

# OPERATING AND MANAGING FREESTANDING CANCER CENTERS

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**T**alking about bottom line issues in health care makes providers uneasy. The prevailing attitude has been that health care is a service. The reality is that health care is now a multibillion dollar industry with all the economic constraints of business tagged on.

While cost containment may have forced hospitals to identify and develop product lines or cost centers, administrators are quick to dilute these harsh referral terms. Administrators may deal with bottom line issues, but they must also temper that reality with traditional health care attitudes.

These concerns hold particularly true for oncology. The reality of cancer care today is that providers are seeking ways to offer multi-modality treatments in cost-effective settings. Controversy aside, freestanding cancer centers (FCCs) are seen as one way to offer such care. How FCCs are operated and managed depends greatly on ownership and control issues and the philosophy of care.

## WHO OWNS AND CONTROLS FCCs?

Several different programmatic and ownership configurations come into play when discussing freestanding cancer centers. Some FCCs are merely an outpatient department of a hospital; some are jointly owned by physicians and a hospital; some may be owned by several hospitals; and some FCCs may have financial investors that have no direct involvement in cancer care.

These different ownership configurations have a bearing on who controls the cancer program. If an FCC is an outpatient department of a hospital, the cancer program will likely be operated as any other outpatient department of the hospital. It is when the complexities of joint ventures come into play that ownership and control issues become clouded. (see page 16).

Richard Taylor, a senior partner with Cancer CarePoint, Inc., an Atlanta-based

consulting firm, defines a joint venture for a cancer program as "a relationship between a hospital and a group of physicians or a group of physicians alone working together, which have ownership position in either the assets and/or operations of a cancer center."

Who owns the assets or the building and equipment, and who controls the operations or the administrative and clinical components, impacts on how decisions are made. These are two different but interrelating aspects. Decisions to purchase a new linear accelerator, or to offer a particular service, affect an FCC's viability.

## GETTING THE PHYSICIAN COMMUNITY INVOLVED

One of the critical issues facing the successful operation of a freestanding cancer center depends on the willingness of referring physicians to cooperate with the cancer center. The intricacies of cancer patient management often become difficult to explain to nonspecialists, especially when the oncologist suggests that a cancer patient remain under his supervision and care.

John J. Lynch, M.D., chief of oncology at the Washington Hospital Center in Washington, D.C., recognizes the concerns of referring physicians. Lynch is overseeing the development of a cancer center at The Washington Hospital Center, and he has been out in the

community seeking physician support. "We recognize the need to be responsive to referring physicians. Every effort will be made to get the patient back to the referring physician, or to give information on the patient's condition," notes Lynch.

Over recent years, patient referral patterns within the specialty of oncology have changed. Patients that surgeons previously managed alone are now referred to medical and radiation oncologists for additional care. Medical and radiation oncologists may refer to each other, but radiation oncologists are generally on the receiving end. In some cases, the surgical oncologists and radiation oncologists may be at odds as to which modality is appropriate for certain stages of cancer.

"Typically, the attending physician refers to a surgeon or a medical oncologist. Most frequently, it is the surgeon who first sees the cancer patient. If appropriate, he may then refer the patient to either a medical or radiation oncologist," says Rose Guererro, president of Professional Oncology Resources.

Although battling for patient referrals is inherent to the specialty, there are other physician conflicts. The disparity of income between surgeons, medical oncologists, and radiation oncologists sometimes creates tension between the groups. Surgeons may still dominate the cancer program and radiation oncologists may make the most money, but medical

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# The Antiemetic Prescribed Most\*

## Compazine®

brand of

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See complete prescribing information in SK&F literature or PDR. The following is a brief summary.

**Indications:** For control of severe nausea and vomiting.

**Contraindications:** Comatose or greatly depressed states due to C.N.S. depressants; pediatric surgery; use in children under 2 years of age or under 20 lbs.; use in children for conditions for which dosage has not been established.

**Warnings:** The extrapyramidal symptoms which can occur secondary to 'Compazine' may be confused with the central nervous system signs of an undiagnosed primary disease responsible for the vomiting, e.g., Reye's syndrome or other encephalopathy. The use of 'Compazine' and other potential hepatotoxins should be avoided in children and adolescents whose signs and symptoms suggest Reye's syndrome.

May cause tardive dyskinesia in some patients on neuroleptic (antipsychotic) therapy, usually long-term. This syndrome consists of potentially irreversible, involuntary dyskinetic movements. The risk of tardive dyskinesia and likelihood of irreversibility are thought related to duration of treatment and total cumulative dose of neuroleptic drugs.

Neuroleptic Malignant Syndrome (NMS), a potentially fatal symptom complex, has been reported in association with antipsychotic drugs. Clinical manifestations include: hyperpyrexia, muscle rigidity, altered mental status and evidence of autonomic instability.

The management of NMS should include 1) immediate discontinuation of antipsychotic drugs and other drugs not essential to concurrent therapy, 2) intensive symptomatic treatment and medical monitoring, and 3) treatment, if available, of any concomitant serious medical problems.

'Compazine' Ampuls contain sodium bisulfite and sodium sulfite, sulfites that may cause allergic-type reactions including anaphylactic symptoms and life-threatening or less severe asthmatic episodes in certain susceptible people. The overall prevalence of sulfite sensitivity in the general population is unknown and probably low. Sulfite sensitivity is seen more frequently in asthmatic than in nonasthmatic people.

Use in patients with bone marrow depression only when potential benefits outweigh risks. Patients who develop a hypersensitivity reaction (e.g., blood dyscrasias or jaundice) to a phenothiazine generally should not be reexposed to any phenothiazine. Caution patients about activities requiring alertness (e.g., operating vehicle or machinery), especially during the first few days' therapy. Prochlorperazine may intensify or prolong the action of other C.N.S. depressants.

Use in pregnancy is not recommended except in cases so serious and intractable that, in the physician's judgment, drug intervention is required and potential benefits outweigh possible hazards. There have been instances of prolonged jaundice, extrapyramidal signs, hyperreflexia or hyporeflexia in newborn infants whose mothers received phenothiazines. There is evidence that phenothiazines are excreted in the breast milk of nursing mothers.

**Precautions:** The antiemetic action of 'Compazine' may mask the signs and symptoms of overdosage of other drugs and may obscure the diagnosis and treatment of other conditions such as intestinal obstruction, brain tumor and Reye's syndrome (See Warnings). Postoperative aspiration of vomitus has occurred in a few surgical patients who received prochlorperazine as an antiemetic. When used concomitantly with cancer chemotherapeutic drugs, may obscure vomiting as a sign of these agents' toxicity. Deep sleep and coma have been reported with prochlorperazine, usually with overdosage.

Neuroleptic drugs cause elevated prolactin levels that persist during chronic administration. Since approximately one-third of human breast cancers are prolactin-dependent *in vitro*, this elevation is of potential importance if neuroleptic drug administration is contemplated in a patient with a previously detected breast cancer. Neither clinical nor epidemiologic studies to date, however, have shown an association between the chronic administration of neuroleptic drugs and mammary tumorigenesis.

Permanently stop neuroleptic therapy if neuromuscular reactions occur in pregnant women or in children.

**In children with acute illnesses or dehydration, use only under close supervision.** Avoid high doses and parenteral administration when cardiovascular system is impaired since hypotension has occurred. Use cautiously in patients with glaucoma. Use with caution in persons who will be exposed to extreme heat since phenothiazines may interfere with thermoregulatory mechanisms. Phenothiazines can diminish the effect of oral anticoagulants. Phenothiazines can produce alpha-adrenergic blockade. Thiazide diuretics may accentuate orthostatic hypotension that may occur with phenothiazines. Antihypertensive effects of guanethidine and related compounds may be counteracted when phenothiazines are used concomitantly. Concomitant administration of phenothiazines with propranolol results in increased plasma levels of both drugs and may also precipitate phenytoin toxicity. Phenothiazines may lower the convulsive threshold; dosage adjustments of anticonvulsants may be necessary. Presence of phenothiazines may produce false positive phenylketonuria (PKU) test results. Patients should not receive 'Compazine' 48 hours before or 24 hours after myelography with the contrast medium metrizamide.

**Adverse Reactions:** Drowsiness, dizziness, amenorrhea, blurred vision, skin reactions. Hypotension. Cholestatic jaundice, leukopenia, agranulocytosis. Fatty changes in the liver have been observed in a few patients who died while receiving the drug (no causal relationship has been established). Neuromuscular (extrapyramidal) reactions: motor restlessness, dystonias, pseudo-parkinsonism, tardive dyskinesia, and a variant, tardive dystonia. Contact dermatitis is a possibility if 'Compazine' injection (solution) inadvertently gets on hands or clothing.

**Other adverse reactions reported with 'Compazine' or other phenothiazines:** Some adverse effects are more frequent or intense in specific disorders (e.g., severe hypotension in mitral insufficiency or pheochromocytoma). Grand mal and petit mal convulsions; altered cerebrospinal fluid proteins; cerebral edema; prolongation and intensification of the action of C.N.S. depressants, atropine, heat and organophosphorus insecticides; dryness of mouth, nasal congestion, headache, nausea, constipation, obstipation, adynamic ileus, ejaculatory disorders/impotence, priapism, atonic colon, urinary retention, miosis and mydriasis; reactivation of psychotic processes, catatonik-like states; hypotension (sometimes fatal); cardiac arrest; pancytopenia, thrombocytopenia, purpura, eosinophilia, hemolytic anemia, aplastic anemia; biliary stasis; hyperglycemia, hypoglycemia, glycosuria, lactation, galactorrhea, gynecomastia, menstrual irregularities, false positive pregnancy tests; photosensitivity, itching, erythema, urticaria, eczema up to exfoliative dermatitis; asthma, laryngeal edema; angio-neurotic edema, anaphylactoid reactions; peripheral edema; reversed epinephrine effect; hyperpyrexia; mild fever after large I.M. doses; increased appetite; increased weight; a systemic lupus erythematosus-like syndrome; pigmentary retinopathy; with prolonged administration of substantial doses, skin pigmentation, epithelial keratopathy, and lenticular and corneal deposits.

EKG changes have been reported. Discontinue long-term, high-dose therapy gradually.

**Note:** Sudden death in patients taking phenothiazines (apparently due to cardiac arrest or asphyxia due to failure of cough reflex) has been reported.

**Supplied:** Tablets—5, 10 and 25 mg., in bottles of 100; Spansule® capsules—10, 15 and 30 mg., in bottles of 50; Injection—5 mg./mL. in 2 mL. ampuls, 10 mL. vials and 2 mL. disposable syringes; Suppositories—2½, 5 and 25 mg.; Syrup—5 mg./5 mL.; Single Unit Packages of 100 (intended for institutional use only)—5 and 10 mg. tablets; 10, 15 and 30 mg. 'Spansule' capsules.

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oncologists are becoming more assertive.

"The medical oncologists want a greater piece of the pie. We are now seeing more medical oncologists practicing together. Certainly, five medical oncologists working independently of each other in one town does not wield as much power as those same five working together," states Cancer CarePoint's Richard Taylor.

Taylor suggests that medical oncologists are becoming more dominate in cancer program development for two reasons: "First, the subspecialty of medical oncology has grown, and now more qualified medical oncologists are in the system. Secondly, the medical community now recognizes that the medical oncologist is two people: He is a family practitioner of the cancer patient,

*Surgeons may still dominate the cancer program and radiation oncologists may make the most money, but medical oncologists are becoming more assertive.*

and he is a chemotherapist. In his first role, he has more say on how cancer programs are developed."

A primary reason for hospital interest in FCCs is that it can be a vehicle to gain more referrals. Since radiation oncologists can provide therapy in outpatient settings, and since medical oncologists can offer chemotherapy and other ancillary services in their office, both specialties are treating large groups of patients outside the inpatient setting. Hospital administrators want to bond oncologists and referring physicians more to the services of the hospital.

To do so, however, hospital administrators need to devise a system where everyone benefits, and this can become quite a challenge. For instance, a hospital may want the FCC to control laboratory, ancillary, and pharmacy billings, which many oncologists now use to supplement their practice income.

Clearly, the ability to recognize physician sensitivities is a pertinent operational consideration. Responding effectively to physicians' concerns will likely generate a strong competitive edge over other cancer programs.

## THE FINANCIAL CONSIDERATIONS OF OPERATING AN FCC

### Reimbursement

Not surprisingly, this past July the Health Care Financing Administration (HCFA) issued a transmittal (Manual Transmittal 1200), which seeks to reduce Medicare payment for radiation oncologists' professional fees. It has been long anticipated that HCFA would seek ways to curb outpatient expenses. This action appears to be the first national stance at making uniform changes in reimbursement.

"We all know that it is the intent and impact of this transmittal to reduce Medicare payments for radiation therapy. It was

only a matter of time," says Otha W. Linton, associate executive director of the American College of Radiology (ACR).

Recently, the ACR leadership and the radiation therapy leadership of the American Society of Radiologists and Oncologists (ASTRO) addressed the issue. The respective organizations encouraged members to meet with their individual carriers. "We know that many carriers leaped with glad cries," says Linton, "but, there were some carriers unfamiliar with the transmittal. We wanted our members to be prepared, and we suggested they talk with their carriers to know the potential impact."

The ACR and ASTRO leadership proposed to HCFA that in lieu of daily physician charges, a weekly medical charge be assessed. The weekly charge would represent an average payment for the weekly management of a cancer patient in any specific diagnosis category.

(On Friday, November 13th, as we went to press, HCFA released another transmittal agreeing to the weekly medical charge. As of this writing it is too early to determine all the implications of this new move.)

Yet, the new fee structure is bound to impact some FCCs. "There is an enormous range of freestanding cancer centers," notes ACR's Linton. "A facility that uses only cobalt treatment may provide good palliative care, but that facility's technical charges are not as high as a facility using more sophisticated equipment. We have talked to HCFA about this, but we recognize HCFA's difficulty to be responsive to one problem without having to carry a lot of people with it."

Although the recent HCFA trans-

cer center is affiliated with a hospital, the FCC can use the hospital's provider number to bill for the technical component of care. The technical charges cover expenses associated with the use of clinical and administrative staff, ancillary services, and the building and equipment. The physicians bill separately for their professional

"Most carriers do not understand cancer and what it takes to provide state-of-the-art cancer care. Carriers do not know that a linear accelerator can cost \$1 million, or that an FCC costs more to build because of the shielding requirements. Since 40 to 60% of all cancer patients are covered by Medicare, radiation

*HCFA agreed to ACR's weekly charge assessment idea. It is still too early to tell impact.*

services."

The other model uses a physician or a physician group provider number. "If the facility is physician-owned and has no hospital affiliation, the physicians can use a physician provider number. Physicians bill global charges, which include both technical and professional fee components," says Bookbinder.

However, using a group physician provider number can be risky. Since physician Medicare reimbursement varies from region to region, it is wise to find out current and projected status of your local reimbursement policies.

On the other hand, according to Bookbinder, if the FCC is a joint venture between a hospital, a group of physicians, and/or other investors, you may be able to use either provider number. "To use the hospital provider number for an FCC, you must meet the hospital codes and quality assurance guidelines set by the Joint Commission. As a result, cancer center facilities using hospital outpatient provider numbers are more expensive than those designed as physician offices,"

and medical oncologists should spend more time talking with their carrier, making them understand the level of sophisticated care that it takes to treat a cancer patient," suggests Bookbinder.

#### Operational Costs

Despite concerns of the potential loss of revenues for radiation oncologists, some consultants submit that hospitals have been losing money on radiation therapy for some time. The technical billing for hospital radiation therapy departments has been poorly managed. This is because most hospital billing systems are structured around inpatient services.

"It has been my experience that most hospital radiation therapy departments can tell you how they bill, but they can't tell you how much they collect on a patient. How much you collect is the true measure of financial viability," advises C. D. Pruett, president of CDP Associates, one of the firms developing freestanding cancer centers.

Hospital radiation therapy departments do not seem to charge, bill, or collect effectively. Lost revenues of a radiation therapy department may not significantly impact a large hospital, which might generate annual revenues of \$100 million, but smaller hospitals may want to reassess how they manage these departments.

An explanation as to why radiation therapy departments are not billing appropriately may be attributed to the fact that as radiation therapy departments became separate entities, hospital administrators were not looking at the uniqueness of the care delivered. And, since radiation

## *Hospital Administrators want to bond oncologists*

mittal has caused concern, FCCs face other reimbursement issues. FCC reimbursement varies and depends on what fee mechanisms are used, global fees and/or hospital and physician fees.

According to Nancy Bookbinder, director of Planning and Economic Analysis for the SHC Health Resources Group, a freestanding cancer center can bill based on two models: "If the freestanding can-

advises Bookbinder.

It is important to note that while reimbursement is erratic, it can be negotiated. The success of an FCC may depend on how well the principals educate the carriers. To do this effectively, the principals need to know their costs, the kinds of cancer patient they most commonly care for, and the projected cancer patient load.

oncologists bill separately for professional fees (at least for now), they do not spend much time worrying about the hospital's lost revenues.

"In many instances, we find that the administrator of a hospital's radiation therapy department is also the administrator of the radiology department. There are no similarities between radiation therapy and radiology, except that the first four letters of each word are the same. Period. If there is no assigned administrator, you might then find a technician assigned with the task of billing," notes Cancer CarePoint's Richard Taylor.

All this suggests that moving cancer care to an outpatient setting may be more profitable for a hospital. This seems to be a trend as evidenced by the growing number of hospitals designating cancer as a product line.

Yet, the blunders of ill-managed hospital radiation therapy departments may not be sufficient reasons for starting a freestanding cancer center. There are many costs associated with operating an FCC, not all of which are easily identifiable. For instance, the cost of administering chemotherapy outside of a physician's office needs to be identified. And, the non-reimbursable costs for supportive care contributes to the total operational costs of an FCC. Support services include programs such as nutritional and financial counselling and psychosocial care.

The costs of outpatient care differs from inpatient care. Outpatient billing requires different input. Even if the FCC is hospital-affiliated, creating a new billing system specifically for outpatient cancer treatment may prove beneficial in the long run.

charges," advises Richard Taylor of Cancer CarePoint.

Recently, the Harrington Cancer Center in Amarillo, Texas, designed and implemented its own billing system. Jack McCullough, the administrator for the Harrington facility, suggests that any outpatient billing system must be flexible. "Outpatient facilities will always

putting together a cancer program. Dr. Rodger L. Bick, owner and medical director of The Regional Cancer and Blood Disease Center of Kern in Kern, California, has put together three hospital-based cancer programs. Two years ago, he decided to strike out on his own and build a freestanding cancer center, which today sees about 400 new cancer patients.

*"There are no similarities between radiation therapy and radiology, except that the first four letters of each word are the same."*

face reimbursement problems. All third parties change the rules annually. By the time you comply with the rules, they change again. You then have to figure out how to adapt to the new system."

### THE ORGANIZATIONAL STRUCTURE

#### The Medical and Administrative Directors

Regardless of the ownership structure, operating a freestanding cancer center requires two key management players: a medical director and an administrative director. Each manager has a specific role.

Generally, the FCC's medical director oversees the operation of the cancer program -- both clinically and administratively. The quality of care that is delivered, and the staff who delivers that care, must be directed by an individual with clinical and managerial experience.

"How well a freestanding cancer center

"I strongly believe that you can deliver quality cancer care in freestanding facilities. Not only are they more cost effective settings, but they also enhance the quality of life for the cancer patient," states Bick, who also remains a medical director to an area hospital's oncology program.

The reporting structure for the medical director depends on the FCC's ownership and control configurations. If the facility is not affiliated with a hospital, the medical director will likely report to the FCC's Board of Director or its owners. However, if the FCC is affiliated with a hospital, the medical director will likely report to the hospital's medical director and/or cancer committee and, ultimately, to the hospital's Board of Trustees.

The reporting structure for the administrative director also depends on the ownership and control configurations. If the facility is truly freestanding, the administrative director will likely report to the medical director. If the FCC is hospital-based, the administrator will likely report to a senior hospital administrator.

This fall, the Rex Hospital in Raleigh, North Carolina, opened the Rex Cancer Center. Although the cancer center has its own dedicated medical director, Dr. Patrick J. Cavanaugh, the administrator of the Rex Cancer Center also serves as the hospital's Vice President for Ambulatory Services. And, the cancer center's budget is overseen by the hospital's senior vice president.

"Essentially, the cancer center operates as a unit of the hospital, and we can easily identify the center's revenues

*"Since 40 to 60% of all cancer patients are covered by Medicare...oncologists should spend more time talking with their carrier..."*

"Some may say it is inefficient to have a billing system separate from the hospital's, but I believe the cost of purchasing an outpatient billing system is small compared to the benefit of having a higher collection rate. A dedicated billing system can more easily identify all the

works depends on the personality of the physician leader, who must be able to motivate both staff and administration. The medical director should be elected by the physician community," says CDP's Pruett.

Ideally, the medical director should be an oncologist who has had experience

and expenses. All technical revenues are generated the same way, and physicians bill for their own professional services," says Matthew M. Person III, senior vice president of Rex Hospital.

Whether the FCC is hospital-affiliated or an independent facility, the administrative director implements the FCC's policies and procedures and manages several departments. The administrative director needs to understand how to operate and manage a business, but also needs to understand the trends in health care in general and the trends in oncology in specific.

"The administrative director also serves as a goodwill ambassador -- one who is able to deal effectively with the cancer patients and their families, physicians, hospital administration, staff, and the general public," says Rose Guerrero of Professional Oncology Resources.

While the administrative and medical directors have different management roles, there needs to be one major commonality: Each must share the FCC's philosophy of cancer care.

**Physician Prerogatives**

To attract oncologists and referring

physicians to an FCC, owners must respect physician prerogatives and provide for a certain degree of independence. A medical director may oversee the delivery of clinical cancer care, but control over participating physicians is a delicate matter. If physicians are perceived as employees, the FCC will fail because the physicians will pack-up and go home.

Carolyn Sawyer, a physicist at the Orlando Regional Medical Center and the administrator of three privately-owned freestanding radiation therapy centers, suggests that physicians need to be involved in day-to-day management of a center, too. "Physicians need to be in charge of those who work with them. For a physician not to have control would be dangerous. This is from a liability standpoint all the way down the line."

Bringing all the physicians into the decision-making process makes sense. It assures physicians that the FCC's owners are listening to them, and that their concerns matter. Furthermore, it is an added quality assurance measure.

A major operational aspect of the Salick Health Care system is dedicated to promoting better understanding with physicians. "Every other week we hold meetings with physicians to discuss opera-

tional issues. The physicians know that their suggestions are taken into consideration, and that the valid ones will be incorporated into the system," says Dolores Esparza, director of nursing at the Cedars Sinai Comprehensive Cancer Center in Los Angeles, California. Esparza was instrumental in developing operational procedures for Salick's outpatient cancer centers.

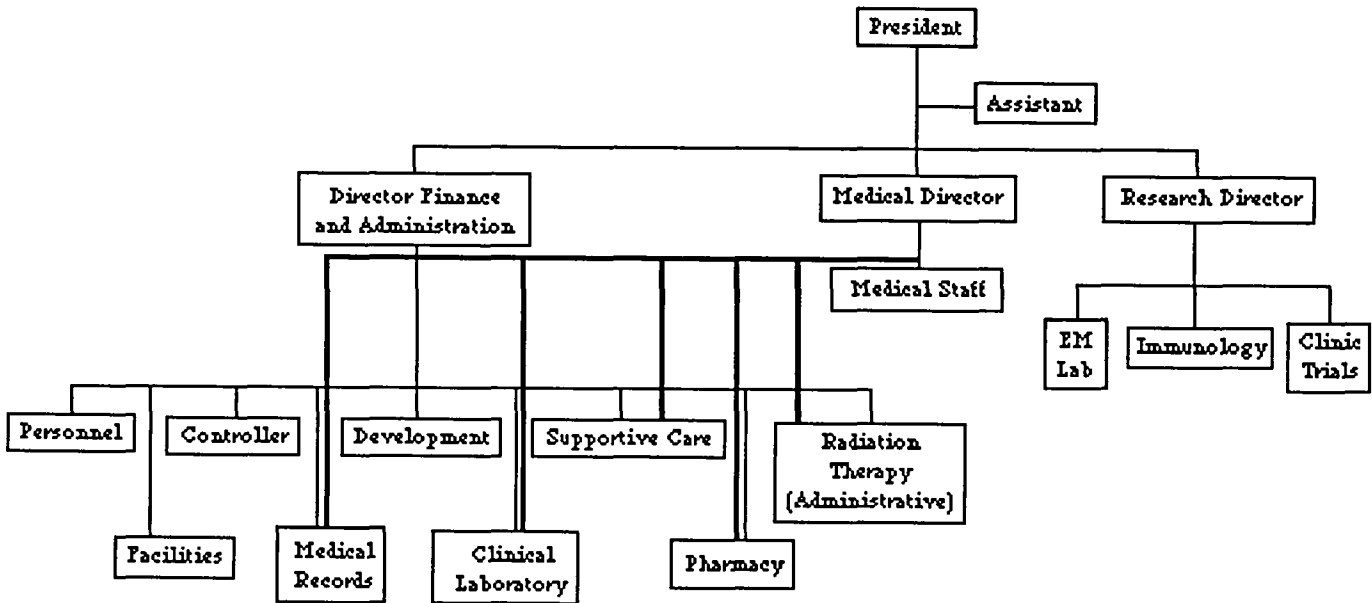
**The Staff**

A well-trained and experienced staff is paramount to the successful operation of a freestanding cancer center. Moreover, the clinical and administrative staff need to share the FCC's philosophy of care.

It is difficult to identify an exact staffing complement. Freestanding cancer centers range in physical size, patient load, and services. In some instances, allocating dedicated staff and services to the cancer center may not be financially feasible. With hospital-affiliated freestanding cancer centers, it is not uncommon to share staff and services. Accordingly, the hospital must have a strong commitment

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**THE DON AND SYBIL HARRINGTON CANCER CENTER  
OPERATIONS REPORTING RELATIONSHIPS**



———— As pertains to medical matters

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to the cancer center to effectively integrate inpatient and outpatient components.

"Some shared services are important because it is impossible to plan for everything. While a hospital gains from the expert services of the cancer center, it is also a security to us to have inpatient services for emergency purposes, which is why our centers always affiliate with a hospital," states Salick's Esparza.

Regardless of the FCC's ownership and management configurations, the staff can be an invaluable source of creativity. The day-to-day interaction with cancer patients enhances the staff's ability to make insightful suggestions. This knowledge can contribute to the FCC's continuing clinical and supportive care development.

"While some management structures have the ability to gain clarity in organizational visibility, these same structures may lose intangible strengths. Managers must constantly communicate with all staff levels. This may be regarded as time-consuming, but the outcome is better quality for both the patient and staff," states Carolyn Sawyer.

## IDENTIFYING AN OPERATING SYSTEM

### Policy and Procedures

Just as no standard programmatic concept model exists for a freestanding cancer center, there seem to be no standing policies and procedures. Other than those standard practice references, such as the Blue Book for radiation therapy, huge var-

cancer patients seen, the physicians' treatment philosophy, the institutional commitment to the program, and the cost of providing care," says Rose Guerrero of Professional Oncology Resources.

Operating procedures are a necessity. From the moment an FCC is conceptualized, begin to document procedures.

And, all operating procedures need to be flexible because the delivery of cancer care constantly changes.

"Every freestanding cancer center should adopt a policy and procedures manual. It makes for a smoother operation, and it provides concrete instructions to the staff. The manual should contain information such as scope of services, the mission statement, an organizational chart, medical records procedures, and even how to contact a physician," suggests Salick's Esparza.

### Data Management Systems

Reliable financial data gives any cancer program a competitive edge. Just as an FCC needs sophisticated treatment equipment, FCC owners should invest in a good financial management system. The ability to identify cost information helps plan for the future.

But, data management systems for freestanding cancer centers are still in a relatively primitive stage. Some radiation

measure. By collecting data, you can identify patterns. If you are unsure what to collect, just try tracking what you are doing for awhile. And, if you own or manage more than one FCC, compare data from one facility to another," suggests Carolyn Sawyer.

One hidden operational cost of a

*Reliable financial data gives any cancer program a competitive edge.*

freestanding cancer center may be the need to collect and report tumor registry data to state agencies. Cancer is a reportable disease in many states, and as more states require hospitals to report cancer patient data, FCCs will likely be designated as facilities that must report.

### Measuring Physician and Staff Productivity

While cancer is a highly complex and technical disease, the emotional needs of cancer patients may take a significant amount of physician and staff time.

How, then, can productivity be measured? Obviously, the intangible needs of the cancer patient can not be regulated. One cancer patient may be more emotionally distraught than another, requiring more physician and staff time. However, measuring time is important. Cancer patients are highly anxious, and making them wait for care just adds to their anxiety.

This is an issue that many freestanding facilities are addressing. "Our policy is that we try not to have a patient wait more than five minutes before someone initiates care, whether it is a physician consulting with the patient, or a nurse escorting the patient to a treatment room," says Salick's Esparza.

"We have tried to classify each category of patient for a certain level of care," continues Esparza, "We know that a new patient requires one hour of physician and staff time, and that a returned patient takes 20 minutes. Then there are certain emergency procedures that we can estimate. For instance, a patient coming in with a low white count takes 20 minutes for evaluation."

*"Outpatient facilities will always face reimbursement problems. All third parties change the rules annually."*

iations in FCC operating procedures range from patient/nurse ratios to how many telephone calls a receptionist should be able to answer within a minute.

"There are certain accepted rules-of-thumb that cancer programs follow -- for instance, two technicians per machine. But, there are many factors that impact how a center is operated -- factors such as the types of services rendered, the type of

therapy equipment manufacturers provide patient tracking software as an adjunct to their equipment. Yet, there is little uniformity in collection and no comparative information from freestanding cancer centers. Although individual radiation therapy practices and individual entrepreneurs have developed their own software, no national standard has emerged.

"Collecting data is a quality assurance

Recognizing that psychosocial care is important to every cancer patient, the Salick centers provide for all patients to be evaluated by a social worker. Esparza notes that each new cancer patient requires a minimum of 30 minutes with a social worker.

Carolyn Sawyer suggests that some staff productivity is easier to evaluate than others. "Quantitative evaluation of an office manager is relatively easy. Part of our office managers' jobs is to post and

the cancer patients are truly taken to heart, freestanding cancer centers may serve both the patient and the provider.

"The philosophy of FCCs should be the willingness to forego the profit of a normal oncology office and to put more effort and money into education, quality assurance, and quality control. If the FCC is dedicated to quality, it will be difficult to fail," says Dr. Rodger Bick whose facility was part of a pilot study by the American College of Surgeons (ACoS) to

management strategies that incorporate good business and medical ethics must sustain freestanding cancer centers.

Throughout the country, freestanding cancer centers have become a topical and major issue. Yet, the operational issues discussed in this article, and the feasibility issues discussed in the last issue of *The Journal of Cancer Program Management*, suggest that there is no one way to pull together all of the necessary components. While numerous hospitals, oncologists, and entrepreneurs are considering developing FCCs in a variety of configurations, they must be mindful that all forms of care will eventually be evaluated for quality as well as for cost effectiveness.

Today, many freestanding cancer centers seem to be effectively bringing together community resources into a combined cancer program. Whether in a separate freestanding facility, or those directly attached to a hospital, these FCCs are providing quality cancer care to geographically underserved regions.

However, while FCCs can be instrumental in filling voids in cancer care, particularly in rural areas, not providing state-of-the-art care is dangerous and unethical. Freestanding cancer centers need to be continually monitored and evaluated for the quality of care delivered. ■

*"The philosophy of FCCs should be the willingness to forego the profit of a normal oncology office and to put more effort and money into education, quality assurance, and quality control."*

collect. The office managers' evaluation will be based partially on the percentage of collections."

"Other ways to measure staff productivity is to look at billable procedures," continues Sawyer. "For instance, we can evaluate a dosimetrist by looking at the number of treatment plans done in a day. Of course, the evaluation considers the complexity of a patient's treatment."

However an FCC measures productivity, the intangible needs of physicians and the staff, like those of the cancer patient, differ. Some physicians choose to spend more time with their patients than others. And some staff have stronger emotional reactions to the needs of the cancer patient than others.

**MEASURING QUALITY OF CARE**

Bringing together the different factions of cancer care providers can be valuable to a community. If the needs of

assess freestanding cancer centers. According to Bick, the facility met every ACoS requirement except accreditation by the Joint Commission.

Recently, the Joint Commission approached the Association of Community Cancer Centers to discuss how the two organizations could work together to assess the quality of cancer care delivered in outpatient settings. Until such qualitative and quantitative measurements can be developed, sound operational and