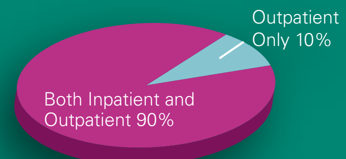
2010 Cancer Care Trends
in Community Cancer Centers

Information from this member survey will help drive ACCC's advocacy efforts, assist member programs to understand nationwide developments in the business aspects of cancer care, and allow member programs to benchmark their performance against similar organizations. This survey is year 2 of a 3-year joint project between ACCC and Eli Lilly.

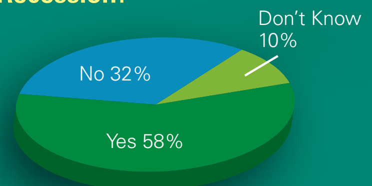
Although a higher percentage of academic cancer centers responded to this year's survey, the vast majority of respondents (73%) were cancer centers located at community hospitals.

In year 2, community cancer centers began to feel the effect of the economic downturn and responded by reducing travel and education expenses and delaying equipment purchases. Almost 60% of respondents reported delaying construction projects and instituting hiring freezes.

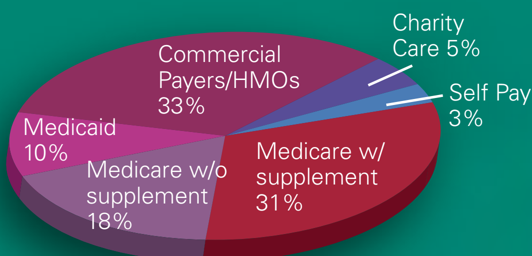
Type of Oncology Services Provided



Has Your Program Made Changes as a Result of the Current Economic Recession?



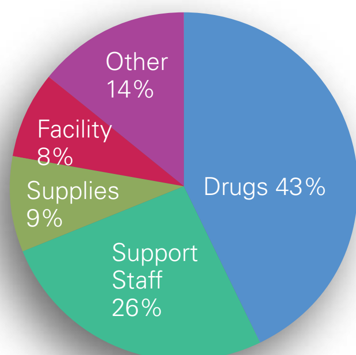
Respondents' Payer Mix



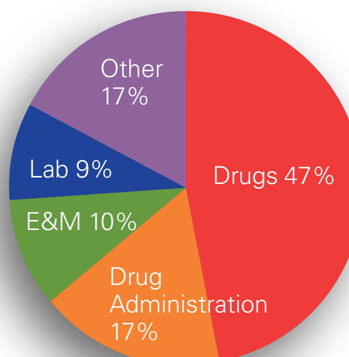
Drugs and Biologicals

Drugs still represent the largest cost in community cancer centers. On the other side of the equation, drugs comprise only 47% of hospital cancer program revenues. (Studies show that about 80% of community practice revenue comes from drugs.)

2008 Expenses



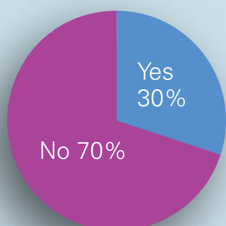
2008 Gross Service Charges



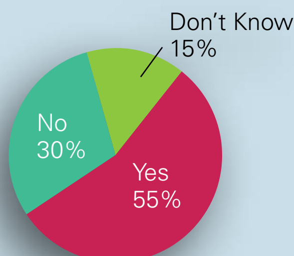
About half of the cancer programs (51%) purchase drugs through multiple distributors; 30% purchase drugs through a single distributor. More cancer programs now use a single GPO—44% in year 2 of the survey compared to 35% in year 1.

Medication is typically stocked in the hospital pharmacy (64%), with 46% of cancer programs stocking drug inventory in the infusion center. The vast majority reported that the pharmacy department is responsible for managing drug inventory (86%). Only 10% reported that drug inventory is managed by nursing staff.

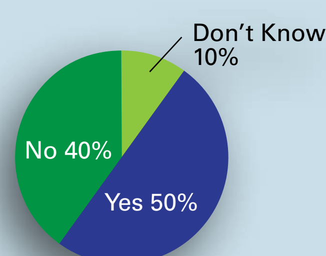
Infusion Center Has Retail Pharmacy?



Programs to Assist with Compliance with Oral Agents?



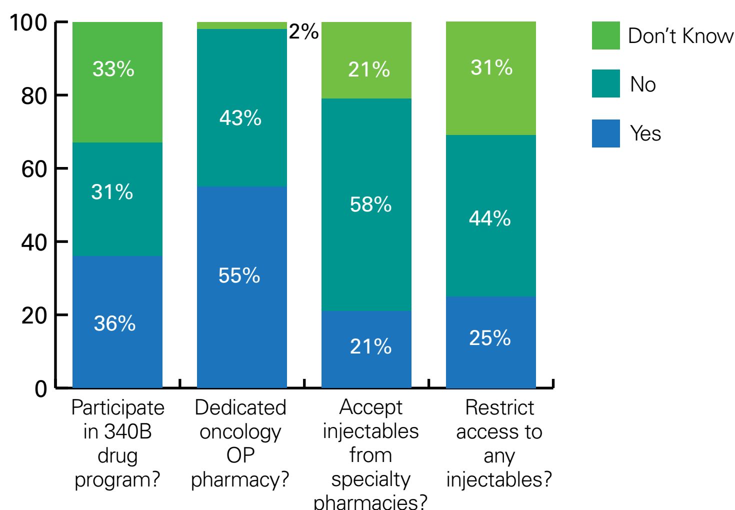
Quality Initiatives Related to Oral Agents?



Oral Agents

- While oral anti-cancer agents remain unpopular, more cancer programs are dispensing them—24% in year 2 of the survey compared to 21% in year 1. Still, 64% of year 2 respondents do *not* dispense oral agents at their infusion centers.
- The number of cancer programs offering quality initiatives related to oral agents increased 7% from year 1 to year 2 of the survey.

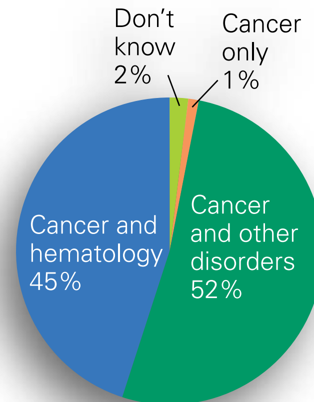
Drug Acquisition



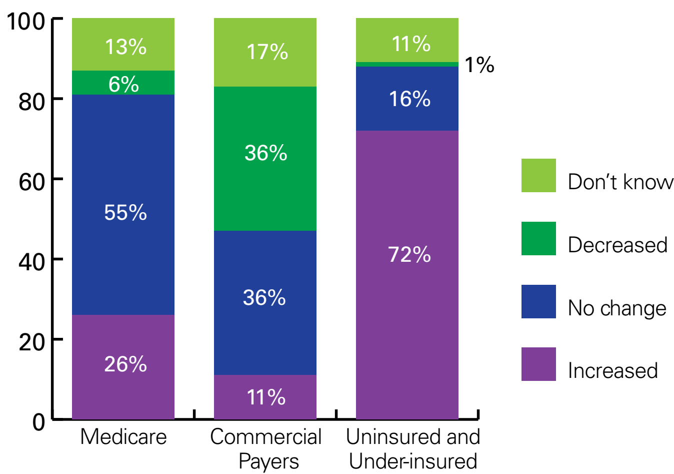
Infusion Centers At-a-Glance

- Mean number of infusion patients daily per infusion chair is 5.2
- Mean number of infusion patients per FTE nurse is 6.1
- More pharmacists, fewer nurses, are mixing drugs—95% this year, compared to 89% last year
- Hospitals with dedicated OP pharmacies are less likely to restrict access to injectables
- Mean infusion center square footage is 5,591 feet
- Mean number of infusion beds and chairs is 16

Infusion Center Dedicated to Cancer?

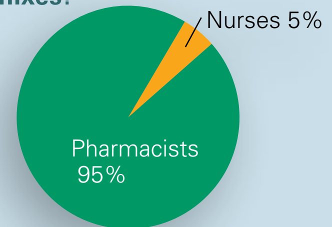


Changes in the Number of Patients Receiving Chemotherapy Infusions

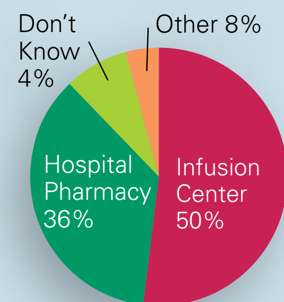


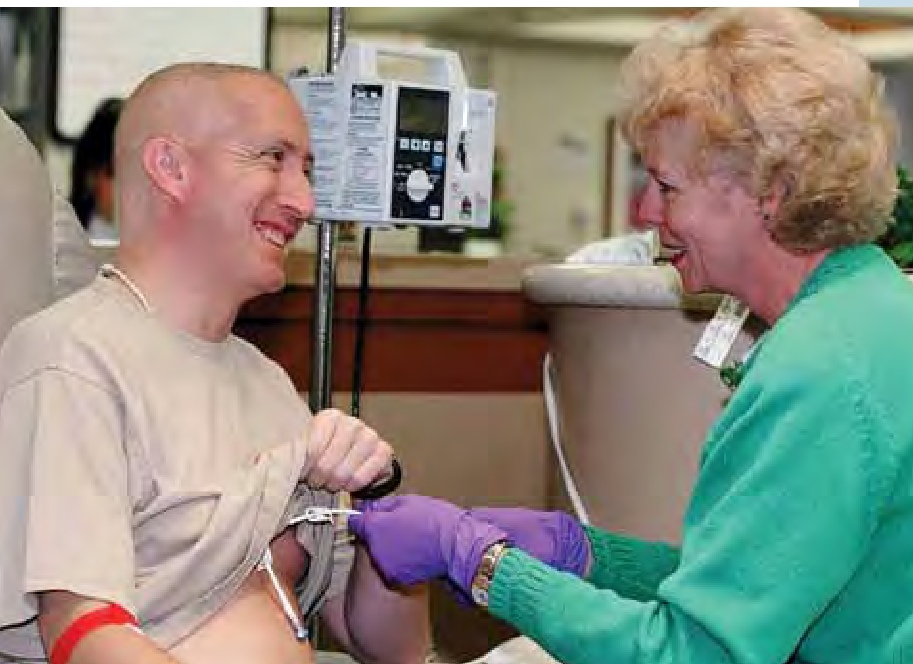
Chemotherapy Infusion Mixing

Who mixes?



Where?





Want to Learn More? Visit *www.accc-cancer.org*

Staffing

What We Did

For year 2, 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. The consulting firm of Kantar Health collected responses, conducted follow-up interviews in November and December 2009, and analyzed results. Full survey results are available in the Members-only section of ACCC's website, *www.accc-cancer.org*.

Steering Committee members include: Ernest R. Anderson, Jr., MS, RPh, Caritas Christi Health Care System; 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.

In addition, members of the Advisory Committee include: Connie Bollin, MBA, RN, Akron General Medical Center, Akron General McDowell Cancer Center; Albert B. Einstein, MD, Swedish Cancer Institute; John E. Feldmann, MD, FACP, Regional Cancer Center, Moses Cone Health System; Brendan Fitzpatrick, MBA, Alamance Cancer Center; Jennifer Michelson, RN, BSN, Kingsbury Cancer Center; Richard Reiling, MD, FACS, Presbyterian Hospital - Charlotte; and Virginia Vaitones, MSW, OSW-C, Penobscot Bay Medical Center.

As in year 1 of the survey, after drug costs, staffing costs remain the second highest expenditure for cancer programs. Nursing and administrative staff account for the most FTEs. While most cancer programs rely heavily on private practice physicians, this year's survey showed an increase in physicians employed by the cancer program. This trend is based in part on declining reimbursement rates and a hospital's ability to offer financial stability to its physicians.

Where Do Your Physicians Come From?

Medical Oncologists and Hematologists

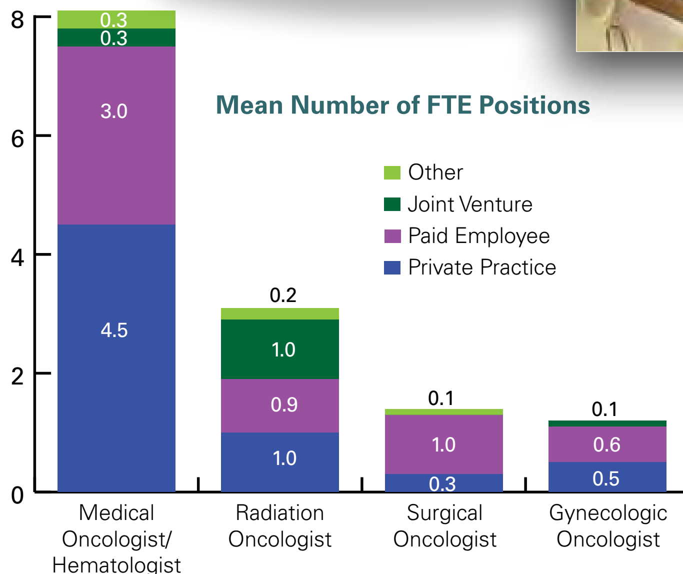
In private practice	56%
Paid employees of hospital	50%
Professional services agreements	12%
Joint venture (not paid by hospital)	5%

Radiation Oncologists

In private practice	33%
Paid employees of hospital	26%
Professional services agreements	42%
Joint venture (not paid by hospital)	7%

Surgical Oncologists

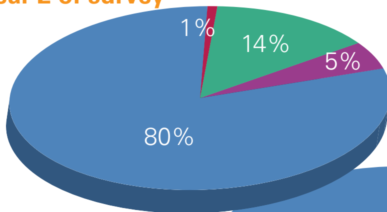
In private practice	18%
Paid employees of hospital	21%
Professional services agreements	1%
Joint venture (not paid by hospital)	2%

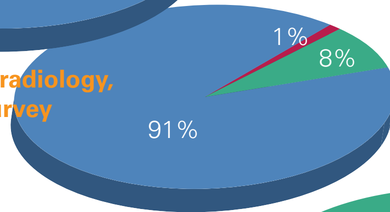


The Marketplace

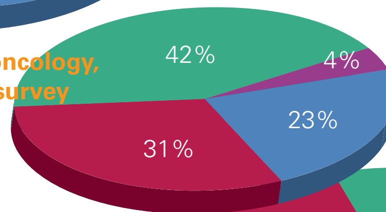
Accelerating consolidation of cancer programs is a clear trend. In the past year, 17% of responding programs reported consolidation of programs within their market area. In the next one to two years, one in three hospital respondents expect consolidation within their primary market area. That compares to less than one in five in year 1 of the survey. Physician oncology practices are consolidating even faster. In the next one to two years, almost half of respondents expect consolidation of physician oncology practices in their primary market area, up from 30% in year 1 of the survey.

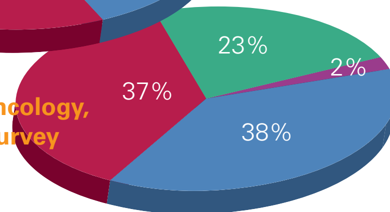
Surgical Oncology & Diagnostic Radiology Included in Cancer Service Line?



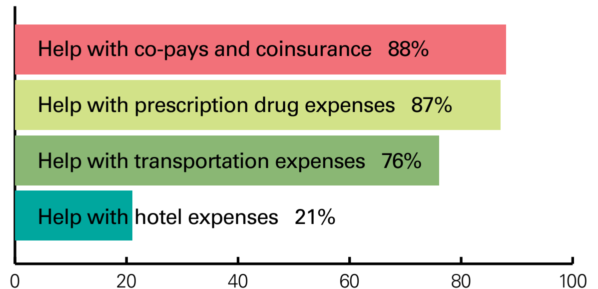


No (separate entity)
Not Offered
Yes
Don't Know

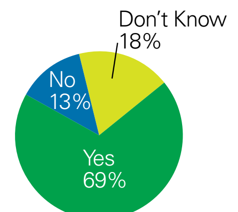




Recession Affecting Patients, Too.
More Patients Need…



More Patient Referrals Based on Inability to Pay for Expensive Drugs?



Oncology-Related Services

1

New trend! Almost across the board this year, philanthropy is paying for a larger percentage of oncology-related services, although most funding continues to come from general operating funds.

2

Patients paying more too! This year, patients are paying a larger percentage of nutrition, social work, rehabilitation services, and clinical research costs.

3

Money matters! Financial counseling is offered by 94% of programs. Nearly 60% have reimbursement specialists on staff.

4

Cutting back! Fewer programs offer social work and psychological support than last year—82% in year 2 of the survey versus 94% in year 1.

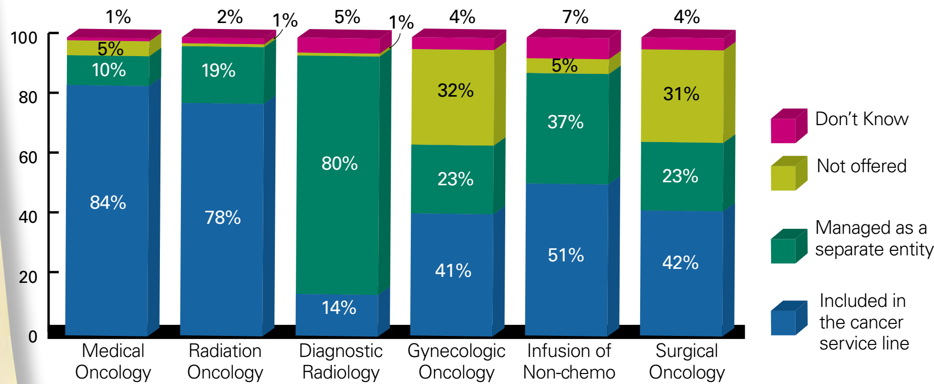
5

Patient-centered care! More programs are offering survivorship services (74% in year 2 versus 63% in year 1) and nurse-led patient navigation services (69% in year 2 versus 66% in year 1).

Recession-related Changes to Your Cancer Program

- ✓ Reduced travel and education 86%
- ✓ Renegotiated vendor contracts 65%
- ✓ Delayed equipment purchases 61%
- ✓ Delayed construction projects 59%
- ✓ Cut administrative costs 59%
- ✓ Froze hiring 57%
- ✓ Delayed IT improvements 43%
- ✓ Reduced staff 29%
- ✓ Reduced services 10%
- ✓ Opened outpatient pharmacies 6%

Scope of Oncology Services

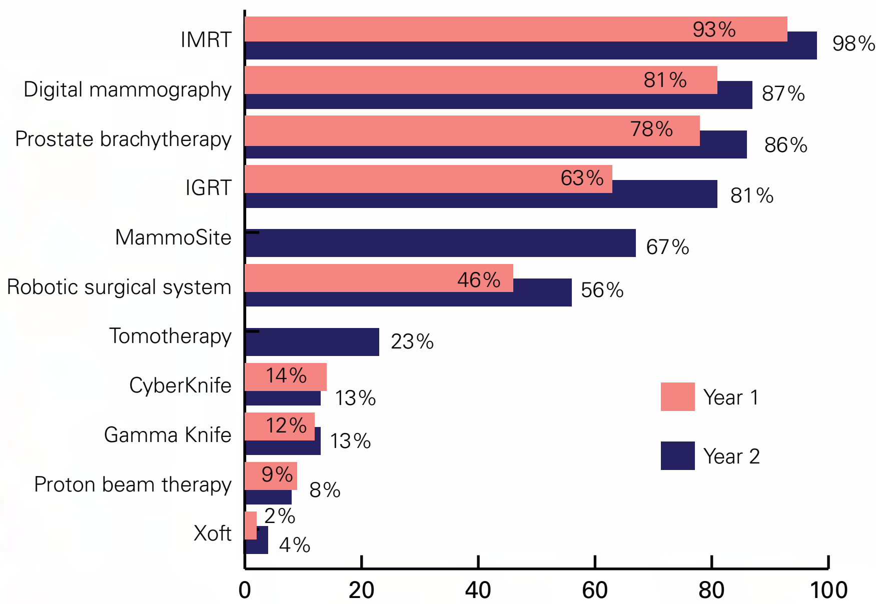


Sources for Funding Oncology-Related Services. *Arrows show relationship to year 1 data.*

	General Operating Funds	Endow-ment	Philan-thropy	Grants	State Funding	Trial Sponsors	Patient Pays	Insurance
Nutrition	87% ↓	1% ↔	11% ↑	6% ↑	1% ↔	0% ↔	24% ↑	18% ↔
Social Work (psychological support)	94% ↓	6% ↑	16% ↑	3% ↑	4% ↑	0% ↓	9% ↑	2% ↑
NEW! Social Work (financial counseling)	94%	3%	10%	6%	4%	10%	6%	6%
Clinical Research	76% ↓	8% ↔	27% ↑	50% ↓	11% ↑	81% ↑	16% ↑	39% ↓
Genetic Counseling	75% ↑	2% ↔	11% ↑	11% ↑	4% ↑	2% ↔	42% ↓	40% ↔
Nurse Navigators	86% ↓	2% ↓	24% ↑	28% ↑	3% ↓	0% ↔	0% ↔	2% ↑
Cancer Rehabilitation	78% ↓	2% ↑	7% ↓	9% ↑	0% ↔	0% ↔	65% ↑	70% ↑
Survivorship	66% ↓	8% ↔	42% ↓	34% ↓	2% ↓	0% ↔	10% ↑	10% ↑
General Operating Funds	66% ↓	8% ↔	42% ↓	34% ↓	2% ↓	0% ↔	10% ↑	10% ↑
Psychology	64% ↓	4% ↑	12% ↑	12% ↑	2% ↔	0% ↔	32% ↓	46% ↑
Integrative/Complementary Services	55% ↓	2% ↓	57% ↑	23% ↓	2% ↓	0% ↓	41% ↑	21% ↑
Patient Navigators	70% ↓	0% ↓	23% ↑	30% ↑	7% ↓	0% ↔	3% ↑	3% ↑
Tissue Banking	55% ↑	0% ↓	18% ↓	41% ↓	14% ↑	9% ↓	9% ↓	0% ↓
Bone and Bone Marrow Transplantation	73% ↓	0% ↔	9% ↔	18% ↑	9% ↔	18% ↑	73% ↑	91% ↑

Service Line Offerings

Despite the recession, most cancer programs have increased their service line offerings. The biggest increases were programs that offered IGRT (81% in year 2 versus 63% in year 1); robotic surgery (56% in year 2 versus 46% in year 1); and prostate brachytherapy (86% in year 2 versus 78% in year 1).



EHR Use

Use of electronic health records continues to increase. In year 2 of the survey, 84% of programs used an EHR—up from 65% in year 1. IMPAC Medical System's MOSAIQ and Varian's ARIA appear to be approaching "industry standard" status. More than half (51%) use MOSAIQ. More than one-third (31%) selected ARIA. However, 54% of respondents reported using more than one EHR software—up from 47% in year 1.

Financial Performance

Recession Has Had Impact, but Programs Still Healthy

Cancer programs are adapting to the recession by replacing management teams, initiating cost-cutting efforts, increasing marketing to raise patient volumes, and affiliating and/or consolidating with other local providers, among other efforts.

Despite the economic downturn, most respondents (78%) characterize their cancer program's financial status as good or very good. Just 7% report poor financial health. These findings may not trend upward. In last year's survey, 90% reported their cancer program's financial status as good or very good.

Hospital-based cancer programs seem to be weathering the recession better than community practices because of their more diversified revenue streams, including labs and diagnostic imaging.

In Their Own Words

In our early detection programs, such as screening mammography, we have seen a decline in patient volume, but a steady number of oncology patients in the last year. The big difference is that so many more patients have no insurance or limited insurance. Our applications for "county aid" have greatly increased and the social worker's and financial advocate's workload is enormous. Our program continues to manage travel, education, and productivity very closely. Our referral volume stability is partially the result of the number of primary care and specialty physicians who have sought to be hired by our hospital system during the last year.

Luana Lamkin, RN, MPH,
Mountain States Tumor Institute, Idaho

In Louisiana, our program's challenges in 2009-2010 are greatly affected by the state budget. As an agency of the state, when state coffers fall so do agency budgets, particularly healthcare and higher education, of which we are both. At the same time, we treat a large volume of under- and uninsured patients—over 65% are either free care or Medicaid. We are facing budget cuts, which may lead to reduction of staff and services, while continuing to be required by state legislation to treat all residents of Louisiana without regard of their ability to pay. Our main concerns: How can our cancer program continue to treat the ever increasing number of patients with not only the same number of FTEs but possibly less? What do we do about replacing antiquated equipment? How do we keep excellent faculty and staff without adequate compensation? The picture of the foreseeable future is not rosy, but people enter the world of cancer care because they are stimulated by challenges. This motivation will drive process improvement, work redesign, changes in inventory, and more, so we can continue to serve the patients of our community and entire state.

Rebecca DeKay, MBA,
Feist-Weiller Cancer Center, Louisiana

The recession is still affecting cancer care delivery. Multiple changes in healthcare plans, higher deductibles, limitations on access, increasing utilization of prior authorization—are all continuing to burden both cancer programs and their patients. It is imperative that we continue to advocate for our patients, apply lean principles to costs of supply and the delivery of care, and continue to excel at evidence-based quality cancer care medicine.

Sabrina S. Mosseau BS, RN, OCN,
Albany Memorial/Samaritan Hospital, New York