



The Queen of Loss-Leader Revenue Programs

Margaret A. Riley

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At this moment I am preparing our oncology program for the American College of Surgeons' Commission on Cancer (CoC) survey in July. The Commission has set forth comprehensive, definitive—and voluntary—standards for accreditation of cancer programs. Despite the survey's voluntary nature, I have yet to encounter cancer program staff willing to settle for anything less than a stellar program.

By their very nature and commitment to cancer care, staff are passionate in their pursuit of the very best for patients, families, and the community. Such has been my experience for both hospital and office practice settings of care. Likewise, there has never been a question that Saint Joseph's Hospital of Atlanta would pursue anything less than full CoC accreditation. Instead, the question has been how to support the costs of providing comprehensive services and support programs, since most are non-revenue-producing endeavors.

At my hospital, I have been affectionately referred to as the "Queen of Loss-Leader Revenue Programs," ever since our first CCOP grant was bestowed in 1987. There was great excitement about being a part of the national effort to cure cancer through clinical trials in the community. As the grantee organization, I asked our hospital to offset the cost of developing the central office as part of this important research initiative. It was the right thing to do as a cancer program and for patient care as well. Our hospital agreed. Funds from St. Joseph's, along with contributions from each of our seven affiliates, have offset the research program for twelve years!

In 1989, a proposal was submitted to the hospital administrator to support a comprehensive cancer screening program. Again, this was the right thing for a comprehensive cancer program to do. CanScreen was soon launched as a year-round approach to this component of cancer care. The following year, a multidisciplinary group from the oncology committee asked to visit Dr. Henry Lynch at Creighton University to explore risk assessment services through genetics. Once again, support was provided for travel to Omaha, Nebr., for our field study in genetics.

When it came time to launch the genetics program in 1997, we explained to our administration that genetics was the new frontier in unraveling the code of cancer, and it was right for patient care. We wanted to be part of the developing knowledge and study the psychosocial and financial impact on people who wished to participate. The administration's answer, of course, was "yes."

All through the 1990s, development of our Cancer Survivors Network has grown from an annual event to

a full-service program with an advisory board of survivors, support groups, visitation and telephone connection programs, a library, newsletters, and more. Initially the program coordinator was supported by a foundation grant, but after two years it has become a budgeted position because of my now familiar request—it is best for patients, families, and the community.

I tell these stories not because our program is so unique but because they tell the real story of cancer care and what we all try to offer patients. With each request for FTEs, offices, equipment, supplies, and marketing, the question posed to me has been, "Is there any revenue attached?" or "Is there a way to fund this?" to which I would answer "No" and "Perhaps," respectively. True, oncology revenues can be gleaned from many departments, such as pharmacy, lab, radiology, and not in any one cost center. Still, after many years of trying to justify support programs by examining the bottom line of each lab, X-ray, and drug, I need a support group for beleaguered administrators! And all along, foundation funds have been tapped, grants have been written, indigent care funds sought, operational budgets manipulated, and prayers of the Sisters of Mercy offered to make ends meet.

Furthermore, clinical advances have moved oncology treatment from inpatient to outpatient settings, and now we have ambulatory care cuts. Over the past year, there has been a constant effort on the part of nurses, physicians, administrators, and patients to explain, defend, and plead for reasonable cancer care reimbursement in the outpatient setting. The Health Care Financing Administration's proposed regulations for Ambulatory Payment Classifications (APCs) are causing hospital-based ambulatory infusion programs to critically review their viability. Likewise, calls by some members of Congress to reduce chemotherapy reimbursement in physician practices to AWP minus 17 percent require the same critical review of services provided.

Through it all, the real dilemma involves the comprehensive care needs of patients with cancer and their families. Our legislators and regulators must recognize our need to be paid for the comprehensive services we provide. Ironically, these are the same services they would insist upon should they receive a diagnosis of cancer.

Margaret A. Riley