Oncology Issues

ISSN: 1046-3356 (Print) 2573-1777 (Online) Journal homepage: https://www.tandfonline.com/loi/uacc20

ACCC's Future Role: Survival Training in Oncology

Oncology Issues
The Journal of the Association of Community Cancer Centers

Senior Editor
Lee E. Mortenson, M.S., M.P.A.
ACCC Executive Director

Managing Editor
Marilyn Mannisto

Production Editor
Carol K. Johnson

Oncology Issues is published quarterly at the Association of Community Cancer Centers' Executive Office, 11600 Nebel Street, Suite 201, Rockville, Maryland 20852. Editorial correspondence, changes of address, manuscripts, and letters to the Editor should be addressed to: Lee E. Mortenson, Senior Editor, *Oncology Issues*, 11600 Nebel Street, Suite 201, Rockville, Maryland 20852.

INFORMATION FOR CONTRIBUTORS

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.
Notes to Contributors, containing detailed information about article submission guidelines, are available upon request.

Subscription Rates

Individual: $40.00 per year; Institutional and Libraries: $60.00 per year. ACCC membership dues cover general and delegate member subscriptions. Copies are available for a fee. Bulk rates available upon request.

Advertising

Send correspondence, display advertising, insertion orders, printing materials to Marilyn Mannisto, Managing Editor, *Oncology Issues*, 11600 Nebel Street, Suite 201, Rockville, Maryland 20852. Questions for general information may be directed to Marilyn Mannisto at 301-984-9496.

Postage Privileges

Postmaster: Please send address changes to Association of Community Cancer Centers, 11600 Nebel Street, Suite 201, Rockville, Maryland 20852.

ACCC's FUTURE ROLE: SURVIVAL TRAINING IN ONCOLOGY

It's a hard world out there. As I travel around the country, I see the difficulties that the oncology profession is facing as it integrates the need to be business-like with the realities of medicine, as it attempts to prepare for the biological revolution, and, at the same time, cope with declines in both reimbursement and capital availability. Things aren't going to get easier.

The shock of practicing in today's world is apparent whenever I speak with oncologists. The last few weeks in the states of Washington, Oregon, and California, I've heard the same questions: "How do we deal with these changes? What does it all mean to my practice and my hospital?

The way I see it, there are a number of converging trends which are going to impact the practice of oncology. First, there are the reimbursement problems. As Marilyn Mannisto's review article in this issue points out, more difficulties and complexities are on the way. These events are going to make it increasingly difficult to make a living and to provide the quality of care that should be available to patients.

Second, many community hospitals are going to have a devil of a time finding a way to adopt new technology. Some oncologists and hospitals are "bonding" and jointly developing fourth-modality technologies, like bone marrow transplantation. These new technologies require major investments in equipment, in facilities, and in physician and nursing staff development. Yet, not everyone will recognize the potential of these developments, and not everyone that recognizes the potential will have the wherewithal to develop and implement them.

Which brings me to the next trend. I believe that we will see major disparities in the types of services community cancer programs offer. Some hospitals will mount programs in new technology areas, while others will not. Still others will procrastinate. It is my belief that if hospital cancer programs do not make an investment in fourth-modality technology in the near future, they risk being shut out of its development due to a lack of capital, low returns on investment, and constraints by third-party payers, who will attempt to limit the number of facilities that supply high tech, high cost, intensive cancer therapies. Thus, our own capital requirements and our own procrastination beyond the windows of opportunity are likely to create the kind of specialization, and perhaps regionalization, of community cancer programs that we have attempted to avoid.

Of course not all of the new technology in cancer care will require major expenditures or major changes in support personnel. But the flood of new technology that is close to being marketed will require sophisticated cancer programs that know how to sort through the choices and to select "good" versus "bad" opportunities. Which means that the successful programs are most likely to have a medical director who can constantly review new opportunities and determine which ones are important to pursue, and which should be avoided. The current reimbursement situation will be an important factor in those decisions.

So let's see. Tighter reimbursement. Harder to survive. More bonding of physicians and oncology groups to hospitals. Exciting new technology. A separation of community hospital programs into two (or more) classes: those with new technology and those without. A growing need for leadership, especially cancer program medical directors. The need to set up systems to constantly evaluate new technologies and the implications of reimbursement. That's my forecast.

Now, you might ask, how can ACCC help? Well, in some ways we need to facilitate these changes; in others, we need to see if we can alter the direction of change. For example,

(Continued on page 7)

to a sufficient number of beneficiaries), and its ability to negotiate financial arrangements with eligible institutions.

According to Prudential, incentives for patient utilization include travel expenses to the facility for the patient and a companion, coverage for other necessary expenses the companion incurs during the patient's confinement, and enhanced benefit levels.

To date, seven institutions are participating in Prudential's allogeneic bone marrow transplant network: Johns Hopkins Medical Institutions, Baltimore, MD; City of Hope National Medical Center, Duarte, CA; Fred Hutchinson Cancer Research Center, Seattle, WA; University of Minnesota Hospital and Clinic, Minneapolis; the Medical Center at the University of California, San Francisco, CA (pediatric only); Barnes Hospital and the Washington University School of Medicine, St. Louis, MO; and Shands Hospital at the University of Florida, Gainesville.

Other planned networks for the future, in addition to autologous bone marrow transplants, include coronary artery bypass and angioplasty, brain and spinal cord injury rehabilitation, and select neurosurgical procedures.

ONS SALARY SURVEY

Salaries for oncology nurses range from almost $13 per hour for entry-level staff nurses to almost $19 per hour for clinical nurse specialists, according to the *1989 National Survey of Salary, Staffing, and Professional Practice Patterns in Oncology Nursing* by the Oncology Nursing Society. The survey also found that the methods for awarding routine salary increases for staff nurses included merit, based on performance evaluation (70.5 percent); across-the-board administrative increases (43 percent); and fulfillment of a contractual agreement (18.6 percent).

Overall institutional vacancy rates for professional nurses ranged from a low of 7.36 to a high of 12.83. The turnover rate on oncology units averaged 14.8 percent, ranging from 13 percent in pediatric oncology units to 32.5 percent in hematology units. The average number of FTE staff nursing positions by type of oncology unit ranged from 26 positions in a bone marrow transplant unit with a median of 11 beds to 15.5 positions in a gynecologic oncology unit with 32 beds. The average professional nurse/patient ratio ranged from 8.45 on the night shift of a combined medical/surgical oncology unit to 0.57 on the day shift in a biological unit.

CALL FOR PROPOSED BYLAWS AMENDMENT

ACCC Bylaws, adopted March 1984 by the House of Delegates, state: "Bylaws may be amended by the vote or written assent of two-thirds of the Delegate Representatives voting. Written notice of proposed Bylaws amendments must be sent to voting members at least 30 days prior to the meeting at which they are to be acted on."

Any delegate representative who wishes to suggest a Bylaws change must inform the ACCC Executive Office of that intent no later than Dec. 1, 1990, for consideration by the House of Delegates in March 1991.

All suggested amendments should be sent to the attention of Carol Johnson, Director, ACCC, 11600 Nebel St., Suite 201, Rockville, MD 20852.

CALL FOR OFFICER AND TRUSTEE NOMINATIONS

The ACCC Nominating Committee is soliciting nominations for the following 1991-1992 board positions:

- ❑ President-Elect
- ❑ Treasurer
- ❑ Four Trustee Seats

The term of President-Elect is one year. The Treasurer and Trustee positions are two-year terms. Although nominees are not required to be the voting representative of their institution, they must represent an ACCC Delegate Institution.

Letters of nomination should be sent to the ACCC Executive Office, citing the nominees' names and their respective Delegate Institution, along with a copy of their curriculum vitae. **Nominations must be received no later than December 1, 1990.**

Further information about the nomination process may be obtained from Carol Johnson, Director, ACCC Executive Office (301/984-9496). ■

From The Editor

(Continued from page 3)

the Association's reimbursement initiatives are directed toward helping make practice survival possible. The new brochure with information for patients on better insurance language should help. Our efforts to back up ASCO's initiatives with HCFA on coding and the RVS method of physician payment should help. Our state-level efforts to develop and pass legislation that guarantees reliance on the three compendia and the involvement of state organizations in resolving disputes with carriers should also help.

What about new technology? Our new technology forums provide a simplified way for program administrative managers and physician leaders to review new technology that is ready to be introduced to the community setting, and to evaluate how it might be useful to developing cancer programs. And, clearly, the ACCC's Collaborative Research Group will serve as a mechanism to gain access to new technology that is unobtainable through traditional pathways.

In terms of bonding physicians and developing programs that are current and viable, the Association's Program Committee will, no doubt, continue to secure conference speakers who are experts on Federal legislation and rulemaking, program development, leadership, marketing, facilities management, reimbursement alternatives, and physician arrangements. These are the topics that speakers will be addressing at this fall's meeting in Las Vegas.

Of course, ACCC can't solve all of the problems that confront the profession. Indeed, the trends that I've outlined above are going to make the challenges ahead far more difficult that any of us could have predicted just two or three years ago. But, if the Association can provide some of the help you need, on some of the issues that you face everyday, then your investment in us is paying off.

Lee E. Mortenson, M.S., M.P.A.
Senior Editor,
ACCC Executive Director