A Model Clinical Study Review Process | 28
The Role Clinical Trials Play in an Affiliation | 36
Multidisciplinary Thoracic Oncology Clinics | 40

ONCOLOGY ISSUES

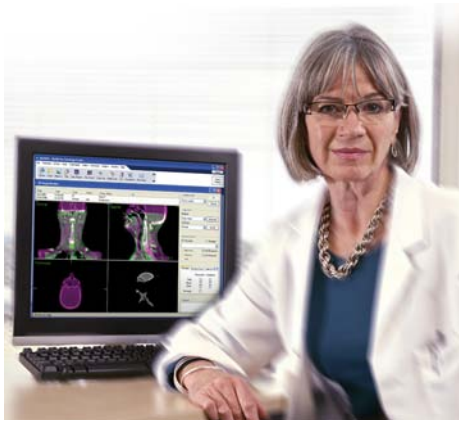
The Journal of the Association of Community Cancer Centers
May | June 2013

Acquiring a Physician Practice?

Ensure a Good Fit for Your Hospital

imagine

...***one*** software system that integrates your multiple locations



With MOSAIQ®, it's reality.

Effective data management across disparate departments and locations can be a challenge, particularly if each has unique hardware, workflow and administrative needs. As the standard in OIS scalability, MOSAIQ efficiently manages everything from the single physician practice to the most sophisticated provider networks.

contents

Oncology Issues
May | June 2013
Vol. 28 | No. 3

28 Improving Your Study Review Process
After failing to meet its clinical trial accrual in 2011, St. Luke's Mountain States Tumor Institute reviewed its existing processes and developed a formalized, accountable, and organized method for tracking and reviewing potential new clinical research studies.
By Deborah Jones

36 Cancer Clinical Trials & Affiliation Evaluation
Here are six clinical trial dimensions to assess during any affiliation evaluation process.
By Louis Pavia

40 An Integrated Approach to Lung Cancer in a Community Setting
Read how two competing hospitals, a freestanding cancer center, and private practice physicians came together to develop a multidisciplinary thoracic cancer clinic in Erie, Pa.
By Jan M. Rothman and Shelley D. Kubaney

46 Developing a Multidisciplinary Thoracic Oncology Clinic
In this model, an NP serves as the coordinator for the multidisciplinary conference.
By Kimberly Rohan

20 Acquiring a Physician Practice?
Central Baptist Hospital shares the programmatic benefits it has realized from just such an acquisition, including standardization of care and streamlined workflow, as well as challenges related to staffing, billing, and financial incentives. Key to success are physician engagement and communication.
By Amanda Henson

Cover photo by Chad J. Shaffer / Getty Images

DEPARTMENTS

2 **From the Editor** | Getting It Done
3 **President's Message** | It Takes a Team
4 **Fast Facts** | Sunshine Act survey, government recovery efforts, and more
6 **Issues** | Congress Passed One Budget—Now What?
8 **Compliance** | Billing Challenges for Survivorship Services
14 **Spotlight** | The University of Alabama at Birmingham Comprehensive Cancer Center, Birmingham, Ala.
18 **Tools** | Approved drugs, and more
45 **Careers** | Director of Nursing, and more
48 **Action** | The ACCC 39th Annual National Meeting, and more
52 **Views** | The Story Behind the Dream Hat

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

Getting It Done

BY CHRISTIAN DOWNS, JD, MHA

At the March ACCC 39th Annual National Meeting in Washington, D.C., about 60 attendees visited their representatives on Capitol Hill. It was a great showing of physicians, nurses, pharmacists, administrators, and social workers all talking about quality cancer care.

Many of your colleagues experienced firsthand the gridlock that has overtaken the country's legislative process. From sequesters to healthcare reform, your fellow providers saw how maddeningly difficult it is for Congress to get any work done.

Now, compare what is happening in Washington, D.C., with what is happening out in our communities around the delivery of quality cancer care. This edition of *Oncology Issues* highlights just a few of your activities.

For example, we're all familiar with the market consolidation that is happening across our industry. Amanda Henson's piece on Central Baptist Hospital focuses on the hospital's efforts to integrate a new physician group. According to Henson, "The good news [is that] these relationships can be developed successfully, and integrated delivery of care can benefit all parties involved—providers, hospitals, and patients." She also shares some of the challenges related to staffing, billing, and financial incentives. Henson's takeaway message is that physician engagement and communication are key to the success of any physician acquisition.

Next, with the new CoC standards, many ACCC members are trying to improve or enhance their research programs. After failing to meet its clinical trial accrual in 2011, St. Luke's Mountain States Tumor Institute took immediate action. The first step: a comprehensive review of its existing processes. With this data in mind, a dedicated team was then able to develop a formalized, accountable, and organized method for tracking and reviewing potential new clinical research studies. Read about their experience and the tools they subsequently developed to strengthen MSTI's research program.

In that same vein, Louis Pavia's article highlights the relationship between research and affiliation. If your physician practice or cancer program is looking into an affiliation arrangement, Pavia suggests that you first assess six clinical trial dimensions: vision and culture, trials portfolio, trial initiation, accrual, outreach, and support.

Finally, Congress can learn much from Jan Rothman and his colleagues about working together to overcome challenges and barriers. In his article, Rothman shares how two competing hospitals, a freestanding cancer center, and private practice physicians were able to come together and develop a multidisciplinary thoracic cancer clinic in Erie, Pa. In a companion article, Kimberly Rohan talks about her program's thoracic cancer clinic model. At Edward Hospital in Naperville, Ill., a nurse practitioner coordinates the multidisciplinary conference and collects data related to the clinic's PI goals.

Amazing! In this one issue of our journal, ACCC member programs offer four strong examples of providers taking action to get things done—real action, action that means something to our patients and communities.

ACCC is holding its third Hill Day on March 31, 2014, in conjunction with the ACCC 40th Annual National Meeting. Next year, join your colleagues and help educate Congress about the issues affecting your cancer programs and cancer patients. And who knows? You might even give your representatives a few ideas about "how to get things done" in Washington, D.C. OI

PRESIDENT'S MESSAGE

It Takes a Team

BY VIRGINIA T. VAITONES, MSW, OSW-C

Greetings to the ACCC membership!

As I write this, my first column for *Oncology Issues,* I still feel the thrill of becoming president of this great organization.

Many of my colleagues see the Association of Community Cancer Centers as an organization for cancer program managers and administrators. They ask me how and why I became involved with ACCC. I tell them that ACCC is a multidisciplinary organization that is looking to expand its programs, webinars, publications, and other resources for *all* the members of the cancer team—physicians, nurses, administrators, pharmacists, social workers, navigators, coders and billers, cancer registry staff, and more. In fact, one of ACCC's fastest growing disciplines is counselors and advocates who offer financial assistance services to cancer patients and their families.

Another selling point for ACCC is its advocacy work on behalf of our cancer programs and patients. Because of ACCC's efforts, I am able to get the "big picture" of how our government (both legislators and regulators) and our payers (both public and private) affect our hospitals, cancer programs, practices, and patients.

Educate and advocate. It's what ACCC does best. And it's why I've become involved with this organization, first as a committee member, and then as a member of the board of trustees, and now as president.

This brings me to my presidential theme for 2013–2014: "It takes a team that works together to help our patients and their caregivers negotiate the complex world of cancer care." Each year, at least from my vantage point, it has become more challenging for providers to care for their cancer patients. To ensure patients receive the best possible care, it truly does require a team approach where each member of the team has specific expertise and skills. It is through the efforts of this team that patients and caregivers receive the care and support they need to combat their disease. My goal for this year is to promote this multidisciplinary team and many of its "unsung" members who don't always get recognized for their contributions in caring for patients and their families. Cancer care teams that truly value and utilize *all* of their members deliver safe, effective, quality patient care.

Beyond my column in *Oncology Issues,* another venue for ACCC to promote my presidential theme is during ACCC meetings. Next month, on June 11, ACCC will host its third Spring Regional Oncology Economic and Management Meeting in East Lansing, Mich. Held in collaboration with the Michigan Society of Hematology and Oncology, this meeting is free to ACCC members and offers a broad view of current trends and issues, plus the nuts and bolts of financial assistance, billing and coding, quality reporting, and more. Fall Regional Oncology Economic and Management Meetings are scheduled in Eugene, Ore. (Oct. 22), St. Louis, Mo. (Nov. 7), and Savannah, Ga. (Dec. 10).

Of course, my presidential theme will be front and center at the ACCC 30th National Oncology Conference, Oct. 2–5, in Boston, Mass. For the third year, ACCC will recognize and honor member programs that advance the goals of improving access, quality, and/or cost-effectiveness of cancer care. Turn to page 15 to see the list of ACCC's 2013 Innovator Award Winners. Then attend the Boston meeting, learn from these programs and teams, and take their innovative strategies and solutions back to share at your own programs. I strongly encourage you to join me in Boston and leave you with this thought: the first medical social worker was hired in 1905—in the city of Boston. OI

Coming in Your 2013 *ONCOLOGY ISSUES*

- 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
- New Approaches to Maximize Patient Flow and Reduce Inpatient LOS
- Biosimilars: Emerging Issues for Cancer Programs?
- A Model Breast Care Center
- Establishing & Managing a Patient Assistance Fund at a Community Cancer Center
- Building a Psychosocial Oncology Program within a Cancer Center

more online @ www.accc-cancer.org

Town Hall on Shift in Site of Care VIDEO

View video of ACCC's "Shift in Site of Care, Real or Fiction?" Town Hall meeting and read our highlights blog at *www.accc-cancer.org/townhall*.

Oncology Issues Annual Survey SURVEY

Let us know how we're doing and what you think. Take ACCC's annual survey today at *www.surveymonkey.com/s/accccommunications*.

ACCC 2012–2013 Annual Report REPORT

Last year ACCC harnessed technology and new tools, including the MyNetwork online community, digital publications, and virtual meeting sessions, to better reach its membership. Read more at *www.accc-cancer.org/association/pdf/annualReport-2013.pdf*.

Financial Assistance Toolkit TOOL

Tools to assess benefits and to 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*.

Oncology Issues is published bimonthly at the Association of Community Cancer Centers, 11600 Nebel St., Suite 201, Rockville, MD 20852. Editorial correspondence, changes of address, manuscripts, and letters to the editor should be addressed to: Managing Editor, Oncology Issues, 11600 Nebel St., Suite 201, Rockville, MD 20852-2557. Author's instructions available at *www.accc-cancer.org*.

Articles, editorials, letters to the editor, and other contributed materials represent the opinions of the authors and do not represent the opinions of the Association of Community Cancer Centers or the institution with which the author is affiliated unless the contrary is specified.

Subscription Rates | Basic rate: $55 per year for healthcare providers, plus $4.99 for shipping. ACCC membership dues pay for general, delegate, and chapter member subscriptions. Back issues available for $12.50 per copy, prepaid. Bulk rates available upon request.

Advertising | Send correspondence, display advertising, insertion orders, printing materials to Mal Milburn, Oncology Issues, 11600 Nebel St., Suite 201, Rockville, MD 20852. Questions for general information may be directed to 301-984-5704.

Postage Privileges | Please send address changes to Association of Community Cancer Centers, 11600 Nebel St., Suite 201, Rockville, MD 20852.

fast

Increase in Drug Costs Expected in 2013

- 1% to 3% increase in drug expenditures across all settings
- 2% to 4% increase for clinic-administered drugs
- 1.5% increase for hospitals.

Source. American Society of Health-System Pharmacists. Projecting Future Drug Expenditures in U.S. Non-Federal Hospitals and Clinics—2013. *Journal of Health-System Pharmacy*.

Don't Get Burned!

- **37%** of Americans believe they are not at risk for skin cancer—in spite of statistics that report **1** in **5** Americans will develop skin cancer annually
- Only **24%** of American adults have had a skin check by a dermatologist
- Only **23%** of Americans perform monthly mole self-checks
- Melanoma continues to rise and is the leading cause of cancer death in women ages **25** to **30** and second only to breast cancer in women ages **30** to **34**.

Source. MELA Sciences, Inc. A Harris Interactive Survey. January 2013.

facts

Sunshine Act Survey Findings

- More than 50% of physicians didn't know that the law requires pharmaceutical and medical device companies to report on expenditures annually
- 63% were deeply concerned that a record of these payments will be available in a publicly searchable database.

Source. MMIS, Inc. and Healthcare Data Solutions Survey.

GOVERNMENT RECOVERY EFFORTS

Medicare's RACs returned $488 million in improper payments to the Medicare Trust Fund in FY 2011. In 2010 RACs identified and corrected only $92 million in improper payments.

Source. CMS. Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011. Available online at *www.cms.gov.*

The government recovered $4.2 billion in FY 2012 due to health fraud enforcement.

Source. Feb. 12, 2013. BNA *Health Care Daily Report.*

The Cost of Shift in Site of Care

Hospital employment of physicians has contributed to the migration of services from freestanding offices to hospital outpatient departments. E/M spending would increase by $1.2 billion if services continue to move to hospitals. Payment differences across care settings will be discussed in MedPAC's June report to Congress. One option: to reduce OPD payment rates for E/M visits to align with services provided to freestanding physician practices.

Source. The Medicare Payment Advisory Commission. As reported in the March 11, 2013, BNA *Health Care Daily Report.*

Congress Passed One Budget and Introduced Two More—Now What?

BY MATTHEW FARBER, MA

March was a very busy month for both houses of Congress. In rare moves, Congress passed a budget to keep the federal government funded for the rest of the fiscal year (through September 30, 2013), and the Senate introduced a budget for 2013–2014. These are rare occurrences because Congress does not act in a bipartisan way much anymore, and this budget is the first one from the Senate in more than four years.

Does this signal a new era of bipartisanship and forward thinking on the budget? The answer, unfortunately, is no. While it's refreshing to see the parties working together to avoid a government shutdown, we are now waiting for the next crisis, which will be the showdown over the debt ceiling this summer.

Sadly, the Senate budget is not actually a momentous event. The President introduces a budget each year, as does the House of Representatives. Each document is, as they say of many partisan bills, dead on arrival in the opposing Houses. The House budget has no chance of passing the Senate, and the Presidential and Senate budgets have no chance of passing the House. If this is the case, why do they even bother?

The simple answer is that the budget document lays out each party's priorities for that year. The Senate budget, which was passed by the Democratic majority, includes tax increases and lessens cuts to domestic spending. The House budget, does the opposite, including no increase in taxes, but changes to entitlement programs and other cuts, with the ultimate goal of balancing the budget in 10 years. The Senate budget does not make balancing the budget a specific target.

This leaves one overriding question: Now what?

Basically, Congress will work together on many of these issues, and it remains to be seen if they can come to a grand bargain, as many, including the President, hope they will. Despite this uncertainty, it is as important as ever to stay involved with educating Congress on how these issues affect community cancer care. A prime example is telling the story of how the sequester is affecting cancer care providers and their patients.

It is as important as ever to stay involved with educating Congress on how these issues affect community cancer care.

ACCC not only encourages you to get involved, we're here to help you make your voice heard. At ACCC's Annual Meeting in March, more than 50 members attended ACCC's Capitol Hill Day, meeting with their elected officials in Washington, D.C. From these discussions, further meetings have been scheduled, on issues ranging from cuts to research spending, to SGR reform, to oral parity. ACCC will continue this effort throughout the year. And if you missed ACCC's Capitol Hill Day this year, be sure to plan ahead to join us next year, when we will be visiting Capitol Hill as part of the ACCC 40th Annual National Meeting.

One final, important message: Do not get discouraged by Congressional workings (or lack thereof). Congress is a very deliberative governing body and change, even incremental change, can take time. In 2013, while we may not see long-term budget agreement, we may see other action, including possible long-term fixes to the Sustainable Growth Rate (SGR), or perhaps further legislation addressing drug shortages. ACCC will keep you informed. OI

—Matthew Farber, MA, is ACCC's director of provider economics & public policy.

THE CANCER GENOME ATLAS

http://cancergenome.nih.gov

Funding Opportunities Are Ending Soon …

Join TCGA Now!

The Cancer Genome Atlas (TCGA) is a pioneering effort of the National Institutes of Health to catalog the genetic changes associated with specific cancers. TCGA is building genetic profiles for many common and rare tumor types. These can be used for targeting new cancer treatments.

Join TCGA as a tissue source site and you get :

- **Funding support for biospecimen distribution to TCGA** *(retrospectively and prospectively collected annotated specimens accepted)*
- **Authorship on the initial in-network manuscript, if samples are received in time for inclusion**
- **Genomic data on biospecimens from your institution**
- **Ability to retain residual material from every case profiled by TCGA**

Applying to participate in TCGA's network is simple.

The process to award and manage subcontracts is supported by SAIC-Frederick, Inc., which operates the Frederick National Laboratory for Cancer Research for the National Cancer Institute.

The SAIC-Frederick technical team is standing by to assist investigators/institutions with proposal generation.

For more information, please contact:

Mr. Lenny Smith
Clinical Project Manager
SAIC-Frederick, Inc.
NCIFTSS@mail.nih.gov
301-228-4488

Act Now! All biospecimens must be shipped to TCGA by the end of 2013, so this is our LAST CALL to receive proposals.

http://www.fdbdo.com/s12-335

SAIC® Frederick

DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health • National Cancer Institute
204210

Billing Challenges for Survivorship Services

BY CINDY PARMAN, CPC, CPC-H, RCC

Although cancer remains the nation's second leading cause of death, many cancers are now treatable if detected early. The term "survivorship" describes the patient's experience of moving beyond the cancer diagnosis and treatment toward maintenance, prophylactic therapy, and wellness. Thanks to early detection, innovative medical treatments, and supportive care from family and friends, more than 13 million cancer survivors live in the United States today. This number is expected to reach 18 million by 2022.[1]

Many people think that the end of treatment should be a time of relief and happiness for the cancer patient. However, many survivors feel mixed emotions when the treatment routine ends and describe a feeling of being cast adrift without scheduled follow-up services. Although many survivors feel well when treatment ends, studies have illustrated that a significant percentage of cancer survivors deal with chronic health problems that may be related to their cancer treatment. For example, patients may experience pain, fatigue, cognitive impairment, or depression during the survivorship phase of the cancer care continuum.

Prior to providing survivorship services, providers typically develop a written cancer treatment summary and follow-up care plan. This document includes:

- The survivor's current health status
- A summary of the cancer treatment received by the individual patient
- Recommended follow-up visits
- Necessary services for cancer surveillance
- Method(s) to address late and long-term effects of the patient's disease and treatment; symptom management; and psychosocial, spiritual, and financial concerns.

For some cancer programs, the treatment summary will be part of the goal of transitioning the patient back to the care of their primary care physician, so the summary will include a plan specifying which provider will be responsible for each aspect of patient care.

The American Society of Clinical Oncology (ASCO) recommendations for achieving high-quality cancer survivorship care state:[1]

Specific efforts will be concentrated on developing guidance for oncology care providers on the clinical management of cancer survivors, increasing collaboration between oncologists and primary care providers (PCPs) in the provision of cancer survivorship services, improving health professional education and training, increasing patient and family education and self-advocacy, supporting research on cancer survivorship, and promoting policy change to ensure cancer survivors have access to appropriate health care services, including improving the payment environment so that adequate, uniform reimbursement for prevention counseling, interventions, and therapies is provided by payors.

ASCO adds that increased efforts are needed to define quality cancer survivorship care and identify strategies to implement a comprehensive care plan in a variety of clinical settings.[1] In addition, while survivorship care has been identified as an important patient service, there may be little or no revenue for significant components of this care.[1]

Services Performed

According to an October 6, 2011, article in *Cancer Epidemiology, Biomarkers & Prevention,* it has been a standard practice to provide long-term follow-up after completing treatment for many types of cancer.[2] Historically, follow-up services have primarily consisted of patient visits and diagnostic tests ordered by the medical or radiation oncologist, often for a prolonged period of time.

There is no single standard for how survivorship programs are structured. The diversity of survivors, their needs, and the survivorship treatment models currently in use make it difficult to identify a single protocol for clinical survivorship care that will meet the needs of all survivors. The lack of long-term population-based tracking of physical and psychological impacts combined with continuous advances in treatments leaves the possibility of many unknown late and long-term side effects that require treatment and management for an individual patient.

In addition to acute care services, there may be a need for preventive medicine evaluation and management of post-treatment infants, children, adolescents, and adults. If an abnormality is encountered or a pre-existing problem

Continued on page 12

Your budget for consulting assistance may be limited...

But our ability to skillfully assist you is not

The experts at ONCOLOGY MANAGEMENT CONSULTING GROUP have supported hundreds of hospital oncology programs, comprehensive breast centers, medical oncology and radiation oncology practices and free standing facilities across the US for many years. We work closely with you and your team - within your budget - to bring you the most targeted, most professional support that your money can buy. We invite you to call us at 215-766-1280...ask us how we can help you!

OMC GROUP...

Outstanding experts, Outstanding results!

Oncology MANAGEMENT CONSULTING GROUP

- Financial and Market Analyses
- New Center Development
- Hospital/Physician Integration
- Strategic Planning
- Operational Assessments
- Revenue Cycle Reviews
- Implementation and Interim Leadership
- Performance and Financial Benchmarking

215-766-1280
oncologymgmt.com
solutions@oncologymgmt.com

Table 1. Procedure Codes for Potential Survivorship Services

CODES	DESCRIPTION
99211 – 99215	The physician, midlevel provider, or facility can only charge for a medical visit with established patient visit codes when the patient has a medically necessary face-to-face visit with documentation of history, examination, and medical decision-making. Established patient visit services would include ongoing treatment for complications, late effects of therapy, long-term effects of the neoplastic process, or other sequelae of the disease and/or treatment process.
99381 – 99387	Initial comprehensive preventive medicine evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, new patient.
99391 – 99397	Periodic comprehensive preventive medicine re-evaluation and management of an individual, including an age and gender appropriate history, examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of laboratory/diagnostic procedures, established patient. Of note, an insignificant or trivial problem that is detected during the performance of a preventive medicine evaluation and management service and which does not require additional work or the key components of a problem-oriented E/M service should not be separately reported.
99401 – 99404	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure). Because this service is designated as a "separate procedure," it will not be charged if any other service is performed on the same service date.
99411 – 99412	Preventive medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting (separate procedure).
99406 – 99407	Smoking and tobacco use cessation counseling visit.
99408 – 99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST) and brief intervention (SBI) services.
97802 – 97804	Medical nutrition therapy.
90901	Biofeedback training by any modality.
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family. Genetic testing will be separately charged.
96150 – 96155	Health and behavior assessment (e.g., health-focused clinical interview, behavioral observations, psycho-physiological monitoring, health-oriented questionnaires) or health and behavior intervention.
99605 – 99607	Medication therapy management services.
99078	Physician or other qualified healthcare professional qualified by education, training, licensure/regulation (when applicable), educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions).

COMING SOON

LOOK what's on the horizon

Boehringer Ingelheim

Table 2. HCPCS Codes for Potential Survivorship Services

CODES	DESCRIPTION
S0220 – S0221	Medical conference by a physician with interdisciplinary team of health professionals or representatives of community agencies to coordinate activities of patient care (patient is present).
S0255	Hospice referral visit (advising patient and family of care options) performed by nurse, social worker, or other designated staff.
S0257	Counseling and discussion regarding advance directives or end-of-life care planning and decisions, with patient and/or surrogate. (List separately in addition to code for appropriate E/M service.)
S0265	Genetic counseling, under physician supervision, each 15 minutes.
S0315 – S0320	Disease management program services.
S5190	Wellness assessment, performed by non-physician.
S9449	Weight management classes, non-physician provider, per session.
S9451	Exercise classes, non-physician provider, per session.
S9452	Nutrition classes, non-physician provider, per session.
S9453	Smoking cessation classes, non-physician provider, per session.
S9454	Stress management classes, non-physician provider, per session.
S9470	Nutritional counseling, dietitian visit.

Continued from page 8

is addressed in the process of performing this preventive medicine assessment, and if the problem or abnormality is significant enough to require additional work to perform the key components of a problem-oriented E/M service, then an appropriate patient visit service may also be reported.[3]

The determination of whether there is a procedure code that can be charged to the patient will depend on the nature of the services performed and documented in the individual medical record.

Table 1 (page 10) includes some potential services performed as part of survivorship programs and the available procedure codes; this table is not considered to be an exhaustive list. It is essential to keep in mind that even when a procedure code exists for a particular service, there may not be any insurance reimbursement for the procedure performed.

Last, remember these services may have specific performance criteria and documentation requirements that may not be listed in the code descriptor; services are never charged unless all coding requirements are met.

In addition to the standard procedure codes for survivorship services, the *HCPCS Manual* includes a section of codes that may be reported to Blue Cross Blue Shield and other payers that recognize this procedure code list. Table 2 (above) includes a list of these HCPCS codes that may be performed as part of a comprehensive survivorship program. When these codes apply, they typically replace CPT® procedure codes for the same or similar services.

Other services that may be necessary as part of a survivorship program include:

- Home care
- Skilled-nursing home care
- Hospice care
- Psychotherapy
- Rehabilitation services
- Pain management
- Fertility preservation
- Sleep management
- Assistance helping cancer survivors access family, peer, community support, and other resources they need for coping with their disease.

While some of these services are represented with procedure codes that can be charged by the attending physician and/or facility, not all services performed as part of a survivorship program can be separately billed to the patient. The Centers for Disease Control and Prevention publishes a Cancer Survivorship guide, which is available for download at *www.cdc.gov/cancer/survivorship/pdf/brochure.pdf*. This guide includes information on the CDC's *National Action Plan* to identify and prioritize cancer survivorship needs within a public health context. Cancer programs should monitor CDC, ASCO, ACCC, and other oncology organizations to maintain awareness of changes to billing for survivorship services. OI

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

References

1. McCabe MS, Bhatia S, Oeffinger KC, Reaman GH, et al. American Society of Clinical Oncology statement: achieving high-quality cancer survivorship care. *J Clin Oncol.* 2013;31(5):631-640.
2. Grunfeld E, Earle CC, Stovall E. A framework for cancer survivorship research and translation to policy. *Cancer Epidemiol Biomarkers Prev.* October 2011;20(10):2099-2104.
3. American Medical Association. Current Procedural Terminology (CPT) Standard 2013.

SHOULDN'T A PATIENT SUPPORT PROGRAM BE EASY TO NAVIGATE?

IncyteCARES

Connecting your patients who are prescribed Jakafi® (ruxolitinib), and who are eligible for the program, to ongoing support and resources during their treatment

ACCESS AND REIMBURSEMENT SERVICES

- Benefit verification
- Prior authorization
- Appeal support
- Co-pay assistance
- Free medication program
- Referrals and assistance with independent not-for-profit organizations

PATIENT EDUCATION AND SUPPORT

- Access to trained nurses
- Educational information to help teach your patients about their condition
- Patient packet

Visit www.IncyteCARES.com or call 1-855-4-JAKAFI (1-855-452-5234) Monday–Friday, 8 AM–8 PM ET, to learn more about how to connect your patients to IncyteCARES.

spotlight

The University of Alabama at Birmingham Comprehensive Cancer Center

Bridging the care gap

The University of Alabama at Birmingham (UAB) Comprehensive Cancer Center is an NCI-designated comprehensive cancer center, and has continuously held this designation for 41 years. UAB's reach is vast, encompassing more than 150,000-square-feet of research space, and is one of the nation's leading cancer research and treatment centers, staffed by more than 330 physicians and researchers. These resources give the cancer center the obligation and the opportunity to provide cutting-edge care to all in the community, said Edward Partridge, MD, Director, UAB Comprehensive Cancer Center.

State-of-the-Art Care

UAB functions as a matrix cancer center, meaning it is located on the University of Alabama at Birmingham's campus and is an official part of the university's structure. A designated building houses the core structure of the UAB Comprehensive Cancer Center. Within this facility, four floors are dedicated to basic research and two floors are devoted to administrative and team support. Clinical research programs are carried out in a number of other facilities on campus. The majority of outpatient clinical activity for the entire university occurs in the Kirklin Clinic. In addition to some of the cancer departments, the facility also includes cardiology, diabetes, medicine, and EMT.

UAB Cancer Center is one of the few institutions to have been awarded three or more Specialized Program of Research Excellence (SPORE) grants from the National Cancer Institute. The cancer center currently holds SPOREs in breast, brain, and pancreatic cancers, and is partnered with Johns Hopkins University on a cervical cancer SPORE.

All GYN oncology services are located in the Women and Infants Center, a new facility opened in 2010.

The 50,000-square-foot Hazelrig-Salter Radiation Oncology Center, new in 2010, offers the full spectrum of radiation oncology treatment: linear accelerators, 16-slice computed CT, and vaults dedicated to stereotactic radiosurgery in addition to specialty rooms for head and neck patients, observation rooms, and fiber optic and illuminated ceilings for patient comfort.

Adjacent to the building is the Jim Limbaugh Family Park of Hope Honoring Phyllis Limbaugh, a healing garden space for patients and visitors to enjoy.

Erasing Disparities

UAB is situated in a geographic area of the country where disparities are particularly prominent. Since 1992, the cancer center has worked to reduce cancer health disparities in underserved populations.

One program underway in significantly underserved areas of Alabama and Mississippi is the Deep South Network for Cancer Control.

Two decades ago, the program recruited and trained African-Americans as community health advisers in the central portion of Alabama. This region experienced significant disparities in screening rates and subsequently mortality rates between whites and blacks for both breast and cervical cancer. Initially, these lay health advisers were trained to promote breast and cervical cancer screenings. The program helped to reduce a 17 percent gap in screening rates in the Medicare population between whites and blacks to 0.25 percent.

Robust Navigation Services

About five years ago, UAB developed a clinical support program called the Integrated Multidisciplinary Cancer Care Program. All disease sites treated at the center have a dedicated nurse serving as a patient care coordinator. This team member's primary role is to schedule the first visit for all new patients. This coordination ensures that any multispecialty visits, imaging, pre-op testing, etc., are all scheduled to be completed on the first day. The goal is for the patient to receive a treatment plan by the end of the day. In addition to the nine disease-site patient care coordinators, UAB has five dedicated patient navigators.

The cancer center tries in particular to assist low-income patients with navigation services. New patients are contacted via phone to assess their need for navigation services. If a need is identified, the navigators engage the patient and

Continued on page 16

2013 ACCC INNOVATOR AWARDS

Sponsored by GE Healthcare

CONGRATULATIONS

2013 ACCC INNOVATOR AWARD RECIPIENTS

Avera McKennan Hospital and University Health Center, Avera Cancer Institute
Rural Chemotherapy

Baton Rouge General Medical Center, Pennington Cancer Center
Disaster Charts Provide Informational Security Net for Patients

The George Washington University, GW Cancer Institute
Catalyzing Patient-Centered Care to Exceed New Accreditation Standards

Methodist Healthcare System, Methodist Cancer Center
Emergent Care for Oncology Patients via the VIP (Very Immunocompromised Patient) Program

Gibbs Cancer Center & Research Institute
Integration of Palliative Care into a Medical Oncology Practice

St. Luke's Mountain States Tumor Institute
Improving Oncology Genetic Counseling

Temple University Hospital, Temple Cancer Program
Creating Transparency with an Electronic Dosimetry Whiteboard

Texas Health Harris Methodist Hospital Fort Worth, Klabzuba Cancer Center
Community/Corporate Collaborations for Mobile Health Outreach

UT Southwestern Medical Center, Harold C. Simmons Comprehensive Cancer Center
CancerGene Connect—Creating a Virtual Genetic Counseling Environment

Winship Cancer Institute, Emory University
Implementation of a Community-Based Program for Cancer Survivors and Caregivers

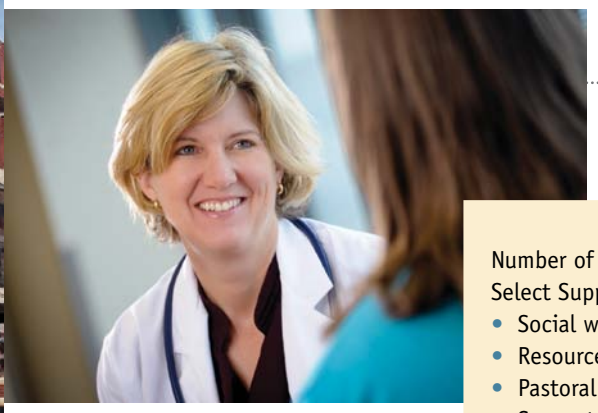
2013 Innovator Award recipients will share their innovations at the 30th National Oncology Conference. Details at www.accc-cancer.org/innovator

ACCC
Association of Community Cancer Centers

GE Healthcare

Spotlight on Success

Association of Community Cancer Centers
30TH National Oncology Conference
October 2-5, 2013 • The Westin Boston Waterfront
Boston, Massachusetts



Number of analytic cases: 5,000
Select Support Services:

- Social work
- Resource library
- Pastoral care
- Support groups
- Nutrition consultations
- Patient navigation
- Educational programs

Continued from page 14
family with the goal of overcoming the barriers to the prescribed treatment.

In addition, UAB has two clinical trials navigators to help low-resource individuals overcome the barriers to clinical trial participation. This initiative has helped to double minority participation in clinical trials. Currently, the cancer center accrues approximately 11 percent of patients to clinical trials annually.

Deep South Cancer Navigation Network

After a decade and a half of experience using traditional navigators, UAB decided in 2012 to spread its navigation initiative to its affiliate community cancer centers, as well as centers in Mississippi and Tennessee.

"We're in the early stages of implementation so we don't know how well it's going to work and certainly if it is successful, we will be on the cutting-edge of designing a perhaps new and better way to deliver cancer care," said Partridge.

Through this initiative, UAB will expand its navigation program into all of its Cancer Care Network affiliated institutions and broaden the scope of navigation to include the full continuum of care from diagnosis through survivorship.

The premise behind the program was that use of navigation services during acute care could anticipate and resolve problems that might lead to emergency room visits, hospitalizations, and ICU admissions. By reducing the number of unnecessary admissions in Medicare patients across the 11 institutions participating in the program, UAB estimates possible savings of $49.8 million over a period of three years.

During the survivorship phase, navigators would engage the patient and their family in healthy behavior (tobacco control and healthy eating, physical activity, management of co-morbidities, etc.) and then also train providers to have conversations with patients and families about choices that patients have at the end-of-life. Hopefully these conversations would lead to getting patients into hospice one month earlier than traditionally (when appropriate) and avoiding non-curative chemotherapy in the last two weeks of life.

UAB Cancer Care Network

The UAB Cancer Care Network, developed by UAB Medicine and the UAB Comprehensive Cancer Center, is a network of hospitals across Alabama, Florida, and Georgia. The goal of this network is to foster affiliations with community hospitals in order to better serve the patients in this region. This program supports community-based oncology services by building collaborative physician relationships, offering local patients the opportunity to enroll in clinical trials, and providing access to UAB's best practices in cancer care at a local level.

Obesity & Cancer

Another initiative UAB is passionate about is the relationship between obesity and cancer.

According to a study published by the CDC in 2012, Alabama ranks fourth highest in the nation for adult obesity rates behind Mississippi, Louisiana, and West Virginia.

"We feel like again we're located in the epicenter of this pandemic. Our research programs at all levels, basic, clinical, and cancer control population-based, need to take a lead in understanding how we might be able to ameliorate and understand this epidemic and its relationship to cancer," said Partridge. He would like UAB to become a national leader in what he calls "energetics in cancer," the relationship between physical activity and healthy or unhealthy eating and cancer.

Courage Companions

One way UAB commits to treating the whole patient is their Courage Companions program. Cancer patients with a new diagnosis can request to be linked to a "courage companion." This volunteer is an individual who has experienced cancer and already gone through treatment and is willing to engage that newly diagnosed person either by phone or by email to answer questions, alleviate fears, and assist with the physical, emotional, and spiritual aspects of a cancer diagnosis. Available if needed, this program is free for all patients and completely confidential.

Visit the UAB Comprehensive Cancer Center's website, *www.uab.edu/cancer,* for more information and check out Dr. Partridge's blog at *http://uabccc.blogspot.com.*

Association of Community Cancer Centers

30TH National Oncology Conference

October 2-5, 2013 • The Westin Boston
Boston, Massachusetts

SAVE THE DATE!

Spotlight on Success

Bring the best home to your patients and your program

ACCC
Association of Community Cancer Centers

Details at www.accc-cancer.org/oncologyconference

tools

Approved Drugs

- The U.S. Food and Drug Administration (FDA) approved Genentech's *(www.gene.com)* **Kadcyla (ado-trastuzumab emtansine)**, a new therapy for patients with HER2-positive, late-stage breast cancer. Kadcyla is intended for patients who were previously treated with trastuzumab, another anti-HER2 therapy, and taxanes, a class of chemotherapy drugs commonly used for the treatment of breast cancer.

- The FDA approved Celegene's *(www.celgene.com)* **Pomalyst (pomalidomide)** to treat patients with multiple myeloma whose disease progressed after being treated with other cancer drugs. Pomalyst is a pill that modulates the body's immune system to destroy cancerous cells and inhibit their growth. It is intended for patients who have received at least two prior therapies, including lenalidomide and bortezomib, and whose disease did not respond to treatment and progressed within 60 days of the last treatment (relapsed and refractory).

- Bayer Healthcare *(www.bayer.com)* and Onyx Pharmaceuticals *(www.onyx.com)* announced that the FDA expanded the approval of **Stivarga (regorafenib) tablets** to treat patients with locally advanced, unresectable, or metastatic gastrointestinal stromal tumors (GIST) who have been previously treated with imatinib mesylate and sunitib malate.

Drugs in the News

- Janssen Research & Development, LLC *(www.janssenrnd.com)*, announced that the FDA has granted breakthrough therapy designations for the investigational oral agent **ibrutinib** as a monotherapy for two B-cell malignancies: in patients with relapsed or refractory mantle cell lymphoma who have received prior therapy, and in patients with Waldenstrom's macroglobulinemia.

- The FDA has granted orphan drug designation to Eisai Inc. *(www.us.eisai.com)* for its investigational drug **lenvatinib (E7080)** for follicular, medullary, anaplastic, and metastatic or locally advanced papillary thyroid cancer.

- Lentigen Corporation *(www.lentigen.com)* announced that the FDA has granted orphan drug status to **P140K methylguanine methyltransferase (MGMT) transduced human CD34** cells (product name: LG631-CD34) for bone marrow protection in the treatment of glioblastoma multiforme.

Approved Devices

- Royal Philips Electronics *(www.philips.com)* announced 510(k) clearance from the FDA for its **MicroDose SI system**, a full-field digital mammography (FFDM) system with the capability to enable future single-shot spectral imaging applications.

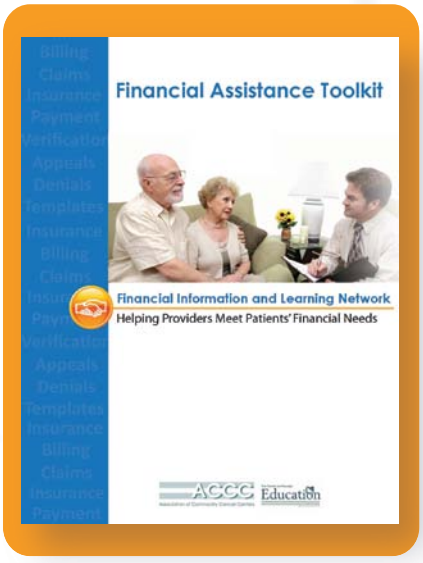
- Elekta *(www.elekta.com)* received 510(k) clearance from the FDA allowing the company to begin shipping and installation of all components of the **Versa HD™ system** within the United States. Fully integrated with the Agility™ 160-leaf multileaf collimator (MLC), Versa HD provides high-definition, high-speed beam shaping over a 40 X 40 cm field.

OPPS Payment Rates for SRS Services

CPT/HCPCS CODE RATE	LONG DESCRIPTOR	APRIL 2013 APC	APRIL 2013 PAYMENT
77371	Radiation treatment delivery, stereotactic radiosurgery (SRS), complete course of treatment of cranial lesion(s) consisting of 1 session; multi-source Cobalt 60 based	0127	$7,911 (Rural hospitals and other excepted hospitals) $3,301 (All other hospitals)
G0173	Linear accelerator based stereotactic radiosurgery, complete course of therapy in one session	0067	$3,301

Source. CMS Manual System. Pub 100-04 Medicare Claims Processing. Transmittal 2664.

Are Your Patients Struggling to Pay for Their Cancer Treatment?



There's no need to reinvent the wheel. The *Financial Assistance Toolkit* is ACCC's newest resource to help you develop a robust patient financial assistance program, and it's filled with the information, tools, and templates you need to help your patients with their financial issues.

For more information, visit www.accc-cancer.org/filn

TOOLS

The toolkit includes:

- Worksheets to help assess benefits
- Tools to estimate the costs of chemo care plans
- Sample appeal and collection letters
- Tools to track patient assistance and drug replacement programs
- Policies for pre-authorizations, denials, appeals, and more!

GET YOUR COPY TODAY!

ACCC Members

- Print Version: $20
- PDF Version: Free

ACCC Non-Members

- Print Version with Binder: $149 (plus shipping)
- Print Version without Binder: $79 (plus shipping)
- PDF Version: $75

PLUS MORE!

The Financial Information and Learning Network education program has additional resources to strengthen and expand your financial assistance services.

- Video Series
- 10-Part Practical Course
- Financial Assistance Forum

ACCC Association of Community Cancer Centers
The Center for Provider Education

This project is sponsored by:
Bristol-Myers Squibb, Genentech, Lilly Oncology, Novartis Oncology, and Teva Oncology

Acquiring a Physician Practice?

Lessons learned from one community hospital

BY AMANDA HENSON, MSHA, MBA, FACHE

IN BRIEF

The acquisition of a private physician practice can undoubtedly add value to a hospital-based cancer program. Increased patient volumes and physician resources coupled with additional revenue are some of the obvious benefits. Other benefits can include diversifying staff, improving operational efficiencies, standardizing cancer care, and streamlining patient care processes. There are also challenges related to a change in culture, coding and billing processes, regulatory and accreditation issues, and more. Understanding and planning for both benefits and challenges can help make the transition smoother—for the hospital *and* the physician practice.

Consolidation within the oncology marketplace is likely to continue to increase over the next few years due to ongoing reimbursement reductions and increased expenses. As a result, many physicians are establishing relationships with hospitals in the form of joint ventures, physician services agreements, or hospital employment. The good news: these relationships can be developed successfully, and integrated delivery of care can benefit all parties involved—providers, the hospitals, and their patients. To ensure success, you must first understand the challenges and opportunities associated with a newly-established relationship between a private physician clinic and a hospital.

Where & How Will Physicians Practice?

One survey by the Physician Foundation reports that only one-third of physicians are projected to be "independent" by the end of 2013—compared to nearly 60 percent of physicians that were considered independent in the year 2000.[1] Additionally, more than half the physicians surveyed said that they plan to "change their practice patterns over the next one to three years," including cutting back on hours, cutting back on the number of patients, seeking employment at a hospital, or starting a concierge practice.[1] The Physician Foundation survey was sent to more than 630,000 physicians, and had more than 13,500 responses.

Specific to oncology, in its 2011 Oncology Roundtable Member Survey, the Advisory Board found that 50 percent of cancer programs responding to the survey employ oncologists, with 25 percent more considering employment within the next year (Figure 1, right).[2] Disaggregated by specialty, at least one-third of respondents are employing surgical and/or radiation oncologists and more than 50 percent are employing medical oncologists (Figure 2, right).[2]

Profitable private physician-owned healthcare entities are diminishing and independent practitioners are now more likely to join other large practices or affiliate with hospitals to ease the burdens they are currently experiencing. For example, due to federal mandates and reimbursement restrictions surrounding electronic medical records (EMRs), some physicians are selling their practices to larger groups or hospitals and going to work for someone else rather than spend money to upgrade their practices with the latest technology. In addition, healthcare reform and increased demands by private payers are placing a greater emphasis on a team approach to medical care, making more physicians accountable for medical errors and quality improvement.[1]

One of the main drivers behind physician decisions to reorganize under hospital employment is shrinking profit margins associated with infusion therapy. Since the Medicare Modernization Act of 2003 (MMA), drug margins have declined at a steady pace. As you can see in Figure 3, right, 60 percent of providers experienced a decline in profit margin from 2009 to 2010. And, this decreased profit is not solely from public payers, private payers are also reducing reimbursement for drugs.

Figure 1. Prevalence of Oncologist Employment

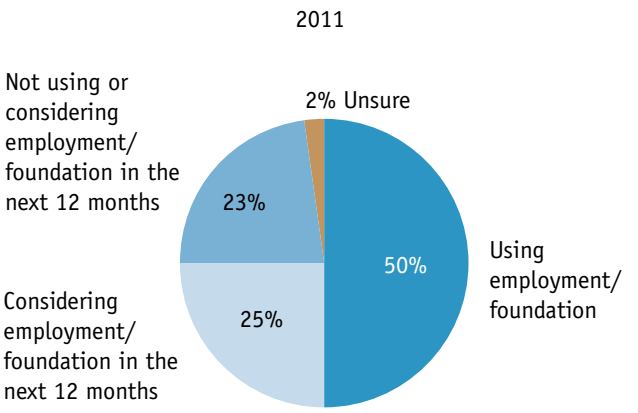


Figure 2. Oncology Employment by Specialty

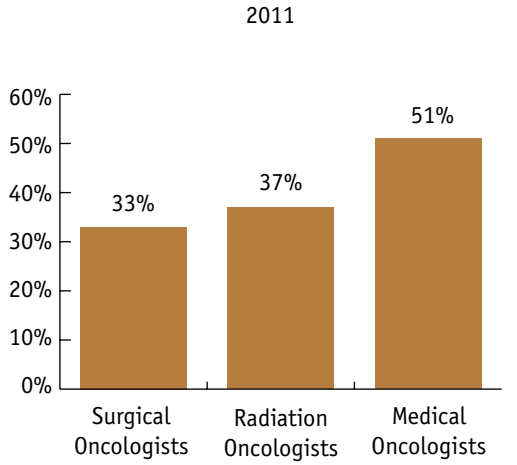


Figure 3. Changes in Profit Margin for Infusion Therapy for Medicare Patients, as Reported by Providers

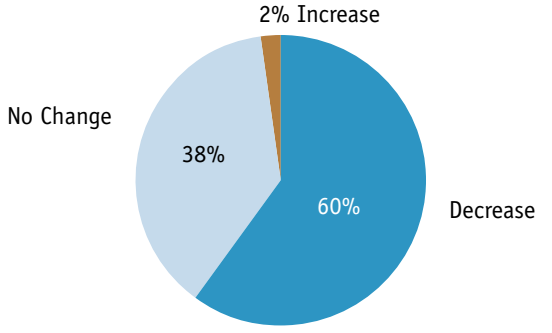


Figure 4. Changes in Profit Margin for Infusion Therapy for Patients with Commercial Insurance, as Reported by Providers

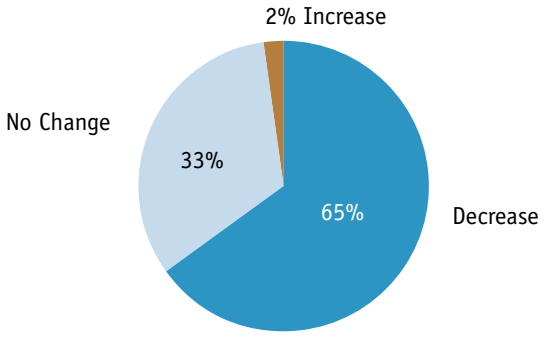
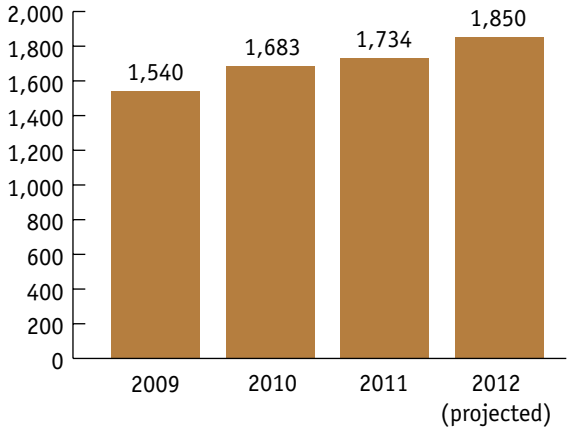


Figure 5. Total Patient Case Counts as Reported by the CBH Tumor Registry



Looking at Figure 4, above, nearly 65 percent of providers experienced this trend from their commercial payers. As a result, with reimbursement decreasing and costs increasing, physicians are finding it difficult to financially manage and sustain a private oncology practice.

Alignment Models

The evolution of physician and hospital relationships has been discussed for many years. Way back in 2007, five alignment models were identified—all with varying relationships, depending on the needs of the community, hospital, and physicians, and the strength of the relationship between both entities.[3] In brief, here's a look at those five models from the least to the most aligned.[3]

- ***Cancer center development accord*** where the hospital and the physicians develop a contract defining each party's role in the growth of the oncology service line.
- ***Co-management contract*** where the hospital and select physicians sign a contract for the physicians to provide management over the oncology service line.
- ***Customized leasing arrangement*** where, under contract, physicians rent services from the cancer center based on their needs, and the hospital pays fair market value for physician services rendered.
- ***Equity joint venture*** is a legal entity including physicians and the hospital in a jointly-owned clinical infrastructure. All risk and profits distributed are based on equity in proportion of governance.
- ***Employment*** where physicians are employed by the hospital and paid a salary and incentive based on RVUs or other productivity measures and administrative responsibilities.

Recent trends suggest that the employment model is becoming the most common method of alignment for 2013 moving forward.

From the physician perspective, there are quite a few benefits associated with hospital employment, particularly from a financial standpoint. Aligning with a hospital can bring financial security to physicians experiencing declining profit margins in their private practice through set salaries based on fair market value and incentives based on productivity. Additionally, hospitals can provide physicians easier access to patient support services, clinical trial participation, and a larger peer network for referring.

As Executive Director of Oncology Services at Central Baptist Hospital (CBH) in Lexington, Kentucky, I received firsthand experience about physician employment after the hospital acquired a medical oncology practice to further develop its growing service line. The following are lessons learned from that experience.

The Players

Located in a highly competitive healthcare market, Central Baptist, a full service community hospital, serves patients from Central and Eastern Kentucky. The robust oncology program diagnoses and/or treats around 1,700 new cancer cases per year. Oncology services include outpatient radiation oncology (with the first CyberKnife in the state), outpatient infusion therapy, surgical oncology specialties, and an inpatient oncology unit. Under a patient-centered care model Central Baptist Hospital offers a large number of support services for patients, including:

- Social work
- Financial counselors
- Nurse navigators
- Dietitians
- Genetic counselors
- Rehab services
- Clinical trials
- Multidisciplinary clinic
- Palliative care.

Additionally, the hospital is accredited through the American College of Surgeons Commission on Cancer and the National Accreditation Program for Breast Centers. It is also the only hospital in Lexington with Nurse Magnet designation.

Baptist Physicians of Lexington, Inc. (BPL) is a multispecialty physician group affiliated with Baptist Health and Central Baptist Hospital. Since October 2006, BPL has grown to include: internal medicine and family medicine practices, oncology, cardiology, pulmonary, and CT surgery. Currently BPL has more than 80 employed physicians spanning a number of specialties. Physician offices are located throughout the Lexington area, as well as on site at Central Baptist Hospital campus. These clinics provide a strong referral base for our hospital and a primary intake of many patients within the Lexington and surrounding communities.

The Kentucky Oncology Clinic (a pseudonym for the private physician clinic now employed with the hospital) was once a private medical oncology physician practice located on the Central Baptist Hospital campus. This private clinic provided outpatient clinic services, as well as infusion services to their private patient base up until acquisition by Baptist Physicians of Lexington in 2010. Prior to acquisition, the group had a trusted and collaborative relationship with the hospital and its providers were considered valuable members of the medical community. Prior to the employment, there were three full-time medical oncology physicians and two ARNPs (advanced registered nurse practitioners). Currently, there are six medical oncologists and two ARNPs.

A Tale of Two Practices

In June 2010 Baptist Physicians of Lexington began an onboarding process of the Kentucky Oncology Clinic. This process included pre-acquisition strategic and operating plan development by BPL along with an analysis of common goals between Kentucky Oncology Clinic and BPL. The alignment of both entities resulted in a proposal to the Kentucky Oncology Clinic physicians and ARNPs to become part of the BPL network. Once negotiations concluded and contracts were signed, the clinic physicians started under their newly-employed role in the summer of 2010.

The initial acquisition also included the hire of all original clinic staff, both clinical and non-clinical. All staff obtained a benefit and salary structure similar to what was already set up within the BPL organization. In addition, BPL took over all expenses and overhead, as well as all billing responsibilities for the oncology practice. The infusion center owned and operated by the physicians was combined with the existing Central Baptist Hospital infusion center. The physician infusion staff became hospital employees; the combined infusion center hospital-based.

The hospital experienced positive downstream revenue when BPL acquired the Kentucky Oncology Clinic. Prior to the acquisition, patients treated in the physician's private infusion center and who may never have entered the hospital for the treatment or diagnosis of cancer, were not counted in hospital registry data. After the acquisition, the hospital's total case counts reported by tumor registry increased significantly from 2009 to 2011 (see Figure 5, left).

The hospital also experienced a significant increase in infusion visits after the consolidation of the physician office and hospital infusion center. From 2009 to 2010, the hospital's infusion visits increased by 104 percent (Figure 6, below). Specifically, when the physicians signed on with BPL in June 2010, the hospital saw a 134 percent increase in infusion visits in the second half of 2010 (June through December) compared to the second half of 2009. Infusion visits have continued to increase by 25 percent in 2011 and 16 percent in the annualized 2012.

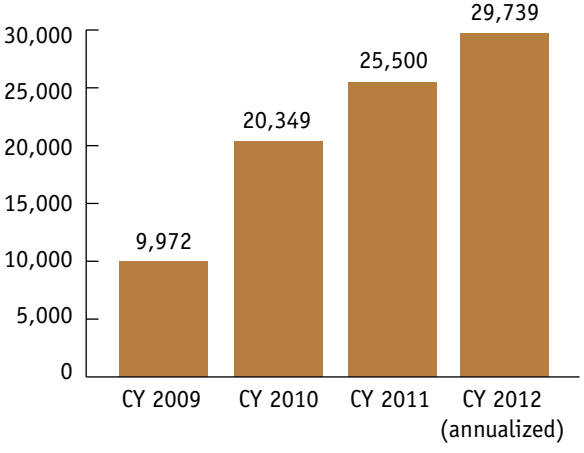
The Central Baptist Hospital Experience

As Central Baptist Hospital's cancer program continued to expand, ensuring operational efficiencies and administrative oversight consistencies within the entire cancer program became critical.

Two management structures were essentially in place, with the hospital managing radiation oncology, outpatient infusion, inpatient oncology, and all oncology support services and BPL managing the outpatient medical oncology clinic staff. There were noticeable inconsistencies between the two management structures. Thus, bringing medical oncology, one of the most critical components of the program, underneath the hospital management structure seemed necessary to ensure continuity of care and growth of a unified program.

Further, there was a programmatic initiative for the cancer service line to come together within a new space (currently under construction) as part of a patient tower expansion on the hospital campus. The goal is to provide a comprehensive cancer program in one location, including all outpatient services

Figure 6. CBH Infusion Room Visits



for medical and radiation oncology. (The current services are separated in various buildings on campus.) In addition to improving patient convenience and cancer program efficiency, bringing together services in one location would enable cross training of staff so they have flexibility to work between different departments. Utilizing staff this way would be difficult to manage if some staff worked for Baptist Physicians of Lexington and others were hospital-employed. To ensure a more operationally efficient, comprehensive cancer program, leadership determined that moving the entire cancer program under the hospital "umbrella" would offer the most long-term benefit.

In November 2011, the medical oncology clinic transitioned from office-based under BPL to a hospital-based clinic under Central Baptist Hospital. This shift in site of service ultimately changed the billing and staffing structure. From a billing standpoint, BPL billed only the professional fees for the physicians, while the hospital billed a facility fee. All clinic staff became Central Baptist Hospital employees, with the exception of the physicians who remained with BPL. While this conversion had the potential to increase revenue for the hospital because of the facility fee, the added expenses for clinic operations and overhead made any revenue minimal. For BPL, the decrease in expenses (operating and overhead) far outweighed any revenue lost (provider fees were reduced) upon transitioning from an office-based clinic to a hospital-based clinic.

Programmatic & Staffing Benefits

From a staffing perspective, the clinic acquisition helped bring a shared vision of the cancer program to the employees, removing silos and ensuring employees were held accountable to the same standards. The entire patient throughput process became easier to manage. Additionally, standardization of policies and procedures allowed the hospital to streamline the workflow and communication between staff. The hospital already had a system in place for overseeing revenues and expenses, including a process to monitor billing and medical record and documentation compliance and established hospital purchasing contracts.

For physicians, the benefits of hospital employment are realized mainly through financial incentives, including fewer financial stresses, increased work and life balance, contracted salary, and productivity incentives.

For physicians, the benefits of hospital employment are realized mainly through financial incentives, including fewer financial stresses, increased work and life balance, contracted salary, and productivity incentives. Other benefits include removal of stressors, such as managing practice staff, billing and collection responsibilities, and medical malpractice and legal responsibilities, as well as ongoing changes to reimbursement, which continue to constrain an already tightened profit margin.

For the physicians in the Kentucky Oncology Clinic, the main benefit to hospital employment was financial. The practice faced financial pressure from increased overhead and decreased revenues. Its ability to make a profit was becoming more difficult and patient volumes continued to increase with little incentive. The practice needed to recruit additional physicians to keep up with growing patient demand, especially since two of the senior medical oncologists looked to decrease their work loads. Through employment with BPL, the physicians could also shift the burden of managing their practice (including the human resource, billing, and collections aspects) to the hospital and secure a set salary based on fair market value while recruiting for additional physician partners. Ultimately, these changes enabled the physicians to create a better work and life balance.

Further, as expectations of accrediting organizations continue to increase, it is becoming mandatory for hospitals to provide a full range of support services. The additional expenses that smaller private practices in particular would have to pay to remain competitive with growing comprehensive cancer programs would be too costly.

Patient Benefits

From the patient perspective, numerous benefits were associated with the hospital's acquisition. Central Baptist Hospital Cancer Center's cornerstone philosophy is a comprehensive "patient-centered care model" that surrounds patients with a clinical care team of experts, ranging from oncology certified nurses in the infusion center to dietitians and genetic counselors. Under this model, patients are assessed at each visit for any distress or need and referred to the wide range of services the hospital offers in its cancer center. The transition from a practice-based clinic to a hospital cancer program made it easier for our patients to access these support services, which falls in line with the evolution of care and the holistic nature of treating complex cancer cases. Coordination and communication by our caregivers ensure that patients receive support throughout their treatment and beyond. A true partnership model exists between the patients, their practitioners, and the hospital's support services (see Figure 7, right). This partnership between physicians and hospitals on behalf of the patient can truly elevate the care and opportunities provided to patients.

Figure 7. Central Baptist Hospital's Patient-Centered Model of Care

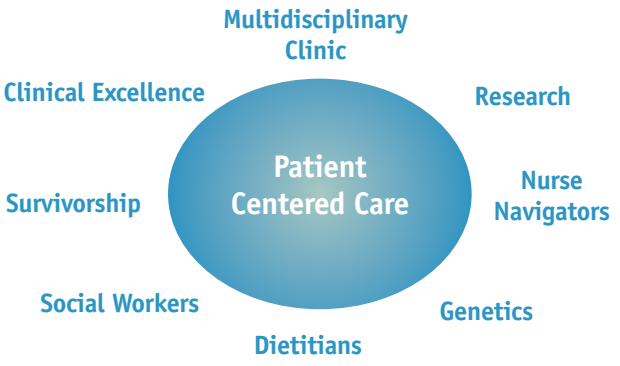
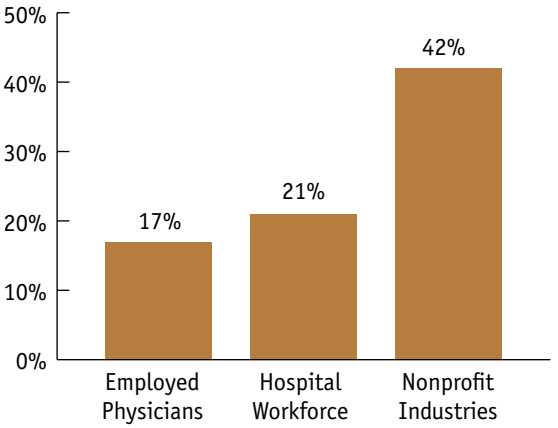


Figure 8. Percentage of Highly Engaged Staff by Industry[1]



Staffing Challenges & Lessons Learned

Despite the multiple benefits, the transition also had its challenges—not only for the physicians, but also for the staff, the hospital, and the patients. During both transition phases, staff who were used to a different salary, benefit, and management structure were required to change. Staff that may have had more freedom in the practice setting were now held accountable to well-defined HR policies and procedures. These changes met with some initial resistance. One of the steps the hospital took to minimize staff anxiety was to sit down with each employee privately—with a member of the hospital HR team—and review specific policies and procedures related to: payroll and paid time off accrual, benefits, time and attendance policy, and dress code. The meetings were conducted in the weeks leading up to the hospital's acquisition of the practice.

Additionally, the hospital hired a new practice manager with hospital experience. This individual was a positive influence, and was able to advocate for the hospital during the transition to a new management structure. The office manager also played a key role in providing development opportunities for the staff. Connecting staff with resources within the hospital, she worked on improving communication and phone skills, leadership and team development, and appropriate peer relationships.

Combining the two separate infusion centers also added to complexities in staffing, so we worked hard to coordinate and standardize staffing at both locations. Although the locations were physically situated next door to each other and connected by a hallway, the communication between the nurse manager and staff RNs played a more integral role. As a magnet nursing hospital, we encourage all RNs to obtain their bachelor degree or beyond, and we require 100 percent oncology nurse certification. Fortunately, infusion staff from the physician office was willing to meet these expectations, and the practice infusion team and the hospital infusion team were integrated almost seamlessly.

In addition to the HR issues, there was added stress from adjusting to an overall new work environment. Federal, state, and local hospital policies, as well as regulatory organizations like The Joint Commission (TJC), brought immediate changes to some of the private clinic's long-standing practices. From a regulatory standpoint, the practice staff and physicians were required to make multiple changes in their physical environment. Storage of supplies, inventory of supplies, infection prevention precautions, and other environment of care regulations created numerous challenges for the clinic. Being sympathetic to the magnitude of changes being made and explaining the reasons for the change was critical for staff and physician buy-in. It is important for hospital staff to understand change from the perspective of physicians and staff that have spent years practicing in a private clinic setting. Additionally, physicians unaware of program accreditation requirements for entities such as TJC and ACoS are challenged to participate in quality studies, cancer committee, chart reviews, and many other initiatives that begin to shape a more structured clinic practice.

EMR adoption brought its own challenges. When developing the initial contract for hospital employment, it is important to prepare physicians for the transition to an EMR. Physician participation and buy-in with the EMR product is instrumental to successful implementation of the technology. Luckily, hospitals can provide more support to physicians and allocate more resources for a successful EMR implementation than most private practices. During the last few months of EMR implementation within Central Baptist Hospital's outpatient

cancer clinics and treatment centers, successful implementation depended, in large part, on physician engagement.

Billing Challenges & Lessons Learned

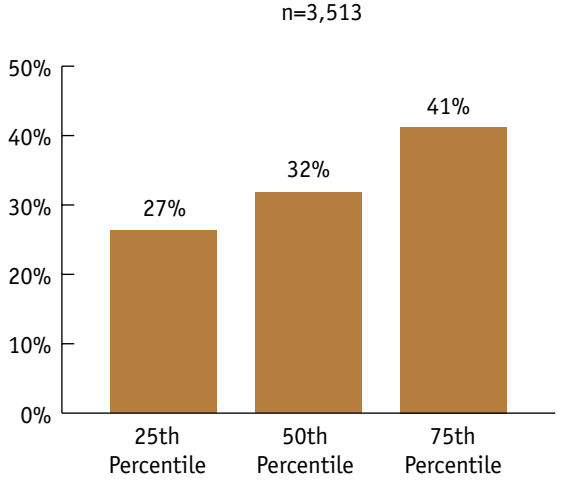
Another challenge was the implementation of a hospital billing and coding process to increase physician attentiveness to ordering infusion therapy. The hospital has very structured processes in place for pre-authorization, coding, and billing oncology services. Due to an organized pre-certification process, these changes have helped minimize, if not eliminate, denials of chemotherapy drugs. Hospital staff had to walk physicians through the billing and revenue cycle so they were aware of these processes. With this knowledge, physicians understood why patients could not start on a chemotherapy regimen the same day they saw the physician. (Of course, there are always exceptions to this rule.)

Staff solely dedicated to obtaining pre-authorization sit next door to the physician clinic so communication is as fluid as possible.

The hospital has provided support to physicians on its coding and documentation requirements. Each patient visit is audited for charge code capture, and if needed, education is provided on site with the physician if there is a question about coding. Likewise we have educated the physicians on their responsibilities for properly completing orders so that coders can efficiently file claims on chemotherapy infusions. This process of support and accountability has been challenging to implement with a physician practice not used to strict processes.

Having a new boss (the hospital), who brings a new set of policies and procedures, billing and documentation processes, and regulatory requirements is challenging, no matter how easy going and flexible the physicians you hire. Thus, educating the physicians on changes and why they are vital to the success of the transition and the future of the cancer program is essential. Initially, during the first several months after the transition from clinic-based to hospital-based, frequent meetings with staff and physicians kept lines of communication as clear as possible.

Figure 9. Percentage of Physicians Engaged by Hospital[4]



Source. Advisory Board Physician Engagement Survey Cohort; 2012.

The Patient Perspective

Hospitals must communicate changes to patients before, during, and after the acquisition of a private practice. Central Baptist Hospital mailed letters to all patients in its database, outlining the conversion of the clinic from an office-based practice to a hospital-based practice. The hospital also posted signs in the clinic, as well as educated front desk staff on what to say to patients who checked-in following the conversion.

In hindsight, converting the clinic to a hospital-based clinic had a much greater financial impact than the hospital had originally anticipated. For example, patients with high deductibles started receiving large facility fee bills to coincide with the physician charge (professional fee). Several upset patients did not understand the reasons for the increased charge. Having financial specialists close by made conversations with patients easier, and took some of the pressure off staff who were not as educated about the differences between hospital- and office-based billing.

Physician Engagement

An important component of a successful physician practice aquisition is identifying physicians who will complement and engage in your hospital's culture. Additionally, understanding the potential challenges associated with employing physicians long-term will help the hospital make the right decisions at the beginning of the physician negotiations. Maintaining physician engagement in your cancer program is critical to a successful partnership with your employed physicians. As federal regulations and payments are tied to quality metrics and as payments begin moving away from a fee-for-service model to an accountable care model, the partnerships established between hospitals and physicians will be critical to putting your organization in a position to succeed in a quality-driven environment.

The physicians with whom the hospital aligns must be advocates for the cancer program. Competition will continue to drive patient referrals, and physicians will be the key to your program's strategic development in order to increase market share. The physicians you employ need to be agreeable to potentially expanding their services to other markets (i.e., satellite clinics) and helping the hospital compete for market share.

Recruiting oncology physicians is difficult because there is a growing shortage of physicians going into this specialty. Hospitals must understand the important role these physicians play in the organization and plan ways to work with aging providers to develop recruitment strategies targeted at oncology graduates.

Interestingly, according to a 2012 survey of employed, or nearly employed physicians, employment alone does not guarantee increased physician engagement. The Advisory Board Engagement Survey found that only 17 percent of employed or closely-affiliated physicians were considered highly engaged (Figure 8, page 25).[4] Even among high-scoring organizations, engagement is lacking. Data shows that even among hospitals at the 75th percentile, only 41 percent of physicians were considered engaged (Figure 9, left).

Improving patient care and the efficiency of care delivery takes collaboration. In hospitals, physicians are responsible for the largest percentage of healthcare spending decisions; just as many quality indicators rely on physicians alone as rely on physician and hospitals combined. That means, in the future of value- and outcomes-driven healthcare, a partnership with engaged physicians will deliver the high-quality product a cancer program and hospital needs to be successful.[4]

Dollars & Sense

One of the most difficult aspects of hospital and physician alignment is identifying the right financial incentives to offer so that physicians continue to sustain long-term productivity that coincides with the ongoing growth in patient volumes. Tying productivity benchmarks to physician compensation is an important component of any initial contract. That said, productivity should not be the only element to the contract. A substantive contract should include ways to measure physician quality, participation in patient satisfaction and accreditation initiatives, and other hospital- and program-specific needs. As our healthcare environment begins to shift to an accountable care model, we all must look for ways to be good stewards in the use of resources and partner together to identify methods to deliver high-quality care in the most cost-effective way. Thus, the alignment between a hospital and physicians must be tied to the shared risks and benefits of such a partnership.

At the employment onset, hospitals must consider how to best incentivize physicians beyond salary, and reward productivity in order to diffuse a salary mindset. Additionally, decision-making requires alignment of expectations, and physicians must be incorporated in the decision-making for the cancer program.

Communication & Culture are Key

Communication should not be underestimated, particularly when employing physicians who have never worked for a hospital or those who have been in the private practice model their entire career. Federal, state, and hospital regulations are different for hospital-based clinics, so physicians must understand the changes that will need to be made or there will be anxiety and confusion. Introducing hospital support services can help ease this transition; collaboration between physicians and these support services can make process changes easier.

Establishing a strong and efficient partnership between a hospital and its employed physicians takes time. A sustainable relationship needs to have open communication and participation from both parties—hospital and physician group—to achieve performance measures that impact both parties. If physicians are motivated to contribute more to a hospital than just clinical service, then the culture of the organization in terms of patient and employee satisfaction increases, as does the cooperation towards meeting quality, financial, and performance measures. A physician who focuses solely on clinical performance will not achieve the level the hospitals need when challenges or new initiatives face the cancer program. A physician who feels connected to the hospital and to the success of the cancer program will come to the table with ideas, input for changes, and a positive attitude. OI

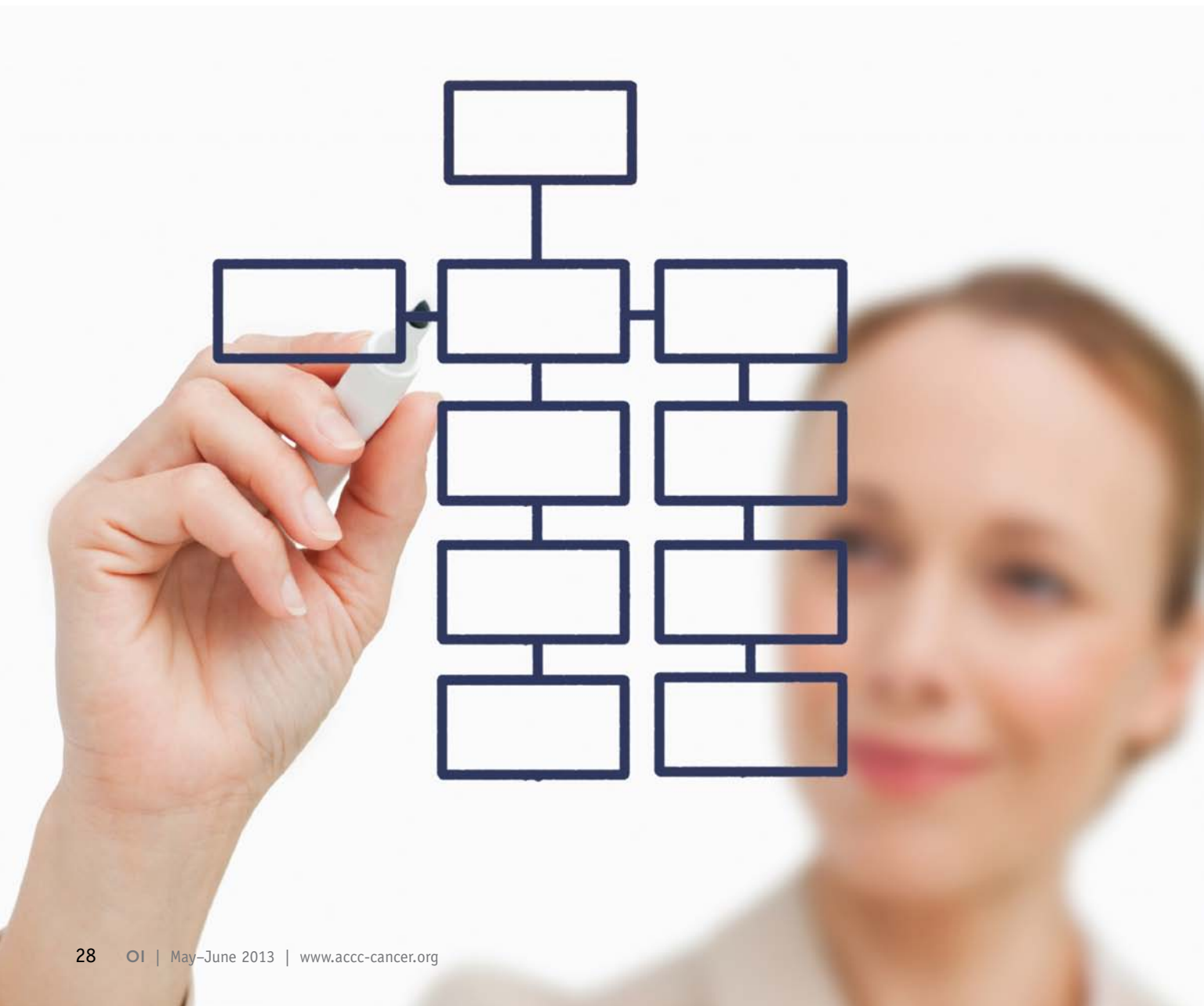
—Amanda Henson, MSHA, MBA, is executive director, Cancer Services, Central Baptist Hospital, Lexington, Ky.

References

1. Jaspen B. Docs Work Less as Flood of New Patients Looms, 10/8/12. Available online at *www.forbes.com*. Last accessed March 4, 2013.
2. The Advisory Board. 2012 Oncology Roundtable Member Survey. Available online to Advisory Board Members at *www.advisory.com*.
3. Farber M, Cheng A, Cuff A. Hospital and private practice partnerships: which model is right for you? *J Oncol Practice*. 2007;3(3)130-132.
4. The Advisory Board. Achieving Sustainable Hospital-Physician Alignment in Oncology. October 2012. Available online to Advisory Board Members at *www.advisory.com*.

Improving Your Study

BY DEBORAH JONES, RN, BSN, OCN, CCRC



Review Process

In 2011 a small group of St. Luke's Mountain States Tumor Institute (MSTI) Adult Clinical Research staff evaluated existing processes for bringing new studies forward for IRB Review to identify all possible barriers to achieving efficient review. In hindsight, the situation in which the MSTI Research Department found itself had all the required elements for a "perfect storm" to occur. In this context, the phrase "perfect storm" refers to several developments that evolved throughout a one-year period that collectively hampered clinical research within our department, including:

- Not meeting clinical trial accrual goals. In 2011 MSTI had the lowest level of adult patient enrollment into oncology clinical trials in several years.
- Multiple studies closing to enrollment.
- Very few new clinical trials being opened and available to our patient population.

As a department, we also felt stymied in our ability to fulfill our mission of working with healthcare providers to offer opportunities for education and participation in clinical trials for the advancement of cancer care to the community. These "perfect storm" developments were the result of changes that occurred both within the larger St. Luke's Health System Office of Research Administration and within our own department. System changes included infrastructure, research software program implementation, administrative review process, and IRB submission process changes. Internally, departmental changes were tied to changes in the operational system research process and to the goal of meeting the clinical trials pillar deliverables of the NCI National Community Cancer Centers Program federal contract that was awarded to MSTI in April 2010.

The Importance of an Internal Review Process

In May-June 2011, informal but frequent small-group discussions focused on staff frustration and struggles with opening new clinical research studies. These group discussions led to a dissection of our current process. We developed a poster-sized flowchart of our existing new study review process and hung it in the office where it served as a reference tool during the focus group's internal evaluation (see Figure 1, page 30).

Our internal evaluation of the existing process revealed a lack of organization and consistent coordination. Additionally, the existing flowchart lacked well-defined directives for staff. In other words, the flowchart did not allow individual staff to clearly understand their role and responsibility in the process. The flowchart did not identify timelines at any point during the process—it was simply too general.

It was clear to our focus group that we needed to develop a more formalized, accountable, and organized process for tracking and reviewing potential new clinical research studies. A more clearly defined and articulated process would ensure that staff understood the underlying goals and the individual job responsibilities that were tied to the success of these goals. Our hopes were that research staff would hold each other accountable to this new process, improving both quality of and efficiency with new study review and resulting in greater numbers of new studies for IRB review in a timely manner.

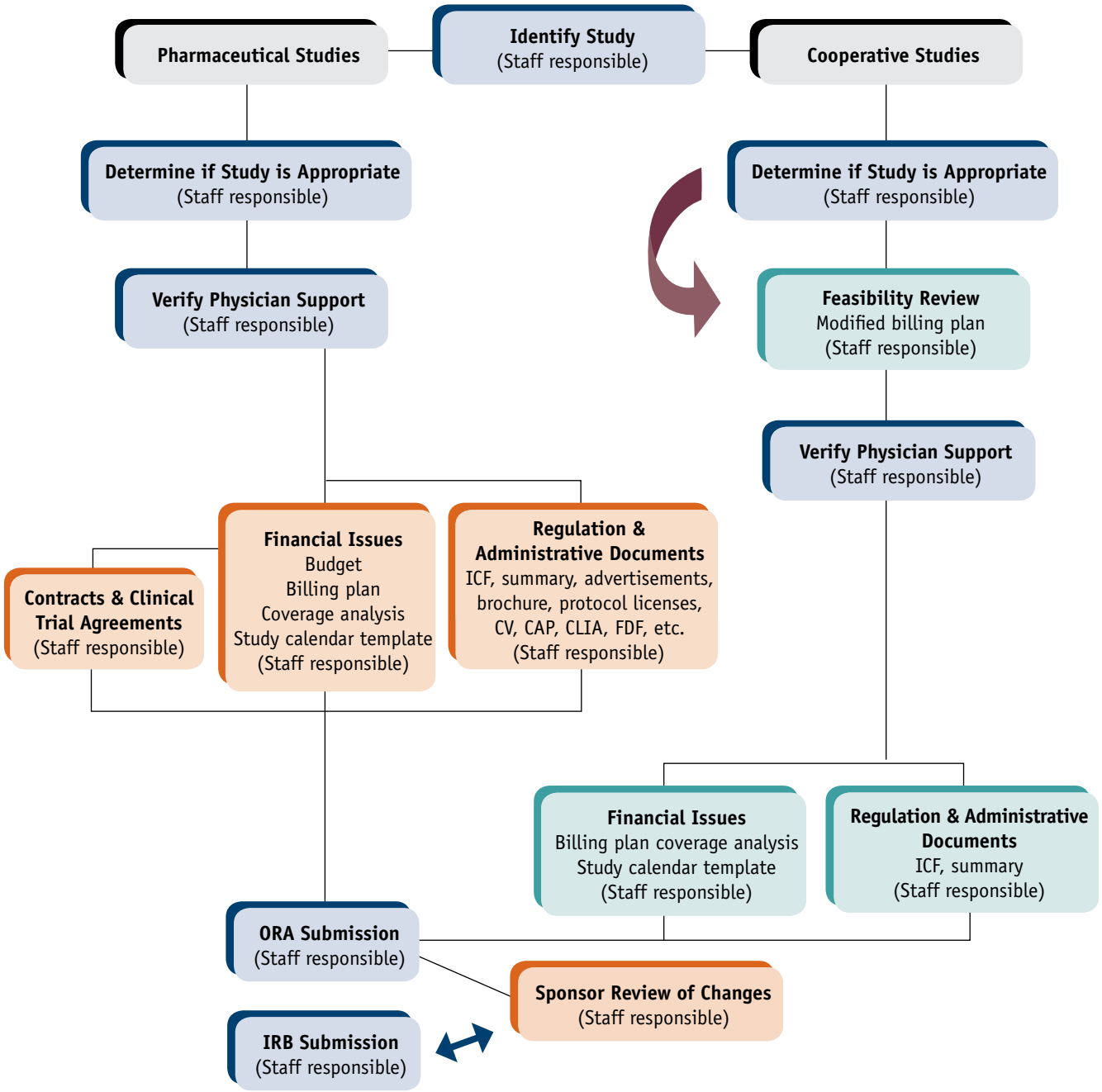
New Process Flows & Tools

The outpouring of thoughts and ideas from the focus group clearly demonstrated they were fully engaged in this process improvement. Using the existing (but flawed) flowchart, the next step was to revise the new study review process and develop a flowchart of the revised process. In the end, because of differences between cooperative group studies and pharmaceutical studies, the focus group developed two flowcharts: a cooperative study flowchart (Figure 2, page 31) and a pharmaceutical study flowchart (Figure 3, page 32).

Next, the focus group modified its existing study tracker document (Figure 4, page 32). This tool was originally created by our newly-hired research assistant (RA), a new position within MSTI adult research and supported through the federal NCCCP contract. Recognizing the need to organize existing sponsor correspondence and track new study information, the

continued on page 31

Figure 1. Process Flowchart for New Adult & Pediatric MSTI Protocols



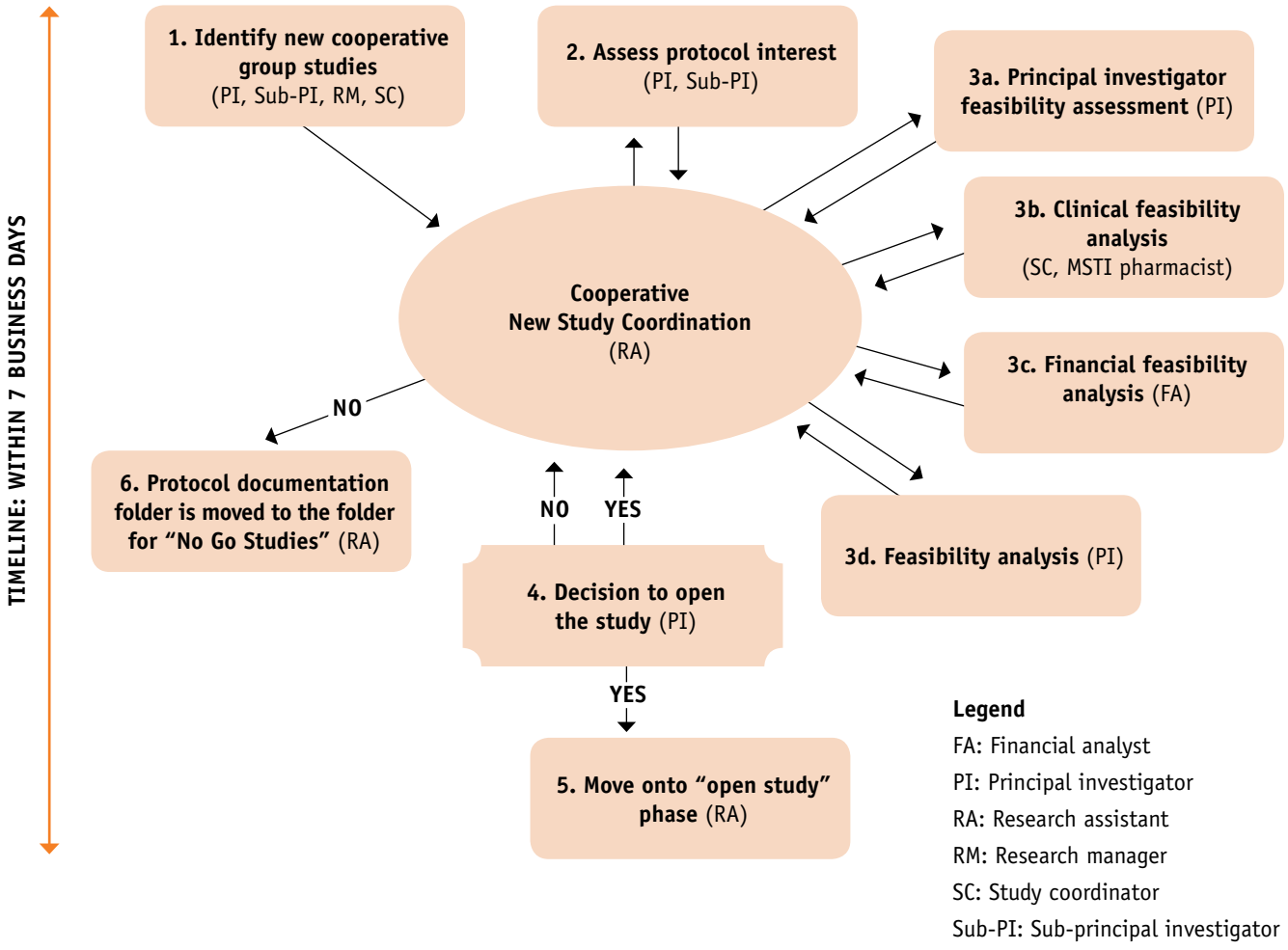
Key

- Blue box applies to all new studies
- Green box applies to only cooperative studies
- Orange box applies to only pharmaceutical studies

Legend

CAP: College of American Pathologists certification
CLIA: Clinical Laboratory Improvement Amendments
CV: Curriculum Vitae
ICF: Informed consent form
FDF: Financial disclosure forms
ORA: Office of Research Administration

Figure 2. Process Flowchart for New Review of Cooperative Group Studies



continued from page 29

RA had created the study tracker a few months prior. As the focus group created the two new flowcharts for cooperative group and industry-sponsored studies, they recognized the value of the study tracker to the overall process improvement development. The updated study tracker now separates out pharmaceutical study tracking (Figure 5, page 33) from cooperative group tracking (Figure 4).

With the new flowcharts and study trackers in place, the focus group created a research resource utilization form (originally titled protocol feasibility review form) to clearly articulate the responsibilities assigned to each research staff position involved in the new process. Known as the RRUF, this form (Figure 6, page 34) incorporates the due diligence requirements for each new study review. Research team members responsible for completing elements of this review include the study-specific principal investigator, research nurse coordinator, MSTI pharmacist, and research financial analyst.

As part of this formal review process all five MSTI sites (Boise, Fruitland, Meridian, Nampa, and Twin Falls) are evaluated on the same criteria to determine feasibility of individual site participation. This portion of the review is completed using the MSTI adult research site resources list, a companion document to the research resource utilization form. The review areas include but are not limited to:

- Identifying any potential competing studies
- Assessing adequacy of patient population for enrollment into the clinical trial, therapeutic intent, patient considerations (financial impact, visit flexibility, patient responsibility requirements, etc.), and institutional resources (lab, pathology, imaging, pharmacy, radiation therapy, etc.)
- Evaluating the cost effectiveness of opening and managing the specific clinical trial.

For due diligence, individuals are required to sign-off on each section they complete on the RRUF. If it is determined that the study may require time from another department that is

continued on page 35

Figure 3. Process Flowchart for New Review of Pharmaceutical Group Studies

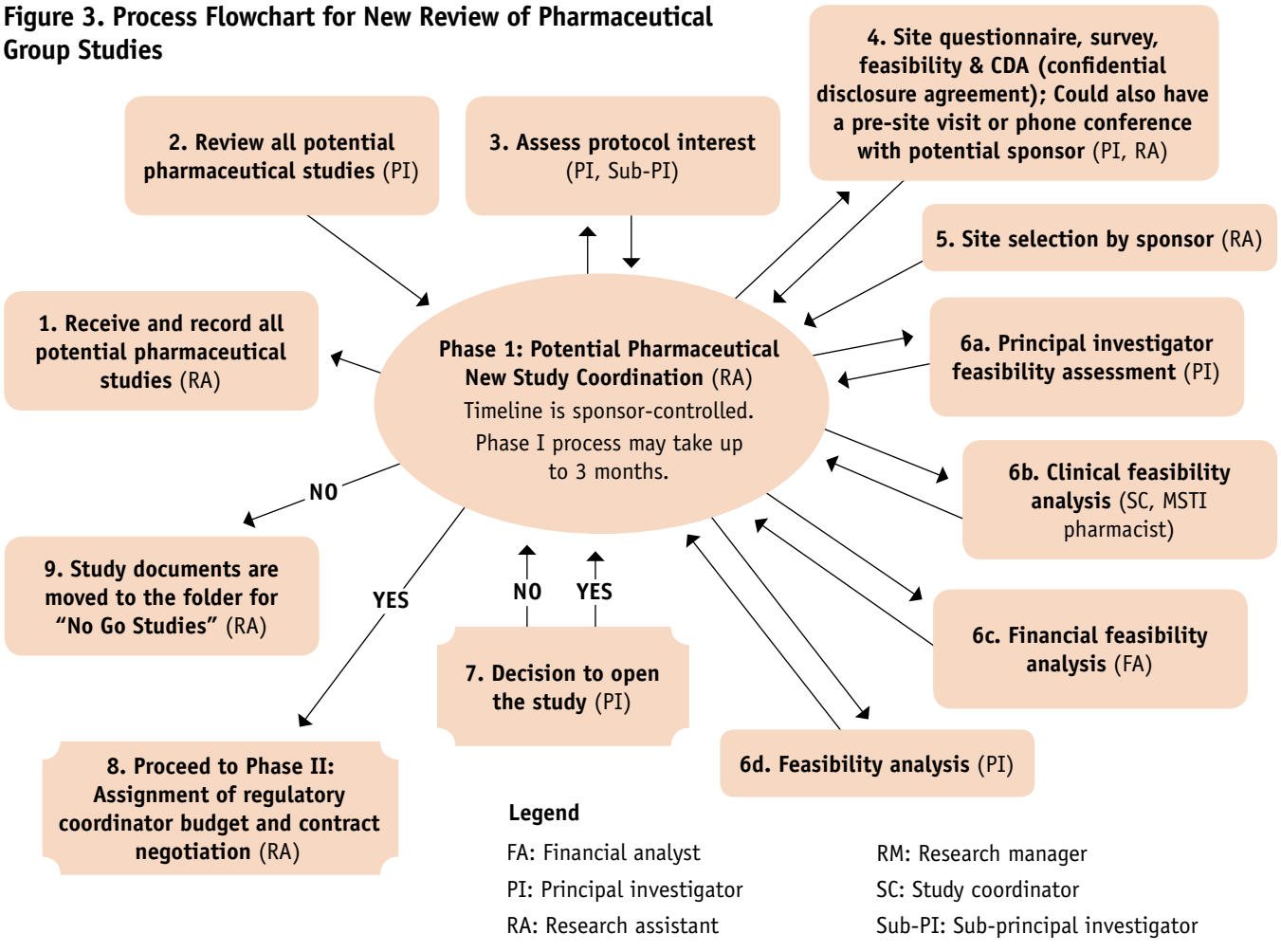


Figure 4. Cooperative Tracking Worksheet

Item or Action	RA Received from & Date	RA Sent to	RA Date Sent	Date Due	Date Completed	Status	Notes
New cooperative study identified							
RA sets up folders							
PI feasibility							
Clinical feasibility							
Financial feasibility							
Pharmacy feasibility							
Sub-PI feedback							
Signed research resource utilization form (RRUF)							
Decision to open study							
Regulatory team alerted to begin study							
RA begins to upload COIs (conflict of interests) into IMedRIS							
Regulatory submitted draft in IMedRIS							
IMedRIS notification study is presented to IRB							

Figure 5. Pharmaceutical Tracking Worksheet

Item or Action	RA Received from & Date	RA Sent to	RA Date Sent	Date Due	Date Completed	Status	Notes
Study information received							
RA sets up folders							
Site questionnaire							
Pre-site visit							
Phone conference							
Confidential disclosure agreement (time received to approved CDA)							
Signed CDA							
Site selection							
PI feasibility							
Clinical feasibility							
Financial feasibility							
Pharmacy feasibility							
Sub-PI feedback							
Signed research resource utilization form (RRUF)							
Decline study							
Regulatory team alerted to begin study							
RA begins to upload COIs (conflict of interests) into IMedRIS							
Financial disclosure forms							
Regulatory submitted draft in IMedRIS							
IMedRIS notification study is presented to IRB							

Figure 6. MSTI Research Resource Utilization Form (RRUF)

Study:
Patient: Clinical Research Manager: Study Coordinator: Financial Analyst:

Line of Treatment: ☐ Neo-Adjuvant ☐ Adjuvant ☐ 1st Line ☐ 2nd Line ☐ 3rd Line ☐ Metastatic ☐ Recurrent ☐ Preventative ☐ Other

Investigator Considerations	PI			Coordinator			Coordinator			Financial Analyst		
	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Does this study compete with any opened studies? If yes, which study?												
Do we have adequate patient volumes for this study? If yes, how many?												
Please list all treatment drugs that are considered investigational in this study:												
Study Coordinator Considerations	Y	N	N/A	Y	N	N/A	Y	N	N/A			
Does the study provide for flexibility in visit scheduling?												
Are the inclusion and exclusion criteria too restrictive?												
Are patient responsibility requirements too burdensome?												
Do we have experience in the therapeutic area under investigation?												
Do we have adequate staffing for the trial?												
Are the procedures consistent with standards of care?												
If there are sub-studies, are they feasible?												
Are sponsor pathology requirements feasible?												
Are sponsor laboratory requirements feasible?												
Are sponsor imaging requirements feasible?												
Study Coordinator: Special Considerations				Y	N	N/A	Y	N	N/A			
Is any special equipment required? (Steps, EKGs, etc.)												
Special coordination with other departments or services?												
Are investigators able to complete sponsor required credentialing?												
Does the length of the total clinic visit (lab, MD, treatment) meet the current clinic hours of operation?												
Any special (CIC) training involved?												
Do you have previous experience with the sponsor or CRO?												
Pharmacy Considerations	Y	N	N/A	Y	N	N/A	Y	N	N/A	Initials of Pharmacy Personnel		
Are there special requirements from Pharmacy? If yes, please explain.												
Is Pharmacy in agreement with sponsor requirements?												
Special Pharmacy Notes:												
Department Specific Specialized Tests (Completed by designated individual or departmental representative)	**Concern**						Y	N	N/A	Initials of Individual or Dept. Rep. Consulted		
Is radiation therapy in agreement with sponsor requirements?												
Is imaging in agreement with sponsor requirements?												
Is laboratory in agreement with sponsor requirements?												
Financial Analyst Considerations	Y	N	N/A	Y	N	N/A	Y	N	N/A	Y	N	N/A
Does the Medicare coverage analysis support the study being done?												
Is there Federal funding involved with the study? (Pertains to Cooperative Groups) GGA notified (date): / /												
Study Review Team Recommendations to PI to Proceed to Open?				Y	N		Y	N		Y	N	

Which MSTI location(s) are able to participate? ☐ Boise ☐ Meridian ☐ Twin Falls ☐ Nampa ☐ Fruitland
PI Evaluation: ☐ Feasible ☐ Feasible with considerations ☐ Not recommended ☐ Other:

Principal Investigator Sign-off

Principal Investigator Signature: Date: / /

Regulatory Notified Date: / / Anticipated IMedRIS Submission Date: / /

Special Consideration Explanation:	**Special Consideration Resolution:**

continued from page 31
outside their normal scope of function and/or practice, an additional sign-off and marked check-box will be required by a representative from that department acknowledging that they have been consulted about study specific requirements. Once reviewers have completed their due diligence, the document goes back to the PI for a final review and sign-off. After the PI has approved and signed off on the RRUF, the new study review process is complete and the clinical research assistant assigns a regulatory coordinator to prepare for IRB review.

The Role of the Clinical Research Assistant in the New Process

During these process improvements, our focus group realized the necessity of designating a research staff position to: 1) serve as a point of contact for sponsors and new study information, 2) conduct the new study review flow process with consistency and continuity, 3) act as gatekeeper to maintaining the new process, and 4) be empowered with the authority to hold staff accountable. The focus group unanimously agreed the staff position best suited for these responsibilities was the newly-added clinical research assistant position. Accordingly, the responsibilities identified above were incorporated into the existing job description.

This "customized" research assistant position was instrumental in assembling adult oncology clinical trials and disseminating the information to the review team. Once the new study review team commits to a feasibility review of a potential new study, the research assistant orchestrates the communication between the sponsor, principal investigator, and various members of the research staff. The research assistant then gathers essential documents and steers the new clinical trial through the review process. The position requires very strong organizational and computer skills. This skill-set allows this individual to keep track of multiple clinical trials in a variety of phases of the review process. The position requires excellent communication skills and the ability to "flex" communication styles to best fit the individual needing the information.

Improved Efficiency & Quality

The well-defined and consistent study review process has lived up to the focus group's hopes of improving the quality and efficiency of new study review, supporting research staff accountability to the process, and improving the number of new studies for review. Further, the new review process demonstrates cost effectiveness for the institution by scrutinizing new studies through a rigorous review. This review begins with assessing the potential MSTI patient population for study enrollment. The MSTI tumor registry department assists us in this area by providing cancer diagnoses data. As required by our new study review process, we now complete a financial feasibility assessment using a Medicare coverage analysis. The financial review scrutinizes which costs are paid by a sponsor versus what is billable to insurance or the patient. In turn, this process helps the MSTI research department better serve its patients by offering research studies at minimal financial hardship to patients.

Key Challenges, Successes, & Lessons

Study sponsors may have their own ideas and/or expectations for review and IRB preparation, and their ideas and expectations may not align with our new process. Our clinical research assistant has been very successful in communicating to the sponsor the importance of working with our process, and why it is important for them to do so. Our department has found when we stray from this new study review and flow process, we lose our focus and efficiency. The new process is an efficient use of our study review team's time and efforts.

The overall project goal identified at the outset was to evaluate possible MSTI research department barriers to efficient IRB review; our focus group achieved this goal. Internal evaluation helped the focus group identify inefficiencies and develop a new study review process that has had a positive impact on the MSTI adult research program.

In November 2011, MSTI adult research implemented the practice of metrics. Metrics collection and reporting provide an objective tool for evaluating inter-departmental work practices and process improvements. Metrics are collected for research coordinator clinical practices, regulatory practices, and research financials. Data are presented and reviewed quarterly to the research department staff, MSTI research director, and MSTI director of clinical support services during a department meeting. The data presented facilitate questions from and discussion within the group. If needed, further strategies are identified for minimizing barriers to successful outcomes. OI

—Deborah Jones, RN, BSN, OCN, CCRC, is clinical research manager, St. Luke's Mountain States Tumor Institute, Boise, Idaho. St. Luke's Mountain States Tumor Institute was a 2011 and 2012 ACCC Innovator Award recipient.

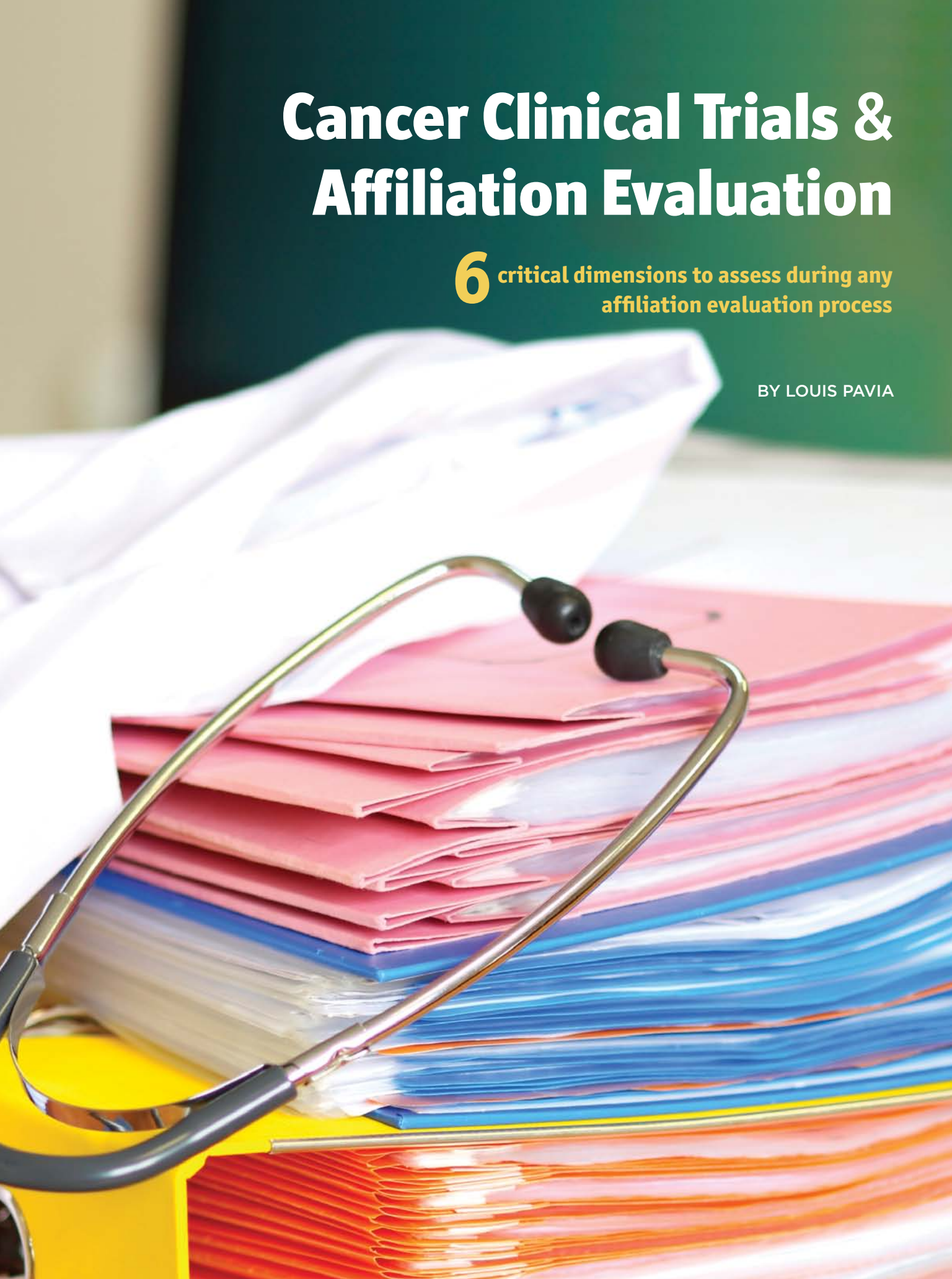
Acknowledgements

A special thank you to the following Adult MSTI Research staff for their commitment, teamwork, and perseverance to this process improvement: financial analyst, Debra Briggs; research nurse coordinators, Vivian Goldsmith (now retired) and Diana McDonagh; regulatory coordinator, Lauryn Pyke (the original research assistant and who is now in PA school); and present clinical research assistant, Paula Fink.

Cancer Clinical Trials & Affiliation Evaluation

6 critical dimensions to assess during any affiliation evaluation process

BY LOUIS PAVIA



Oncology services are experiencing a wave of consolidation. While financial pressures are often the primary factor driving consolidation, improving patient care quality should be key criteria for evaluating potential affiliation partners. The Institute of Medicine (IOM)[1], the National Comprehensive Cancer Network[2], and leading cancer care providers agree, the best care for a patient diagnosed with cancer is on a clinical trial. Integrating research into routine cancer care at the community level is vital to expanding access to quality care for patients close to home and necessary for community oncologists to deliver high quality care and attract and retain patients. Cancer clinical trials (CCTs), when executed effectively, can also be instrumental in physician alignment, clinical integration, and market share development.

The Changing Landscape

An annual survey of oncology practices found that over the past 4.5 years 241 oncology clinics have closed, 392 oncology practices have entered into purchase or management services agreements with hospitals, and 132 practices have merged or been acquired.[3] Some oncology practices are consolidating back office functions or entering into services agreements with hospitals or management companies to gain economies of scale and improve infrastructure (e.g., Carolinas Cancer Care with Carolinas HealthCare System). Others are merging to offer coordinated care on a regional or statewide basis (e.g., Regional Cancer Care Associates, Tennessee Oncology with Chattanooga Oncology and Hematology Associates).

Consolidation is also affecting hospital-based providers. Hospitals are merging and consolidating their cancer programs to increase patient volumes and improve efficiency (e.g., University of California San Diego Health System and Nevada Cancer Institute; Temple University Health System and Fox Chase Cancer Center; University of Rochester and Pluta Cancer Center; Kansas University Cancer Center and the Kansas City Cancer Center).

Community cancer centers are networking with NCI-designated cancer centers and academic medical centers to expand the scope and quality of care they offer (e.g., The University of Arizona Cancer Center and St. Joseph's Hospital and Medical Center; UCSF Helen Diller Family Comprehensive Cancer Center and Community Hospital of the Monterey Peninsula; Duke Medicine and Augusta Health Cancer Center).

To manage cancer care and share financial risks and rewards, health systems, payers, and oncology practices are forming cancer accountable care organizations (ACOs) (e.g., Baptist Health South Florida/Florida Blue/American Medical Specialties) and medical homes (Space Coast Cancer Center).

The State of Clinical Trials Today

Patients understand the value of research and are willing to participate in CCTs but often lack the information and support to do so. Seventy-six percent of Americans believe clinical trials are of great value and another 22 percent believe they are of some value.[4] The Mayo Clinic found that 76 percent of patients expected their doctor to inform them about clinical trials, but only 58 percent were satisfied with their current knowledge of CCTs.[5] Patients trust their doctor most for health information, but only 10 to 20 percent of patients with cancer are informed about clinical trials by their oncologist.[6]

While community oncologists are integral to the CCT process, they must have the knowledge, tools, and inclination to educate patients about CCTs as a treatment option when available. One study of nearly 500 medical oncologists found that 60 percent referred or enrolled one or fewer patients per month to a clinical trial.[7] For other cancer specialties, nearly 60 percent refer or enroll less than 1 per year.[7] Referring physicians can play an important role in educating patients diagnosed with cancer about clinical trials as a treatment option, but 98 percent of these referring physicians never discuss clinical trials with patients they refer to a cancer specialist.[8]

Perhaps the greatest barrier to accelerating improvements in cancer care is the failure of the clinical trial enterprise. Forty percent of NCI-supported trials do not achieve accrual goals and are not completed or published.[9] Among the Phase III trials, nearly 64 percent did not achieve accrual success, and about half of Phase III trials closed to accrual with enrollments less than 25 percent of the originally stated accrual goal.[9] (Some trials do close early because of unanticipated side effects or other clinical factors).[9] Stunningly, 38.8 percent of cooperative group trials and 20.6 percent of non-cooperative group trials failed to accrue a single patient.[10]

Clinical Trials: A Benefit of Affiliation

So what can be done to improve CCTs? One way to fully capitalize on the benefits of clinical trials may be through an affiliation that allows the cancer program to expand access to clinical trials and deliver quality patient care. While cancer clinical trials are frequently identified as a potential benefit of an affiliation, there is often too little due diligence on the means and capabilities of capitalizing on that opportunity. Following are six critical dimensions of CCTs that should be assessed as part of any affiliation evaluation process. They can also provide a framework to continually assess the value of the relationship.

1. Vision and culture
2. Trials portfolio
3. Trial initiation
4. Accrual
5. Outreach
6. Support.

Cancer care is becoming increasingly complex and, ideally, more personalized. The trend toward targeted therapy and personalized medicine—as well as the increasing availability of genomic analysis for relevant targeted therapies and clinical trials—requires the screening of large numbers of patients to find particular population subsets who may be interested in participating in these trials. Community oncologists who

participate in clinical trials not only extend quality care and trial access to the patients they serve, but also gain the experience and expertise they need to provide the resulting personalized care that is appropriate and expected by their patients.

1—Vision & Culture

Having a vision for cancer research that recognizes the role of clinical trials in quality patient care is paramount. Keep in mind, however, that the vision articulated in a statement may not be shared or reflected in the actual culture of the organization. In order to understand your potential partner's true vision and culture you should determine:

- What is the role of research in the mission and strategy of the organization?
- Is the stated vision understood and internalized throughout the organization (executives, managers, clinicians, and research staff) and reflected in actual behavior?
- How is the vision reflected in the budget and compensation scheme?
- Are their resources sufficient to achieve the vision?
- Are priorities consistent across departments and do they communicate and cooperate on research projects?
- Is research an expected part of quality patient care and reflected in performance measures?
- What is the strategy and capacity for handling biospecimens, new research plans, and future direction?

2—Trials Portfolio

Protocols are becoming increasingly complex and exclusion criteria more stringent. The appropriate mix of well-designed trials must be available if your patients and clinicians are to participate in the CCT process. This means assessing:

- Do the trials offered match the incidence of diseases and stages of your patient population?
- Is the mix of therapeutic and interventional studies by phase appropriate?
- Can your patient population qualify for the studies or will common co-morbidities or other factors typically exclude them?
- Can your clinicians and patients comply with the protocol requirements?
- Is there an appropriate mix of industry and grant-funded research?
- Is there an effective process for selecting trials to be offered?
- Are innovative trial design concepts (virtual, cluster randomization, adaptive design) being utilized?

3—Trial Initiation

There is a strong correlation between the time it takes to activate a trial and success in achieving accrual goals. Trials requiring less than 12 months of development are significantly more likely to achieve accrual goals.[8] You should determine:

- How long does it take, on average, for an investigator-initiated trial to be designed and approved?
- How long for an NCI Cooperative study to be approved?
- How long for an industry study to be approved?
- How long does the contracting process typically take?
- Are the appropriate patient protection protocols in place (IRB process)?
- Is the approval process efficient and effective?

4—Accrual

There are numerous barriers to participation in clinical trials from trial design, to timeliness, to patient resistance, to poor communications. But before patients can participate in a clinical trial they must first be offered the opportunity. The Education Network to Advance Cancer Clinical Trials (ENACCT) has identified several key goals and best practices for the CCT accrual process, including 100 percent of patients beginning cancer treatment to be effectively screened and 100 percent of eligible patients to be offered participation and provided the information they need to make an informed decision.[11] Tools and processes for screening patients, obtaining informed consent, and complying with the trial requirements are critical to effective accrual. When you look at the organization with which you are considering affiliating, first ask:

- What percent of trials achieve their accrual targets?
- What percent accrue 0 patients?
- How are open trials identified and accessed?
- How are they promoted?
- What percent of patients are (pre) screened?
- What screening tools (e.g., EMR, EHR, health information exchange) and techniques are used?
- Who is involved in screening (e.g., navigators, case managers, trial support staff)?
- Is there a systematic approach to screening patient charts for eligibility?
- Are all eligible patients actually approached?
- Are there culturally appropriate informed consent materials and processes?

5—Outreach

Patients need time to process their cancer diagnosis before they make decisions about treatment, but time is often of the essence. Less than 10 percent of newly-diagnosed cancer patients are informed about the possibility of participating in a cancer clinical trial by their physician.[12] Most patients are willing to participate in a CCT when asked; focus groups with the public and caregivers found that negative attitudes significantly changed after learning more about clinical trials.[6] ENACCT has demonstrated that training programs can increase knowledge and behavioral intent among community-based organizations *and* referring providers.[13] In order to ensure your community is aware of the potential benefits of CCTs, you should find out from your affiliating partner:

- What programs and materials are used to raise awareness in the patient community? Among oncologists? With primary care providers (PCPs) and other referring physicians (GI, OB/gyn, neuro, urology, breast surgeons)?

- What joint outreach initiatives will be undertaken?
- What role do community oncologists and referring physicians play in the care of patients on clinical trials?
- What outreach events are planned, when are they scheduled, and what is the CCT component?
- What is the social media plan for building CCT awareness?

6—Support

Cancer clinical trials are often complex and expensive undertakings. A successful partnership affiliation will remove barriers to CCT participation for both physicians and patients and expedite access and accrual. Support is available. To get started, ask your potential partners these questions:

- What training is available to community-based patient advocate groups and your outreach staff to leverage awareness building?
- Is education available for clinicians and staff on CCT processes and procedures?
- What infrastructure and support will be provided by the clinical trials support staff?
- Is help available achieving your accreditation requirements?
- What financial support is available to clinicians participating in CCTs?
- How will CCTs help you achieve regulatory compliance?
- Is there support for credentialing and auditing?
- How will clinicians be informed and educated about specific trial protocols?
- Is there a PI mentoring program?
- What technology is available to improve efficiency (telemedicine, EMR flags, recruiting apps, guidelines and pathways/decision support, etc.)?
- Are there tools for collecting, analyzing, and reporting required information?
- What role will local physicians play on tumor boards and conferences?
- What support is provided to ensure that patients are able to comply with protocols?

This affiliation evaluation process is adapted from the ENACCT 360° CCT Assessment and Improvement Protocol in which ENACCT conducts individual and group interviews with a cross section of leaders and staff in an affiliation with a research-based cancer center. Relevant data and documents are collected and analyzed in order to identify gaps and weaknesses in the CCT process and recommend strategies for improvement. A similar online self-assessment will be available for community cancer centers in 2013.

—Louis Pavia is chairman, ENACCT (Education Network to Advance Cancer Clinical Trials) Development Committee, Bethesda, Md. He has more than 30 years experience working with healthcare providers to accelerate their success.

References

1. IOM. A National Cancer Clinical Trials System for the 21st Century: Reinvigorating the NCI Cooperative Group Program; 2010. Available online at *http://iom.edu/Reports/2010/A-National-Cancer-Clinical-Trials-System-for-the-21st-Century-Reinvigorating-the-NCI-Cooperative.aspx*. Last accessed March 1, 2013.
2. NCCN. Clinical Trials at NCCN Member Institutions. Available online at *www.nccn.com/clinical-trials.html*. Last accessed March 1, 2013.
3. Community Oncology Alliance. Community Oncology Practice Impact Report: The Changing Landscape of Cancer Care. Available online at: *www.communityoncology.org/pdfs/community-oncology-practice-impact-report.pdf*. Last accessed March 1, 2013.
4. Research America! Research Enterprise Survey 2010. Available online at *www.researchamerica.org/uploads/ResearchEnterprisePoll.pdf*. Last accessed March 1, 2013.
5. Sood A, Prasad K, Chhatwani L, Shinozaki E, et al. Patients' attitudes and preferences about participation and recruitment strategies in clinical trials. *Mayo Clin Proc.* 2009 Mar;84(3):243-247.
6. Michaels M, Weiss ES, Guidry JA, et al: The promise of community-based advocacy and education efforts for increasing cancer clinical trials accrual. *J Cancer Ed.* 2012 Mar;27(1):67-74.
7. Klabunde CN, Keating NL, Potosky AL, Ambs A, et al. Population-based assessment of specialty physician involvement in cancer clinical trials. *J Natl Cancer Inst.* 2011;103(5): 384-397.
8. Crosson K, Eisner E, Brown C, et al. Primary care physicians' attitudes, knowledge, and practices related to cancer clinical trials. *J Cancer Educ.* 2001;16:188-192.
9. Cheng SK, Dietrich MS, Dilts DM. A sense of urgency: evaluating the link between clinical trial development time and the accrual performance of Cancer Therapy Evaluation Program (NCI-CTEP) sponsored studies. *Clin Cancer Research.* 2010;16:5557-5563.
10. Dilts DM, Cheng SK, Crites JS, Sandler AB, et al. Phase III clinical trial development: a process of chutes and ladders. *Clin Cancer Research.* 2010;16:5381-5389.
11. ENACCT. A Quality Improvement Program to Improve Cancer Clinical Trial Recruitment, Accrual, and Retention: Lessons Learned from the National Cancer Clinical Trials Pilot Breakthrough Collaborative. Available at: *www.enacct.org/sites/default/files/NCCTBC%20Final%20Report_November%202012_0.pdf*. Last accessed March 1, 2013.
12. Comis RL and Miller JD. Cancer clinical trials awareness and attitudes in cancer survivors. Philadelphia: Coalition of Cancer Cooperative Groups; 2005. *J Clin Oncol.* 2006:24, (18S): 6061.
13. National Institutes of Health. Pretesting NIH Clinical Trial Awareness Messages: A Focus Study with Patients, Caregivers, and the General Public. Bethesda, MD: April, 2011. Available online at *www.nih.gov*. Last accessed March 1, 2013.

An Integrated Approach to Lung Cancer in a Community Setting

The multidisciplinary thoracic clinic at Erie Regional Cancer Center

BY JAN M. ROTHMAN, MD, AND SHELLEY D. KUBANEY, RN, OCN

Multidisciplinary care is an integrated approach to healthcare in which medical and allied healthcare professionals consider all relevant treatment options and collaboratively develop individual treatment plans for patients (see Table 1, page 42). Multidisciplinary cancer clinics allow physicians in different subspecialties to work side-by-side, developing a patient's care plan with consensus.

In traditional models of multimodality cancer care, patients often undergo sequential referrals where they are shuttled from clinician to clinician at different stages of diagnosis and treatment (see Table 2, page 42). This so-called "integrated" approach can be a confusing experience for the patient, resulting in conflicting information from different healthcare professionals. On the other hand, multidisciplinary clinics can provide more consistent information to patients.

As cancer care becomes more complex, fewer patients are being treated with single modality therapy. Multidisciplinary clinics allow specialists to develop evidence-based recommendations in accordance with guidelines and protocols endorsed by the clinical team. Indeed, in the United States, the American College of Surgeons Commission on Cancer requires multidisciplinary cancer care conferences for the accreditation of cancer centers.

Emerging evidence shows that multidisciplinary care has the potential to reduce mortality, improve quality of life, and even reduce healthcare costs.[1] Further, data indicate that treatment delays can translate to reduced overall survival, specifically in lung cancer.[2]

This information and data served as the basis and impetus for Erie Regional Cancer Center to establish and implement its multidisciplinary thoracic clinic.

Setting the Stage

Two competing hospitals—Saint Vincent Health System and Hamot Medical Center—provide most of the care in the city of Erie, Pennsylvania. As both hospitals share a common goal of improving the delivery of cancer care to the community, they were able to come together in a joint venture in 1987 to create the Erie Regional Cancer Center. Today Erie Regional Cancer Center is a freestanding cancer treatment center, treating approximately 220 new thoracic malignancies per year.

In 2008 the two hospitals identified a need to implement a multidisciplinary thoracic oncology clinic in order to improve the flow of patients into the healthcare system. The clinic would be established in a community setting and focus solely on diagnosis and treatment of thoracic malignances.

In May 2008 a group comprised of administrators from the two hospitals and Erie Regional Cancer Center and healthcare providers involved in the diagnosis, management, and treatment decisions of patients with thoracic malignancies, met to discuss what this multidisciplinary clinic might look like.

At this meeting, the group developed five core principles that served as the clinic's framework:

1. A team approach
2. Communication among team members
3. Access to full therapeutic range of services
4. Provision of care in accordance with nationally agreed standards
5. Patient involvement in treatment decision making.

The group set up an initial algorithm to determine which patient population was appropriate to be seen in the multidisciplinary thoracic clinic versus patients who should be seen by surgery or pulmonary prior to clinic visit. Patients with a definitive diagnosis were deemed appropriate for multidisciplinary clinic visits. Additionally, the group agreed that patients who may benefit from neo-adjuvant chemotherapy and/or radiation would be seen in the multidisciplinary thoracic clinic by all three specialists prior to any treatment initiation. The group identified point people at the surgical, pulmonary, and oncology practices. These individuals would facilitate inter-office coordination of appointments and patient care.

The decision was made to implement a standing clinic day, as the group felt this model would best facilitate collaboration with medical oncology, radiation oncology, and thoracic surgery, as well as the support services deemed necessary by providers. In addition to offering chemotherapy and radiation treatments, Erie Regional Cancer Center has a full complement of onsite patient services, including diagnostic radiology, PET/CT, lab, nutrition services, palliative care, pharmacy, and social services. Accordingly the team decided to hold the clinic at the cancer center, ensuring that patients received an all inclusive appointment. Erie Regional Cancer Center was also selected because the group viewed it as a "neutral" location.

A medical oncologist from the cancer center was selected to serve as the Medical Director of the new multidisciplinary thoracic clinic (MTC). The MTC started seeing patients in June 2008.

Table 1. Multidisciplinary Approach to Healthcare
Instant communication among various specialists
Reduction in time from diagnosis to physician appointments
Access to full resources
Consensus recommendation in accordance with national guidelines
Enhanced interspecialty relationships
Promote peer review among specialists
Avoid duplication of unnecessary services

Table 2. Traditional Approach to Healthcare
Fragmented and uncoordinated care
Long delays and waiting times between appointments
Poor patient satisfaction
Non-uniform access to patient care
Variations in treatments not often guidelines-based

MTC Implementation

Historically, the prevailing belief was that successful multidisciplinary clinics were only achievable at academic medical centers where all the physicians are employed by the same facility. But with the sacrifice and commitment of all of the participating physicians—particularly the thoracic surgeons who are willing to fold their thoracic practice into the joint cancer center—Erie Regional Cancer Center was able to successfully develop an MTC in a community setting. Six factors helped to ensure successful implementation of the MTC.

1—Hospital and cancer center support. While all providers involved felt that the MTC would substantially improve the delivery of care to patients, the clinic faced its fair share of challenges. As stated previously, Erie Regional Cancer Center is essentially a joint venture owned by two competing hospitals, with day-to-day operational management and supervision carried out by the University of Pittsburgh Medical Center. If the MTC was to be successful, full support from *all* institutions was necessary—regardless of the institutions' different and unique agendas. Support from cancer center providers was more easily achieved as the majority of physicians are employed with the same practice and facility.

2—Surgeon support and involvement. The two hospitals each have approximately four to five cardiovascular surgeons with varying interest in thoracic surgery. Both were willing to select one or two thoracic surgeons each to act as primary physicians in the clinic. Under this model, patients were seen expeditiously and consistently by the surgeons or a designated backup when appropriate.

3—Pulmonologist support. Erie has a pulmonology group that serves both hospitals. Although the pulmonologists are not directly involved in seeing patients in the MTC, they serve as the main referral sources. Gaining their support and understanding of the MTC is critical to the clinic's success. The cancer center has developed a close working relationship with these physicians and their nurses, which allows for effective exchange of information and timely appointments for patients.

4—Nurse coordinator. A nurse coordinator serves as the point of contact for patients from diagnosis through initiation of the treatment plan. This nurse coordinator is extremely valuable to the success of the MTC. Under our clinic model, upon referral to the MTC, the nurse coordinator obtains and reviews patient records and determines which physicians need to evaluate patients. The nurse coordinator also obtains films (if needed) and coordinates appointments with medical oncology, radiation oncology, and surgery. This model allows patients to see the appropriate physician(s) in the MTC on the same day. If possible, prior to the initial appointment in the thoracic clinic, the nurse coordinator will review records with the medical director and arrange to have diagnostic studies, such as PET scans, available at the MTC to allow for complete staging information. In brief, the nurse coordinator responsibilities include:

- Initiating the physician meeting to discuss cases at the beginning of each clinic day
- Meeting with each patient
- Arranging ancillary services at patient visits
- Ensuring each patient understands the plan of care at the completion of the MTC
- Ensuring treatment appointments and follow-up visits are scheduled
- Documenting data from the MTC.

From the point of diagnosis, staff at the pulmonary and/or surgical offices communicate directly with the nurse coordinator. This communication is key, resulting in timely workups that are condensed into days as opposed to weeks in more traditional care delivery models.

5—Physician champion. Dynamic clinical leadership is critical to creating a shared vision and understanding about the benefits of a multidisciplinary clinic. The selection of a "physician champion" is critical to the success of an MTC. This physician can promote the value of the clinic to his or her peers and help ensure its success with referring physicians and the community at large. Successful physician champions:

- Promote the value and effectiveness of the multidisciplinary clinic
- Share the benefits of patient participation and communicate these to other physicians
- Meet with and educate referring physicians in the community
- Act as an interface between the administration and outside referral source(s)
- Advocate for patient participation in clinical studies
- Lead colleagues through the difficult process of changing clinical behaviors.

At Erie Regional Cancer Center, our physician champion plays a significant role in managing the participation of both employed and private practice physicians in the MTC.

6—Clinical trials. A successful MTC can increase clinical trials enrollment. The MTC offers a venue for a research nurse to provide education and expertise regarding clinical research trials to members of the team and patients. At Erie Regional Cancer Center, patients are proactively screened for available lung and esophageal cancer trials. Eligibility is discussed as a group at a pre-clinic conference and, if appropriate, the research nurse is invited to discuss enrollment with the patient the day of the MTC. When physicians promote clinical trials as treatment opportunities, patients are more likely to participate. Since the MTC was established, Erie Regional Cancer Center has seen both more clinical trials available (lung cancer in particular) and more patients enrolled. In fact, the cancer center's enrollment to lung cancer clinical trials nearly doubled from 2009 to 2010.

As a byproduct of the clinic, Erie Regional Cancer Center ranked #2 in enrollment for the RTOG-0617 trial. Currently, several of our lung-based trials have closed and we continue our efforts to search for new clinical trials and offer participation to all patients that come to the MTC.

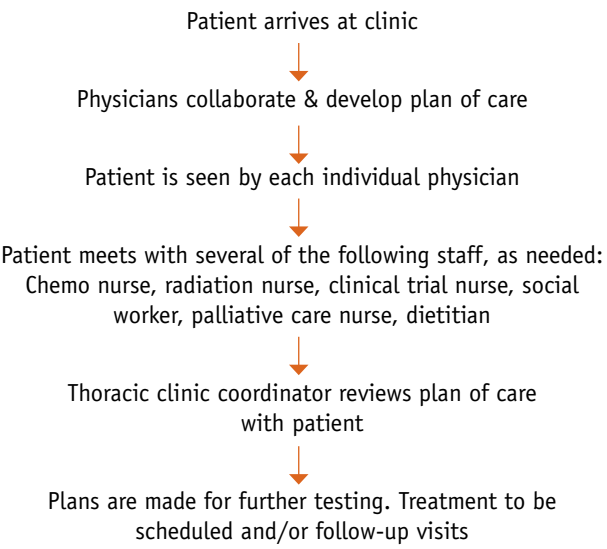
Clinic Day

A typical clinic day may be very time consuming for patients based on their needs and the number of physicians and associated staff they need to see. A representative from the MTC calls new patients prior to the first visit to explain the clinic process and timeframe. The success of clinic visits depends greatly on the patience and flexibility of physicians, staff, patients, and families. A usual clinic day is summarized in Figure 1, right.

Overcoming Challenges

Multidisciplinary care, including MTCs, is more complex than traditional care. Multidisciplinary clinics require a blend of internal and external program operations to ensure the success of patient flow. Consequently, multidisciplinary clinics are time and resource intensive and riddled with potential pitfalls. Indeed, a poorly-designed clinic with ill-defined roles can complicate patient management by creating redundancies and discrepancies in patient care and communication. Further, practical concerns, such as organizational meetings, can create significant burden on the time of team members if there is inadequate administrative and nursing support. The following are challenges that we have overcome during the implementation of our multidisciplinary thoracic clinic.

Figure 1. Typical Clinic Day



1—Juggling physician time. In our MTC model Erie Regional Cancer Center serves as the primary site for all meetings with patients and relevant members of the MTC team. Therefore, both surgical groups from the two participating hospitals commit at least one surgeon per week to travel to the cancer center at an established time. This time commitment impacts the surgeon's schedule, affecting his private office schedule, surgery, or personal time. The surgeon may see fewer patients in the MTC than he or she would have seen at their office during the same time period. Fortunately, Erie Regional Cancer Center is located approximately 10 minutes from the two hospitals and both surgical offices. We have overcome this hurdle mainly due to the dedication of all surgeons involved, as they will either come to the MTC to see patients after completion of surgical cases or prior to seeing patients in their office.

2—Multidisciplinary clinics are often intensive for physicians, staff, and patients. This scenario is particularly true when dealing with thoracic malignancies, as numerous issues must be addressed in addition to treatment recommendations, including symptoms and side effects, pain management, and social concerns.

Most new patient visits to the MTC are long and involved. On average the patient could spend three to four hours at the MTC, especially when all three physicians (medical oncology, radiation oncology, and surgery) are

The MTC offers a venue for a research nurse to provide education and expertise regarding clinical research trials to members of the team and patients.

The MTC means less duplication in work and more clearly defined roles of what each staff member provides to the patient.

involved. Often patients also meet with a chemo or radiation nurse, social worker, palliative care nurse, and/or dietitian. Prior to MTC implementation, patients would meet with most of this staff, likely over several visits. With the MTC there is more coordination of care among team members, as we are able to meet as a group to discuss patient needs. The MTC means less duplication in work and more clearly defined roles of what each staff member provides to the patient. Despite the extended day for the MTC, new patients are satisfied and know that it can condense three potential visits—often at multiple week intervals—into one clinic day.

3—Financial cost and burden to administration and cancer center. Development and implementation of a multidisciplinary clinic can often be less profitable, especially from the perspective of the institution. Nursing and resource utilization, physician commitments to potentially fewer patients on the clinic day, and time management where much of the focus is done outside of the actual consultation with the patient can all lead to increased costs—both financial and for the staff. Certainly these factors need to be considered for the clinic to run in a profitable fashion. However, due to improvements in care coordination, Erie Regional Cancer Center has maintained excellent retention rates; most patients opt to have chemo and radiation treatments, as well as follow-up care at our cancer center. To ensure that clinical outcomes are not compromised simply for profitability, we adhere to the basic principle of seeing every patient referred to MTC—regardless of their financial status.

4—Lack of patient participation. If patients do not participate in decision making, it violates a key principle of multidisciplinary care and can compromise the integrity of the clinic. When multidisciplinary team meetings occur prior to the patient visit, complete medical history, social situation, and patient opinion are not known and taken into account as a plan is developed. This process could lead to inappropriate treatment decisions, thus negating the benefit of the multidisciplinary discussion. Here is how we have overcome this challenge at Erie Regional Cancer Center.

Our initial discussion takes place prior to patient arrival. As each physician meets with the patient and complete information is obtained, our physicians conduct intermediate discussions between visits to take into account all appropriate information. This dynamic process allows physicians to update care plans, ultimately allowing the patient to make an educated decision regarding care.

As we undertook the development and implementation of our multidisciplinary thoracic clinic, all participants were well cognizant of the potential downside and challenges. Through hard work, communication, and cooperation we have been able to achieve many, if not all, of our goals despite these challenges.

Evaluating the MTC

Although multidisciplinary clinics have generally been endorsed and accepted at academic centers, the impact of these clinics in a community setting has yet to be established. Little quantitative or qualitative research has been done to determine the impact of multidisciplinary clinics—both on patient outcomes and feasibility in the community setting. Therefore, in order to ensure success of the MTC and demonstrate its ongoing viability, Erie Regional Cancer Center established certain criteria to measure clinic success. Tools were developed and implemented with the input and assistance of the director of nursing. The criteria require ongoing documentation and periodic review. As multidisciplinary clinics require a substantial amount of clinical and institutional resources, measurement tools must be in place to ensure ongoing efficacy, including:

- Time from referral to appointment
- Time from appointment to initiation of treatment
- Number of multidisciplinary visits
- Number of new patients
- Attrition rate (percentage of patients that leave for treatment elsewhere).

Our data collection has told us that patient volume alone does not provide an adequate picture of the financial health of the multidisciplinary thoracic clinic. As we know, patients diagnosed with lung cancer often participate in ongoing revenue-generating clinical studies, in addition to the obvious chemotherapy and radiation treatments. Often these clinical trials require radiographic studies and new technology, such as PET scans and ENB, all which help ensure the financial integrity of the institution.

Due to the success and commitment of the team, and with the full support of cancer center administration, the MTC continues to grow in volume and has served as the basis for the development of other disease-site-specific multidisciplinary clinics at the Erie Regional Cancer Center.

—Jan M. Rothman, MD, is medical director of the Multidisciplinary Thoracic Clinic and Shelley D. Kubaney, RN, OCN, is the thoracic clinic coordinator at Erie Regional Cancer Center, Erie, Pa.

References

1. Pawlik T, et al. Evaluating the impact of a single day multidisciplinary clinic on the management of pancreatic cancer. *Annals of Surg Oncol.* 2008;15:2081.2088.

2. Conron M, Phuah S, Steinfort D, et al. Analysis of multidisciplinary lung cancer practice. *Internal Med J.* 2007;37:18-25.

careers

ASSISTANT PROFESSOR
HEMATOLOGY-ONCOLOGY | Shreveport, LA

LSU Health Sciences Center at Shreveport in the Section of Hematology-Oncology Feist-Weiller Cancer Center is seeking full-time physicians at the Assistant Professor level. Practice includes all facets of the Department of Medicine and the Feist-Weiller Cancer Center to include serving as an attending faculty on the clinical services staffed by the Section of Feist-Weiller Cancer Center. In addition, qualified candidates will be expected to participate in overall faculty activities, including medical student, house staff, and fellow teaching responsibilities; conduct research and publish findings in journals; and make presentations at medical conferences; MD or equivalent. Applicants must qualify for a Louisiana license. BE/BC necessary. Opportunities available now. Positions will remain open until filled.

LSU is an Equal Opportunity/Affirmative Action employer.

Please submit CV and three letters of reference to *shvfacultyrecruitment@lsuhsc.edu*.

DIRECTOR OF NURSING
Nashville, Tennessee

Tennessee Oncology is seeking an experienced Director of Nursing to provide oversight and management of our nursing staff. This is an excellent opportunity for long-term success with an established, stable, and successful practice.

Education and Experience

- Masters of Science in Nursing (MSN) or RN with Master of Healthcare Administration (MHA) or a Nurse Practitioner (ANP) with Certification in Oncology Nursing (AOCN)
- 3 years oncology clinical experience
- 3 years director-level experience and/or 5 years management experience. Strongly prefer multi-site outpatient physician practice clinical management experience
- Willing to travel to various clinics sites operated by Tennessee Oncology.

Apply online at *resumes@tnonc.com*.

MEDICAL ONCOLOGIST
Various Locations

Cancer Treatment Centers of America is seeking an experienced hematologist/oncologist to join our medical staff at any of our five locations: Goodyear, Arizona; Newnan, Georgia; Philadelphia, Pennsylvania; Tulsa, Oklahoma; or Zion, Illinois. The ideal candidate will be a skilled clinician who has successfully completed a fellowship and is currently board certified. Duties include:

- Providing services for patients
- Participating in clinical research and design
- Maintaining EMRs
- Assisting in development of new programs and clinical services.

Typically, our physicians see 10 to 15 patients a day. You will be a member of a multidisciplinary team, with access to our subspecialists, including surgical oncologists and radiation oncologist, as well as a palliative care team, mind-body medicine, strong nutritional support, and spiritual counseling. We are an equal opportunity employer.

Contact: Drexa Unverzagt, RN, MS, National Director of Physician Recruitment, Phone: 847.746.4384; Email: *drexa.unverzagt@ctca-hope.com*.

NURSES
South Weymouth, Massachusetts

The Dana-Farber/Brigham and Women's Cancer Center, in clinical affiliation with South Shore Hospital, provides local access to world-leading care and support. Experts from Dana-Farber Cancer Institute, Brigham and Women's Hospital, and South Shore Hospital provide services in the Center. This unique clinical collaboration among the three organizations makes it possible to offer many advanced treatments developed at Dana-Farber/Brigham and Women's Cancer Center, including clinical trials. We currently have these exciting new job opportunities available:

- Clinical nurse coordinator, radiation oncology. Must have radiation oncology and management experience.
- Research nurse. Must have oncology nursing and research experience.
- Radiation oncology RN. New position to support our growing radiation oncology department. Recent oncology experience required.

For more information and to apply online, go to *www.southshorehospital.org/findajob*. Equal Opportunity Employer.

Developing a Multidisciplinary Thoracic Oncology Clinic

THE EDWARD HOSPITAL EXPERIENCE

BY KIMBERLY ROHAN, ANP-BC, AOCN

In February 2009, while discussing with a medical oncologist the case of a patient with lung cancer who required neo-adjuvant treatment, our thoracic surgeon suggested holding a weekly conference to discuss such cases to better coordinate the care of lung cancer patients at Edward Hospital. The other involved disciplines—including radiation oncology, pulmonology, radiology, and administration—discussed the possibility of such a multidisciplinary conference, and agreed that the clinic was a good idea. Since these clinics are often held in university oncology programs, plans for the clinic focused on translating such a program to the community setting. One of the first decisions: a nurse practitioner would serve as the coordinator for this multidisciplinary conference.

On March 11, 2009, our thoracic oncology clinic saw its first patients. To spread the word about the clinic opening, letters were sent to all the primary and family care physicians and pulmonologists on staff at the hospital and in the surrounding communities. The hospital marketing team ran ads and stories in local and regional newspapers, in addition to marketing the clinic on the hospital's website and intranet. The clinic began slowly but ramped up quickly, with a rapid increase in the number of patients seen per month once people became aware of the clinic.

Performance Improvement Goals

Once our clinic was established, our team developed several performance improvement (PI) goals for the clinic:

- All patients would be offered an appointment within five business days of calling for the appointment.
- Treatment would be assessed in a timely manner, with a goal of two weeks from first visit to first treatment.
- The percentage of patients that had post-treatment surveillance scans would be performed according to National Comprehensive Cancer Network (NCCN) guidelines.
- Recruitment and retention data would be collected. Specifically, we could assess how many patients diagnosed at Edward Hospital stayed for treatment at Edward Hospital and how many patients diagnosed elsewhere and seen for another opinion remained for treatment at Edward Hospital.
- Develop a process that would help increase our percentage of matching clinical with pathologic staging. These percentages have been tracked now for several years.

Table 1 shows how we did in meeting those PI Goals.

Growing the Clinic

Our thoracic oncology clinic has grown substantially over the past three years and now includes pathology, interventional pulmonology, nursing (both medical oncology and radiation oncology), CT technicians, a dietitian, a tumor registrar, and social work. We hope to incorporate a palliative care physician in the near future.

In 2012 we used this framework to initiate a lung screening program to ensure patients meet NCCN screening criteria. In brief, here's how our process works. The Edward multidisciplinary thoracic oncology clinic (EMTOC) team reviews all screening CT scans. The thoracic oncology clinic navigator then calls each patient to discuss the results and treatment recommendations, if any. A letter with the results and recommendations is also sent to the patient's physician providers. The thoracic oncology clinic navigator sends a letter one month prior to the date of the recommended follow-up scan—both to the patient and his or her physician. Our

Table 1. Data on PI Goals

MATRIX	GOAL	2010 DATA	2011 DATA	2012 DATA
Appointment within 5 days	100%	97%	99.5%	98%
Time from first visit to first treatment	2 weeks	82.5%	89.5%	88%
Surveillance scans per NCCN guidelines	100%	100%	98.5%	98%
Percent of patients diagnosed and treated at Edward Hospital	90%	86.5%	86.3%	85%*
Clinical correlation with pathologic staging	90%	40%	83.3%	85%*

*Based on Cancer Registry data to date

multidisciplinary team reviews all follow-up scans per NCCN guideline recommendations.

Patient & Provider Response

Our patient satisfaction scores for the thoracic oncology clinic are excellent. Patients appreciate that they can see all their doctors in one visit and that they leave with a care plan in hand. One grateful and generous patient left a portion of his estate to the program, which allowed Edward Hospital to develop an endoscopic ultrasound program.

Referring physicians also have a great deal of satisfaction with the clinic, as they feel patient care is more efficient and that all providers and the patient are on the same page regarding the plan of care.

In the beginning physician attendance was sporadic, but after a few months, physicians cleared their schedules to participate and are disappointed when they cannot be in clinic.

Initially, clinic referrals came primarily from the physician participants. Today primary care physicians refer patients directly to the clinic. The primary care physicians appreciate the performance of appropriate diagnostic procedures and that patients receive the appropriate care in an efficient manner. Referring physicians are updated on the plan of care after the conference—either by email or phone—so that they know what the plan is and can ask questions. Several primary care physicians have attended the multidisciplinary conference or have called in to the conference to hear the discussion and to provide insight into the patient and their co-morbidities and social situation.

In addition, several patients have self-referred after learning about the clinic from the Internet or hospital website.

We have also established partnerships with several of the local academic facilities that have referred their patients to us so they may receive care closer to home.

Looking Ahead

Our thoracic oncology clinic currently reviews approximately 20 to 25 new cases per month, with 55 to 60 follow-up cases. The multidisciplinary team sees patients in the clinic and also cases that are referred to the conference for recommendations when the patient cannot be in attendance.

All new patients are seen by one of the physicians and their case is then reviewed in conference. The physicians involved in the treatment plan also see the patient prior to discharge from clinic. The follow-up cases receive a review of recommended scans and evaluation of treatment progress. We have conducted 15 lung screenings—all requiring future follow-up.

All current smokers receive information on smoking cessation and support groups. Our next endeavor is to initiate a smoking cessation clinic that will be run by a nurse practitioner. Patients will be referred to this clinic from the cancer center, as well as from physicians outside the cancer center and hospital.

On February 20, 2013, we hosted a half-day symposium on lung cancer, highlighting our thoracic oncology clinic. To illustrate the inner workings of the clinic to physicians and healthcare professionals, cases were presented as if it were in the multidisciplinary conference.

The thoracic oncology clinic was such a successful endeavor that Edward Hospital subsequently developed a neuro-oncology, GU oncology, breast clinic, and an oncology genetics clinic. In the future, we will look to add a GI multidisciplinary clinic and a survivorship clinic.

While each clinic has a slightly different format, our hope is that the positive outcome for patients and physicians will be the same.

As the nurse navigator, it is a challenge at times to ensure completion of diagnostic testing and to ensure that patients and their families have a good understanding of the plan of care so that no one falls through the cracks. A trigger on our new electronic medical record has made it easier to track testing and follow-up. We continue to explore ways to improve our thoracic oncology clinic for patients and providers, including keeping a close eye on future technology and clinical trial results. OI

—Kimberly Rohan, ANP-BC, AOCN, is thoracic oncology clinic navigator at Edward Hospital and Health Services, Naperville, Ill.

action

The ACCC 39th Annual National Meeting Wrap-up

With a focus on business, economics, and policy, the March 2013 meeting gave attendees insight on how best to continue to ensure access to quality care in the face of unprecedented challenges. Read on for meeting highlights.

▲ ACCC's Capitol Hill Day kicked off the 39th Annual National Meeting. On March 6, more than 50 ACCC members braved snow and freezing rain to visit their congressional representatives to discuss issues key to ensuring access to quality care, such as eliminating the sequester, fixing the SGR formula, ensuring oral parity, and resolving drug shortages.

▲"Distress should be the sixth vital sign. It's part of total cancer care," said Jimmie Holland, MD, ACCC Annual Achievement Award recipient (center). Internationally recognized as the founder of the subspecialty of psycho-oncology, Dr. Holland is the Wayne E. Chapman Chair in Psychiatric Oncology at Memorial Sloan-Kettering Cancer Center. "In recent years there's been a real movement forward in terms of patient-centered care," she said in her acceptance remarks. "A change, a tipping point, has been reached. We can look forward to much more interest in supportive care." Also pictured is ACCC Immediate Past President George Kovach, MD, (L) and ACCC Executive Director Christian Downs, JD, MHA (R).

◀ Thursday morning's panel on "What a Continually Divided Congress Means for Healthcare" discussed what to expect from Congress in the coming months. Pictured are panel moderator (on L) Matt Farber, ACCC; panelists (L to R) Sydney Abbott, ACCC; Joseph M. Hill, American Society of Health-System Pharmacists; and Cara Tenenbaum, Ovarian Cancer National Alliance. Panelists discussed the likelihood of healthcare-related bills being passed in 2013, particularly those relating to drug shortages and track and trace. While panelists disagreed about the likelihood of Congress's hyper-partisanship waning in the near future, all agreed that, "At a certain point political differences will have to take a backseat to real problems people are facing."

▲"Healthcare will change more in this decade than it did in the last 50 years," keynote speaker Jeffrey Bauer, PhD, told attendees. Bauer, a health futurist and medical economist, forecast that by 2015, 30 percent of all healthcare entities will cease to exist as currently organized; 45 percent will exist as currently organized, but precariously; and 25 percent will thrive by changing the way healthcare is delivered. "One theme I hear everywhere," he said, "is that the biggest revolution we will see over the next two years is a shift from fee-for-service to value-based payment [quality]."

▲ At Friday's luncheon, Patrick J. Flynn, MD, (L) was presented with ACCC's David King Community Clinical Scientist Award for his outstanding service, leadership, and commitment to the oncology community. Dr. Flynn received the award for his efforts to increase clinical trial accruals. Under his leadership as director of research, Minnesota Oncology Hematology, PA, and medical director, Autologous Bone Marrow and Stem Cell Transplant at Abbott-Northwestern Hospital, clinical trial accrual has risen from 50 to 500 patients per year, achieving success through a consortium of physicians, clinics, and hospitals that cover the entire metropolitan Twin Cities and beyond. Pictured here with ACCC Immediate Past President George Kovach, MD, (R) and ACCC Executive Director Christian Downs, JD, MHA (C).

◀ At ACCC's House of Delegates meeting on March 8, results of the election of new officers and trustees were announced. Incoming President Virginia T. Vaitones, MSW, OSW-C, (L) is the first oncology social worker to serve in the role.

action

ACCC EDUCATION UPDATES

The Center for Provider Education
ACCC
Association of Community Cancer Centers

Community Resource Centers Announced!

ACCC's 39th Annual National Meeting in March 2013 provided a backdrop for the announcement of the Association's Community Resource Centers (CRCs). CRCs are ACCC-member programs that have extensive experience treating patients with multiple myeloma (MM) and other small-population cancers, including chronic myeloid leukemia (CML) and acute promyelocytic leukemia (APL). As virtual experts-in-residence, the CRCs will serve as resources and mentors for other community cancer centers that treat patients with these small-population cancers. The selected CRCs are:

- Hackensack University Medical Center, John Theurer Cancer Center, Hackensack, New Jersey (for CML)
- St. Vincent Hospital/Peyton Manning Children's Hospital, Indianapolis, Indiana (for adult and pediatric APL)
- Seattle Cancer Care Alliance, Seattle, Washington (for APL, CML, and MM)
- The Nebraska Medical Center, Omaha, Nebraska (for CML and MM)
- Winship Cancer Institute, Emory University, Atlanta, Georgia (for APL, CML, and MM).

Each of these CRCs will be available through the newly-created, ACCC members-only Small-Population Cancers (SPC) Forum on MyNetwork, where you can post questions and receive a response in real time or connect with the CRCs directly by using the contact information listed. Questions will be answered by one of the CRC's team-based clinicians. In addition, there will be a resource library available where you can access full-text, peer-reviewed journal articles on each of these small-population cancers.

For more information on the Community Resource Centers and the new Small-Population Cancers Forum, read the special supplement that mailed with this *Oncology Issues* or visit *www.accc-cancer.org/education/SPC-Overview.asp*.

ACCC Launches Daily Clinical Newsletter

ACCC is now offering members a customizable daily newsletter providing direct links to the latest clinical news and information, aggregated from dozens of news sources from around the country. This free subscription allows you to:

- Customize newsfeeds by the criteria that matter most to you.
- Select preferences based on company, pathway, tumor, product, and other areas of interest.

To subscribe go to *www.obrintel.com/user/obrdaily/ACCC,* create a username and password, and select your preferences. ACCC has partnered with OBR, a leading publisher of oncology news and information to provide this exciting new service.

ACCC Welcomes its Newest Members

Methodist Healthcare System
Methodist Cancer Center
San Antonio, Tex.
Delegate Rep: Jonathan Tinker
Website: *www.sahealth.com*

Mountain States Health Alliance
Regional Cancer Center at Johnson City Medical Center
Johnson City, Tenn.
Delegate Rep: Vanessa Bramble
Website: *www.msha.com/oncology*

Southwest MS Regional Medical Center
The Mississippi Cancer Institute
McComb, Miss.
Delegate Rep: Chastity Burnette
Website: *www.smrmc.com*

SAVE THE DATE!

ACCC Regional Oncology Economic & Management Meetings

- **June 11, 2013** | East Lansing Marriott at University Place East Lansing, Mich.
- **Oct. 22, 2013** | Hilton Eugene & Conference Center Eugene, Ore.
- **Nov. 7, 2013** | Doubletree Hotel St. Louis at Westport St. Louis, Mo.
- **Dec. 10, 2013** | Hilton Savannah Desoto Savannah, Ga.

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

Boehringer Ingelheim 11
www.boehringer-ingelheim.com

Careers 35

Elekta ..... Cover 2
www.elekta.com/experience

Incyte 13
www.incyte.com

The Leukemia & Lymphoma Society ..... Cover 3
www.lls.org

Oncology Management Consulting Group 9
www.oncologymgmt.com

The Cancer Genome Atlas 7
http://cancergenome.nih.gov

Varian Medical Systems ..... Cover 4
www.varian.com

Wal-star, Inc. 51
www.wal-star.com

This index is provided as an additional service.
The publisher does not assume liability for error or omissions.

The Story Behind the Dream Hat

BY RAE REAM, RN, BSN, CNOR

As a staff nurse in the operating room at the Ohio State University Comprehensive Cancer Center, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, (The James) I do not have the opportunity to spend a lot of time with our patients while they are awake, so I try to make the most of the little "awake" time that I do get to spend with them before they come back to the Operating Room. This is one such experience with a particular patient who I did have the privilege to meet and spend a little time with in the pre-op area before her surgery.

The patient was a 22-year-old woman newly diagnosed with breast cancer. She was understandably anxious and frightened about her upcoming surgery.

I introduced myself as her operating room nurse and held her hand as I answered some questions for her.

We talked a little about her future ambitions to become a nurse. I learned that she was a nursing student who had put her plans on hold while undergoing treatment. She shared with me that her biggest fear was not the surgery she was undergoing today, but the possibility that she might have to undergo chemo and radiation treatments after her surgery.

She was worried about losing her hair and what she might look like.

She had noticed all of the colorful hats that the staff and I were wearing and said that she might look into purchasing some for herself to wear "just in case."

Surrounded by several family members, she told me that they were all praying that her surgery today would come back with good results and further treatment would not be needed. I told her that I, too, would pray for her.

After leaving the patient I immediately went to my locker where I keep several hats that I make for myself and staff to wear as part of our scrub attire while working in the operating room. I selected a hat that I thought my patient would like. It was a fun hat made up of stethoscopes, B/P cuffs, and nursing caps.

I then went back to the pre-op area where my patient was anxiously waiting with her parents. Showing her the hat, I asked her if she liked it. She said she *loved* it! Then I told her that while she was not a nurse, I believed when she did become a nurse she would be an excellent one. I said that I wanted her to have the hat and to remember—even if she did lose her hair—nurses are all heart and soul, and the hair does not really matter. In other words, it is not what you look like on the outside that matters, but the compassion and empathy you feel on the inside that makes the difference. With tears in her eyes, my patient thanked me and gave me a hug.

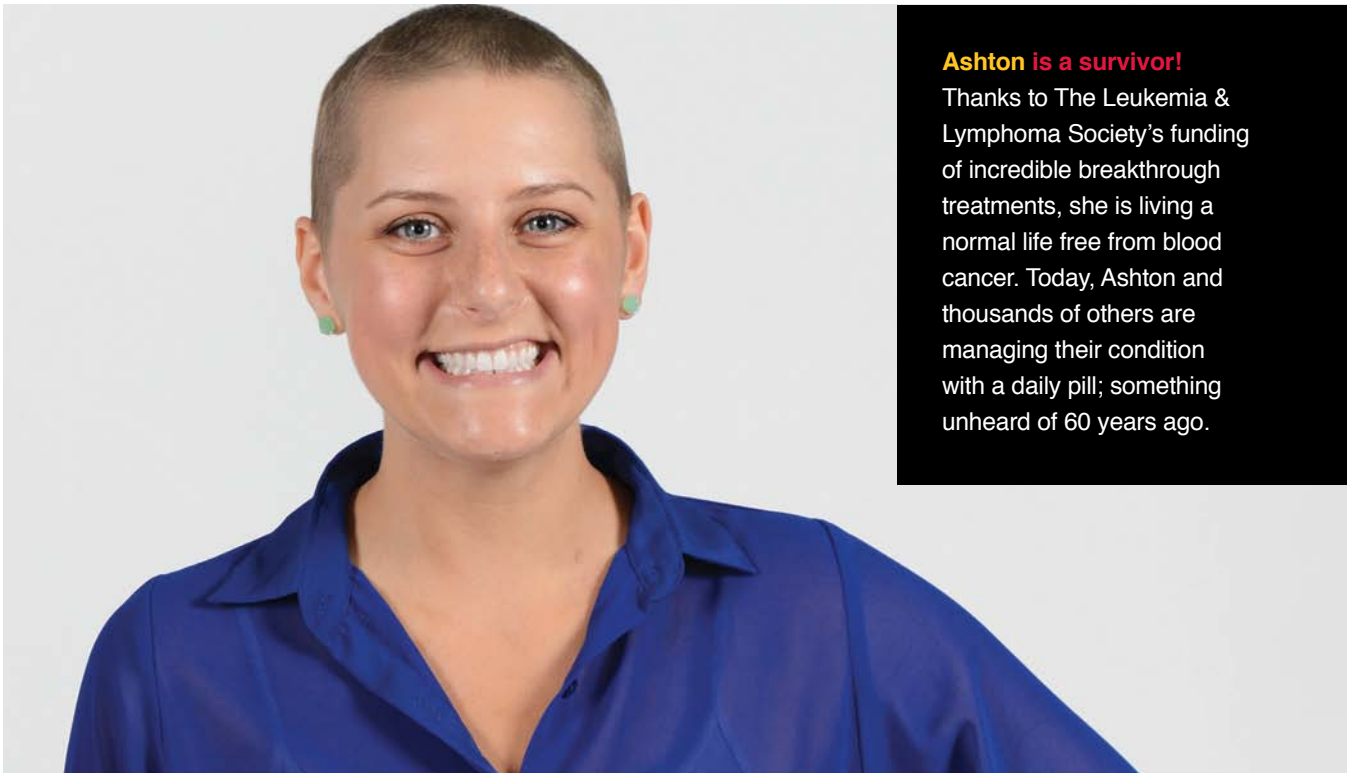
Overwhelmed at my patient's response to my simple gesture, I was inspired to develop the *Dream Hats Project*. My goal: for every cancer patient to receive a hat. For patients facing chemo and the possibility of losing their hair, a hat can offer a sense of dignity and confidence. For others a hat can be a reminder of the challenges they must overcome; for still others a special hat may help inspire the courage to go forward. While that is my goal, my dream is for every patient to face the future with faith, hope, and a resolve to one day cure cancer.

The *Dream Hats Project* has now expanded beyond the walls of The James. We are piloting the project in several surrounding hospitals and cancer centers. The "Dream Team" is indeed dreaming big and one day we will wake up and find that we live in a cancer-free world. A world where the cloud of a cancer diagnosis is only a distant memory and that finally cancer and even the *Dream Hats Project* no longer exists.

For more information about Dream Hats, Inc., visit us at *www.dreamhats.org* or follow us on Facebook at *www.facebook.com/JamesDreamHats*.

—Rae Ream, RN, BSN, CNOR, is an operating room staff nurse at the Ohio State University Comprehensive Cancer Center, Arthur G. James Cancer Hospital and Richard J. Solove Research Institute, Columbus, Ohio.

we can see the end of cancer from here.



Ashton is a survivor!
Thanks to The Leukemia & Lymphoma Society's funding of incredible breakthrough treatments, she is living a normal life free from blood cancer. Today, Ashton and thousands of others are managing their condition with a daily pill; something unheard of 60 years ago.

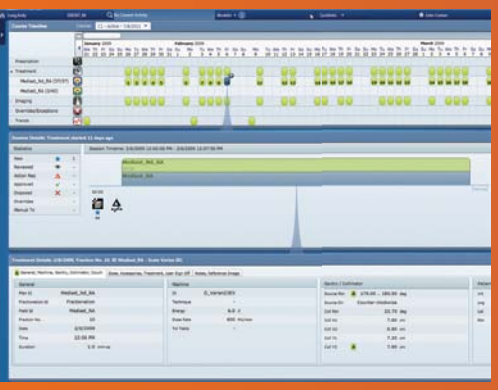
Please join us for upcoming telephone/web education programs:

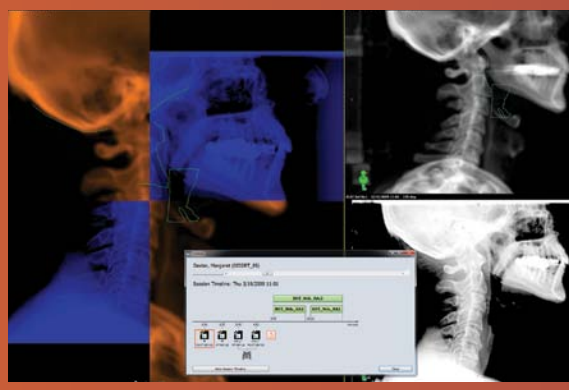
- **May 21st** on **Slow-Growing Lymphomas**, featuring **Stephen M. Ansell, MD, PhD**
- **May 29th** on **Peripheral T-Cell Lymphoma**, featuring **Julie M. Vose, MD, MBA**
- **June 3rd** on **Myeloma**, featuring **S. Vincent Rajkumar, MD**.

Register at www.LLS.org/professionaled.

someday is today | LEUKEMIA & LYMPHOMA SOCIETY®
fighting blood cancers

Find out more at lls.org or call 800.955.4572
Refer your patients to the LLS Information Resource Center for personalized advice specialists.





BRIDGE ONCOLOGY CARE AND TECHNOLOGY.

ARIA® Oncology Information System

Provide the foundation to optimize care coordination and clinical efficiency with ARIA — a powerful information and image management solution. It's designed to support the specific clinical needs of your oncology practice and your clinical workflow. With ARIA, leverage the power of technology to assist you in providing quality, personalized care for each of your patients.

See us at ASCO 2013, booth #20083. To learn more, visit varian.com/ARIA

VARIAN
medical systems
A partner for **life**