers at one visit to learn of their treatment options in detail. Multidisciplinary tumor boards and case conferences are also frequently used to collaboratively care for patients. Typically, these care teams consist of surgeons, medical oncologists, radiation oncologists, pathologists, nurses, and other practitioners depending on institutional resources.[11] In recent years, however, it has become important to include genetics specialists on these teams as well, as reflected in ACCC's *Cancer Program Guidelines*.[12] This staff could include genetic counselors (practitioners that have specialized graduate degrees and experience in the areas of medical genetics and counseling), medical geneticists, and/or nurses with specialized training.

Because molecular testing and genetic risk assessment can impact surgical and treatment decisions, the gathering of family history and discussions about molecular testing are often initiated at, or shortly after, the time of cancer diagnosis. Outcomes of these tests may impact the work of other team members. For example, a 40-year-old woman with a newly-diagnosed breast cancer may opt to undergo testing for mutations in the *BRCA1* and *BRCA2* genes prior to determining the extent of her surgical treatment (lumpectomy vs. mastectomy +/- contralateral prophylactic mastectomy). This same patient may also benefit from molecular profiling of her tumor to determine her recurrence risk prior to considering chemotherapeutic options (see Figure 2, page 29). Genetic counselors and other genetics specialists may lend expertise and aid in conveying these often complicated options to patients, including the differences between molecular testing for hereditary risk and molecular testing of a tumor for treatment information (see Figure 3, below).

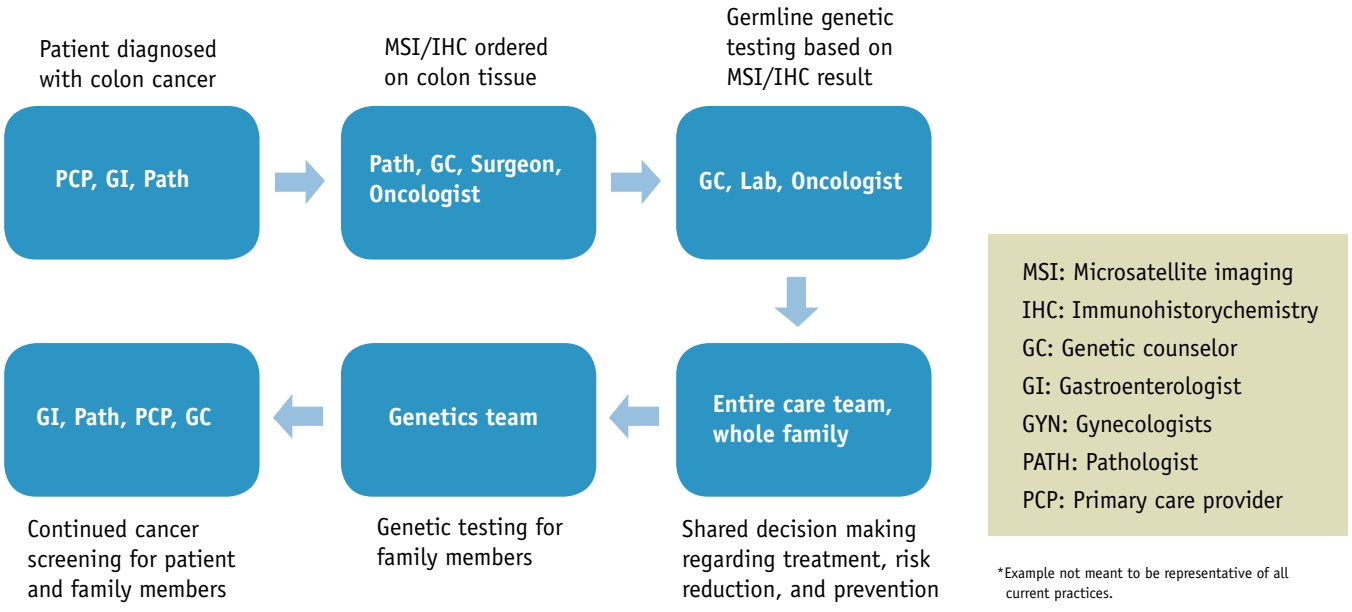
Recognizing the importance and impact of genetic testing in clinical care, some accreditation bodies, including the American College of Surgeons Commission on Cancer (CoC) and the National Accreditation Program for Breast Centers (NAPBC), have included the provision of genetic risk assessment in their most recent standards.[13,14] Many professional organizations, including the American Society of Clinical Oncology[15] and the Society of Gynecologic Oncologists[16], have position statements regarding cancer genetic testing that specifically state that testing should be performed in the context of genetic counseling.

Structuring Genetic Counseling Services

Over the years with increasing demands on institutional resources and more widespread use of molecular testing, several models of genetic service delivery have emerged in oncology. The Service Delivery Model Task Force of the National Society of Genetic Counselors recently summarized four commonly-used genetic counseling clinical models:[17]

- ***In-person genetic counseling.*** A traditional model where patients present in-person for genetic counseling.
- ***Telephone genetic counseling.*** Genetic counseling that is delivered by telephone.

Figure 3. Simplified Example of Multidisciplinary Involvement in Colon Cancer Case*



*Example not meant to be representative of all current practices.

- ***Group genetic counseling.*** When multiple individuals present for genetic counseling at one time.
- ***Telegenetics.*** Web-based and telemedicine where genetic counseling is provided remotely.

In many instances, a cancer center may choose to employ a combination of these services to best meet the growing needs of their patients. Cancer genetic services are most commonly provided by a dedicated genetic counselor or other specialist directly employed by the institution. When this model is not possible, however, an institution may consider options for contracting with a genetic counselor to provide telephone counseling or counseling via telegenetics, which uses video conferencing capabilities. Some genetic counselors provide contract work directly, while others provide services through institutional contract with their primary employer. In either model, the genetic counselor works as part of the comprehensive cancer care team and communicates directly with referring physicians to determine the appropriate personalized management plan for each patient.

There are several ways to bill for cancer genetic services and genetic counseling can be directly reimbursed using CPT code 96040. Typically, each institution determines the most appropriate model for its given situation, which could depend on institution-specific credentialing guidelines, types of providers and payers, and/or state licensing requirements. The National Society of Genetic Counselors has compiled information in this area, including electronic courses that broadly review some of the most common billing practices. These resources can be found online at *www.nsgc.org*.

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MORE FROM ACCC

Access additional resources from ACCC's "Molecular Testing in the Community Oncology Setting" education project at *www.accc-cancer.org/moleculartesting*. Read project key findings and the final report, including annotated bibliography and case studies. View the archived "Molecular Testing 101" webinar presented by Jessica Everett, MS, CGC, and Leigha Senter, MS, CGC, for this project.

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What You Need to Know *Before* Acquiring an Oncology Practice

BY MATTHEW R. STURM, MBA
AND JESSICA L. TURGON, MBA

Over the last several years, a remarkable number of private medical oncology groups have shifted to hospital and/or health system employment. As reported in the Medical Group Management Association (MGMA) *Physician Compensation and Production Surveys,* between 2006 and 2011, the percentage of medical oncology physicians employed by hospitals and/or health systems increased from 22 percent to nearly 50 percent (see Figure 1, right). Similarly, a report published by the Community Oncology Alliance indicated that over a three-and-a-half year period, more than 40 percent of the surveyed medical oncology clinics (426 out of 1,042) were acquired by a hospital or other entity.[1]

Given the critical importance of the oncology service line, many hospitals and health systems have either acquired a group of medical oncologists or are likely to do so in the near future. While the acquisition of a medical oncology practice offers a variety of benefits to a hospital and/or health system, the expected financial results are frequently not attained. To ensure strong financial performance of the acquired practice, hospitals and health systems must take into consideration a number of issues as discussed below.

Understand the Business Model

Generally, three major components make up a medical oncology practice's business model: a clinical practice, infusion therapy services, and ancillary testing.

Clinical practice. Like other medical specialties, medical oncology physicians provide significant consultative and follow-up patient care in the office and inpatient settings throughout the course of a cancer patient's treatment and survivorship.

Infusion therapy. Oncology treatment requires the administration of therapeutic, chemotherapy, and/or biological agents to patients. The margin on these agents has generally been favorable and contributed substantially to oncologists' incomes.

Ancillary testing. Oncology practices have varying ancillary service capabilities, ranging from laboratory testing to advanced imaging services, such as PET/CT. Not only do these modalities enable physicians to provide more comprehensive and convenient care to patients, but also they economically benefit the practice.

As shown in Figures 2 and 3, page 34, median work relative value unit (WRVU) production levels per physician FTE are similar between internal medicine and hematology/oncology. However, median incomes per physician FTE for hematology/oncology are nearly double those of internal medicine. The difference in income versus WRVU production is due largely to the infusion practice, which generates nominal WRVUs

for the administration of therapeutic agents but substantial income due to the margins on chemotherapy drugs.

As reported in various sources, median drug acquisition costs for medical oncology range from $2.0 million to $2.5 million annually per physician FTE.[2] However, hospitals and health systems need to understand that the attendant operating margins of approximately 8 to 12 percent increase the susceptibility of the financial performance of the medical oncology practice to relatively minor changes in drug costs and/or reimbursement.[2]

Three key areas typically drive the financial performance of all medical oncology practices (whether employed or independent): drug acquisition costs, reimbursement rates, and patient education and assistance.

To truly understand the financial implications of acquiring a practice and limit the associated business risk, hospitals and health systems should devote considerable time and resources to analyzing these three components. Likewise, hospital and health system leadership must ensure that management implements strong operating practices to support these areas post-transaction.

Drug Acquisition Costs

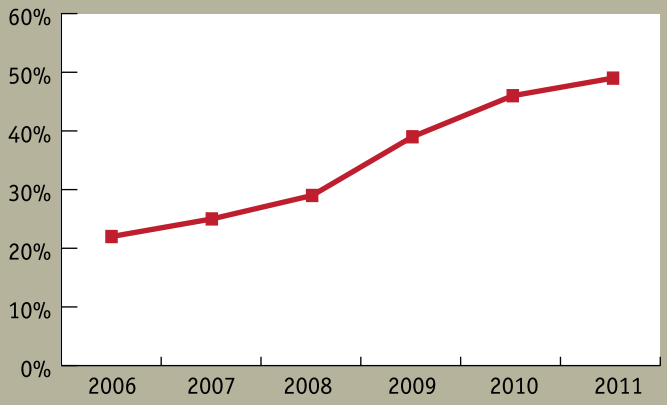
Acquisition costs are derived both from the type and price of purchased products. The factors impacting drug acquisition costs are summarized below.

GPO pricing. Begin by examining negotiated prices for drugs and determining how the group's pricing compares to that of the hospital and/or health system. A medical oncology group may have better pricing on at least some of the most commonly-used drugs. Performing a detailed side-by-side analysis is a good way to identify opportunities to renegotiate GPO contracts. This analysis should also incorporate historical volumes, as drugs with minor cost differences can have a dramatic impact if the volumes are high enough. Depending on the confidentiality terms in the GPO contracts, you may need to enlist the support of a third party to perform this assessment to avoid violating the contract.

Formularies. Today, many hospitals and health systems have established formularies. When undertaking an examination of drug acquisition costs, the P&T committee must have access to the necessary data to make informed choices, particularly with respect to evidence-based medicine and pharmaco-economic decisions. It is also important to ensure that physicians from the medical oncology practice have an opportunity to either present their perspectives to the P&T committee or participate on the P&T committee. (In many cases, a cancer chemotherapy committee, comprised of the oncology pharmacist and medical oncologists, is instituted to refine formulary decisions within a center.) Prior to completing the acquisition, compare the group's formulary or utilization patterns to the the hospital or health system's formulary to identify potential variances and to enable a financial analysis of the implications of the new formulary.

340B Drug Pricing Program. This federal program enables qualifying organizations to purchase outpatient drugs at significantly discounted prices. The typical savings realized on drug acquisition costs through the 340B program is, on average, about $500,000 per physician FTE (this data is based on average annual drug expenses of $2 to $2.5 million per physician FTE and average savings of 20 to 40 percent.) If the affiliating hospital participates in 340B, the business model should be constructed in a fashion that enables the cancer center to use the program to its fullest, ensuring that all eligible patients (including those who are commercially insured) receive drugs purchased through 340B. The savings from the acquisition price is often re-invested into cancer programming in the form of patient navigators, social workers, and other operational improvements. Notably, hospitals that do not qualify for the 340B program may explore partnerships with affiliated hospitals (located within 35 miles) in their health system to access 340B pricing.

Figure 1. Percentage of Hematology/Oncology Physicians Employed by Hospitals and/or Health Systems



SOURCE: MGMA. *PHYSICIAN COMPENSATION AND PRODUCTION SURVEYS,* 2007 TO 2012.

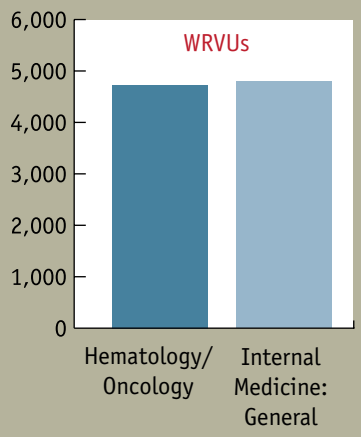
Inventory management. Processes should be in place to monitor compliance with the organization's formulary and use of generic drugs when indicated; formulary compliance not only drives standardization of care, but also enables the organization to leverage the pricing negotiated with the GPO (e.g., lower prices for higher volume drugs). Due to the high cost of pharmaceutical agents, most oncology practices adopt a just-in-time inventory policy, typically receiving drugs less than 24 hours before administering them. If the hospital or health system does not currently have such a model in place, it should work closely with the medical oncology group to develop stringent standards for maintaining low inventories of expensive oncology drugs.

Manufacturer rebates. For years, manufacturers have commonly offered rebates on various brand-name drugs. Hospitals and health systems should work with staff from the medical oncology practice, pharmacy, and finance departments to ensure that the appropriate processes are in place to identify and participate in these programs.

Reimbursement Rates

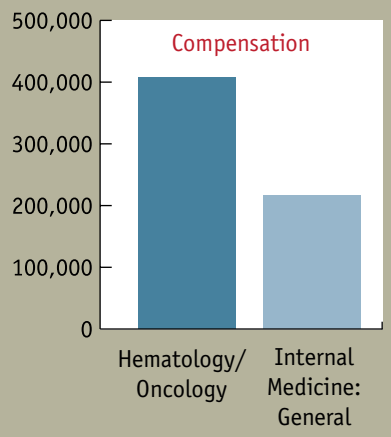
When evaluating reimbursement trends among commercial payers for infusion services, hospitals and health systems

Figure 2. Comparison of Median WRVU Production per FTE



Source. MGMA. *Physician Compensation and Production Survey: 2012 Report Based on 2011 Data.*

Figure 3. Comparison of Median Compensation per FTE



Source. MGMA. *Physician Compensation and Production Survey: 2012 Report Based on 2011 Data.*

should complete two analyses:

- Identify how the oncology service would perform under the hospital or health system's commercial rates
- Identify how commercial rates within the hospital or health system compare if the practice is structured as a hospital outpatient department versus a freestanding practice under the hospital's contracts.

These analyses will point out opportunities to negotiate the most favorable reimbursement rates, as well as determine the impact of remaining a freestanding clinic or designating the infusion clinic as a hospital outpatient department. Due to confidentially requirements in the associated agreements, you may need to enlist the support of a third party to perform this assessment and report findings and at aggregate level.

Patient Education & Assistance

High-performing medical oncology practices are proactive in their communication with patients, providing an explanation of a patient's third-party payer benefits and the cost of treatment prior to initiating the care regimen. Typical patient education and assistance services include:

- ***Pre-authorization.*** A financial specialist or staff member evaluates the patient's benefits and determines what the insurance company will pay, as well as the responsibility of the patient.
- ***Patient education.*** The financial specialist meets with the patient to review the projected cost of care and the patient's responsibility. At this point, staff may discuss payment plan options or explore other alternatives, such as enrollment in financial assistance programs.
- ***Provider communication.*** Staff will research any disallowances (non-covered services or drugs) by a health plan, so that the decision may be appealed or the course of treatment altered before it commences.
- ***Replacement drugs.*** If the patient qualifies, staff should access drug replacement programs for underinsured cancer patients. These programs not only assist with infusion drugs but can also help with supportive care regimens. For oncology practices, a well-designed drug replacement program is critical to the financial success of the infusion unit.
- ***Ongoing communication.*** Throughout the patient's course of care, trained staff members should manage communication between the patient, providers, billing department, insurance carriers, and assistance programs regarding all financial matters.

Commonly, medical oncology practices with a financial specialist role see less denied and rejected claims and bad debt rates due to patients accessing financial support programs and participating in payment plans.

Going Forward

Unique challenges exist for hospitals and health systems acquiring medical oncology groups. Before any purchase, hospitals and health systems should realistically assess the financial performance of the medical oncology group, given varying assumptions about volume, revenue, and cost. Ideally, this assessment will begin prior to acquisition, when the business model for the group is in initial development. Yet, the long-term success of the program is dependent on the careful monitoring of the issues identified in this article. OI

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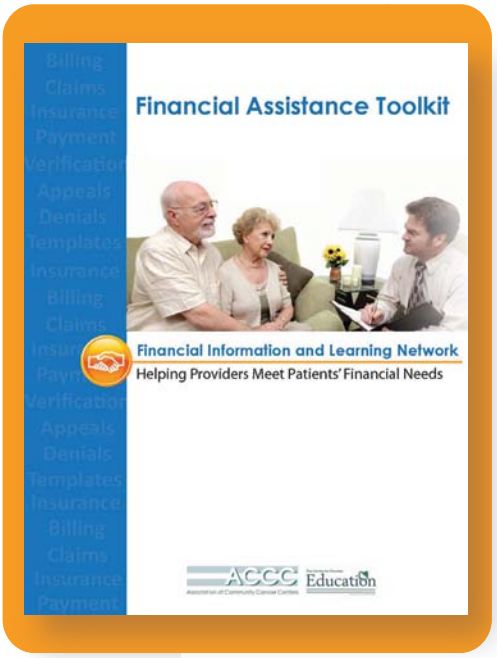
Are Your Patients Struggling to Pay for Their Cancer Treatment?



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Accelerated Partial Breast Irradiation

Strengthen your program by providing another option for early-stage breast cancer patients

BY DEANNA J. ATTAI, MD, FACS, AND JON STRASSER, MD

Community cancer centers have a significant new opportunity to expand and improve their treatment of patients with early-stage breast cancer. Centers that are committed to offering a full range of cancer care services can strengthen that claim by offering accelerated partial breast irradiation (APBI) or breast brachytherapy. Whole breast irradiation (WBI) is still considered the standard of care for radiation following a lumpectomy; however, maturing data and experience is proving APBI to be an acceptable treatment option for select patients.

Why APBI?

Due to the significant barriers that women must overcome in order to accommodate six weeks of standard WBI, many patients pursue mastectomy or forgo radiation altogether after their lumpectomy. For appropriately-selected women, APBI is an acceptable treatment alternative, delivering the entire course of radiation treatment in just five days. This shortened duration of treatment reduces time and travel, especially for patients in more rural areas, and allows more women to have access to the benefits of radiation. As clinicians, we believe that offering a full-range of treatment options is a cornerstone of patient-centered care.

Once limited to tertiary centers, this treatment approach has become more readily available and should be considered an option at the community cancer center—not only to enhance clinical care, but also to allow facilities to set themselves apart from their marketplace competitors. In our experience, breast brachytherapy delivers:

- More precise targeting of the radiation dose, resulting in better cosmesis, very low toxicity, and equivalent or superior clinical outcomes
- Strong patient satisfaction for a clinically proven, five-day alternative, compared to the six weeks required for WBI

Table 1. APBI Patient Selection Criteria of Professional Medical Societies

	ABS	ASBS		ASTRO (Suitable)	ASTRO (Cautionary)	ASTRO (Unsuitable)
Age	≥ 50 years of age	≥ 45 years of age		≥ 60 years of age	50–59 years of age	< 50 years of age
T-size	≤ 3 cm	≤ 3 cm		≤ 2 cm	2 cm – 3 cm	>3 cm
Nodes	Negative	Negative		Negative	N/A	Positive
Histology	IDC (infiltrating ductal carcinoma)	IDC ≥ 45 years of age	DCIS ≥ 50 years of age	IDC	ILC or DCIS (ductal carcinoma in situ)	N/A
Pathology	No EIC (extensive intraductal carcinoma) or LVI (lymphovascular invasion)	No EIC or LVI		No EIC or LVI	EIC or focal LVI	Extensive LVI
Margins	Negative	Negative (>2mm)		Negative (>2mm)	Close (<2mm)	Positive

- Targeting of tissue at greatest risk for subclinical disease and recurrence
- Reduced toxicity to the skin, lung, heart, and normal breast tissue
- Strategic differentiation for community centers that offer this modality.

As clinicians, we have counseled numerous patients who chose ABPI over WBI—not only because of the convenience, but also because of the documented excellent outcomes.

Our female patients talk about brachytherapy outside of the office, especially online, and their enthusiasm has led to well-established, online networks of women who encourage others to choose this treatment when appropriate. These communications can be persuasive. For example, a University of California, San Diego study concluded that a support network for brachytherapy *(www.SAVISisters.com)* "helped alleviate anxiety, thereby increasing their [women's] confidence in their choice of treatment." A UCSD survey found that the website and social network's activities were rated as either "very" or "extremely helpful" by a strong majority of respondents.[1]

This combination of patient satisfaction, excellent clinical outcomes, and potential competitive advantage makes brachytherapy a treatment well-suited to community cancer centers. Yet less than one-quarter of women who are eligible for brachytherapy are offered this treatment option. As clinicians, these data may indicate that we are not doing the best job of providing women with all their appropriate treatment choices.

In this article we draw upon our clinical research and practice to answer two questions:

- Why is breast brachytherapy a good treatment option for many patients?
- Why does breast brachytherapy fit so well within the community cancer center setting?

Despite the advantages of breast conservation therapy (BCT), involving lumpectomy plus radiation, only about 50 percent of candidates receive this treatment option. One of the reasons women opt for mastectomy instead of BCT is the inconvenience of multiple appointments and the lengthy time required for traditional radiation treatment with an external beam. One powerful way to overcome these objections is to offer accelerated partial breast irradiation, of which breast brachytherapy is the most common form.

Five-day brachytherapy provides a substantial benefit for women who have a family, a job, or other obligations, as well as those who would have to travel significant distance to receive WBI. Many women also like knowing that brachytherapy preserves future treatment options if needed.

Brachytherapy has been intensively studied and a part of modern clinical practice for more than 20 years. Growth of this technology accelerated with the introduction of the MammoSite balloon applicator about a decade ago.

Today the latest brachytherapy applicators offer significant improvements over the older, single lumen balloon device. The new applicators have multiple channels for more precise and tailored delivery of radiation and offer relatively easy insertion. The strut-based applicator, for example, has multiple sizes to fit each patient's anatomy and allows precise sculpting of the radiation dose—which greatly expands the number of women who can benefit from brachytherapy.

Who is a Candidate for APBI? Several professional medical societies have issued statements that outline patient selection criteria, including the American Brachytherapy Society (ABS)[2], the American Society for Radiation Oncology (ASTRO)[3], and

the American Society of Breast Surgeons (ASBS)[4]. Although all three societies agree that select patients may be appropriate candidates for APBI, the specific criteria vary between societies. For example, the ASBS consensus statement states APBI is an acceptable treatment for women who meet these criteria:

- 45 and older with invasive cancer; 50 and older with DCIS
- Total tumor size ≤ 3 cm
- Negative microscopic surgical margins of excision
- Sentinel lymph node negative.

For those women that do not meet the criteria, the NSABP B-39/RTOG 0413 clinical trial comparing APBI to WBI is currently accruing high-risk breast cancer patients. Table 1, page 37, compares the patient selection criteria of the various professional medical societies.

Clinical Data on APBI

Dr. Robert Kuske, the radiation oncologist who helped pioneer breast brachytherapy, summarizes the state of research findings this way: "Clinical outcomes to date have been reported in over 30 publications, including 10-year matched pair comparisons of PBI to WBI, a cooperative group Phase II trial, and two published Phase III clinical trials. The tumor control, toxicity rates, and cosmetic results compare favorably to breast conservation with whole breast irradiation (WBI) and mastectomy."[5]

Recent findings include:

- Data from the MammoSite Registry Trial, which is compiled by the American Society of Breast Surgeons, reported in 2012 that brachytherapy appears more effective in preventing local recurrence than whole breast irradiation. The study comprised 1,449 breast cancer patients at 97 institutions.[6]
- A four-year, three-site study on brachytherapy with a strut-based applicator concluded that it is a well-tolerated, effective treatment for early-stage breast cancer, and that it also broadens the pool of candidates for the treatment. The study, presented at the Breast Cancer Coordinated Care Conference in July 2012, had a median follow-up of four years on 70 patients, the longest term yet reported for patients receiving this form of brachytherapy. The cancer recurrence rate was comparable to the recurrence rate reported in the literature for WBI.[7]
- Among 1,010 patients at 12 centers, researchers found that strut-based brachytherapy provides excellent or good cosmetic outcomes in the majority of patients and can safely and effectively treat the broadest range of women. The data was presented at the 2012 National Interdisciplinary Breast Center Conference.[8]
- A study presented at the 2012 annual meeting of the American Society of Breast Disease, led by Dr. Strasser, showed low rates of toxicities among patients who received strut-based brachytherapy. The 12-site data found that rates of seroma, fat necrosis, and telangiectasia—potential side effects of any form of APBI—were favorably low among several hundred patients at one and two years after therapy.[9]

Establishing a Brachytherapy Program

Brachytherapy is becoming more prevalent in community cancer centers. Much of the research on the latest forms of breast brachytherapy is being done by clinicians practicing in community settings. It's clearly not necessary for patients to go to major academic centers to receive excellent results for this five-day therapy. Community-based cancer programs can effectively establish strong ABPI programs in both the private practice and hospital-based setting.

As part of our medical practices, we have treated more than 150 patients with strut-based brachytherapy, and we contribute to ongoing research and databases on the treatment. Based on our experience, here are some key elements that make a brachytherapy program succeed:

- The program may be initiated by a surgeon or radiation oncologist; however, a multidisciplinary team approach including surgeons, radiation oncologists, medical physicists, nurses, and radiologists is essential
- Reliable access to a high-dose rate (HDR) afterloader unit
- Ongoing communication among the surgeon, radiation oncologist, medical physicist, center coordinator, and nurse navigator
- Training and guidance for each specific kind of brachytherapy catheter, which is available from the manufacturers.

Once a brachytherapy program begins, the treatment team should reach a point where it completes at least 30 procedures per year to stay technically proficient. At that level, physicists who administer the dosage plans can maintain a high level

of consistency and speed, and surgeons and oncologists are ready to handle any unexpected issues.

Community Outreach

Once your brachytherapy program is established, your team must educate patients and other providers about the program.

Community cancer centers can take advantage of customizable tools that are provided by some of the device manufacturers. Our practices, for example, have used practice-marketing and other growth resources to communicate to patients, referring physicians, and the media. These materials include information to provide to physicians who refer patients to your cancer center, along with presentation slides and press releases to help generate public awareness of your brachytherapy service line.

Other materials to reach patients include content for your cancer center's website and access to an online affinity program, which helps patients communicate with others who have had the therapy.

One such affinity program website, *www.SAVISisters.com*, was the subject of a presentation at the 2012 conference of the National Consortium of Breast Centers by researchers at Johns Hopkins University and the Kimmel Cancer Center of Thomas Jefferson University.[10] The researchers, who also looked at the program's Facebook page, reported "the uptake and utilization of social media by women interested in radiation therapy was very rapid."[10] The program's Facebook page grew nearly 1,000 percent in 2011, to more than 8,300 followers, and as of August 2012, the page had more than 23,000 followers. Researchers also noted substantial growth in traffic to the website, with women's own stories being the most popular item on the site. These stories, shared by women about their experiences with APBI, prove to be one of the most important forms of communication for women making their treatment decisions. In addition to consulting with their surgeon and radiation oncologist, it's helpful for these women to have access to other women who have gone through the experience.

Is APBI for *Your* Program?

Establishing a program that uses five-day brachytherapy provides multiple advantages for community cancer centers, physicians, and patients. Your cancer program can gain a strategic competitive edge by adding this option to its offerings and providing the most comprehensive community-based care. Moreover, the technology has become a popular option with women, leading to high levels of satisfaction and strong clinical outcomes. OI

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BY ERNIE ELEMENTO, PT, MBA,
AND VASIA CRADDICK, RNC, BSN

We Hear You!

HOW PATIENT & STAFF FEEDBACK IMPROVED PROCESSES & SATISFACTION SCORES AT SOUTHWEST CANCER CENTER

2012 ACCC INNOVATOR AWARD
ASSOCIATION OF COMMUNITY CANCER CENTERS

In 2012 Southwest Cancer Center, part of UMC Health System, Lubbock, Tex., received an ACCC Innovator Award for its process improvement efforts. Read about the development and accomplishments of the cancer center's Patient Advisory Committee and Score Team.

The Patient Advisory Committee

Formed in March 2007, Southwest Cancer Center's Patient Advisory Committee is made up of patients and caregivers who meet monthly to discuss issues related to quality care and patient satisfaction. The committee's mission: to strengthen collaborations between patients and members of the healthcare team in order to enhance the cancer center's ability to deliver the highest standard of comprehensive and compassionate care. The Patient Advisory Committee shares needs and concerns with administration and staff and then works with both to make changes that will have a positive impact on patients and family members. To do so, the committee began by looking first at the cancer center's patient satisfaction questionnaire and asking two basic questions:

- What does the patient satisfaction survey actually mean to patients?
- What could be improved at the cancer center?

With this information in mind, Southwest Cancer Center was able to make significant process improvements related to scheduling, mentoring, cancer center design, survivorship, and more. In brief, here are a few of its successes.

Radiology Read Times

From the Patient Advisory Committee, staff learned that the most grueling time for patients was the wait time from when they receive an imaging study to the time they see a physician. Patients are nervous and scared. On average, patients were waiting 15 to 30 days between appointments. To improve the patient experience, Southwest Cancer Center had to first answer the question: What is a realistic time from radiology exam to physician visit? Staff, working together with the Patient Advisory Committee, was soon able to come to consensus on radiology read times. Today patients are scheduled to see a physician 72 hours (3 days) after the exam. For example, if the patient's imaging appointment is on a Friday, he or she will see a physician and receive the results on Monday. If the patient's appointment is on a Tuesday, he or she will be seen on Friday.

Patient Mentoring Program

The Patient Advisory Committee was instrumental in the development of the cancer center's patient mentoring program. Committee members actually came up with the wording for the mentoring program: "As a patient, wouldn't it be nice to have someone who has gone through the same cancer experience that you are now experiencing? Someone who understands how you're feeling and can provide cancer support? Someone who has 'been there and done that'?"

A cancer diagnosis is an overwhelming experience, and the cancer center's mentoring program is an outreach effort to help those newly-diagnosed patients. Mentors are cancer survivors who can offer comfort, reassurance, information, coping skills, positive strategies, and practical advice.

The process is simple. For patient confidentiality purposes, staff asks all newly-diagnosed patients if they are interested in having a mentor. If the answer is yes, staff then gives the patient's contact information to a mentor, who will contact the patient directly. Southwest Cancer Center has found that some of the relationships established in its patient mentoring program have lasted for years.

Cancer Center Design

Southwest Cancer Center has had two renovations since 1992, growing from a 16,000-square-foot facility to a 37,000-square-foot facility. The Patient Advisory Committee provided valuable feedback and input into the design of patient care areas. For example, committee members helped identify comfortable chemo chairs; the committee was also integral in the design of comfortable and friendly pediatric exam rooms.

Another joint project between staff and the Patient Advisory Committee is the cancer center's patient emergency cards. These cards contain vital patient information, including chemo regimen and physician contact information. Now, no matter where patients are, if they have to seek treatment, the treating physician has all the necessary information right at his or her fingertips.

Survivorship Efforts

Another idea that came from the Patient Advisory Committee is the "chemo bell" in our chemotherapy department. When patients finish their treatment, they get to ring the bell. It's a big celebration for everyone—patients, families, and staff.

The committee was instrumental in the development of the cancer center's "Graduation in Radiation" program. When patients come out of the linear accelerator room after their last treatment, they go through a finish line where staff and families blow bubbles and celebrate with music and hats.

Since forming the Patient Advisory Committee, Southwest Cancer Center has hosted four annual survivor celebrations.

The cancer center also celebrates its patients' birthdays. If patients are in treatment during their birthday, the cancer center hosts a party for them. Other patients receive birthday cards in the mail signed by cancer center staff.

Celebrate Today

Another big initiative that the Patient Advisory Committee developed is the cancer center's Celebrate Today Fund. This fund helps patients pay for items that are not covered by insurers, including wigs, gas vouchers, lymphedema sleeves, nutritional products, and more. To raise funds, committee members initially hosted a benefit concert in November 2009. In August 2012 the Patient Advisory Committee also hosted a bicycle ride called "Cycle for Hope." Next, the committee partnered with nationally renowned artist Lynn Haney to create a Santa Claus ornament, *Sharing the Gifts*. The ornament was available for purchase online and in retail stores with a portion of the profits going back to the Celebrate Today Fund.

Hope Lane

One of the most profound and long-lasting changes spearheaded by the Patient Advisory Committee was a street name change.

The cancer center originally was located on Southwest Cancer Center Drive. The feedback the cancer center received from committee members was profound—every time they drove down SW Cancer Center Drive, the street name was a continual reminder that they have cancer. As cancer patients and cancer survivors, they wanted the street name changed to something that would instill hope. Today, Southwest Cancer Center now resides on Hope Lane.

Because the process of getting the street name changed was not simple—it involved much paperwork and many hoops to go through—Southwest Cancer Center made an event of the street name change. All of its patients and the local media

were informed of the initiative, which resulted in a story in the local paper about the re-naming of the street.

Other areas where the Patient Advisory Committee provided valuable contributions include:

- The development of the cancer center's patient information video
- Changes to the cancer center's patient satisfaction questionnaire
- The creation of a dedicated parking lot for cancer patients.

All of these efforts have significantly increased the cancer center's patient satisfaction scores. Prior to the implementation of the Patient Advisory Committee, Southwest Cancer Center's Press Ganey scores were in the 50th percentile; today the cancer center is in the 97th percentile in patient satisfaction.

The Score Team

In tandem with its Patient Advisory Committee, Southwest Cancer Center also solicits employee feedback through its Score Team. The team was established in 2005 to help solidify internal teamwork at the cancer center. The second purpose: to improve the cancer center's employee satisfaction scores. The cancer center wanted to create a culture of "open communication" with managers listening to staff without prejudice and repercussions. The process wasn't always smooth. As all managers know, it is easy to listen when everything is going well; the situation is more challenging when issues arise and changes need to be made.

The Score Team is comprised of volunteer employees throughout the cancer center—ranging from top performers to more middle-of-the-road performers and with representatives from all departments.

Here's how the process works. A Score Team chairperson meets monthly with the entire Score Team. They talk about any topics that are of concern to the cancer center, for example, patient satisfaction scores. They also discuss operational issues and any morale issues that may have been raised by staff.

Data from Press Ganey clearly showed the Southwest Cancer Center could improve its employee satisfaction scores and also revealed areas where improvement could be made. For example, one of the areas the cancer center needed to improve in was management communication. The Score Team used this information to identify concrete ideas for improvement. Here are a few of the strategies that the Score Team implemented:

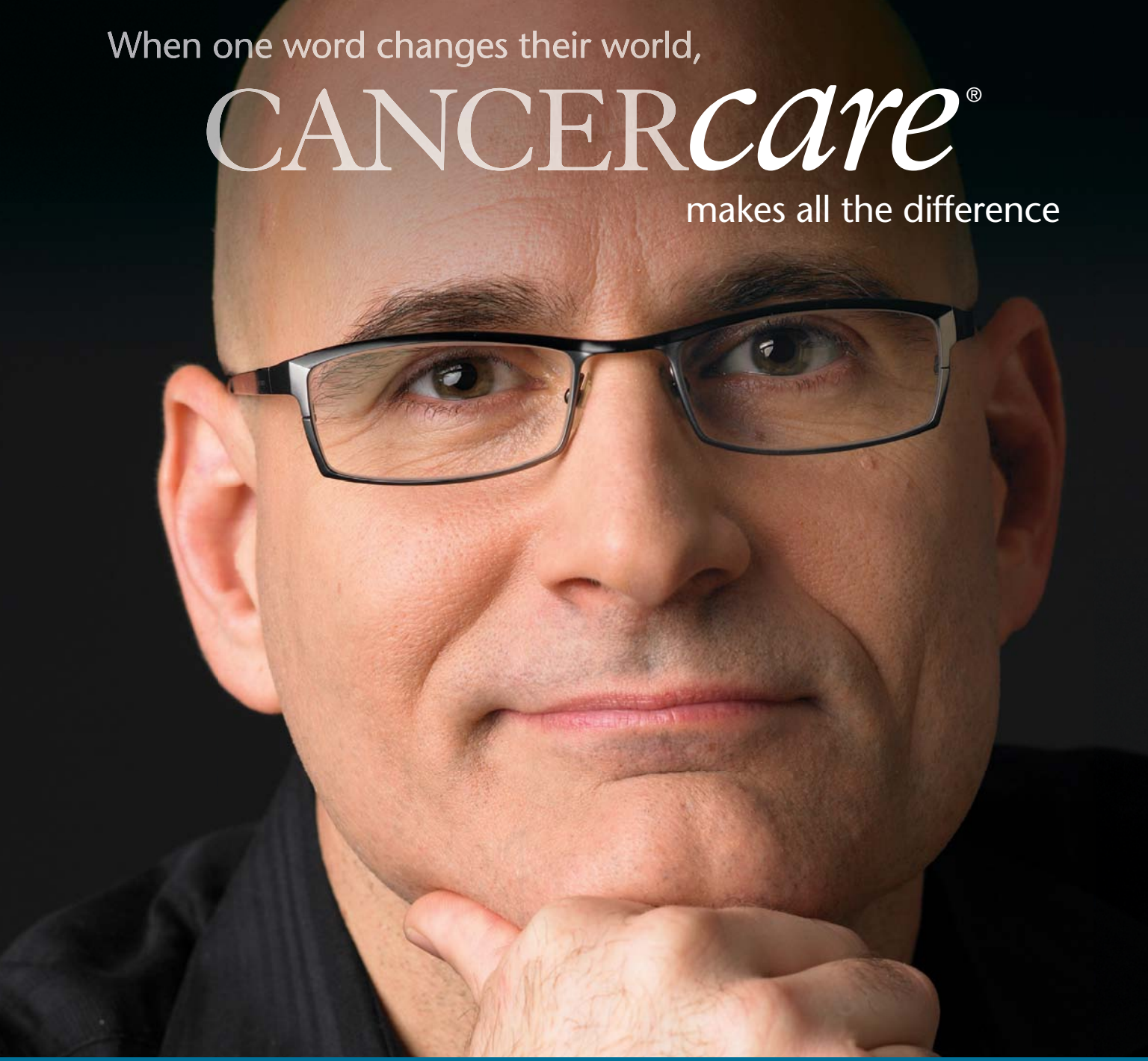
- ***Weekly one-on-one meetings.*** Managers meet with all of their current employees for 30 minutes each week. These meetings provide an opportunity for the staff member to discuss issues with their managers. Topics range from processes that are not working to challenges with a co-worker. The cancer center has found these meetings to be a solid way of forming a relationship with its front line staff.
- ***Quarterly skip-level meetings.*** Based on staff feedback, the cancer center implemented these quarterly meetings in which [the cancer program administrator?] meets with each staff member without their managers present. Similar to the one-on-one meetings, the employee chooses the topic(s). When first implemented, managers and even staff were hesitant about participating in the skip-level meetings. Managers were concerned that the meetings would be all about what they were doing wrong; employees were concerned about how much to share with upper management. Eventually the process was accepted, and staff began to share constructive feedback and ideas.
- ***Monthly Oncology Warrior.*** Southwest Cancer Center staff wanted a concrete way to reward outstanding service. So, each month management and staff come together to pick an Oncology Warrior. There must be an underlying justification for the nomination, and everyone votes. The prize is not big (free movie tickets), but it's a badge of honor.
- ***Staff- and patient-centered activities.*** To improve staff satisfaction scores, the Score Team recognized that it needed to improve staff morale. Today employees at Southwest Cancer Center participate in a number of activities, including annual hot air balloon rides where staff and patients ride together. Staff recently held a few activities around football tailgating. Everyone that participated, including staff from radiation, chemo, and the front office, had a fun time, and the Score Team looks forward to planning future events.

The Score Team has also helped implement initiatives such as the bereavement program, which helps staff to attend the funeral of a patient they were close to or who they had cared for. When possible, another staff member will step in and cover the employee's responsibilities during the time he or she attends the patient's funeral.

Cancer center staff also fundraises for patients by selling burritos. Staff donates supplies and their time, and any money raised is put towards the Celebrate Today Fund discussed earlier.

When the Score Team was first implemented in 2006, Southwest Cancer Center's employee satisfaction scores were in the 83rd percentile. By 2009 the staff turnover rate was around 27 percent. The cancer center has seen significant improvement in both scores. Today, its employee satisfaction scores are in the 95th percentile and staff turnover rate is down to 7.7 percent. For Southwest Cancer Center, the lesson was simple: it pays to listen to patients and employees. OI

—Ernie Elemento, PT, MBA, is administrator and Vasia Craddick, RNC, BSN, is director of Clinical Operations at Southwest Cancer Center, Lubbock, Tex.



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ACCC EDUCATION UPDATES

The Center for Provider Education ACCC

Strategies & Tools to Improve the Patient Experience

Melanoma

New! Education Program on Melanoma

ACCC's Center for Provider Education has launched an initiative entitled, ***Melanoma: Stategies & Tools to Improve the Patient Experience.*** The program is designed to raise awareness about the current methods of treatment and barriers in treating melanoma patients in the community setting. ACCC will compile the most effective practices for improving the patient experience. In addition, ACCC will develop resources and tools to share with cancer care providers across the country. This project is sponsored through a grant from Bristol-Myers Squibb. Stay tuned for more information on this program. Questions? Email us at *providereducation@accc-cancer.org*.

Improving Quality Care in Small-Population Cancers

Multiple Myeloma

Community Resource Centers—Virtual Experts in Residence!

ACCC's 39th Annual National Meeting provided opportunities for members to expand their knowledge on effective practices in the care and treatment of multiple myeloma patients. During a special session, Edward Faber, DO, MS, discussed the latest research and treatments for patients in the relapsed setting. Also unveiled at the meeting: more information about the Community Resource Centers (CRSs), ACCC-member programs experienced in treating patients with multiple myeloma and other small-population cancers, including CML and APL. The CRCs will serve as resources and mentors and can be contacted by other community cancer centers that are treating patients with small-population cancers. Questions that a CRC may respond to include:

- What guidelines should we follow?
- How are patients transitioned between care settings?
- What supportive care is needed?
- What adjuvant therapies are best?
- What side effects are anticipated?
- What is the reimbursement outlook for this treatment?

Visit *www.accc-cancer.org/education/MM-Overview.asp* to learn more.

ACCC Welcomes its Newest Members

Baptist Health System, Baptist Cancer Services
San Antonio, Tex.
Delegate Rep: Morton Kahlenberg MD, FACS
Website: *www.baptisthealthsystem.com*

Northeast Georgia Cancer Care, LLCs
Athens, Ga.
Delegate Rep: Loretta Goodson
Website: *www.negacancer.com*

VCU Health System, VCU Massey Cancer Center
Richmond, Va.
Delegate Rep: Mary Ann Hager
Website: *www.massey.vcu.edu*

SAVE THE DATE!

ACCC Spring Regional Oncology Economic & Management Meetings

- **April 23, 2013** | Fort Lauderdale Marriott North Ft. Lauderdale, Fla.
- **May 9, 2013** | Caesar's Palace Las Vegas, N.V.
- **June 11, 2013** | East Lansing Marriott at University Place East Lansing, Mich.

Register for these FREE meetings at *www.accc-cancer.org/regionalmeetings.*

ACCC 30th National Oncology Conference

October 2–5, 2013 | The Westin Boston Waterfront Boston, Mass.

Learn more and register at *www.accc-cancer.org/oncologyconference.*

ADVERTISER'S INDEX

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The Salon Project

BY CAROL O'NEILL, RN, BSN, OCN

In February 2012 Good Samaritan Cancer Center implemented an outreach project in a rural Nebraska county to educate women about breast health. Our "Take Care of the Girls" Salon Project was designed to:

- Approach women in a common gathering place—hair salons
- Capitalize on pre-existing relationships between cosmetologists and customers
- Utilize cosmetologists as lay educators
- Deliver a scripted verbal message
- Use a light-hearted theme and an eye-catching design to capture customers' attention
- Present credible print information about mammograms, breast health, breast cancer, and available resources.

We chose a specific Nebraska county because it had a lower population per square mile, a higher percentage of residents over the age of 65, a higher percentage of uninsured residents, and a lower compliance rate to mammography recommendations. We specifically designed our Salon Project to reach this rural disparity population.

Getting Started

The first step: reaching out to cancer survivors for their input and ideas. As coordinator of the Salon Project, I attended a local breast cancer support group, explained the project idea, and asked the 13 members present to select a theme that was clever and bold without being offensive. From six options, they selected the "Take Care of the Girls" theme.

Our corporate communications department then designed a mock-up of a three-dimensional handout featuring a brassiere with "cleavage" created by partially revealing a package of two pink snack cakes. The handout included print information regarding:

- Breast cancer risks
- Family history issues
- Clinical breast exams
- Personal breast awareness
- Healthy lifestyle choices
- ACS screening recommendations
- Digital mammography available locally
- Financial resources from *Every Woman Matters,* a program that helps women ages 40 to 74 with limited or no health insurance and low or moderate income receive annual screening mammograms.

The handout also included an anonymous survey that women could complete and leave with the business, mail themselves, or complete online via a designated link.

The next step was to reach out to local providers. The county is home to two critical access hospitals, each offering digital mammography services. Both hospitals are affiliated with Good Samaritan Hospital through the Critical Access Network, so relationships and collaborations already existed. During the planning phase of our Salon Project, I spoke with the administrators at the two hospitals, describing the project in full and discussing our promotional plan. Both expressed strong support and agreed to provide past and future mammography statistics for their facilities. I also contacted administrators at the county medical clinics.

Funding Our Project

In August 2011, I submitted a small grant application for our Salon Project to the Nebraska Affiliate of Susan G. Komen for the Cure. Their response letter expressed support for our efforts to address breast health needs in Nebraska, but reported that they were unable to approve the grant request. Failure to secure grant funding caused us to re-evaluate each project component—from the theme and design to all projected costs. As the theme and design were key project components—using surprise and humor to capture women's attention and elicit conversation—we felt that changing them threatened the essence of our project. In the end, Good Samaritan's corporate communications department designed the promotion pieces, donating most of the production costs as in-kind.

Funds from The American Recovery and Reinvestment Act (ARRA) paid the salary costs for my position (project coordinator). Local newspapers and the radio station offered heavy discounts to publicize our Salon Project. As supplies, mileage, postage, and miscellaneous project costs were moderate, the hospital picked up those costs.

The price of the snack cakes used in the promotion piece was the most significant project cost. While we were unsuccessful in engaging the snack company's corporate office in the project, a local wholesale distributor agreed to

> Screening mammography…improves the chances of breast cancer diagnosis at an early stage when breast cancer is likely to be smaller and still confined to the breast…

discount the snack cakes by more than 50 percent. This discount allowed our Salon Project to move forward.

Reaching Out to Local Salons

Originally intended for rollout during National Breast Cancer Awareness Month in October 2011, the grant denial pushed the date back. Instead, we implemented our Salon Project during a two-week period in February 2012. This decision allowed us to incorporate a Valentine's Day theme of "love yourself" into our promotion.

We contacted 20 licensed cosmetology salons in the county by phone. These "cold calls" were made during business hours and used a written script to present the information succinctly to the salon owners and managers. Most expressed some degree of reluctance to speak about a non-work-related topic and, in some cases, multiple phone calls were necessary to reach the owners and managers at a time convenient for them.

We told these owners and managers that our Salon Project would educate women about breast health. If they agreed to participate in the two-week program, the salon would prominently display handouts, and cosmetologists would wear a "Take Care of the Girls" lapel button designed to catch the attention of customers and prompt questions. Cosmetologists would tell each customer: "We're helping educate women about breast cancer, and we have a handout for you." Cosmetologists would then give each customer the information and

The Unique Needs of Rural Patients

The resources available to rural and non-rural populations vary greatly. These populations also face diverse barriers to care. These differences impact all aspects of rural cancer care: prevention, detection, treatment, and survivorship.

The National Cancer Institute (NCI) defines "cancer health disparities" as "differences in the incident, prevalence, mortality, and burden of cancer and related adverse health conditions that exist among specific population groups in the United States."[2] Based on data from 2007–2009, 12.38 percent of women born today will be diagnosed with breast cancer at some time during their lifetime.[3] Screening mammography, as recommended by the American Cancer Society (ACS), improves the chances of breast cancer diagnosis at an early stage when breast cancer is likely to be smaller and still confined to the breast; factors which improve prognosis.[4]

According to the *Manual of Intervention Strategies to Increase Mammography Rates,* the Center for Disease Control (CDC) identifies characteristics of women less likely to obtain screening mammograms. These socioeconomic factors include education, income factors, and lack of peer support. Knowledge and attitude barriers include not knowing risks or screening guidelines, fear, and mistrust. Access barriers include financial concerns for screening and treatment if disease is found, lack of time, time required away from work, transportation issues, and distance to services.[5]

The interventions we selected for the Salon Project are consistent with evidence-based recommendations by the Task Force on Community Preventative Services and have been shown to increase breast cancer screening by mammography:[6]

1. Small media (print information)
2. One-on-one education.

The primary objective behind our Salon Project was to increase the awareness of and the likelihood of following the mammography recommendations of the ACS for women after age 40. A secondary objective was to build collaborative relationships in the selected county.

encourage completion of the enclosed survey. Owners and managers were responsible for keeping track of the number of handouts distributed and asking for additional handouts if necessary.

We also asked owners and managers if they would commit to sharing a positive message about mammograms, emphasizing that the success of the project relied on customers hearing positive messages—not negative stories.

Fourteen salons in five communities committed to the Salon Project. Once we received verbal commitments by phone, we asked owners and managers to estimate the number of handouts they could distribute in the two-week time period. In total, the salons estimated they could distribute about 900 handouts.

Project Rollout

Once the handouts were printed, the process of hand punching, folding, and stuffing each handout with snack cakes began. This tedious, labor-intense process required numerous cancer staff members plus a dedicated volunteer over several days.

Two county newspapers ran print ads prior to and during the two-week project. One newspaper ran a feature story on a local woman whose breast cancer was diagnosed via a screening mammogram. The radio station conducted an on-air interview regarding the project and also ran 30-second promotional spots.

During the week prior to kick-off, I visited the 14 participating salons. Distance to the salons ranged from 49 miles to 98 miles—one way. At each salon, I introduced myself, reiterated the importance of presenting a positive message about mammograms, and delivered the table-top displays, handouts, lapel buttons, a Q&A sheet for the cosmetologists to review, and my contact information.

During the first week of the project, I called each of the 14 salons, asked for updates on handout numbers, answered questions, and delivered a general pep talk. During the second week, I revisited nine salons, but dangerous winter weather necessitated phone calls to the remaining five.

At the conclusion of the two-week Salon Project, cosmetologists had distributed about 850 handouts to salon customers. With more than 400 surveys returned (a 48 percent return rate), our Salon Project met its primary objectives:

- 76 percent indicated increased awareness about yearly mammograms after age 40
- 68 percent indicated they were "very likely" to follow mammogram recommendations throughout their lifetime.

Lessons Learned

Community outreach helps strengthen and/or foster new relationships between businesses, hospitals, non-profits, and local media. In our case, we found that hair salons, specifically, can be an effective venue and partner in a cancer outreach education program. For community cancer centers looking to develop a similar program, it is critical to clearly communicate expectations to potential partners upfront. We found that businesses in which staff personally knew breast cancer survivors, or were breast cancer survivors themselves, demonstrated the greatest degree of engagement. Looking back, enlisting a breast cancer survivor from each community as a "champion" may have increased the number of salons and the level of interest and enthusiasm in those who participated in our Salon Project. OI

—Carol O'Neill, RN, BSN, OCN, is outreach oncology nurse coordinator, Good Samaritan Hospital Cancer Center, Kearney, Nebr.

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Look for us at the Oncology Nursing Society's Annual Congress in Washington, DC., April 25th-28th.

Matthew, CML survivor

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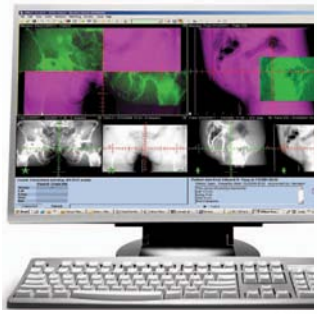

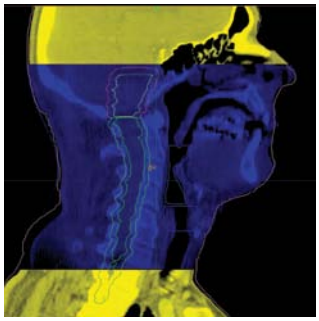

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