

Cancer Care Trends in Community Cancer Centers



A survey
of ACCC membership
2012

Year three of the Association of Community Cancer Centers' member survey provides insight into how cancer programs are working to control costs, implement new standards, launch new organizational strategies, and better serve patients.

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Executive Director, ACCC

Cancer Care Trends in Community Cancer Centers is an ongoing survey of the Association of Community Cancer Centers' membership. Survey goals are to:

- Provide ACCC with information informing its advocacy mission
- Assist member organizations to understand nationwide developments in the business aspects of cancer care
- Assist members to evaluate their own organization's performance relative to similar organizations through a consistent and meaningful benchmark.

This is Year 3 of a three-year survey, and is a joint project between ACCC and Eli Lilly.



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Seven Key Findings:

1. Programs are actively seeking to reduce or control costs without compromising quality and services.

Cancer programs report that their financial health is good or very good. Most are targeting staffing, purchasing, and patient throughput to reduce costs.

Respondents emphasized that they seek the "right" staffing or "flexible" staffing, and not necessarily a reduction in FTEs. Staffing is evaluated with regard to overtime, benefits, retirement program, and call pay.

Less than one-quarter (24 percent) of respondents indicated that their strategies to reduce costs include delaying IT improvements. This is down significantly from 42 percent in last year's survey.

Purchasing is managed aggressively, especially for chemotherapy drugs. Programs reviewed purchasing contracts, utilized just-in-time inventory, and considered using cheaper drugs.

Several respondents mentioned that financial strategy for their cancer program is skewed more toward increasing capacity and revenue than reducing costs. Cancer programs boost revenue through a wide range of strategies, with an emphasis on those that increase volume. Fifty-six percent of responding cancer programs have increased coding reviews to improve the percentage of claims that are submitted correctly, ensure that all services are billed, and increase revenue.

Revenue-Enhancement: In Their Own Words

"We did Six Sigma about 18 months ago. This program helped us increase value added and remove waste. Specifically, we improved the way patients flow through the system and reduced drug inventory."

"Oncology is a revenue-driven business, not a cost-driven business. It's all about increasing capacity."

"We are actually increasing costs because we are understaffed due to growth – but scrutinize that we have the RIGHT staffing."

"We are making sure that we are coding charts properly, that any service we provide is fully reimbursed, and we research denials."

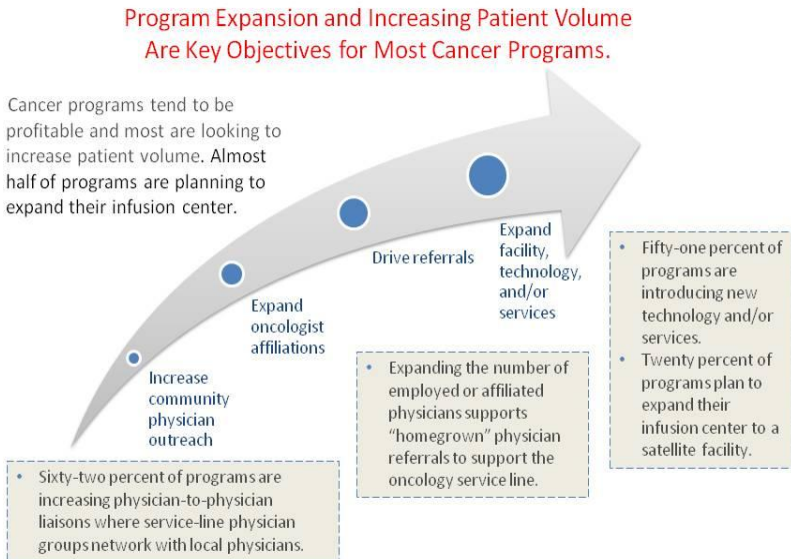
2. Almost half of respondents are planning to expand their infusion center, but expansion and replacement plans for clinical technology are limited.

Forty-six percent of respondents plan to expand their infusion center, including 20 percent that plan to expand to a satellite facility.

"Demand is driving our plans for expansion."

"We would like to catch folks on both sides of town so we don't lose them to another program."

Still, expansion and replacement plans for clinical technology appear to be limited--continuing the trend from last year. Across the line, the numbers of linear accelerators, ultrasound imaging machines, computed tomography scanners, magnetic resonance machines, and PET or PET/CT machines budgeted for purchase in the next fiscal year are down, both in the cancer center and on the hospital campus. Despite the fact that 51 percent of respondents cited new technologies and services as a way to increase revenues, IGRT and CyberKnife are the only areas of significant growth over the three years of this study.



3. Programs are increasing affiliations with community oncologists to drive referrals.

Sixty-two percent of responding programs are increasing physician-to-physician liaisons. Expanding the number of employed or affiliated physicians can increase physician referrals to support the oncology service line.

Professional services agreements (PSAs) are increasing for medical and hematological oncologists. Advantages of PSAs for the hospital include 1) presence of dedicated oncologists on site, which facilitates development of the oncology service line without the constraints of insufficient supervision, and 2) control over oncologist services that is almost similar to control over employees. Moreover, PSAs offer the ability to offer a broad range of oncology services and depth of expertise.

"A lot of oncologists are trying to join the hospital because of economic pressures from Medicare. If they will be located here, we would have to make more infusion space."

"We are adding three hem oncs for the first time to compete with other oncology groups in town."

"PSAs have tied inpatient and outpatient services together better. We also have more control over nursing policies and procedures."

4. The number of patients in need of financial assistance continues to rise.

Cancer programs are seeing more patients who are referred for expensive drugs and need help affording their medication. Programs reported an increase in the percentage of their charges that are charity care.

Cancer programs continue to see an increase in the number of uninsured or underinsured chemotherapy patients.

5. Members agree that the new Commission on Cancer standards are good for patients, but are concerned about meeting the new requirements.

The new standards include the provision of treatment and survivorship plans, palliative care services, genetics services, navigation programs and psychosocial distress screenings. Some programs are more prepared than others, but most anticipate that they will be challenged to maintain accreditation. Even the programs that feel prepared to meet the new accreditation standards expect that one or more of the criteria will require a substantial increase in resources – primarily nursing time. Members were mixed with regard to which services present the biggest challenge.

"Evaluating patients for psychosocial distress is one thing, but we need to have the resources to help these patients when we find them."

"Our biggest challenge will be to justify the cost of additional nursing. Genetics is reimbursed but survivorship and psychosocial distress screening – we can't bill for these in a way that will cover the cost of staff. As reimbursement dwindles, in reality we may have to choose between accreditation and being profitable."

"Most difficult is the treatment summaries and care plans. These are not in EMR and need to be done by hand; very time consuming."

6. Acquisition of injectables through specialty pharmacy continues to increase; pressure from payers drives this trend.

Cancer programs reported serious concerns about accepting injectables from specialty pharmacies. The cancer program is expected to assume the costs of storing and handling, but is not able to bill for these costs. The cancer program faces greater challenges with regard to operations, reimbursement, patient safety and institutional liability.

7. Participation in the 340B drug discount program is on the rise.

Participation in the 340B drug discount program is on the rise, spurred by loosened eligibility criteria and increased discounts included in the Affordable Care Act. ACCC members who participated in follow-up interviews reported that the 340B program is a major contributor to profitability. Moreover, most respondents have seen an increase of local oncology practices seeking affiliation in order to access the economic benefits of the 340B program. The 340B program may contribute to the shift of more oncology therapy to the outpatient setting; however, members emphasized that this trend is occurring regardless of 340B participation.

Section 1. Methodology

Background: Year 1 of the Survey. In July 2008 ACCC's Center for Provider Education under the direction of ACCC Executive Director Christian Downs, JD, MHA, and ACCC Senior Director of Programs and Meetings LuAnne Bankert set up an Advisory Board to select topics and scope of research for its new annual survey of community hospital cancer centers. A Steering Committee refined and approved the final survey instrument, and Year 1 of the survey was launched through an Internet-based data collection conducted between August 6, 2008, and September 23, 2008. Emails were sent to 586 ACCC members. One hundred members completed the online survey. The consulting firm of Mattson Jack DaVinci collected responses, conducted follow-up interviews in November and December 2008, and analyzed results.

Year 2 of the Survey. The Steering Committee further refined the survey instrument. Internet-based data collection was conducted between September 2009 and October 2009. All ACCC Cancer Program Members were invited to participate. Eighty-four completed the online survey. The consulting firm of Kantar Health collected responses, conducted follow-up interviews in November and December 2009, and analyzed results. Twenty members participated in one-on-one follow-up phone interviews. Key preliminary findings of the 2009 survey were released Thursday, March 18, 2010, at ACCC's 36th Annual National Meeting in Baltimore, Md. A summary of final findings appears in the July/August 2010 *Oncology Issues*, and the complete survey results were launched online July 2010.

Current Survey: Year 3. The Steering Committee again refined the survey instrument. Internet-based data collection was conducted between September 2011 and October 2011. All ACCC Cancer Program members were invited to participate. Fifty-nine completed the online survey. The consulting firm of Kantar Health collected responses, conducted follow-up interviews in December 2011, and analyzed results. Twenty members participated in one-on-one follow-up phone interviews. Key preliminary findings of the 2011 survey were released on Wednesday March 14, 2012, at the ACCC 38th Annual National Meeting. A summary of final findings will appear in *Oncology Issues*.

Trend across survey years. Trends across survey years were tested for statistical significance at the 95 percent confidence level ($p < .05$). Where trends are evident and statistically significant they are indicated with a star. Differences across survey years have no statistical significance unless indicated.

Steering Committee members include: Ernest R. Anderson, Jr., MS, RPh, Steward Health Care; Becky L. DeKay, MBA, Feist-Weiller Cancer Center; Patrick A. Grusenmeyer, ScD, FACHE, Helen F. Graham Cancer Center; and Luana R. Lamkin, RN, MPH, Mountain States Tumor Institute.

Members of the Advisory Committee include: Ernest R. Anderson, Jr., MS, RPh, Steward Health Care; Connie Bollin, MBA, RN, Akron General Medical Center, Akron General McDowell Cancer Center; Becky L. DeKay, MBA, Feist-Weiller Cancer Center; Albert B. Einstein, MD, Swedish Cancer Institute (retired) ; John Feldmann, MD, FACP, Hospice & Palliative Care of Greensboro, Greensboro, N.C.; Brendan Fitzpatrick, MBA, Alamance

Cancer Center; Patrick A. Grusenmeyer, ScD, FACHE, Helen F. Graham Cancer Center; Luana R. Lamkin, RN, MPH, Mountain States Tumor Institute; Jennifer Michelson, RN, BSN, Kingsbury Cancer Center; Richard Reiling, MD, FACS, Presbyterian Hospital - Charlotte; and Virginia Vaitones, MSW, OSW-C, Pen BayMedical Center.

Section 2. Participant Characteristics

2.1. Respondent Profile

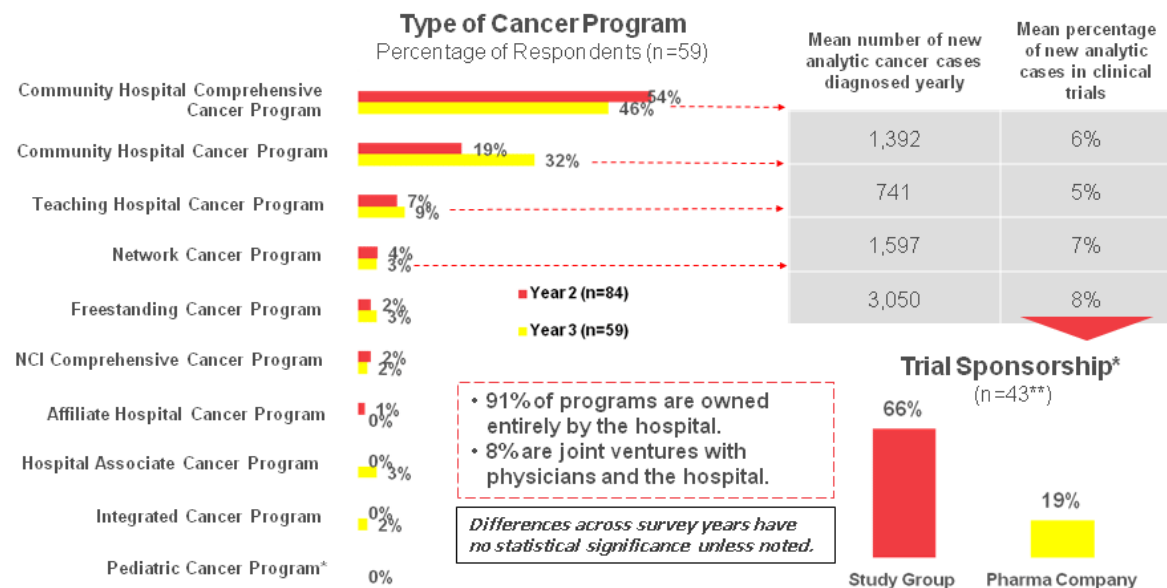
Fifty-nine cancer programs submitted responses to the survey. Of these, 78 percent are community hospitals. The mean number of new analytic cancer cases diagnosed yearly at community hospital cancer program is 1,067.

Nine percent of respondents consider themselves teaching hospital cancer programs. The remainder includes “network” cancer programs, NCI-designated comprehensive cancer centers, freestanding cancer programs, and an affiliate hospital cancer program.

Ninety-one percent of responding programs are owned entirely by the hospital. Eight percent are joint ventures with physicians and the hospitals. Of those hospital cancer programs that noted participation in clinical trials, two-thirds of those trials are sponsored by NCI clinical trials cooperative groups and 19 percent are sponsored by pharmaceutical companies.

Participant Characteristics

Table 1. 78 percent represent community hospital programs.



Q1a. Which of the selections below best describes your cancer program? (SELECT ONLY ONE) Q2h. Which of the following best describes the ownership of your program? (SELECT ONLY ONE) Q2i. What percent of your program is owned by each of the following? Q1b. How many new analytical cancer cases are diagnosed per year in your program? Q1ii. What % of new analytic cases are on clinical trials? Q1iii. What % of these trials are sponsored by each of the following types of organizations?

*New for Survey 3

**Not sure / Don't know, n=16a

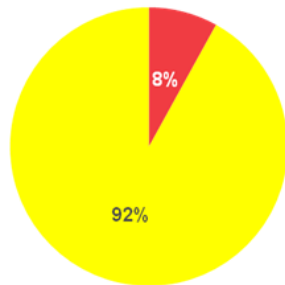


Nearly all respondents describe their program as not-for-profit, providing both in- and outpatient services.

Participant Characteristics

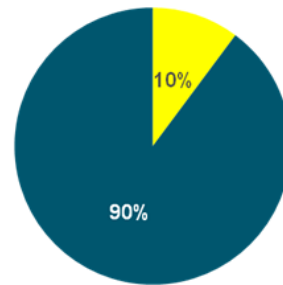
Table 2. As in previous years, a majority represent not-for-profit programs providing both inpatient and outpatient services.

Type of Cancer Program
Percentage of Respondents (n=59)



- For profit
- Not-for-profit
- Don't know

Type of Services Provided
Percentage of Respondents (n=59)



- Inpatient services only
- Outpatient services only
- Both inpatient and outpatient services

Q1a1. Which of the following best describes your cancer program? (SELECT ONLY ONE)
Q1c. Which of the following does your program provide? (SELECT ONLY ONE)

Differences across survey years have no statistical significance unless noted.

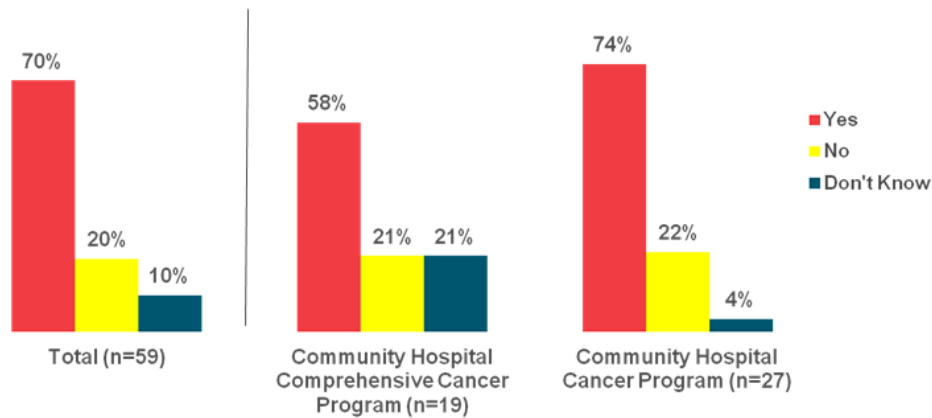


Oncology remains one of the top three service lines for most responding community hospital programs.

Participant Characteristics

Table 3. Oncology remains one of the top three service lines for most responding community hospital programs.

Oncology is One of Top Three Service Lines
Percentage of Respondents by Category*



Q1e. Based on billed charges, is oncology one of the top 3 service lines in the hospital / institution?
*Categories represented by a small sample size are not shown.

Differences across survey years have no statistical significance unless noted.



While most programs include medical and radiation oncology in their cancer service line, the majority of respondents report that diagnostic radiology is managed as a separate hospital department. Compared to previous surveys, a greater percentage of respondents report that medical and radiation oncology services are either managed as a separate hospital department or not offered.

Note: In Table 4, 15 percent of respondents indicate they do not offer medical or radiation oncology in their service line. We might assume that they misread the question. Or, it may be that the lines between care settings appear to be blurring. In our 2010 survey only 5 percent of programs responded that they “did not offer” medical oncology services. Our assumption: their patients may be seeing medical oncologists in private practices “affiliated” with but “separate” from the hospital. This year, 15 percent of programs said they not offer medical oncology services. Radiation oncology services saw a similar increase in programs that “do not offer” these services from 1 percent in 2010 to 14 percent in 2012. Why? If the medical or radiation oncology practice is a separate legal entity, then services may not fall under the umbrella of the hospital’s cancer service line. We know that physician and hospital relationships are changing quickly, and the range of physician services agreements may make this supposedly basic question difficult to answer.

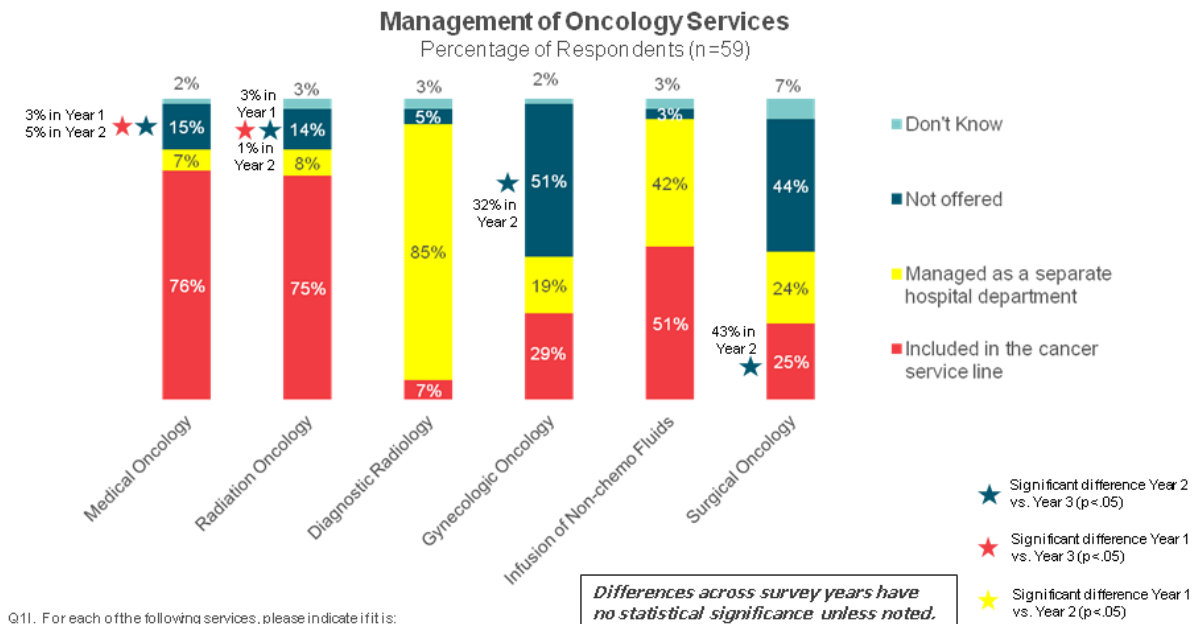
Most, but not all, programs offer the services that are newly required by the Commission on Cancer, including RN patient navigators (75 percent), psychological counseling (73 percent), cancer rehabilitation (69 percent), genetic counseling (63 percent), and survivorship (59 percent).

Fewer programs are offering the surgical and gynecologic oncology service lines, a trend away from comprehensive, integrated offerings. In Year 2 of the survey, for example, 43 percent of respondents indicated surgical oncology as included in the cancer service line. Year 3 shows a significant decrease: 25 percent indicate surgical oncology in the cancer service line. A similar move can be seen in gynecologic oncology. In Year 2 of the survey, 42 percent indicated gynecologic oncology in the cancer service line versus 29 percent in this survey.

Sixty-eight percent of cancer programs reported that their service line manager is fully dedicated to their program.

Participant Characteristics

Table 4. The majority of programs include medical and radiation oncology in their cancer service line.

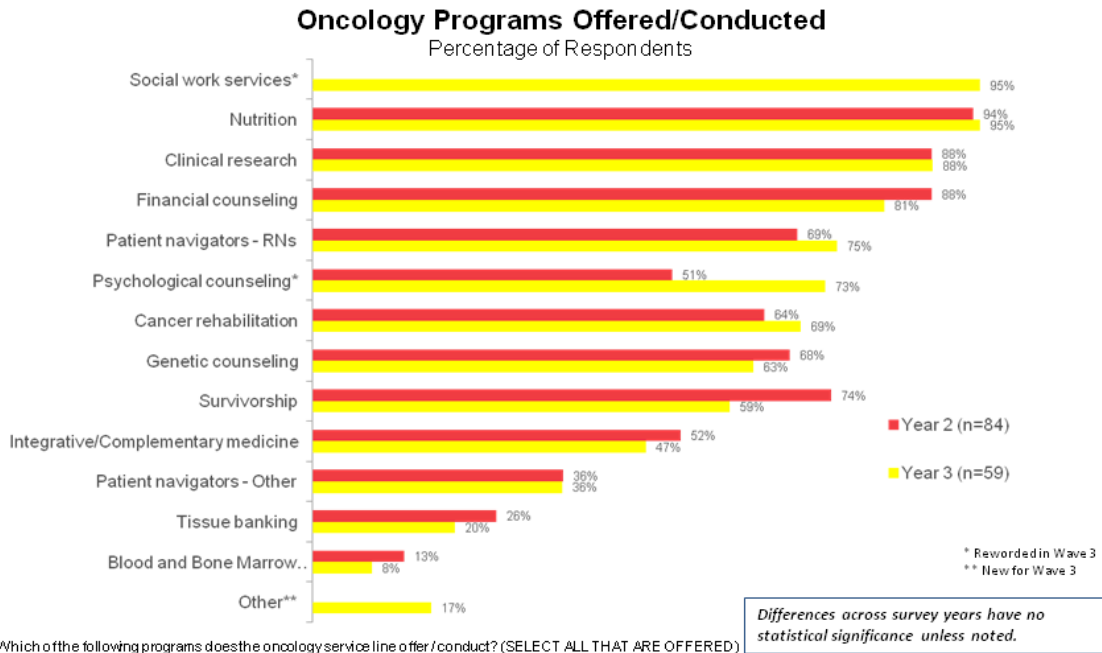


Most programs offer social work services (95 percent), nutritional services (95 percent), clinical research (88 percent), and financial counseling (81 percent).

Fewer programs in this year's survey report genetic counseling, survivorship, and complementary medicine than last year, while more programs report nurse patient navigators, psychological counseling, and cancer rehabilitation in this year's survey than in last year's survey. One in five have tissue banking (down from 1 in 4 from last year) and 8 percent blood and bone marrow transplantation.

Participant Characteristics

Table 5. Nearly all programs offer social work services, nutrition services, and financial counseling.



Q1g. Which of the following programs does the oncology service line offer /conduct? (SELECT ALL THAT ARE OFFERED)

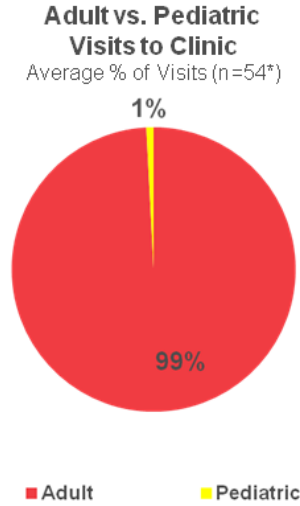


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Most programs focus on adult patient populations. Pediatric patients represent a very small percent of clinic volume.

Participant Characteristics

Table 6. Pediatric patients represent a very small percentage of clinic volume.



*Don't know, n=5

Q6b. What percentage of patient visits in this clinic are pediatric vs. adult?

Differences across survey years have no statistical significance unless noted.



2.2. Primary Service Area

The average program competes with three programs in its primary service area. Cancer care remains a competitive business.

Participant Characteristics

Table 7. As in Year 2, the average cancer program competes with three programs in its primary service area.

Cancer Programs in Market Area

	Mean	Min	Max
Number of cancer programs (all types) in market area (n=55 ^{**})	3.0	0	20
➔ Number of hospital-based, for-profit programs (n=44 ^{***})	0.3	0	2
➔ Number of hospital-based, not-for-profit programs* (n=44 ^{***})	1.5	0	8
➔ Number of community-based programs (n=44 ^{***})	1.1	0	8
➔ Number of university hospital settings (n=44 ^{***})	0.3	0	2

* New for Wave 3

** Don't know, n=4

*** Don't know, n=2

Q1m. How many other cancer programs (of all types) exist within your primary market area?
 Q1n. Of those, how many are: If there are none of a particular type of cancer program, please enter 0.
 1 Hospital-based for profit? RANGE 0 to 99
 4 Hospital-based not for profit? RANGE 0 to 99
 2 Community-based (medical office) programs? RANGE 0 to 99
 3 University hospital settings? RANGE 0 to 99

Differences across survey years have no statistical significance unless noted.



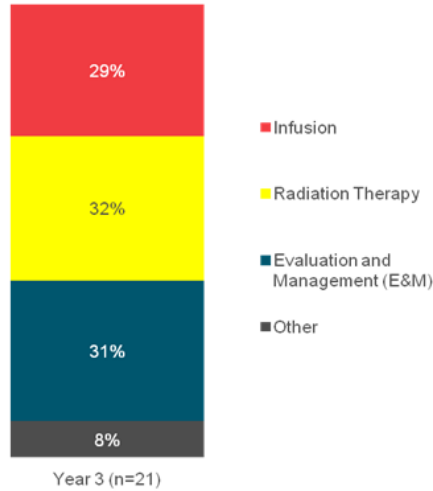
2.3. Patient Visits

Patient visits are balanced evenly across infusion, radiation therapy, and E&M. The mean number of cancer patient visits in 2010 was 1,624.

Participant Characteristics

Table 8. Patients visits are balanced evenly across infusion, radiation therapy and E&M.

Percentage of Patient Visits by Service Category



	Year 3 (n=39)
Number of Patient Visits in Cancer Program (mean)	1,624

Q8b4. In 2010 how many patients entered your cancer program?
 Q8b7. In 2010 what were the number of patient visits to your cancer program by service category?

Differences across survey years have no statistical significance unless noted.

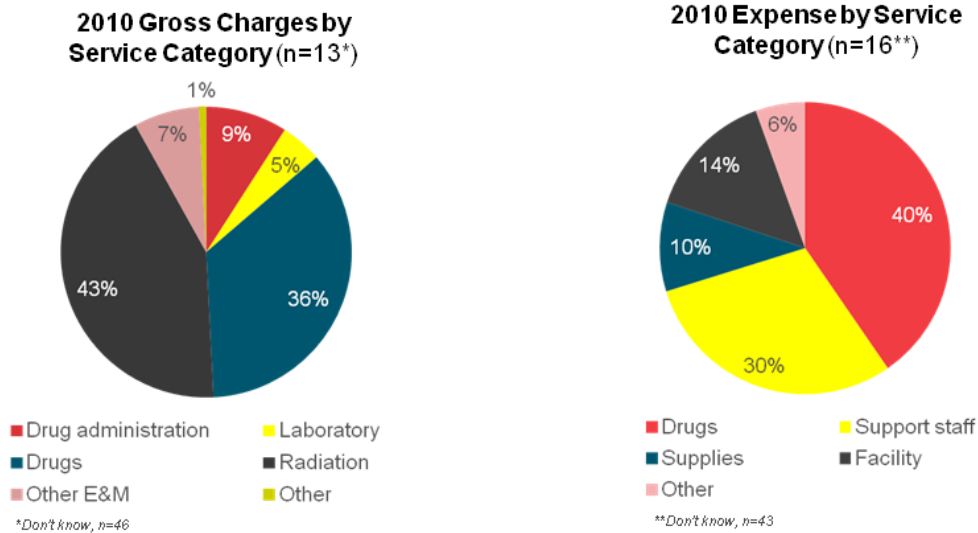


2.4. Gross Charges and Expenses

Drugs represent a large portion of both charges and expenses.

Participant Characteristics

Table 9. Drugs represent a large portion of both charges and expenses.



Q8b1. Please think about 2010 gross charges to your cancer program by service category. [Radiation was added for VW3]
 Q8b2. Please think about 2010 cancer program expenses by service category.

Differences across survey years have no statistical significance unless noted.



2.5. Payer Mix

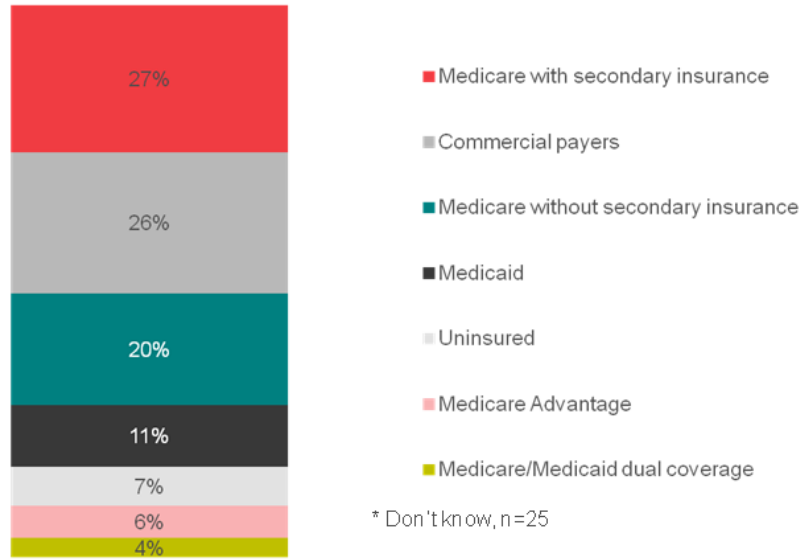
Respondents report that payer mix is 27 percent Medicare with supplemental (compared to 31 percent in last year's survey) and 20 percent Medicare without supplemental (compared to 18 percent in last year's survey). Commercial payer and Medicare plus secondary segments represent more than one half of patients according to survey participants.

Participant Characteristics

Table 10. The commercial payer and Medicare plus secondary segments only represent about half of patients for study participants.

Insurance Mix

Percentage of Patients (n=34)



Q9Di. Please allocate the percentage of patients with each of the following types of insurance being treated by your program. (Total must sum to 100 for each column) NEW QUESTION IN WAVE 3

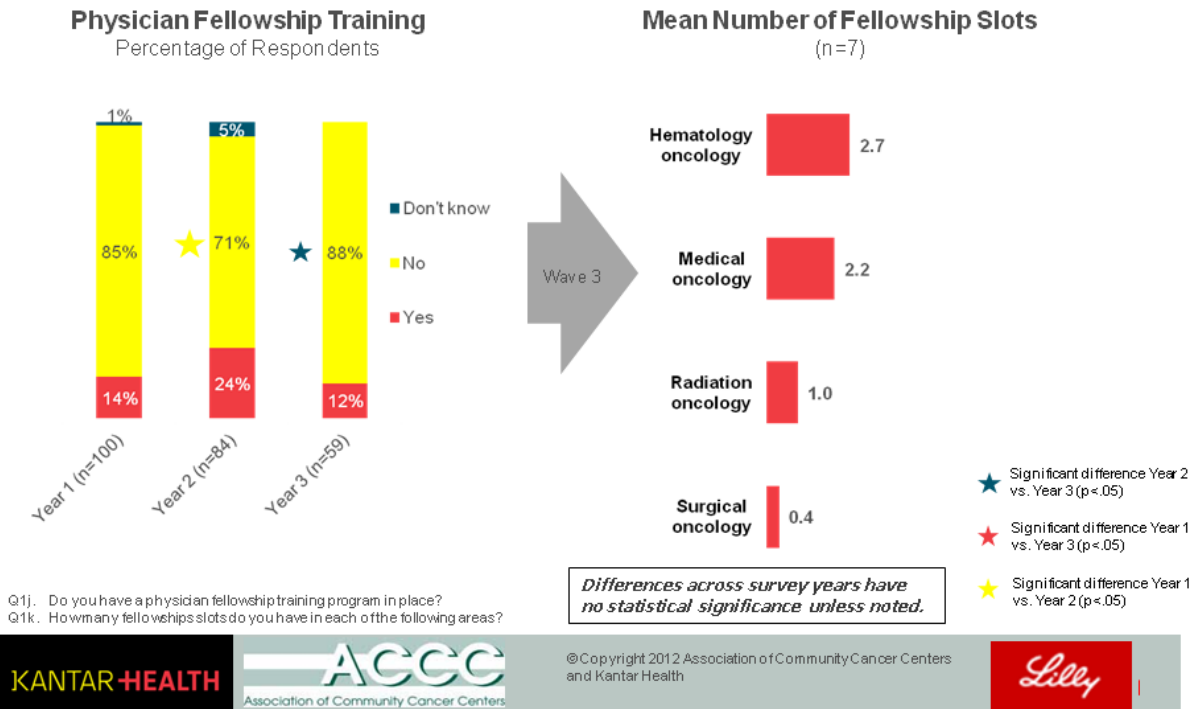


2.6. Fellowships

Just 12 percent of programs surveyed have physician fellowship training in place; on average, medical and hematology oncology have the most fellowship slots.

Participant Characteristics

Table 11. Few programs have physician fellowship training; medical and hematology oncology dominate.



Section 3. Financial Status and Capital Equipment

3.1. Financial Status of Programs

Most respondents characterized their program's financial status as good or very good for 2010; percentages are similar to responses from the previous year's survey.

Still, it is interesting to note that more than one-third (34 percent) of cancer programs do not have sufficient data to track P&L. Of those 34 percent who had sufficient data to track oncology P&L, all actually did track it.

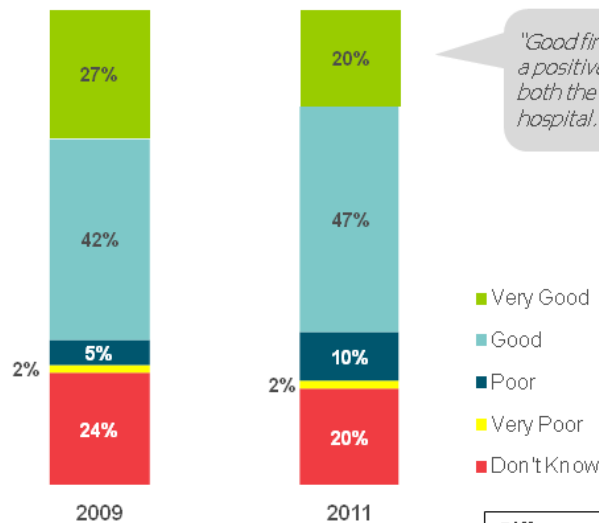
The percentage that had such data has been stable across the three years of the study (63 percent in Year 2 and 66 percent in Year 1) and across types of cancer programs.

Financial Status

Table 12. Most respondents report that their financial health is good or very good.

Cancer Program Financial Health, 2009 vs. 2011

Percentage of Respondents (n=59)



"Good financial health means a positive profit margin for both the program and the hospital."

Differences across survey years have no statistical significance unless noted.

Q8c. How would you characterize the overall financial status of your cancer program? (SELECT ONE RESPONSE.)



3.2. Strategies to Control Costs

Cancer programs are actively seeking to reduce or control costs without compromising quality and services. Key strategies to reduce costs include reduction of travel or education expenses (81 percent); renegotiation of vendor contracts (68 percent); administrative cost cutting (64 percent); and equipment purchase delays (58 percent).

Less than one-third (32 percent) reported hiring freezes compared to 57 percent in last year's survey and fewer than one in four (24 percent) reported IT improvement delays compared to 43 percent in last year's survey.

Financial Status

Table 13. Cancer programs are actively seeking to reduce or control costs without compromising quality and services.



Still, when cost containment versus revenue enhancement is considered, cancer centers target staffing, purchasing, and patient throughput. Interviewed ACCC members scrutinized staffing, purchasing, and throughput to reduce costs. Staff was evaluated with regard to overtime, benefits, retirement program, and call pay. Respondents emphasized that they seek the “right” staffing or “flexible” staffing – and not necessarily a reduction in FTEs.

Two cancer programs had utilized Six Sigma and realized cost reductions in patient care throughput.

Purchasing is also managed aggressively, especially for chemotherapy drugs. Programs reviewed purchasing contracts, utilized just-in-time inventory, and considered using cheaper drugs.

Several respondents mentioned that the financial strategy for their cancer program is skewed more toward increasing capacity and revenue than reducing costs.

"We did Six Sigma about 18 months ago. This program helped us increase value added and remove waste. Specifically, we improved the way patients flow through the system and reduced drug inventory."

"Oncology is a revenue-driven business, not a cost-driven business. It's all about increasing capacity."

"We are actually increasing costs because we are understaffed due to growth – but scrutinize that we have the RIGHT staffing."

3.3. Strategies to Increase Revenue

Cancer programs boost revenue through a wide range of strategies, with an emphasis on those that increase volume, including increased physician-to-physician liaison, increased coding reviews; introduction of new technologies and services; and increased print or online advertising.

Cancer programs rely on their service-line physician groups to network with local physicians who can refer oncology patients. Expanding the number of employed or affiliated physicians may lead to a large volume of "homegrown" physician referrals to support the oncology service line. Cancer programs also expect to attract referrals by expanding infrastructure, technology and program offerings.

"To drive new volume we are looking at adding oncology rehabilitation, outpatient palliative care, and a survivorship clinic."

We have outreach to physician offices to keep referrals coming to us – there are several other options in our market."

"Too many of our patients are seeing independent oncologists – we have strategies to bring them in house and see our [employed] physicians."

Financial Status

Table 14. Cancer programs boost revenue through a wide range of strategies, with an emphasis on those that increase volume.



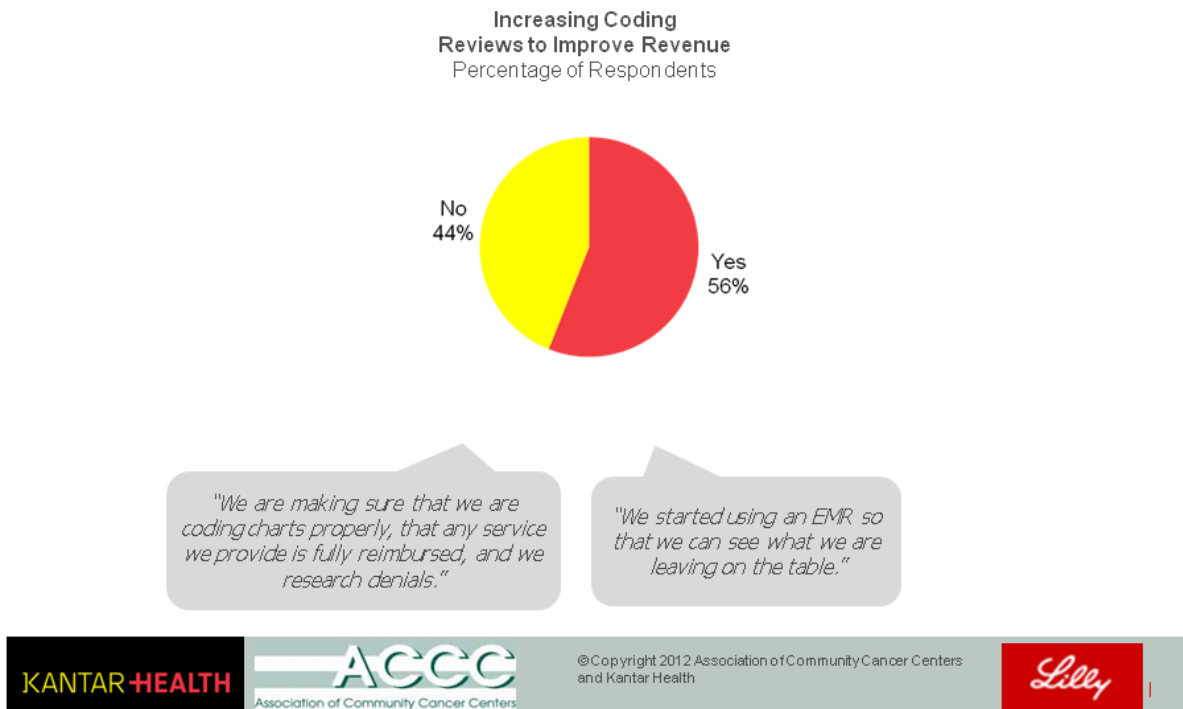
Q9b2 Which of the following strategies is your institution using to increase revenues? NEW QUESTION IN WAVE 3



Cancer programs are expanding their use of coding reviews to increase revenue. Fifty-six percent of cancer programs have increased coding reviews. Their objectives are to 1) improve the percentage of claims that are submitted correctly and completely; 2) ensure that charges are supported by correct documentation; and 3) ensure that all services are billed. For this strategy to be effective, all charges and associated documentation must be captured by cancer center staff. The expanded use of electronic medical records (EMR) facilitates this process.

Financial Status

Table 15: Cancer programs are expanding their use of coding reviews to increase revenue.



3.4. Concerns About Impending Cutbacks in Reimbursement for Radiation Oncology Services

Cancer programs are cautious about the impending cutbacks in reimbursement for radiation oncology services. On November 1, 2011, the Centers for Medicare & Medicaid Services announced the 2012 final Medicare physician fee schedule. Medicare analysts estimate that radiation oncology may experience an impact of -6 percent from all practice expense changes in 2012 and -10 percent in 2013.

Interviewed ACCC members expressed concern about these cutbacks but acknowledged that they will probably be unable to do anything about it. Some respondents considered the potential impact of the cutbacks in the context of their intentions to purchase capital equipment. Generally, the cutbacks were viewed as more impactful to independent radiation oncologists than to cancer programs. For programs where the radiation oncologists are contracted and bill for their own services, impact of the cutbacks may be minimal.

"Yes, there is an economic impact, but this is still a growth business. It's a technology arms race, so I'll replace [equipment] cautiously, but will go high tech when I do."

"We have just replaced all of our radiology equipment so it is not like we can delay capital equipment purchases. We will look carefully at staffing."

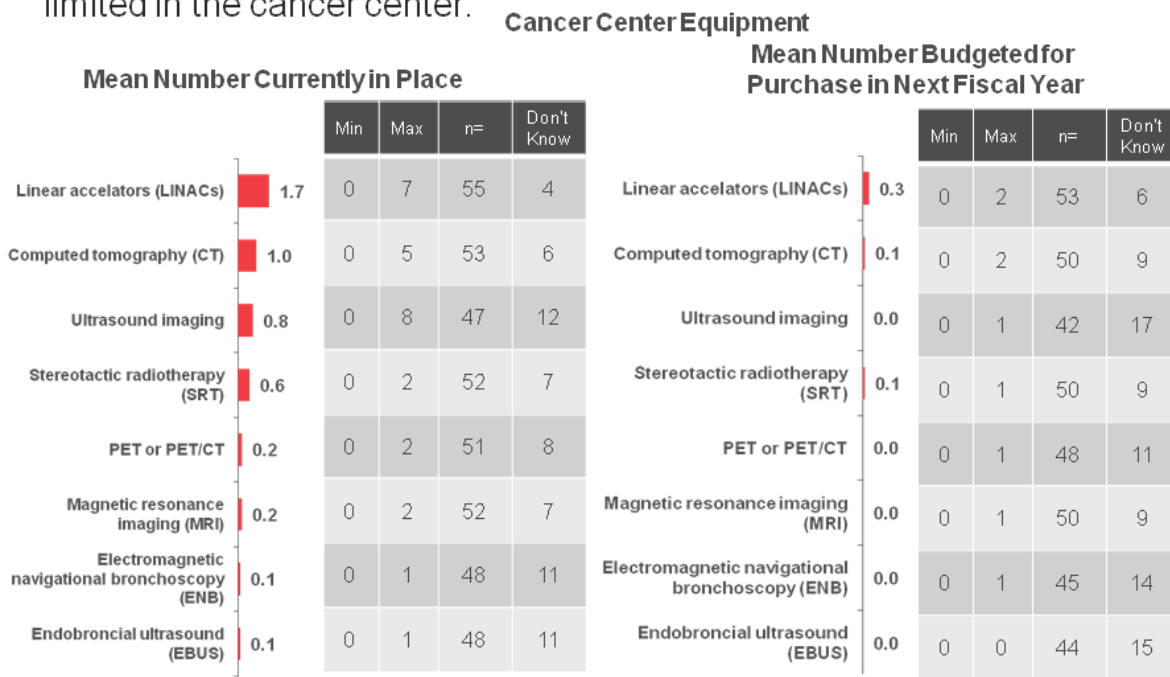
"It does not impact me, but the docs are up in arms."

3.5. Capital Equipment: Expansion and Replacement Plans

Expansion and replacement plans for clinical technology appear to be limited - continuing the trend from last year. Across the line, the numbers of linear accelerators, ultrasound imaging machines, computed tomography scanners, magnetic resonance machines, and PET or PET/CT machines budgeted for purchase in the next fiscal year are down, both in the cancer center and on the hospital campus.

Financial Status

Table 16. Plans to acquire or expand capital equipment continue to be limited in the cancer center.



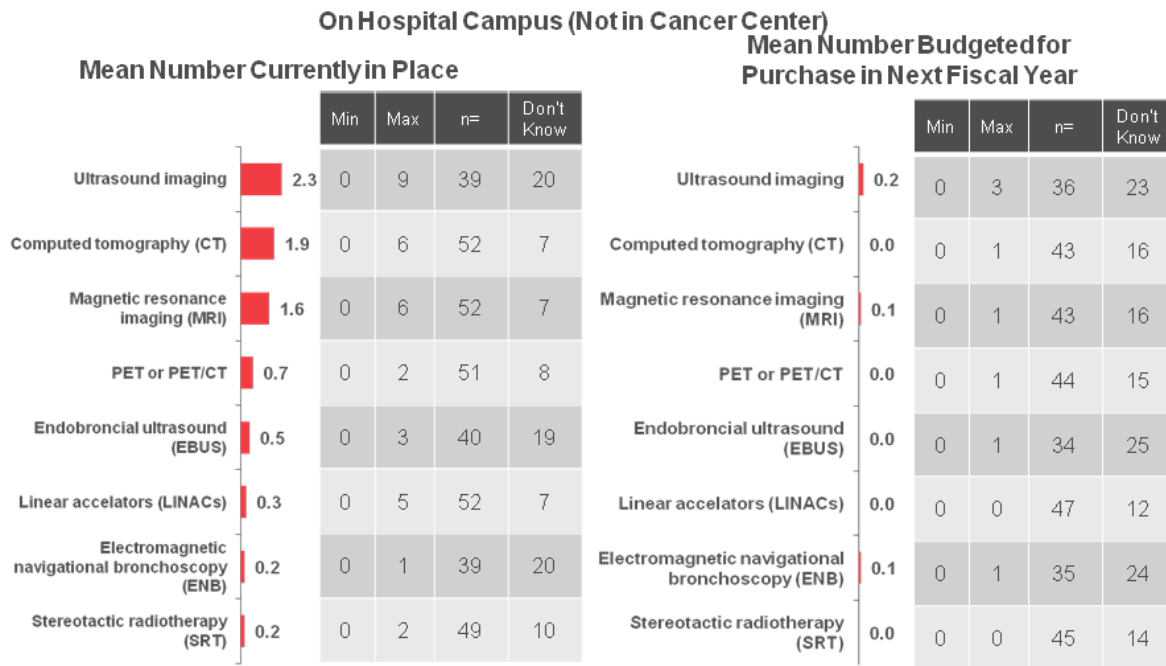
Please see the survey instrument in the Appendix for question wording.



Plans to acquire or expand capital equipment also continue to be limited on the hospital campus.

Financial Status

Table 17. Plans to acquire or expand capital equipment also continue to be limited on the hospital campus.

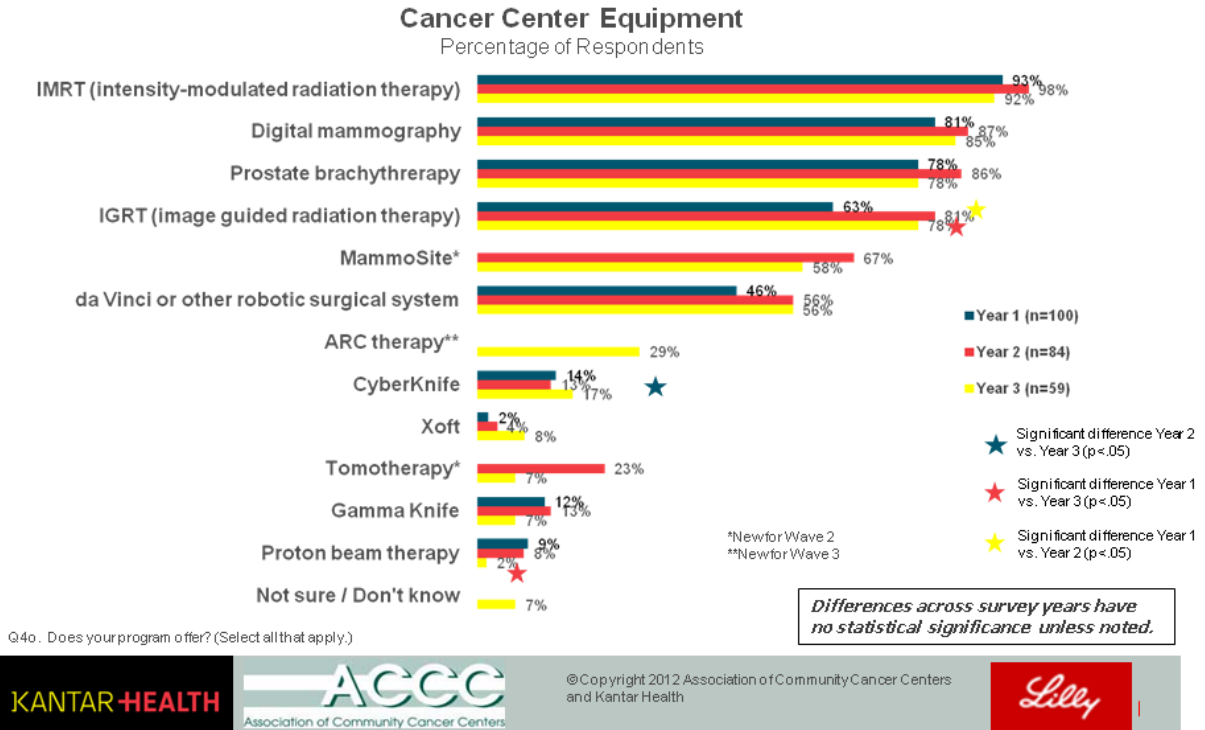


3.5. Other Equipment, Services, and Robotic Surgical Systems

The majority of programs offer IMRT, digital mammography, and prostate brachytherapy. The use of IGRT has decreased significantly from last year. The da Vinci or other robotic surgical systems remains above 50 percent. Use of CyberKnife has increased, while Xofig, tomotherapy, Gamma Knife, and proton beam therapy are limited.

Financial Status

Table 18. The majority of programs offer IMRT, digital mammography, and prostate brachytherapy; those offering IGRT have increased.



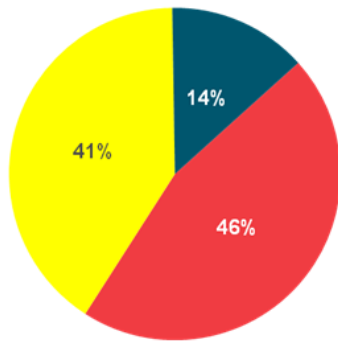
More than half (55 percent) of programs report providing radiofrequency ablation (RFA), similar to last year's survey; only 3 percent of programs report RFA equipment budgeted for next year.

Financial Status

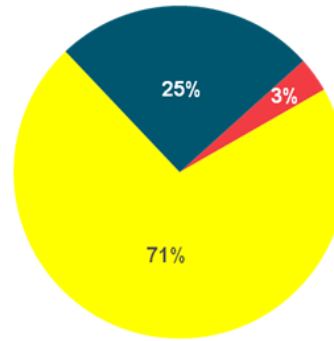
Table 19. Almost half of programs provide radiofrequency ablation (RFA); few programs reported RFA equipment budgeted for next year.

Cancer Center Equipment

Program Provides RFA
Percentage of Respondents (n=59)



RFA Equipment Budgeted for Next Year
Percentage of Respondents (n=59)



■ Yes
■ No
■ Don't Know

Q4m. Does your program provide radiofrequency ablation (RFA)?
Q4n. Is the equipment for RFA budgeted for purchase in the next fiscal year?

Differences across survey years have no statistical significance unless noted.

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Section 4. Impact of the Economy on Patients

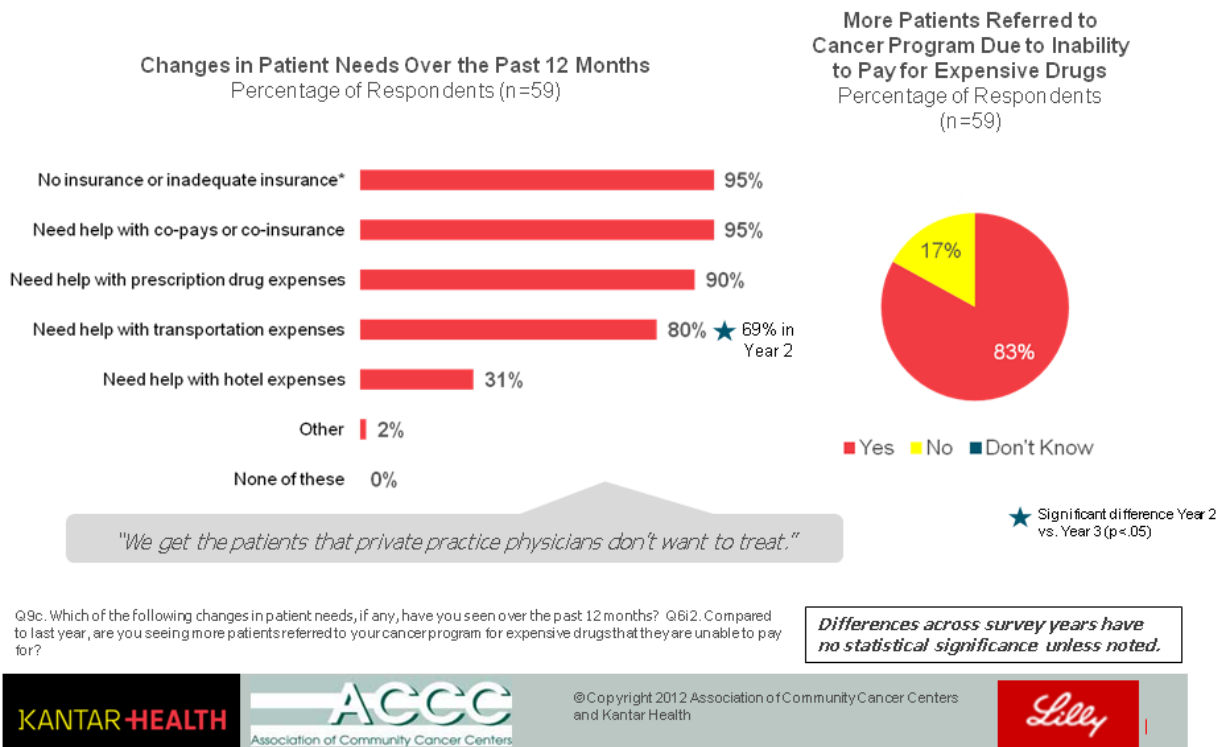
4.1. More Patients Need Help Affording Their Medications

The number of patients in need of financial assistance continues to rise as does the number of patients needing help with transportation expenses.

Cancer programs are seeing more patients who are referred for expensive drugs and need help affording their medication.

Impact of the Economy on Patients

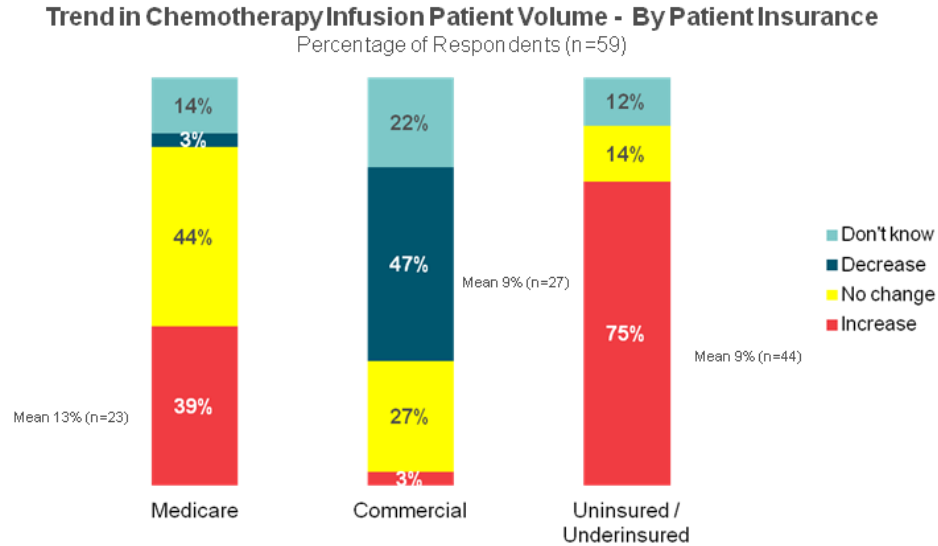
Table 20. Cancer programs are seeing more patients who need help affording their medication.



At the same time, cancer programs report seeing an increased number of uninsured or underinsured chemotherapy patients.

Impact of the Economy on Patients

Table 21. Cancer programs continue to see an increase in the number of uninsured/underinsured chemotherapy patients.



Q9d Have you seen a change in the number of Medicare patients for whom you provide chemotherapy infusions? Q9e Have you seen a change in the number of commercially insured patients for whom you provide chemotherapy infusions? Q9f Have you seen a change in the number of uninsured, underinsured or insured patients for whom you provide chemotherapy infusions?

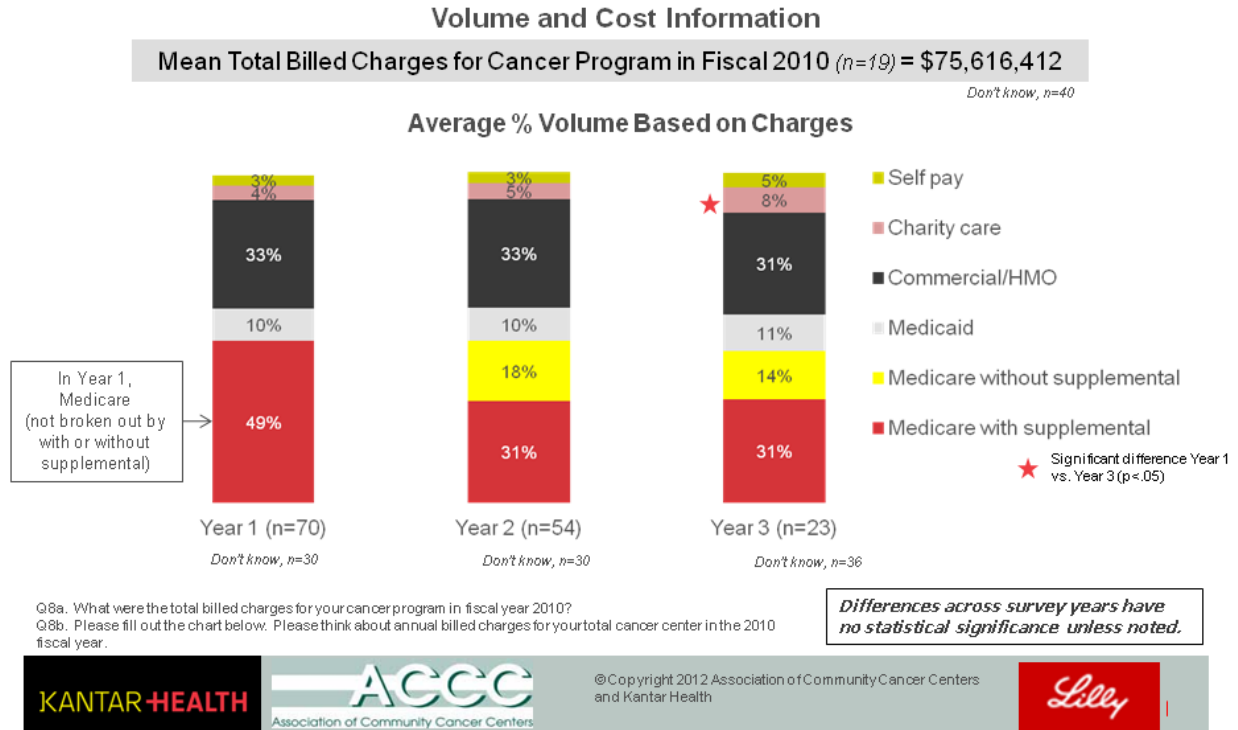
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Programs reported an increase in the volume of charity care patients, up from 5 percent in last year's survey to 8 percent in this year's survey, a significant difference.

Impact of the Economy on Patients

Table 22. Programs reported an increase in volume of charity care patients.



4.2. Strategies to Accommodate Patients Unable to Pay

Cancer programs rely on three primary strategies to accommodate patients who are not able to pay: financial counselors, write-offs or charity care, and drug assistance programs.

Financial counselors. Financial counselors may be oncology specific or general to the hospital; most programs hope to hire an oncology-dedicated financial counselor. Cancer centers have realized economic benefits from financial counselors who verify coverage, obtain PAs for treatment and help patients enroll in drug assistance programs.

Write-off or charity care. Patients unable to pay may experience a delay in care while the program determines how to best accommodate them. These patients may be unable to receive the most current treatment, which is often the most expensive drug.

Drug Assistance Programs. Although uninsured patients typically qualify for drug assistance programs, it can be a challenge to obtain qualification for the underinsured. One cancer program mentioned using an outside organization to obtain free drugs for patients who qualify.

"Moving forward we plan to have a dedicated person to get free and replacement drugs and copay assistance."

"We added a financial counselor when the economy took a downturn and we saw a huge increase in patients needing financial assistance – very successful in tapping into cancer funds and other resources."

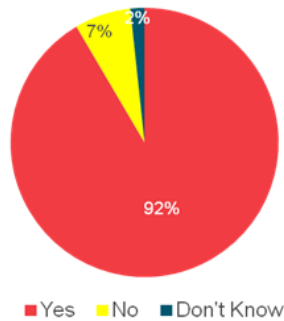
"We are very successful getting reimbursement for high price drugs that have been previously denied and for uninsured patients."

Nearly all responding programs offer financial counseling.

Impact of the Economy on Patients

Table 23. Nearly all of the programs offer financial counseling; the financial benefits of this position to the program are substantial.

Financial Counseling Offered
Percentage of Respondents (n=59)



- Cancer centers have realized substantial economic benefits from financial counselors who verify coverage, obtain prior authorizations for treatment, and help patients enroll in drug assistance programs.

"This has been very successful – we have several high-priced drugs that are often denied for patients with no insurance."

"We added a financial counselor, and I'm sure she saved us several hundred thousand in the first quarter she was here."

Differences across survey years have no statistical significance unless noted.

Q2g. Does your program offer financial counseling to patients and families?



The use of commercial reimbursement specialists is prevalent, but not universal--just 29 percent of respondents use them.

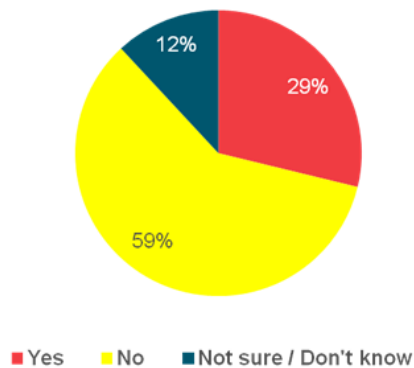
In order for reimbursement specialists to be effective, all charges and associated documentation must be captured by cancer center staff.

Cancer centers have increased coding reviews to improve the percentage of claims that are submitted correctly and completely, ensure that charges are supported by correct documentation, and confirm that all services are billed.

Impact of the Economy on Patients

Table 24. The use of commercial reimbursement specialists is prevalent, but not universal.

Use of Commercial Reimbursement Specialists
Percentage of Respondents (n=59)



Q8d. Have you used commercial reimbursement specialists? [NEW WORDING: "commercial" added in W3]



"We are making sure that we are coding charts properly; ensure that any service we provide is fully reimbursed, and we research denials."

"We hold staff accountable that charges are captured at time of service. Staff ensures correct documentation associated with charges."

Section 5. Staffing

5.1. Physician Staffing

When asked if there has been consolidation of cancer programs or oncology practices in their primary area over the last year, 19 percent reported consolidation through affiliation, 5 percent through acquisition, and 3 percent through merger in the past year.

When asked if they anticipate consolidation of cancer programs or oncology practices in their primary market area in the next one or two years, 31 percent of cancer programs said yes, and 44 percent of practices said yes.

Community relationships between cancer programs and physicians continue to evolve as oncologists in private offices struggle with declining reimbursements and seek financial stability. Many are opting for employment at hospitals. Professional services agreements between cancer programs and medical and hematological oncologists increased compared to previous years, while at the same time respondents report fewer contractual relationships between the hospital and private practice medical, hematological, and radiation oncologists. Still, the mean number of paid FTE medical and hematological oncologists remains steady from this year's survey to last year's.

Cancer programs rely on their service-line physician groups to network with local physicians who can refer oncology patients. Expanding the number of employed or affiliated physicians may lead to a large volume of "homegrown" physician referrals to support the oncology service line.

One cancer program has started a co-management agreement with their physicians to ensure alignment with the oncology service line. Physicians participate in management of the oncology program and receive incentive payments for meeting hospital goals (e.g., decreased 30-day readmissions, throughput, avoiding delays in treatment, patient satisfaction). This type of initiative creates a learning process that could lead to success in an accountable care organization (ACO) environment.

Note: Cancer programs expressed considerable uncertainty about how ACOs will evolve and affect them. ACOs agree to manage all of the health care needs for a defined population in a specific period; they are required to report on utilization, cost, and quality of care.

About half of the interviewed ACCC members seemed aware of and somewhat eager to explore ACOs. However, they agreed that it is difficult to know how ACOs will play out – especially for cancer care. Their concerns centered around the cost parameters in oncology and the practice of oncology, which are very different from primary care – the basis for the ACO model.

"How the money is divided up may be an issue for private practice versus hospital. Physicians may refer to hospitals that give them a bigger piece of the pie."

"I don't see how this will work in oncology. It's for a primary care physician (PCP) level of service. It's like the old days of capitation and is hard to do it in oncology. You don't know how a given patient will react to medications."

"We get concerned with PCPs following oncology patients – they are not knowledgeable of all the things that require monitoring and patients can fall through the cracks."

"It will be a challenge on the oncology side simply because of the cost. Most oncology cases are outliers and the cost of the cancer regimen will not fall within ACO measurements."

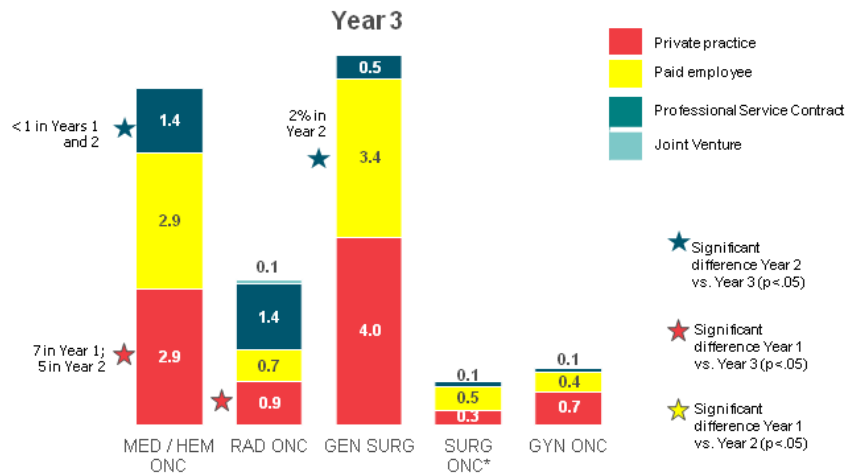
"Too many of our patients are seeing independent oncologists – we have strategies to bring them in house and see our [employed] physicians."

"We have outreach to physician offices to keep referrals coming to us – there are several other options in our market."

Staffing

Table 25. Professional services agreements (PSAs) are increasing for medical and hematological oncologists.

Mean Number of FTE Positions (Base size varies)



Q5a. Please indicate the numbers of full-time equivalent positions (FTEs) for each type of contractual relationship between the physician and the cancer program for each type of physician. Please include physicians employed by your program as well as those who treat patients as part of your cancer program. *Not asked in Year 1.

Differences across survey years have no statistical significance unless noted.



Staffing

Table 26. PSAs have provided a win-win situation in selected markets.

- Only five of the interviewed ACCC members had experience with PSAs. These members reported that the hospital bills for technical services but not for professional services.
- Advantages of PSAs for the hospital include:
 1. Presence of dedicated oncologist on site, which facilitates development of the oncology service line (without the constraints of insufficient supervision)
 2. Control over oncologist services that is almost similar to control over employees
 3. Ability to offer a broad range of oncology services and depth of expertise
 4. Revenues from ancillary technical services like diagnostic imaging and radiation therapy
 5. Ability to invest fewer resources in recruiting oncologists
 6. Align inpatient and outpatient services.

"PSAs have tied inpatient and outpatient services together better. We also have more control over nursing policies and procedures."

"There are lots of variations on PSAs. Relative value units (RVUs) may drive physicians' compensation. RAD ONCs can't earn RVUs without new patients, but MED ONCs can."

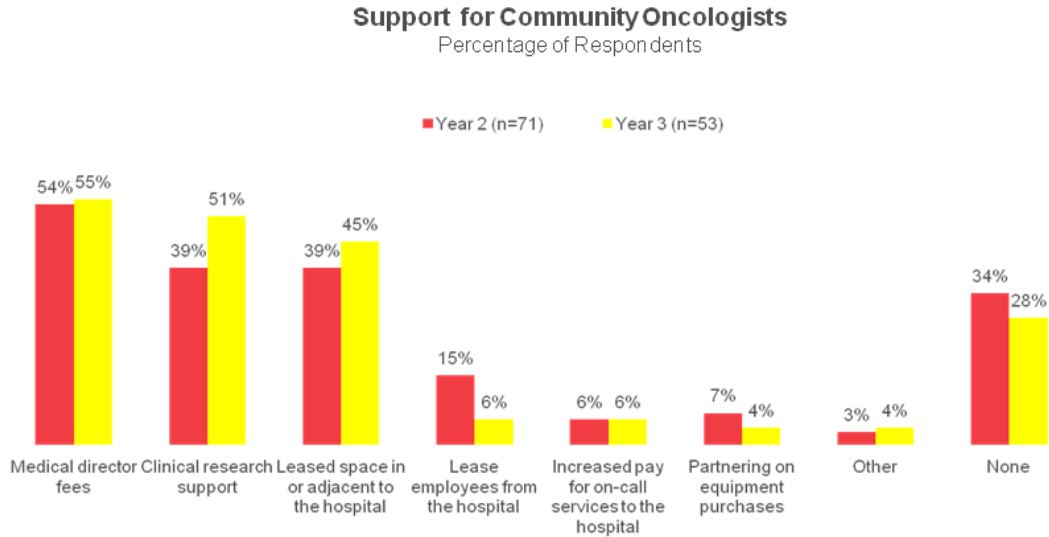
Based on interviewed ACCC members (n=20)



Support for community oncologists remains consistent in terms of leased space in the hospital and partnering on equipment purchases, for example.

Staffing

Table 27. Support for community oncologists has remained consistent over the past year.



Q5b. Which of the following types of support do you offer your community oncologists who are not paid employees?
SELECT ALL THAT APPLY

Differences across survey years have no statistical significance unless noted.



Resources:

- [Professional Services Agreements](#)
- [Hospital Employment of Physicians](#)

5.2. Nurse Staffing

Nursing accounts for the most FTEs, followed by radiation oncology technicians, administrative staff, and clinical research personnel. The mean number of nurses is 14.6.

Staffing

Table 28. Nursing and administrative staff continue to account for the most FTEs.

Number of FTEs in 2011 Fiscal Year

	Mean	Min	Max
RNs, total (n=51)	14.6	0	49
RNs with oncology nursing certification (n=53)	9.5	1	67
RNs focused on chemotherapy administration (n=48)	7.2	0	25
Radiation oncology technicians (n=50)	6.1	0	20
Administrative staff (receptionists, other clerical, hospital information system) (n=49)	6.1	0	40
Clinical research personnel (n=57)	4.7	0	90
Diagnostic radiology (n=32)	4.2	0	80
Non-physician laboratory staff (n=46)	2.9	0	70
Nurse Practitioners, specifically (n=54)	2.3	0	67
Dosimetry personnel (n=54)	2.2	0	10
Medical physicists (n=56)	1.9	0	10
Pharmacists supporting the cancer center, total (n=50)	1.9	0	8

Q7. Please complete the chart below, indicating the number of full-time equivalent positions (FTEs) included in the budget for your cancer program. Please include only those **outpatient** FTEs whose compensation is paid by the cancer program itself. If any FTEs are shared with the hospital for inpatient services, count this as a partial FTE according to percentage of time assigned to the cancer program. One FTE is equivalent to 40 hours per week.

Differences across survey years have no statistical significance unless noted.



5.3. Other Members of the Multidisciplinary Staff

Cancer programs vary widely in the number of patient navigators, pharmacy technicians, physician extenders, and biller and coders they employ. Nutrition, genetic, and survivorship FTEs continue to be few in number.

Staffing

Table 29. Genetic and survivorship FTEs continue to be few in number.

Number of FTEs in 2011 Fiscal Year (continued)

	Mean	Min	Max
Patient navigators (n=56)	1.9	0	11
Pharmacy technicians (n=43)	1.7	0	6
Senior administrative/executive management staff for clinic (n=56)	1.7	0	8
Physician extenders (i.e., RNP/PA, clinical nurse specialists) (n=54)	1.6	0	22
Billing and collection (dedicated to facility whether or not physically present) (n=41)	1.5	0	15
Oncology coders/billing coders (dedicated to facility whether or not physically present) (n=46)	1.3	0	8
Psychologists/social workers focused on mental health counseling (n=54)	1.0	0	5
Oncology social workers or other individuals focused on financial counseling (n=57)	1.0	0	3
Rehabilitation/wellness personnel (n=47)	1.0	0	8
Nutritionists or dietitians (n=55)	0.7	0	2
Genetic counselors (n=55)	0.5	0	3
Non-mental health (e.g., case managers, etc.) (n=53)	0.4	0	6
Survivorship personnel (n=55)	0.3	0	2

Q7. Please complete the chart below indicating the number of full-time equivalent positions (FTEs) included in the budget for your cancer program. Please include only those **outpatient** FTEs whose compensation is paid by the cancer program itself. If any FTEs are shared with the hospital for inpatient services, count this as a partial FTE according to percentage of time assigned to the cancer program. One FTE is equivalent to 40 hours per week.

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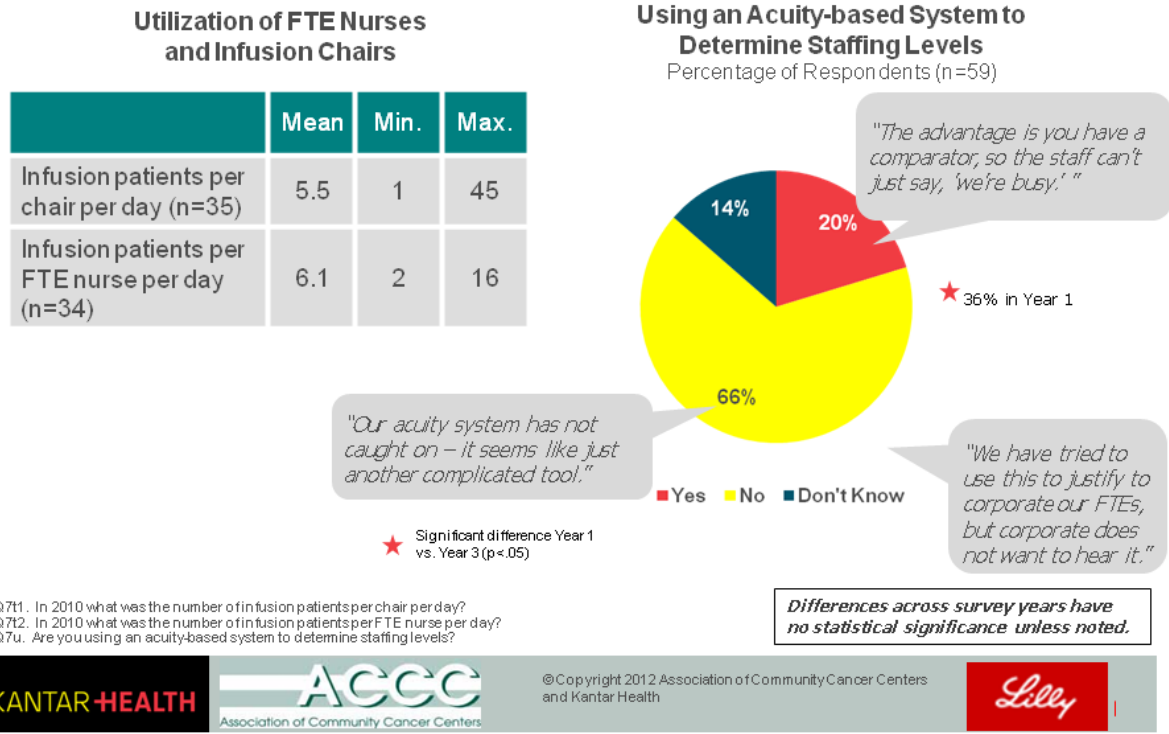


5.4. Staffing Acuity Systems

In this year's survey just 20 percent of respondents indicate using an acuity-based system to determine staffing levels, compared to 36 percent in the first year of the survey, although such systems can decrease turnaround times, improve patient flow, and make a difference in operations.

Staffing

Table 30. Acuity-based systems may have value in justifying staffing levels, but for most cancer programs they have not “caught on.”



After drug costs, the second highest expenditure in any outpatient cancer center is the cost of staff. Two areas to look at include developing appropriate staffing levels and ensuring adequate staff time to accommodate patient volumes. Successfully managing these two areas can save significant money and lead to improved staff morale and retention. For example, infusion centers that use an efficient scheduling system for chemotherapy infusion can simultaneously better accommodate patients and better manage staff expenses.

In this year's survey, the mean number of infusion patients per chair per day was 5.5 (Table 32). The mean number of infusion patients per FTE nurse per day was 6.1 (Table 32).

Anecdotal responses show that acuity systems have not "caught on."

"Our acuity system has not caught on—it seems like just another complicated tool."

"We have tried to use this to justify to corporate our FTEs, but corporate does not want to hear it."

Section 6. Infusion Center and Pharmacy

6.1. Infusion Center

More than three-fourths of programs (78 percent) indicate that infusion of non-chemotherapy fluids is included in the service line. This percentage is up significantly from 52 percent in last year's survey

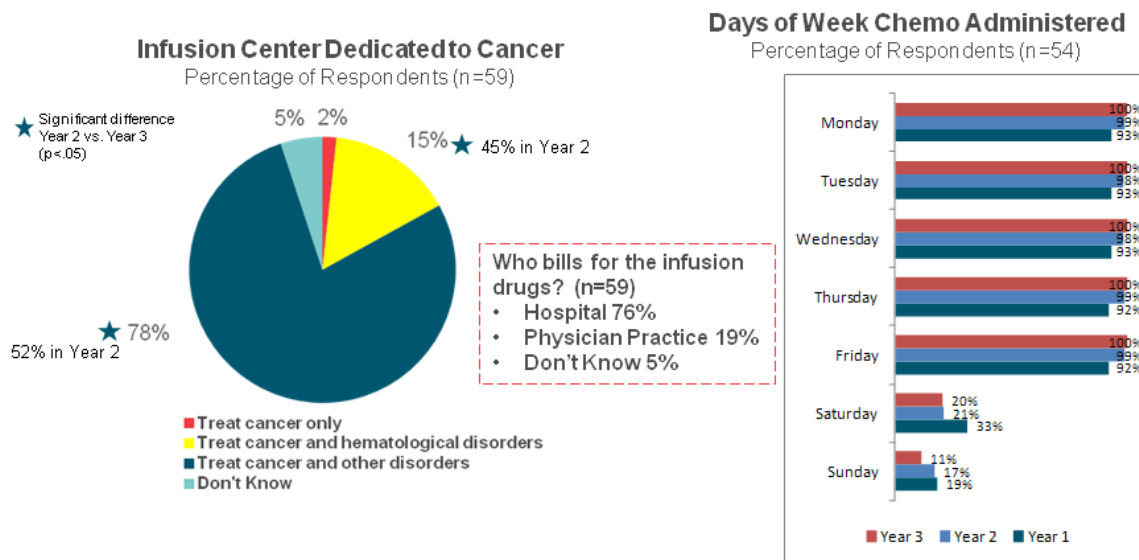
Seventy-six percent of respondents report that the hospital bills for the infusion drugs, whereas 19 percent report that physician practices do the billing.

Most treat Monday through Friday only. Twenty percent of respondents treat on Saturday, and 11 percent treat on Sunday.

Analysis. Saturday infusion helps decompress the other five days of the week, and may be especially good for those patients who are on regimens that last many months and who would prefer not to take off work. Offering Saturday infusion might be an opportunity for cancer centers.

Infusion Center and Pharmacy

Table 31. Most infusion centers treat conditions other than cancer and hematological disorders.



Q6a. Is the infusion center dedicated to cancer? Q6g. Which days of the week are chemotherapy administered in this infusion center?
Q6dd. What is your nurse to patient staffing ratio in the infusion center? Q6f. Who bills for the majority of the infusion drugs used to treat cancer?

Differences across survey years have no statistical significance unless noted.

The mean number of infusion beds/chairs are 17.9 (hospital owned) and 2.9 (included in the cancer program but not hospital owned).

The average FTE nurse to patient ratio in the infusion center is 6:1. Programs reported daily rates of an average of 5.5 infusion patients per chair per day.

Almost half of responding cancer programs report they are planning to expand their infusion center. Plans for expansion of the infusion center are driven by competition for patient volume. To drive referrals, many cancer programs are increasing affiliations with community oncologists, enhancing competitiveness for market share, and supporting community outreach through satellite centers.

An aging population increases the patient pool for all oncology providers. Community referrals for specific insurance types challenge cancer programs to find a way to manage these patients profitably.

"Demand is driving our plans for expansion."

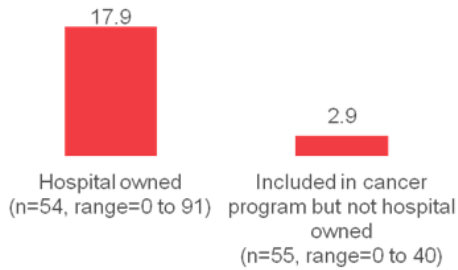
"We would like to catch folks on both sides of town so we don't lose them to another program."

"A lot of oncologists are trying to join the hospital because of economic pressures from Medicare. If they will be located here, we would have to make more infusion space."

Infusion Center and Pharmacy

Table 32. Almost half of the cancer programs are planning to expand their infusion center – many to a satellite facility.

Mean Number of Infusion Beds/Chairs



• 46% plan to expand, including 20% that plan to expand to a satellite facility

"Demand is driving our plans for expansion."

Utilization of FTE Nurses and Infusion Chairs

	Mean	Min.	Max.
Infusion patients per chair per day (n=35)	5.5	1	45
Infusion patients per FTE nurse per day (n=34)	6.1	2	16

Q6d. How many of the IV infusion chairs/beds in your infusion center fall into each of the following types?
 Q6e1. Do you have plans to expand your infusion center (including both adult and pediatric chairs/beds)?
 Q6e2. Do you have plans to expand to a satellite facility?
 Q6b. What percentage of patient visits in this clinic are pediatric vs. adult?
 Q711. In 2010 what was the number of infusion patients per chair per day?
 Q712. In 2010 what was the number of infusion patients per FTE nurse per day?

Differences across survey years have no statistical significance unless noted.



6.2. Mixing

Pharmacists, not nurses, do 97 percent of the chemotherapy infusion mixing in hospitals, whether the pharmacy is in the infusion center or in the hospital pharmacy. This finding has remained consistent over the years.

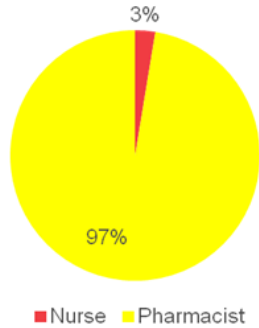
About half of mixing pharmacies are located in the infusion center, while 36 percent are located in the hospital pharmacy.

Infusion Center and Pharmacy

Table 33. Regardless of location, pharmacy personnel mix the infusion drugs.

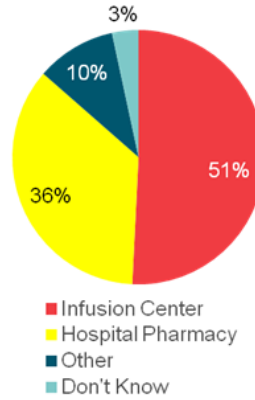
Chemotherapy Infusion Mixing

Average Percent Mixed by:
Percentage of Respondents (n=53*)



* Don't know, n=6

Location of Mixing Pharmacy
Percentage of Respondents (n=59)



Q6h. What percentage of chemotherapy infusions are mixed by each personnel type?
Q6i. Where is the mixing pharmacy located? Select one.

Differences across survey years have no statistical significance unless noted.

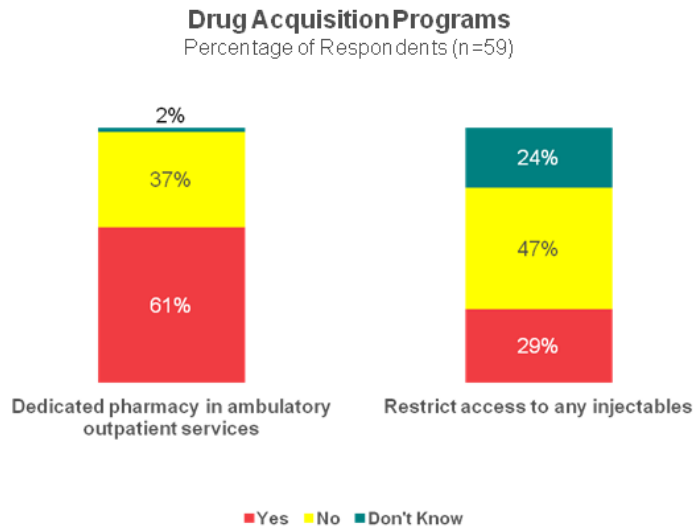


6.3. Dedicated Pharmacy

More than half of respondents (61 percent) have a dedicated pharmacy in ambulatory outpatient services. Hospitals with dedicated pharmacies are less likely to restrict access to injectables.

Infusion Center and Pharmacy

Table 34. Most programs have a dedicated outpatient pharmacy; few restrict access to oncology injectables.



Q3d. Does your program have a dedicated pharmacy in your ambulatory outpatient services?
Q3g. Does your program restrict access to any injectable cancer drugs from use in the cancer

Differences across survey years have no statistical significance unless noted.



6.4. Oral Cancer Drugs

Only one-third of infusion centers dispense oral cancer drugs; however, this percentage is up from 24 percent in last year's survey. Seventy-two percent of those who do dispense oral cancer drugs have quality initiatives related to orals.

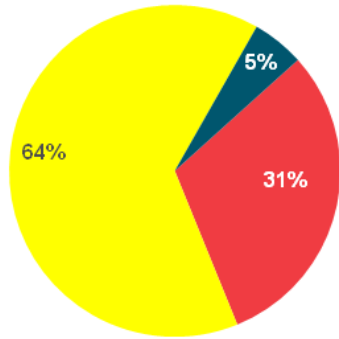
Prices for most orally administered antineoplastic agents can be high and margins tend to be low. Still, the use of oral anti-cancer agents is likely to increase in the coming years with the development and approval of a growing number of new oral formulations to fight cancer. As research identifies new "targets," the subsequent development of new oral agents to affect those targets is changing the approach to treating various malignancies. In some cases, cancer is becoming a chronic disease, where traditional chemotherapy is combined with newer therapies over prolonged periods of time.

Infusion Center and Pharmacy

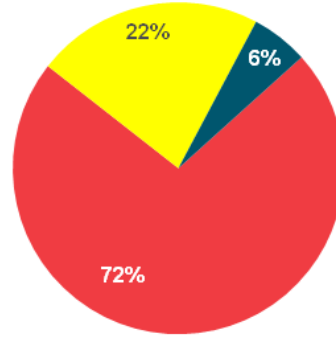
Table 35. Only one-third of hospital programs dispense oral cancer drugs; the majority of these have quality initiatives related to oral cancer drugs.

Oral Cancer Drugs

Dispenses Oral Cancer Drugs
Percentage of Respondents (n=59)



Quality Initiatives
Percentage of Respondents that Dispense Oral Cancer Drugs (n=18)



■ Yes
■ No
■ Don't Know

Q6j. Does your program dispense oral cancer drugs (i.e., Tarceva, Sutent, Femara, Xeloda) for use outside of your facility?
Q6k. Do you have quality initiatives related to oral cancer medications?

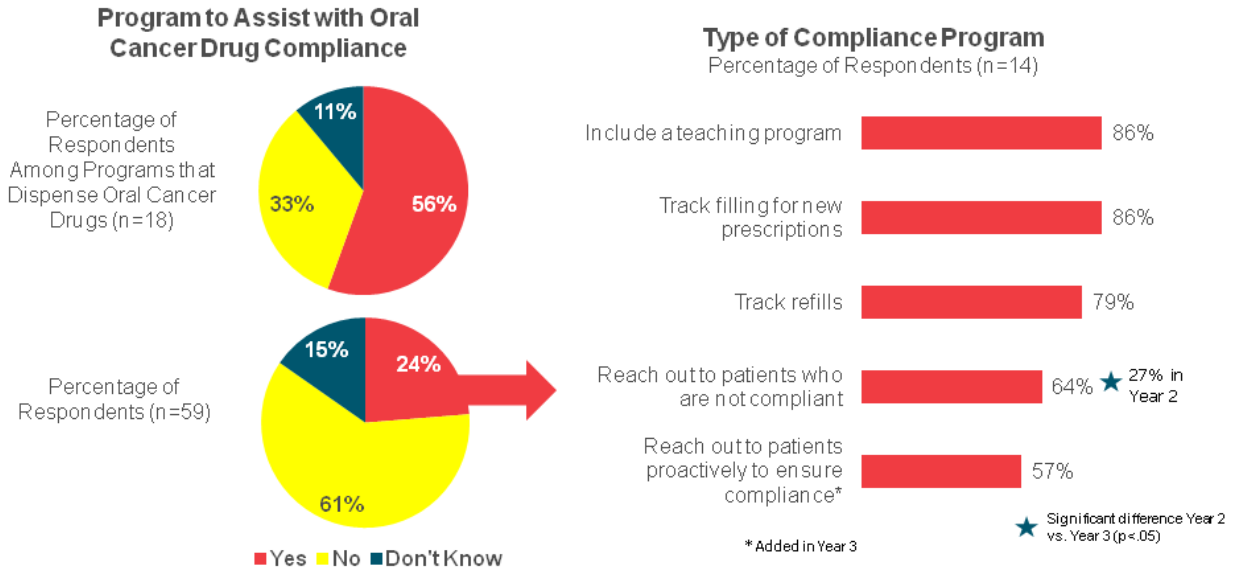
Differences across survey years have no statistical significance unless noted.



Among infusion centers that have a pharmacy, more than half offer a program to assist with compliance. Compliance programs consist of teaching programs, tracking the filling of new prescriptions and refills, and outreach to patients who are not compliant. More than half of respondents reach out to patients proactively to help ensure compliance.

Infusion Center and Pharmacy

Table 36. More than half of the programs that dispense oral cancer drugs have programs to assist with compliance.



Q6k1. Do you have a program in place to assist with compliance for oral medications?
Q6l. [If yes] does this program: (Select all that apply.)

Differences across survey years have no statistical significance unless noted.

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6.5. Purchasing Drugs

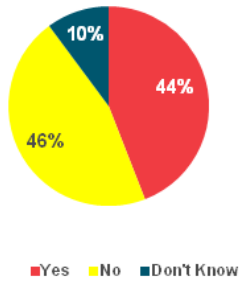
Programs purchase medication either through the hospital pharmacy or through a purchasing program of their own.

Analysis. Drugs and biologicals represent the largest cost in today's medical oncology practice. For most community cancer centers, approximately 20 drugs make up 80 percent of drug costs. Today more than ever, cancer programs need to assign a staff member to monitor drugs costs on a weekly basis and direct purchasing efforts to the least expensive source for the high-cost drugs. (Lower-cost drugs can be monitored on a monthly basis.) Failure to properly manage drug purchases can bankrupt an outpatient cancer center. To ensure that significant cash is not tied up in excess drug stock, cancer programs should regularly review drug stock as well as preset automatic reordering (PAR) levels.

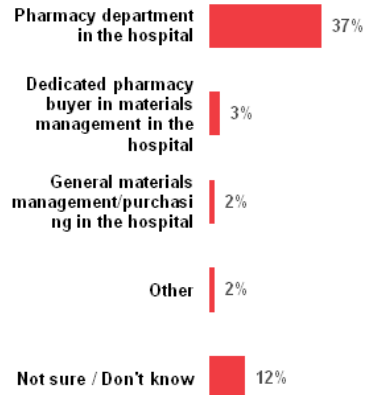
Infusion Center and Pharmacy

Table 37. Programs purchase medication either through the hospital pharmacy department or a purchasing program of their own.

Program Conducts Own Purchasing Program
Percent of Respondents (n=59)



How Medication Is Purchased
Percentage of Respondents (n=59)



Q3h. Is your program responsible for purchasing IV or oral medications itself (i.e. conducts its own purchasing program)? Q3i. How is medication purchasing conducted?

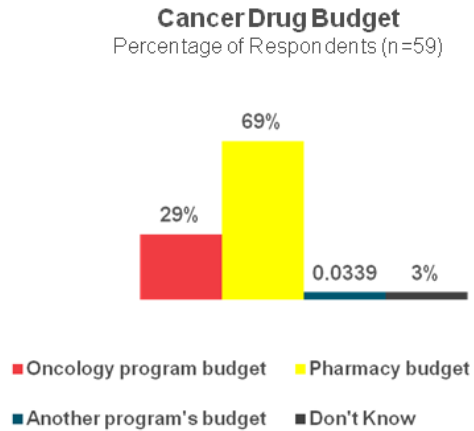
Differences across survey years have no statistical significance unless noted.



The cancer drug budget typically resides in the pharmacy.

Infusion Center and Pharmacy

Table 38. The cancer drug budget typically resides in the pharmacy.



Q6m. *ADDED IN W3* Are cancer drugs part of your oncology program budget, part of the pharmacy budget, or part of another program's budget? Select all that apply.

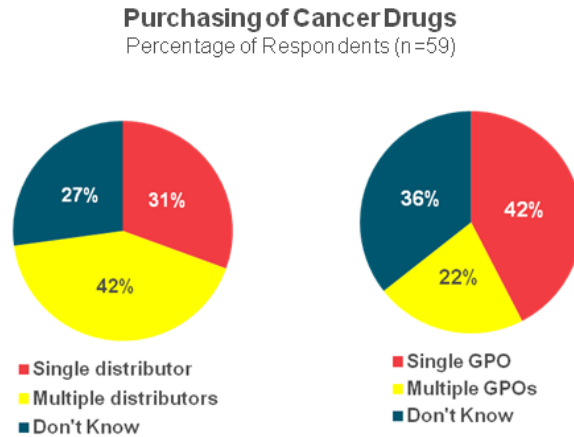
Differences across survey years have no statistical significance unless noted.



Forty-two percent of respondents report they purchase cancer drugs through multiple distributors, but use a single group purchasing organization.

Infusion Center and Pharmacy

Table 39. Most programs purchase cancer drugs through multiple distributors, but only use a single group purchasing organization (GPO).



Q3a/b. How does your program purchase cancer drugs? (SELECT ONLY ONE).

Differences across survey years have no statistical significance unless noted.



6.6. Acquisition of Injectables from Specialty Pharmacies

Acquisition of injectables from specialty pharmacies has increased since 2009; pressure from payers drives this trend. Payers are seeking to increase the role of specialty pharmacies, which offer opportunities to manage costs and increase compliance, including: Utilization management support, simplified and standardized billing, and comprehensive reporting and outcome analysis.

Cancer programs were quick to point out their concerns about accepting injectables from specialty pharmacies.

ACCC members who participated in follow-up interviews (n=12) explained that when they accept products from specialty pharmacies they are expected to assume the costs of storing and handling, as these functions are not billable. Accepting injectables from specialty pharmacies presents challenges for cancer programs with regard to operations, reimbursement, patient safety and institutional liability. For these reasons, it is usually in the cancer program’s best interest to buy and bill for injectable products; in most markets, cancer programs are able to do so.

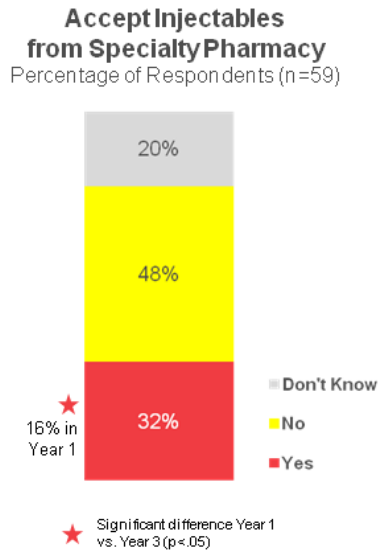
"It is a lot of additional work to verify the source and whether the drug is legitimate. We are not paid to mix and dispense – it is a challenge to appropriately bill for any drugs from the outside. Ultimately, we may need to charge an additional fee for this."

"We don't [accept injectables from specialty pharmacies] because we have no ability to ensure quality. Payers have not yet forced us to do so."

"As part of an integrated health plan, when we are required to [accept injectables from a specialty pharmacy] – we will have to figure out the financial flows. It will be worse for us but better for our whole system."

Infusion Center and Pharmacy

Table 40. Acquisition of injectables from specialty pharmacies has increased since 2009; pressure from payers drives this trend.



Q3f. Does your program accept injectable drugs supplied by specialty pharmacies (who mail you the drug and bill the health plan directly)?

Differences across survey years have no statistical significance unless noted.



6.7. Brown Bagging

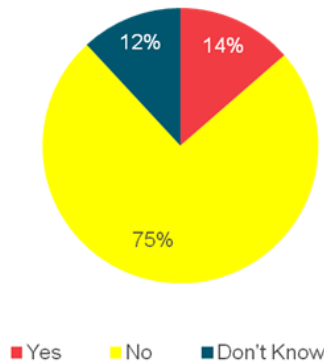
Cancer programs avoid "brown bagging," where the drug is supplied by the patient. Brown bagging is viewed as compromising patient safety and jeopardizing institutional liability as it is impossible to verify the integrity of products that require careful handling and controlled temperatures.

"If the patient brings in their drug we have no control—they may have left it in their car [at high temperatures] over the weekend. We have had cases where we refused to administer patient-provided drugs."

Infusion Center and Pharmacy

Table 41. Cancer programs avoid “brown bagging” (where the drug is supplied by the patient).

Acceptance of Patient-provided Drugs
Percentage of Respondents (n=59)



Q611. Do you accept patient-provided / patient delivered drugs for infusion?

Differences across survey years have no statistical significance unless noted.



6.8. Purchasing Drugs Through the 340B Drug Discount Program

Participation in the 340B Drug Discount Program is on the rise, spurred by loosened eligibility criteria and increased discounts included in the Affordable Care Act. Forty-six percent participate in the 340B program, up from 26 percent in the first year of the survey and 36 percent from last year.

Cancer centers that participate in the 340B program have consistently seen economic benefits. ACCC members who participated in follow-up interviews reported that the 340B program is a major contributor to profitability. Most respondents have seen an increase of local oncology practices seeking affiliation in order to access the economic benefits of the program.

Program 340B administration can be difficult, but members note that it gets easier once they are up and running.

Program 340B may contribute to the shift of more oncology therapy to the outpatient setting; however, members emphasized that this trend is occurring regardless of 340B participation.

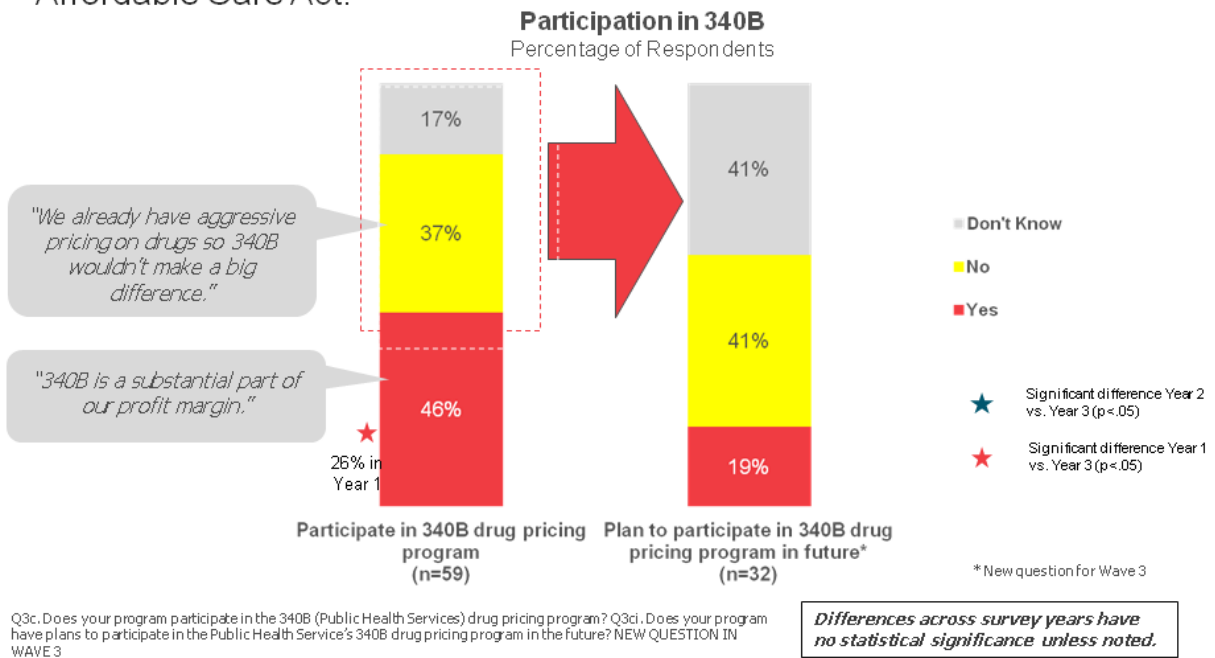
"340B is definitely a negotiating point to get local oncologists to join with us and enjoy savings."

"You need the right staff to administer it. It is not hard but you need a team that is focused and dedicated."

"340B is very difficult to administer because we have to have three stocks of drugs: (1) 340B is only for outpatient treatment, (2) another stock for inpatient treatment, and (3) stock for clinical trials drugs."

Infusion Center and Pharmacy

Table 42. Program 340B participation is on the rise, spurred by loosened eligibility criteria and increased discounts included in the Affordable Care Act.



6.9. Coping with Oncology Drug Shortages

Programs that have been significantly affected by the chemotherapy drug shortages report scrambling to get drugs through distributors or other facilities, often at notably higher cost. Physicians sometimes modify treatment regimens when a drug is not available.

Programs that have been minimally affected have a preventative strategy in place that includes frequent supply checks, early warnings, and aggressive purchasers to mitigate the impact of a shortage.

"We have to change to using less effective or more expensive drugs. We call our GPO and other hospitals to get them, and get what we need about 80% of the time."

"Yes and this has hurt us. We're buying from other hospitals and vendors for more money."

"If we are running low on 5FU we have everyone come in on the same day so there are no unused vials – this requires careful planning."

"We check supply and shortages daily. We use one major supplier who is a clearing house for other suppliers – they have been aggressive so the impact has been minimal."

Section 7. EMR Systems

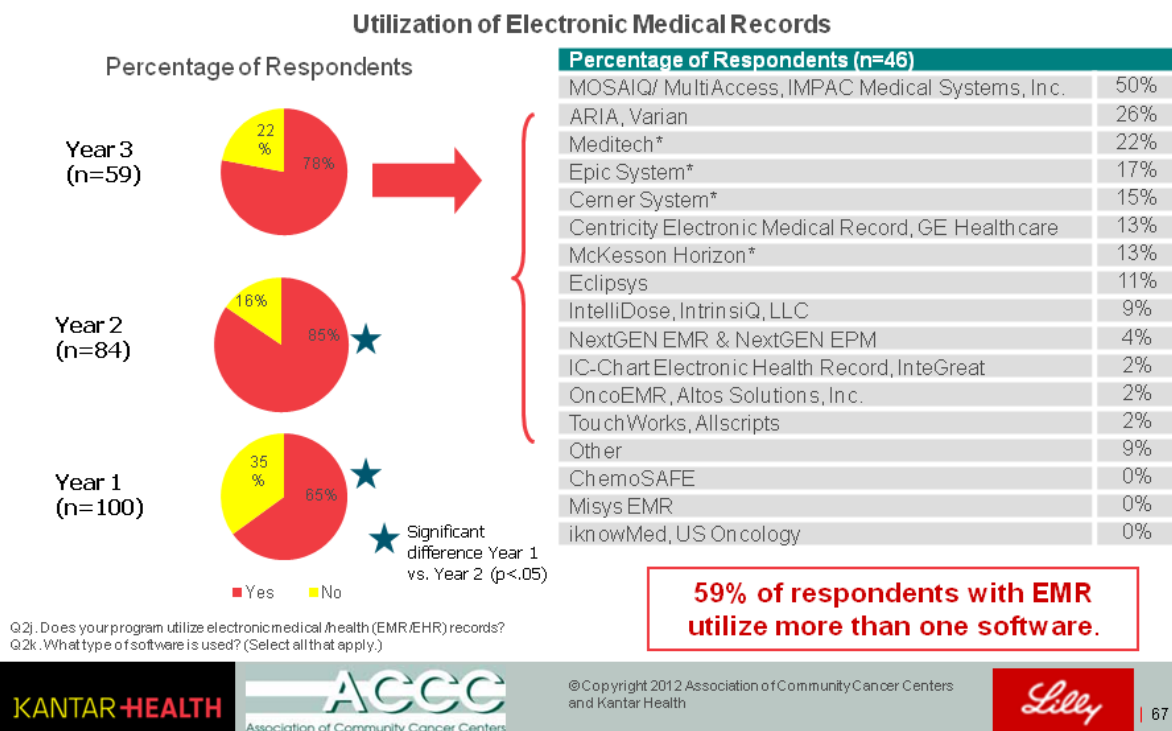
7.1. Use of EMR Systems

Last year we noted that the use of electronic medical records (EMRs) is increasing, but is still not universal in community cancer programs. We can say the same in this year's survey. In 2011, 78 percent of respondents report utilization of EMRs versus 65 percent in the first year of the survey. More than half (59 percent) of respondents that do use EMRs report using more than one software. IMPAC Medical Systems' MOSAIQ and Varian's ARIA are the most frequently used. Radiation oncology departments frequently need separate EMR systems because their needs are not met by whatever system the chemotherapy operations are using.

The Epic System/Beacon is the most popular software for EMR among programs currently in the process of implementing EMR/EHR software. More than one-quarter of programs report they are in the process of implementing EMR/EHR systems. Less than one-quarter (24 percent) of respondents indicated that their strategies to reduce costs include delaying IT improvements (Table 13). This is down significantly from 42 percent in last year's survey.

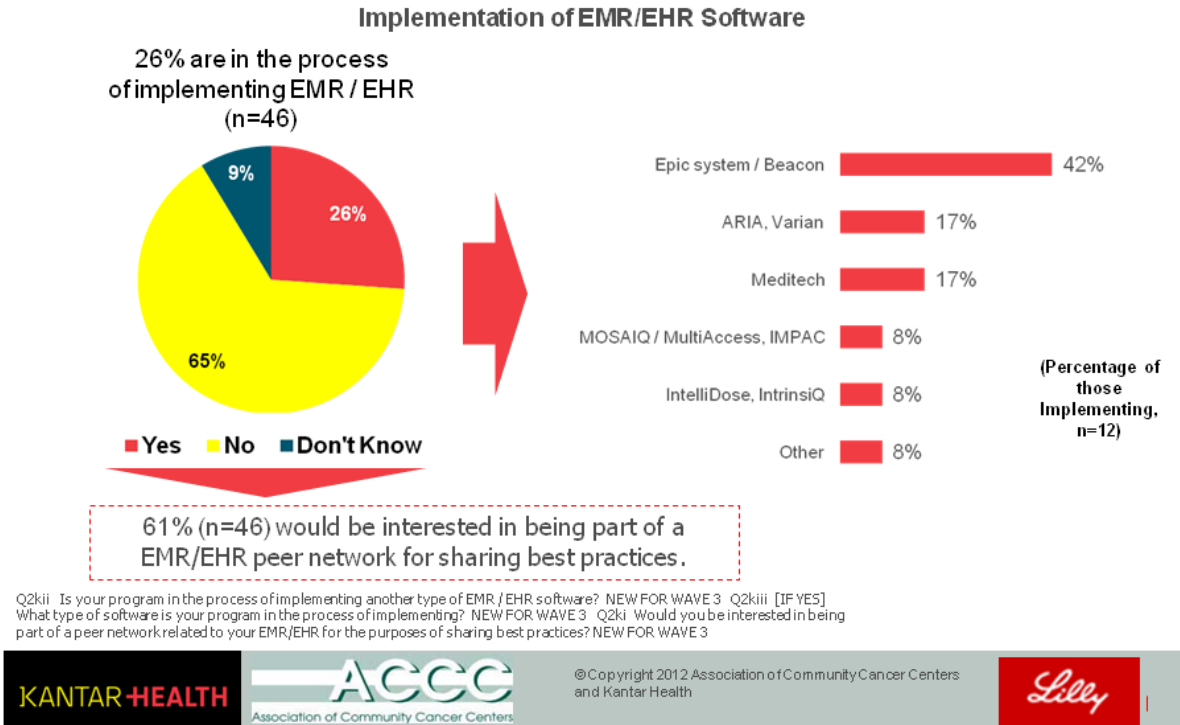
EMR Systems

Table 43. Use of EMR is not yet universal; IMPAC and Varian dominate the EMR market for cancer programs.



EMR Systems

Table 44. Epic Systems/Beacon is the most popular software for EMR and electronic health record (EHR) systems among programs in the process of implementation.



7.2. Selection

Selecting an EMR system for a hospital-based cancer center comes with a steep learning curve before benefits can be realized. Aside from the issues of capital and operating costs, the ideal system must meet the functional needs of the multidisciplinary cancer care team—medical oncologists, hematologists, radiation oncologists, surgeons, pharmacists, nurses, technicians, and administrative staff. Few systems can provide the breadth of functionality desired. Often, the cancer center must select multiple systems from multiple vendors, and attempt to "fit" the systems together. To eliminate redundant data entry by staff, the cancer center must stipulate that all vendors be able to exchange information through interfaces. Last but certainly not least, cancer center (or hospital) IT staff must have the skill sets to support the various technologies, the network, and all interfaces.

Anticipated benefits of EMR are significant and include:

- Access to information from any location
- Electronic signature and prescribing for physicians
- Electronic fax reports and dictation for referring physicians
- Ability to look up information for hospitalized patients.

However, the specific clinical concerns of the oncology program may simply be beyond the capabilities of the hospital's information systems. An oncology-specific EMR can address these issues, including:

- Calculating the appropriate chemotherapy dose
- Tracking lifetime dosages of radiation and chemotherapy medications
- Keeping track of infusion preparation and administration
- Managing tumor staging
- Coordinating treatment protocols for combination therapies.

Oncology-specific EMRs will often have their own patient scheduling, order entry, clinical documentation, pharmacy functions, and billing components. If the hospital already has systems in place that take care of all or some of these functions, the hospital-based cancer center may choose not to implement certain elements in the oncology-specific EMR. In this scenario, the hospital-based information systems and the oncology-specific EMR must be set up to share data back and forth. Often this back-and-forth sharing of data requires specially developed interfaces.

A few survey respondents complained that their EMR is not oncology-specific; however, they suggested that the longer the system has been in place, the more valuable it seems to be.

"You have less work to get information to key people, such as for billing, coding, charge entry, etc."

"The benefit is integration with group practices – all providers communicate with each other and with patients; better coordination of care."

7.3. Resources

- [Patient Portals: The Gateway to Patient-Centered Care and Meaningful Use](#)
- [Technology Expansion in Support of Community Cancer Care--The NCCCP IT Experience](#)
- [Managing Your Practice's Transition from Paper to EHR](#)
- [Implementing EHRs in Community Oncology Practices](#)
- [Is Your Practice Getting the Most from its EHR](#)
- [EMR for Hospital-Based Oncology Programs, Practical Tips and Strategies](#)
- [From Paper to Progress: EMR Implementation at Moses Cone Regional Cancer Center](#)
- [Hybrid EMR Systems: Another Option](#)
- [Medical Information Technology Vendor List](#)

Section 8. Preparation for New ACoS Standards

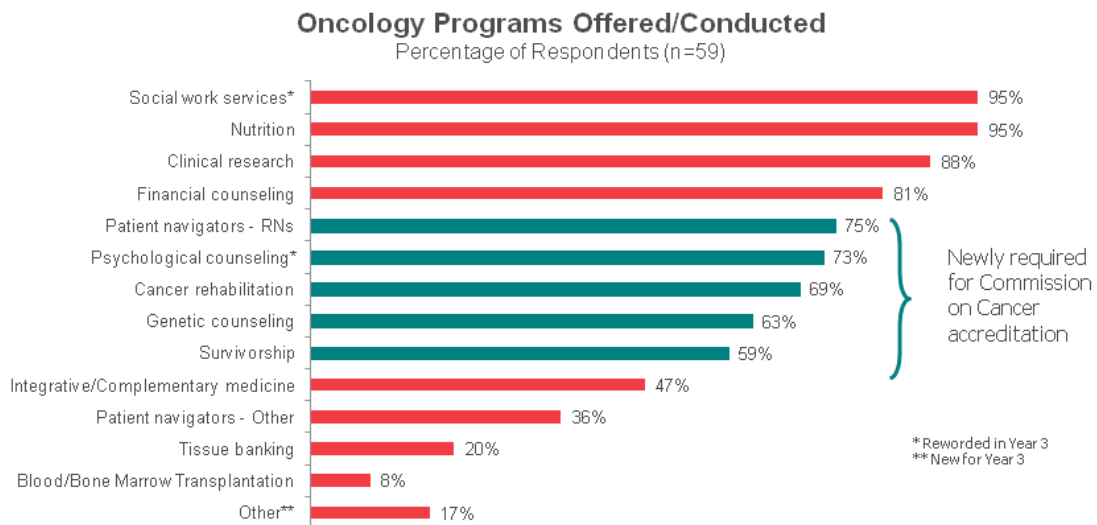
8.1. Concerns

Members agree that the new Commission on Cancer standards are good for patients, but are concerned about meeting the new standards.

The new standards include the provision of treatment and survivorship plans, palliative care services, genetics services, navigation programs and psychosocial distress screenings. Some programs are more prepared than others, but most anticipate that they will be challenged to maintain accreditation. Even the programs that feel prepared to meet the new accreditation standards expect that one or more of the criteria will require a substantial increase in resources – primarily nursing time. Members were mixed with regard to which services present the biggest challenge.

Concerns About ACoS Standards

Table 45. Most, but not all, programs offer the services newly required for accreditation by the Commission on Cancer.



Q1g. Which of the following programs does the oncology service line offer / conduct? (SELECT ALL THAT ARE OFFERED)

Differences across survey years have no statistical significance unless noted.



"Evaluating patients for psychosocial distress is one thing, but we need to have the resources to help these patients when we find them."

"Our biggest challenge will be to justify the cost of additional nursing. Genetics is reimbursed but survivorship and psychosocial distress screening – we can't bill for these in a way that will cover the cost of staff. As reimbursement dwindles – in reality we may have to choose between accreditation and being profitable."

"Most difficult is the treatment summaries and care plans – these are not in EMR and need to be done by hand – very time consuming."