



Cancer Care Trends in Community Cancer Centers, 2009-2010

“This year’s survey of Association of Community Cancer Center member programs provides insight into trends in ambulatory cancer care, effects of the recession, and organizational strategies that may help the cancer care team adapt to the changes in the healthcare marketplace.”

Christian Downs, JD, MHA
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 2 of a three-year survey and is a joint project between ACCC and Eli Lilly.

Since 1974, the Association of Community Cancer Centers (ACCC) has served as the leading national multidisciplinary organization that sets the standard for quality care for patients with cancer. ACCC is dedicated to promoting professional learning opportunities and to providing a forum for members to network and enhance their skills in the business, clinical and management aspects of care for the cancer community. Nearly 17,000 cancer care professionals from approximately 900 hospitals and more than 1,200 private practices are affiliated with ACCC. Our unique membership includes all members of the cancer care team: medical and radiation oncologists, surgeons, cancer program administrators and medical directors, pharmacists, oncology nurses, oncology social workers, and cancer program data managers. For more information, visit ACCC’s website at www.accc-cancer.org. Follow us on Facebook and on ACCC’s online blog, ACCCBuzz, at www.acccbuzz.wordpress.com.

Five Key Findings

1. Cancer programs are weathering the recession by doing more with less.

Fifty-seven percent of survey respondents report putting a freeze on hiring, while 29 percent have reduced staff and 10 percent have reduced services. Still, despite an economic downturn, most respondents (78 percent) characterize their cancer program's financial status as good or very good. Just 7 percent report poor financial health.

Expansion and replacement plans for some clinical technology appear to be limited.

Sixty-one percent report delaying equipment purchases. 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. But some equipment and cancer service line offerings are on the upswing: more programs this year than last are offering digital mammography, prostate brachytherapy, image-guided radiation therapy, intensity-modulated radiation therapy, and robotic surgical systems.

Financial Challenges: In Their Own Words

"In the community setting, we have seen a decline in the volume in our early detection programs such as screening mammography, but a steady number of oncology patients in the last year. The difference is that so many more of them have no insurance or limited insurance. Our applications for "county aid" have really increased and the social workers' and financial advocates' workload are enormous. We continue 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 system during the last year."

Luana Lamkin, RN, MPH, administrator, St. Luke's Mountain States Tumor Institute, Idaho

"We treat a large volume of under/uninsured patients--over 65 percent are either free-care or Medicaid. We are facing budget reductions, which may lead to reduction of staff and services while we continue to be required by the legislation related to state hospitals to treat all residents of Louisiana without regard to their ability to pay. We continually discuss: How do we staff for the new Medicaid pre-certification requirements? How can we 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 very rosy, but people enter the world of cancer care because they are stimulated by challenges. This motivation will drive process improvement, work redesign, and changes in inventory, so we can continue to serve the patients of our community and entire state."

Becky DeKay, MBA, director, Oncology Services, Feist-Weiller Cancer Center, LSU Health Sciences Center, Shreveport, La.

"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, administrative director, Medical Oncology, Albany Memorial/Samaritan Hospital, Troy, N.Y.

2. Accelerating consolidation of cancer programs is a clear trend.

In the past year 17 percent 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. Consolidation is defined as a merger or affiliation with another cancer program or the acquisition of another cancer program or part of another program.

Respondents were asked about consolidation of community oncology practices within their primary market area. Physician oncology practices are consolidating even faster than cancer programs. In the past year, 29 percent of respondents report consolidation of physician oncology practices in their primary market area. In the next one to two years, almost half of respondents expect consolidation of physician oncology practices in their area, up from 30 percent in Year 1 of the survey.

3. Use of electronic medical record systems has jumped.

The use of electronic medical records (EMRs) is increasing, but is still not universal in community cancer programs. In 2009, 84 percent of respondents report utilization of EMRs versus 65 percent in 2008. More than half (54 percent) of respondents that do use EMRs report using more than one software.

4. Financial needs of cancer patients are rising.

Cancer programs report seeing more patients who need help affording their medication, co-pays or co-insurance, prescription drug expenses, and transportation expenses. Cancer programs report a change in the number of patients for whom they provide chemotherapy infusions. Seventy-three percent of respondents report an increase in the number of uninsured/underinsured patients who receive chemotherapy.

5. Use of orally administered anti-cancer agents remains limited.

Just 24 percent of programs dispense oral anti-cancer drugs at the infusion center. These numbers are up only slightly from last year's 21 percent. We expect the numbers will continue to increase as more and more oral agents come to the market and patients demand their greater convenience. Hospitals are well-positioned, since they already have in-house pharmacies. Of those programs that dispense oral anti-cancer drugs, just 40 percent report having quality initiatives related to the use of oral agents in place.

Section 1. Methodology

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 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.

Current survey, 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. 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 1, 2010.

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.

Members of the Advisory Committee include: Ernest R. Anderson, Jr., MS, RPh, Caritas Christi Health Care System; 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; John Feldmann, MD, FACP Regional Cancer Center, Moses Cone Health System; 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, Penobscot Bay Medical Center.

Section 2. A Profile of ACCC Cancer Programs

Section 2.1. Respondent Profile and Oncology-Related Services Offered

Section 2.2. Payer Mix

Section 2.3. Competition

Section 2.4. Screening

Section 2.5. Fellowships

2.1. Respondent Profile and Oncology-Related Services Offered

Eighty-four cancer programs submitted responses to the survey. Of these, 73 percent are community hospitals. Within this group, the mean number of patients on clinical trials varies from 68 (in programs with a mean number of 829 new analytic cancer cases diagnosed yearly) to 203 (in programs with a mean number of 1,096 new analytic cancer cases.) ([Table 1](#)).

Ten percent of respondents consider themselves academic/university cancer programs. This year's survey sample includes a higher percentage of academic cancer centers compared to Year 1 (10 percent vs. 1 percent). Eight percent are teaching hospital cancer programs, close to last year's survey sample. The remainder includes "network" cancer programs, NCI-designated comprehensive cancer centers, and an affiliate hospital cancer program.

Nearly all respondents describe their program as not-for-profit, providing both in- and outpatient services ([Table 2](#)).

Most cancer programs are accredited by both the American College of Surgeons Commission on Cancer (88 percent) and The Joint Commission (75 percent). Thirty-seven percent have American College of Radiology accreditation ([Table 3](#)).

The majority of programs offer nutritional services (94 percent), clinical research and financial counseling (88 percent), social work services (82 percent), and genetic counseling (68 percent) ([Table 4](#)). Fewer programs report social work/psychological support in this year's survey than in last year's survey (94 percent in Year 1 vs. 82 percent in Year 2). Seventy-four percent report having a survivorship program; 69 percent report having a "nurse" navigator; 36 percent "patient" navigators. One in four have tissue banking (up from 1 in 5 from last year) and 13 percent blood and bone marrow transplantation.

Funding for oncology-related services is commonly reported to be from general operating funds ([Table 5](#)).

Service categories. Drugs account for 47 percent of gross charges and 43 percent of expenses. ([Table 6](#)).

Financial counseling. Ninety-four percent report offering financial counseling ([Table 7](#)).

Reimbursement specialists. Fifty-eight percent report having reimbursement specialists [\(Table 8\)](#). Of those respondents who use reimbursement specialists, 49 percent characterize their program's financial status as very good [\(Table 9\)](#).

2.2. Payer Mix

Patients with Medicare plus supplemental decreased as a percentage of payer mix in this year's survey versus last year's survey. Respondents report that payer mix is 31 percent Medicare with supplemental (compared to 49 percent in last year's survey) and 18 percent Medicare without supplemental (compared to 0 percent in last year's survey) [\(Table 10\)](#).

2.3. Competition

Cancer care is a competitive business. Still, survey participants appear to be successfully competing: The average program enjoys an estimated 43 percent market share although competing with on average three programs [\(Table 11\)](#).

2.4. Screening

Screening offers the opportunity to increase referrals while providing benefits for a healthier community. A majority of programs include breast, prostate, skin, and colon cancer screening [\(Table 12\)](#). Forty-nine percent offer cervical screening and 44 percent genetic testing. One in four offers lung cancer screening. Respondents cite limited funding, resources, or lack of physician support as reasons not to offer screening programs.

2.5. Fellowships

Twenty-four percent of programs surveyed have physician fellowship training in place; on average, medical and hematology oncology have the most fellowship slots [\(Table 13\)](#).

Section 3. Scope of Service line

Section 3.1. Scope of Service Line

3.1. Scope of Service Line

While most programs include medical and radiation oncology in their cancer service line ([Table 14](#)), diagnostic radiology is managed as a separate hospital department. Although one-third of respondents do not offer gynecologic or surgical oncology services, these service lines may be expanding, moving in the direction of comprehensive, integrated offering. In Year 1 of the survey, for example, just 23 percent of respondents indicated surgical oncology as included in the cancer service line. Year 2 shows a significant jump: about 43 percent indicate surgical oncology in the cancer service line ([Table 15](#)). A similar move can be seen in gynecologic oncology. In Year 1 of the survey, 27 percent indicated gynecologic oncology in the cancer service line versus 42 percent in Year 2 of the survey ([Table 14](#)).

Section 4. Staffing

Section 4.1. Physician Staffing

Section 4.2. Nurse Staffing

Section 4.3. Cancer Program Director Staffing

Section 4.4. Staffing Acuity Systems

4.1. Physician Staffing

Community relationships between cancer programs and private practice physicians continue to be pivotal. Most cancer programs rely heavily on private practice physicians, but less so than in last year's survey results ([Table 16](#) and [Table 17](#)). Compared with last year's survey, there is a significant decrease in mean number of FTE medical/hematological oncologists and radiation oncologists in a contractual relationship with the cancer program and an increase in those employed by the cancer program. And there is a significant increase in FTE general surgeons who are employed by the cancer program compared with last year.

The mean number of full-time equivalent private practice medical oncologists is 4.5 versus 3.0 paid employees of the hospital. This is a significant difference from last year's numbers: 6.8 versus 2.9 paid employees of the hospital. Thus, compared to Year 1 of the survey, we are seeing fewer medical oncologists/hematologic oncologists in private practice.

The same is true for radiation oncologists -- fewer full-time equivalent radiation oncologists in private practice versus paid employees in this year's survey. The mean number of full-time equivalent private practice radiation oncologists is 1.0 versus 0.9 paid employees of the hospital. Last year's numbers were 2.1 in private practice versus 0.9 paid employees.

The mean number of FTE general surgeons as paid employees of the hospital increased to 2.0 in this year's survey from 0.6 in last year's survey.

As oncologists in private offices struggle with declining reimbursements and seek financial stability, many are opting for employment at hospitals. A major shift in site of care may loom ahead.

4.2. Nurse Staffing

Nurses are a key resource. Nursing accounts for the most FTEs, followed by administrative staff. The mean number of nurses is 15.8, and nurses focused on chemotherapy administration is 7.9 ([Table 18](#)).

4.3. Cancer Service Director Staffing

The cancer programs' senior manager typically holds the title of director ([Table 19](#)) and holds an MBA/MHA/MPH (49 percent) or RN (31 percent) ([Table 20](#)).

Seventy-four percent report that the service line manager is dedicated full time to the cancer program ([Table 21](#)). The remaining quarter report they manage, in addition to the cancer service line, pharmacy, cardiology, and/or women's services ([Table 22](#)).

Reporting lines in hospitals are very important. Most oncology service line managers report to the “C Suite,” which includes the chief operating officer or the chief executive officer ([Table 23](#)). Thirty-five percent report to a vice president. Eleven percent report to a chief nursing executive, while 10 percent report to an administrator and 8 percent to the medical director. Only 2 percent report to the chief financial officer or board of directors. (For more information, see ACCC's 2009 "Cancer Program Administrator Survey," available on the members-only section of its website, www.accc-cancer.org.)

4.4. Staffing Acuity Systems

In 2009 just one out of three cancer service lines report operating an acuity system to determine staffing levels, although such systems can decrease turnaround times, improve patient flow, and make a difference in operations. Of those that are using an acuity system, the mean number of new cancer cases per FTE oncology nurse is 208. Of those not using an acuity system, the mean number increases to 248 ([Table 24](#)). (Note: We cannot determine if this pertains to inpatient or outpatient services.)

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.

Anecdotal responses show that acuity systems are generally perceived positively by staff and patients.

“[With an acuity system] we’ve got the ability to contain costs when we’re overstaffed. Also, if the inpatient census is high, it enables us to justify further staffing.”

Still, the majority of respondents get by without:

“At this point, it’s not an issue [that I don’t have an acuity-based system]. Right now, I can’t complain about the staffing I have.”

Section 5. Infusion Center and Pharmacy

Section 5.1. Infusion Center

Section 5.2. Nurse to Patient Ratio

Section 5.3. Mixing

Section 5.4. Dedicated Pharmacy

Section 5.5. Infusion Center Ownership/Chairs/Size

Section 5.6. Monitoring and Purchasing Drugs

5.1. Infusion Center

Responding programs focus on adult patient populations ([Table 25](#)).

About half of programs (52 percent) indicate that infusion of non-chemotherapy fluids is included in the service line. ([Table 26](#)).

Most treat Monday through Friday only. Twenty-two percent of respondents treat on Saturday, and 17 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.

5.2. Nurse to Patient Ratio

Programs reported daily rates of 5.2 infusion patients per chair. The mean number of infusion patients per FTE nurse is 6.1 ([Table 27](#)).

5.3. Mixing

Pharmacists, not nurses, do 95 percent of the chemotherapy infusion mixing in hospitals, whether the pharmacy is in the infusion center or in the hospital pharmacy ([Table 28](#)).

5.4. Dedicated Pharmacy

More than half of respondents (55 percent) have a dedicated pharmacy in ambulatory outpatient services. Hospitals with dedicated pharmacies are less likely to restrict access to injectables ([Table 29](#)).

5.5. Infusion Center Ownership/Chairs/Size

Hospitals own the majority of space and beds included in the programs ([Table 30](#)), but alternatives exist—8 percent have an infusion center within the cancer program that is not hospital owned. The mean number of (hospital-owned) infusion beds/chairs is 16.4. The mean infusion center square footage is 5,591 square feet, compared to the average physician office, which might be in the hundreds of square feet.

5.6. Monitoring and Purchasing Drugs

Most programs purchase cancer drugs through multiple distributors, but a single GPO ([Table 31](#)).

Most respondents' programs do not participate in alternative acquisition programs ([Table 32](#)). Thirty-six percent participate in the 340B drug pricing program, up from 26 percent in last year's survey.

Most programs report purchasing medication through the pharmacy department rather than conducting their own purchasing program ([Table 33](#)).

Medication is typically stocked in the hospital pharmacy with the pharmacy department responsible for managing the inventory ([Table 34](#)).

Just 20 percent accept injectables from specialty pharmacies ([Table 32](#)).

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.

Section 6. Oral Anti-Cancer Agents

Section 6.1. Dispensing of Oral Anti-Cancer Agents

Section 6.2. Quality Initiatives and Compliance Programs

Section 6.3. Retail Pharmacy

Section 6.4. Trends

6.1. Dispensing of Oral Anti-Cancer Agents

Use of orally administered antineoplastic agents remains low in cancer programs. Just 24 percent of programs dispense oral anti-cancer drugs at the infusion center ([Table 35](#)), up only slightly from 21 percent in last year's survey. More than one in ten respondents did not know whether oral anti-cancer agents are dispensed.

6.2. Quality Initiatives and Compliance Programs

Of those infusion centers that do dispense oral anti-cancer agents, half (50 percent) have quality initiatives in place ([Table 35](#)). One in 10 do not know if they have quality initiatives related to oral anti-cancer medications. That's down from 24 percent in last year's survey.

Just 11 have a program to help patients with compliance to their oral anti-cancer drug regimens. Of those programs, a majority track filling new prescriptions and refills, and include a teaching program.

6.3. Retail Pharmacy

The majority (70 percent) of infusion centers do not have a retail pharmacy. ([Table 36](#)).

6.4. Trends

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.

One respondent reports: *"But I think we are moving more into oral chemotherapy agents. And I believe this move will be physician driven; we have some newer physicians now. They are asking for different protocols. . .they are young."*

As research identifies new "targets," the subsequent development of new 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.

Oral chemotherapy is effective only if patients adhere to their administration schedule. But it can be challenging for providers to monitor true adherence because the patient is not taking the drug at the hospital or practice. Clinicians are further limited by the lack of a gold-standard measurement for assessing patient adherence. Self-administration may increase the risk of medication errors and possibly compromise the effectiveness of the anticancer therapy. Some oral agents may have

drug/drug interactions. To prevent unwanted toxicity and therapeutic misadventures, providers and patients need to understand the mechanisms of action and potential drug/drug interactions associated with these newer agents. Clinicians can then take the necessary steps to prevent problems and maximize the efficacy of oral chemotherapeutic agents. Hospital pharmacies must increase involvement in patient education, counseling, and compliance.

Section 7. EMR Systems

Section 7.1. Use of EMR Systems

Section 7.2. Selection

Section 7.3. Resources

7.1. Use of EMR Systems

The use of electronic medical records (EMRs) is increasing, but is still not universal in community cancer programs ([Table 37](#)). In 2009, 84 percent of respondents report utilization of EMRs versus 65 percent in 2008—a significant increase. More than half (54 percent) of respondents that do use EMRs report using more than one software.

Note that the economic downturn is having an effect on information technology purchase. 43 percent of respondents report delaying IT improvements ([Table 41](#)).

IMPAC Medical Systems' MOSAIQ and Varian's ARIA are the most frequently used. Radiation oncology departments frequently do need separate EMR systems because their needs are not met by whatever system the chemotherapy operations are using.

7.2. Selection

Selecting an EMR system for a hospital-based cancer center is a daunting task. 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.

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.

7.3. Resources

- Implementing EHRs in Community Oncology Practices
http://www.accc-cancer.org/oncology_issues/articles/julaug09/JA09-present.pdf
- Is Your Practice Getting the Most from its EHR
http://www.accc-cancer.org/oncology_issues/articles/julaug09/JA09-presentbosserman.pdf
- EMR for Hospital-Based Oncology Programs, Practical Tips and Strategies
http://www.accc-cancer.org/oncology_issues/articles/janfeb06/EMR_Bedrosian.pdf
- From Paper to Progress: EMR Implementation at Moses Cone Regional Cancer Center
http://www.accc-cancer.org/oncology_issues/articles/janfeb06/EMR_Feldmann.pdf
- Hybrid EMR Systems: Another Option
http://www.accc-cancer.org/oncology_issues/articles/janfeb06/EMR_Kostka.pdf
- Medical Information Technology Vendor List
http://www.accc-cancer.org/oncology_issues/articles/janfeb06/EMR_Systems.pdf

Section 8. Consolidation

Section 8.1. Consolidation

A number of surveys have shown that accelerating consolidation of cancer programs is a clear trend ([Table 38](#)). Consolidation is defined as a merger or affiliation with another cancer program or the acquisition of another cancer program or part of another program.

According to ACCC's own survey, in the past year, 17 percent of responding programs reported consolidation of programs within their market area ([Table 39](#)).

In the next one to two years, one in three hospital respondents expect consolidation within their primary market area ([Table 39](#)). That compares to less than one in five in Year 1 of the survey.

Hospital respondents were asked about consolidation of community oncology practices within their primary market area. According to their responses, physician oncology practices are consolidating even faster than cancer programs. In the past year, 29 percent of respondents report consolidation of physician oncology practices in their primary market area ([Table 39](#)). In the next one to two years, almost half of respondents expect consolidation of physician oncology practices in their area, up from 30 percent in Year 1 of the survey.

Most programs are owned entirely by the hospital; and in most cases hospitals are majority owners in joint ventures ([Table 40](#)). Survey results show that just 6 percent of responding cancer programs are in joint venture with physicians, and 4 percent are in joint ventures with other hospitals ([Table 40](#)).

Anecdotally, some community hospitals are looking to affiliate with large brand name centers. Doing so may attract better contracts and increase access to clinical trials. Some programs reported affiliating around one particular tumor site to gain access to complementary tumor programs. *“...these days, the cost of technology and other fixed costs are too high for any one program to bear alone,”* said one respondent.

Analysis.

In one national survey of oncologists, more than half of community oncologists saw decreased patient volume (MattsonJackDaVinci: Oncology Market Access U.S. 2009; Annual Oncologist Survey, April 2009). Another survey of practice managers saw community practices’ referrals to hospitals for chemotherapy treatment on the rise from 2007 to 2009 (MattsonJack Davinci practice managers survey). All this takes place in a growing trend toward oncologist relocation to hospital-based practice arrangements (Mattson Jack Davinci analysis based on U.S. Physician Distribution of Physicians, Cegedim Dendrite, 2003 to 2008), and a slow but steady shift in care sites as hospitals’ share of chemotherapy treatments steadily grows.

Physicians are seeking to replace falling chemotherapy revenues with fee-generating technologies. An increasing percentage are considering adding radiation services and imaging to diversify revenue streams. In 2009 48 percent of responding oncologists reported considering adding radiation oncology services and 44 percent adding imaging. That compares to 10 percent and 24 percent respectively in 2006 (MattsonJackDaVinci: Oncology Market Access U.S. 2009; Annual Oncologist Survey, April 2009).

Community relationships between cancer programs and private practice physicians continue to be pivotal. Most cancer programs rely heavily on private practice physicians. At the same time, community practices are looking for solutions. They are not selling their practices, but are talking with local hospitals, for example, to discuss consolidation of some of the infusion clinic services.

Section 9. Financial Status

Section 9.1. Impact of the Current Economic Climate on Providers and Patients

Section 9.2. Monitoring Financial Performance

Section 9.3. Financial Status

Section 9.4. In Their Own Words

9.1. Impact of the Current Economic Climate on Providers and Patients

Impact on providers. Clearly, cancer programs felt the current economic recession. More hospitals are adapting to the recession by replacing management teams, initiating cost-cutting efforts, increasing marketing to raise patient volumes, and affiliating/consolidating with other local providers, among other efforts. Fifty-seven percent report putting a freeze on hiring, while 29 percent have reduced staff and 10 percent have reduced services ([Table 41](#)). Four percent are divesting assets.

In last year's survey, the impact of the economic downturn was just beginning. Some cancer programs indicated relatively minor cost reductions, such as cuts in travel or education. Some delayed equipment purchases. In Year 2 of the survey, 58 percent of respondents report making more significant changes due to the economic downturn.

Cancer programs are seeing more patients who need help affording their medication – and an increase in patients referred due to inability to pay for expensive drugs. At the same time cancer programs have seen an increase in the number of uninsured/underinsured chemotherapy patients.

Analysis.

Hospitals are weathering the recession better than community practices. Studies show that about 80 percent of community practice revenue comes from drugs, while drugs comprise just 47 percent of hospital program revenues. Hospitals have more diversified revenue streams than community practices, including labs and diagnostic imaging.

In one national survey of oncologists, more than half of community oncologists saw decreased patient volume (*MattsonJackDaVinci: Oncology Market Access U.S. 2009; Annual Oncologist Survey, April 2009*). Another survey of practice managers saw community practices' referrals to hospitals for chemotherapy treatment on the rise from 2007 to 2009 (*MattsonJack Davinci practice managers survey*). All this is happening in a growing trend toward oncologist relocation to hospital-based practice arrangements (*Mattson Jack Davinci analysis based on U.S. Physician Distribution of Physicians, Cegedim Dendrite, 2003 to 2008*) and a slow but steady shift in care sites as hospitals' share of chemotherapy treatments steadily grows.

Impact on patients. The recession is affecting patients. Financial need is a key driver. Cancer programs report seeing more patients who need help affording their medication, co-pays or co-insurance, prescription drug expenses, and transportation expenses ([Table 42](#)).

Cancer programs have seen an increase in the number of uninsured/underinsured patients for whom they provide chemotherapy infusions ([Table 43](#)). Seventy-three percent of respondents report an increase in the number of uninsured/underinsured patients who receive chemotherapy. An unfavorable pattern has emerged: Commercial volume has dropped as uninsured/underinsured volume has risen.

And 69 percent of respondents report an increase in patients referred due to inability to pay for expensive drugs ([Table 44](#)).

9.2. Monitoring Financial Performance

For most reporting hospitals, oncology is one of the three top service lines based on billed charges ([Table 45](#)). Surprisingly, just two-thirds of respondents reported the ability of the cancer center to track profit and loss ([Table 46](#)). Twenty-nine percent answered no, meaning the cancer center cannot track how efficiently it is operating. Seven percent did not know whether the cancer program could track profit and loss, down slightly from 10 percent in last year's survey.

Analysis. Monitoring financial performance is critical to the financial health of any organization. Some metrics, such as charges and treatment and procedure volumes, should be monitored daily. Others, such as total staffing hours, might be monitored weekly. A full statement of actual revenues and expenses compared to budget should be reviewed monthly. Other non-clinical indicators, such as patient satisfaction, physician satisfaction, and employee engagement should also be monitored.

Hospitals, as primarily inpatient businesses, are often challenged to monitor and report on outpatient services. Meeting this challenge will be critical going forward.

One respondent noted: *"I have the financial data, but it's not given to me in a management report. I can mine it, but I'm a very well-paid resource to do data analytics, which is frustrating. We don't have enough decision support staff..."*

9.3. Financial Status

More than three of four respondents (78 percent) characterize their program's financial status as good or very good ([Table 47](#)). Just 7 percent report poor financial health. The trend line toward happy and healthy finances, however, may not be upward. In last year's survey, 90 percent reported their cancer program's financial status as good or very good, perhaps because the full effects of the recession had not yet been experienced.

Programs with financial or reimbursement specialists are more likely to describe their program's financial status as very good—49 percent vs. 37 percent not using reimbursement specialists ([Table 9](#)).

9.4. In Their Own Words

Cancer program executives speak out about financial challenges.

"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."

"Hope and change haven't arrived yet."

"Financial challenges have impacted many clinical trials programs across the country. In addition to increased scrutiny when filling research staff vacancies or justifications for new hires, trial revenue is flat or losing ground. Cooperative group trials and Expanded Access Programs run at a loss, while the pharma/biotech industry continues to tighten their belts putting the squeeze on sites who are constantly seeking to do more with less. Efforts to increase the efficiency of trial data management are often tied to expensive and immature IS solutions. Despite financial incentives to move practices and hospitals to EHRs, few oncology practices conducting clinical research have found robust best-of-breed IS solutions that efficiently bridge the ever-widening gap between emerging EHRs and the trial sponsor's EDC system or paper CRF. In spite of this, we as a system carry on and do our best to offer all patients across our service area access to promising therapies available only within the context of clinical trials."

"We are a single practice physician office that has had many struggles over the past four to five years. In late 2007 we had to stop treatments at the office and place two-thirds of our office on indefinite layoff. Since then, we have been able to rehire about 50 percent of them back and have brought patients back to the office but not without grave concerns everyday that we will receive adequate reimbursement. We have a practice consultant that has helped us and remains part of our go-to person. Medicare reimbursement along with the removal of consult codes has made us weary; we are 67 percent Medicare. Private insurance contracts only seem to follow Medicare. Our physician has practiced for 30 years and would love to continue to practice so long as the "financial challenges" don't bury him."

Section 10. Capital Equipment

Section 10.1. Capital Equipment Budget

Section 10.2. Radiation Oncology Services and Robotic Surgery Systems

10.1. Capital Equipment Budget

Expansion and replacement plans for clinical technology appear to be limited. 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 ([Table 48](#)).

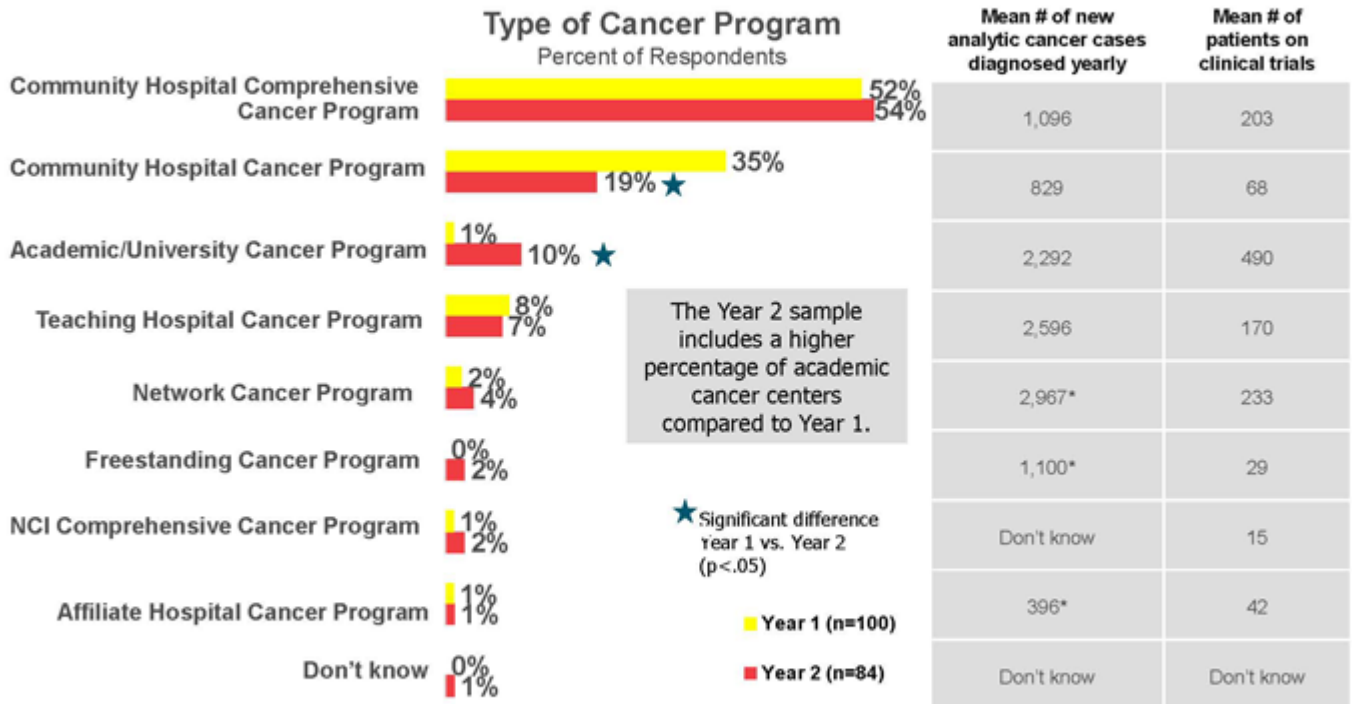
10.2. Radiation Oncology Services and Robotic Surgery Systems

The majority of programs offer IMRT, digital mammography and prostate brachytherapy ([Table 49](#)). The use of IGRT has increased significantly from last year. The da Vinci or other robotic surgical systems has topped 50 percent. Use of Xofig, proton beam therapy, Gamma Knife, and CyberKnife is limited.

More than half (55 percent) of programs report providing radiofrequency ablation (RFA), up from 45 percent of programs in last year's survey; only 7 percent of programs report RFA equipment budgeted for next year ([Table 50](#)).

Addendum: Tables

Table 1. Participant characteristics: 73 percent represent community hospital comprehensive or community hospital cancer programs.



Q1a. Which of the selections below best describes your cancer program? (SELECT ONLY ONE)

Q1b. How many new analytical cancer cases are diagnosed per year in your program? / Q1ii. How many patients are currently on clinical trials? *Extremely small base size

[Go back](#)

Table 2. Nearly all of the respondents' cancer programs were described as not-for-profit and provide both inpatient and outpatient services.

Type of Cancer Program
Percent of Respondents (n=84)



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

Type of Services Provided
Percent of Respondents (n=84)



■ 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)

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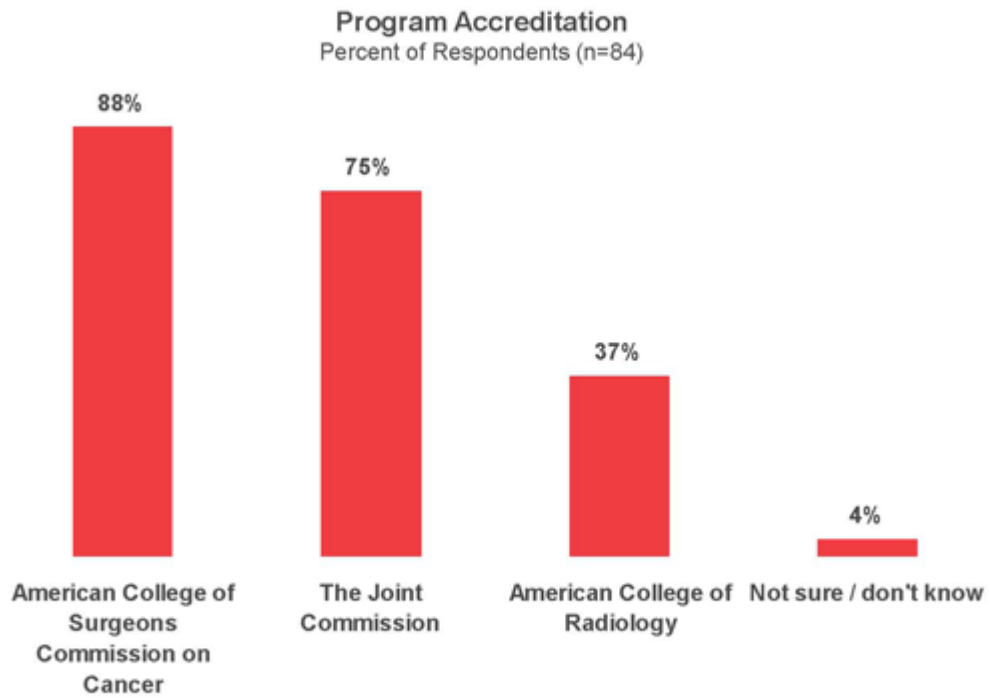


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Table 3. Most cancer programs are accredited by both the American College of Surgeons Commission on Cancer and The Joint Commission.



Q1d. Who accredits the program? (SELECT ALL THAT APPLY)

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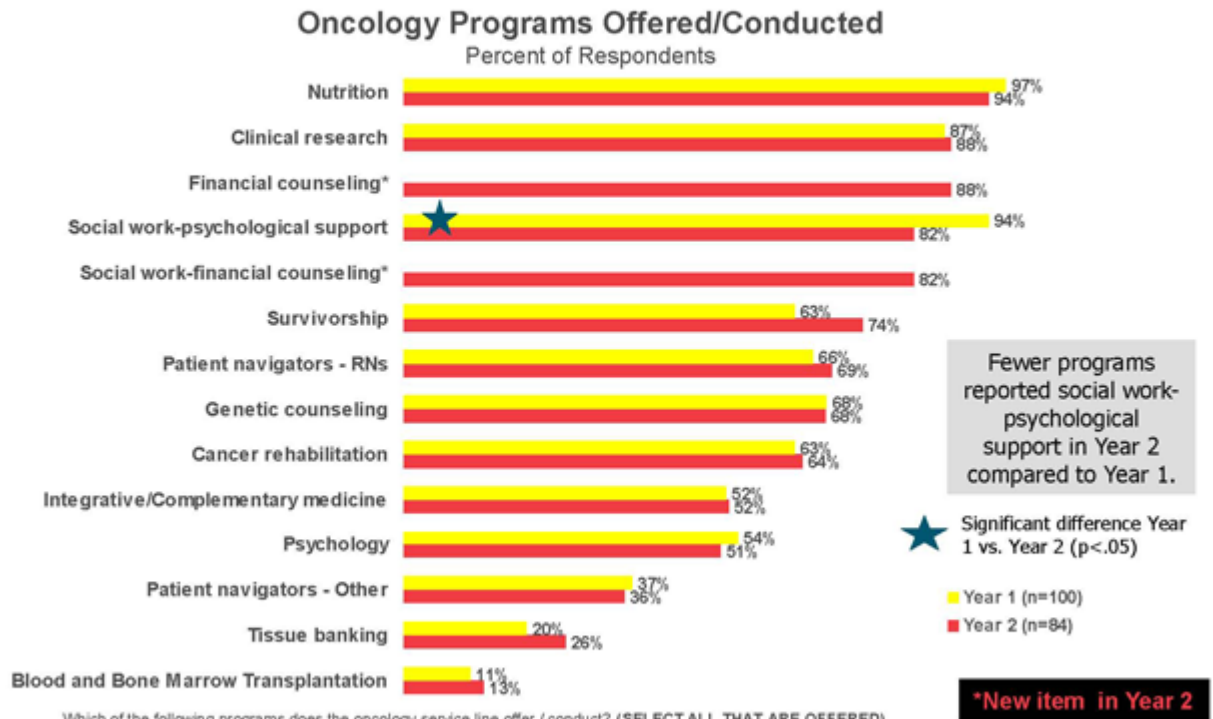
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Table 4. Nearly all programs offer nutrition, social work, and clinical research; only 26 percent offer tissue banking and 13 percent blood and bone marrow transplantation.



Q1g

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

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Table 5. General operating funds were the common source of funding for all programs offered.


Sources of Funding
Percent of Respondents (Base size varies)*

	General Operating Funds	Endowment	Philanthropy	Grants	State funding	Trial sponsors	Patient pays	Insurance	Don't know
Nutrition (n=79)	87%	1%	11%	6%	1%	0%	24%	18%	1%
Social work – Psychological support (n=69)	94%	6%	16%	3%	4%	0%	9%	12%	1%
Social work – financial counseling (n=69)	94%	3%	10%	6%	4%	10%	6%	6%	3%
Clinical Research (n=74)	76%	8%	27%	50%	11%	81%	16%	39%	3%
Genetic counseling (n=57)	75%	2%	11%	11%	4%	2%	42%	40%	4%
Nurse navigators (n=58)	86%	2%	24%	28%	3%	0%	0%	2%	0%
Cancer rehabilitation (n=54)	78%	2%	7%	9%	0%	0%	65%	70%	2%
Survivorship (n=62)	66%	8%	42%	34%	2%	0%	10%	10%	8%
Psychology (n=50)	64%	4%	12%	12%	2%	0%	32%	46%	6%
Integrative/Complementary medicine (n=44)	55%	2%	57%	23%	2%	0%	41%	21%	2%
Patient navigators (n=30)	70%	0%	23%	30%	7%	0%	3%	3%	7%
Tissue banking (n=22)	55%	0%	18%	41%	14%	9%	9%	0%	9%
Blood and bone marrow transplantation (n=11)	73%	0%	9%	18%	9%	18%	73%	91%	0%

Only those respondents with a particular program were asked source of funding.
 Oth. What is the source of funding for (FILL IN EACH RESPONSE FROM Q1g)? (SELECT ALL THAT APPLY)

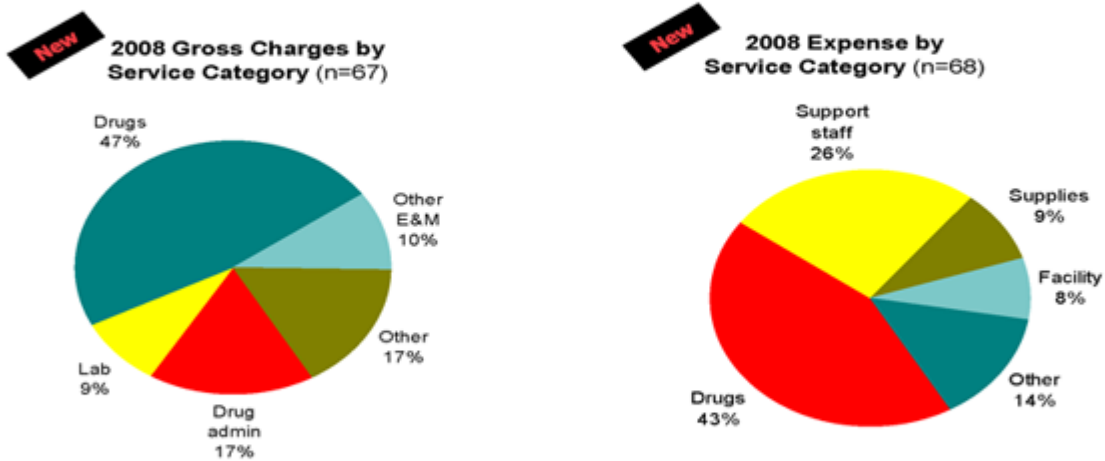



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Table 6. Cancer programs shared their gross charges and expenses by service category.



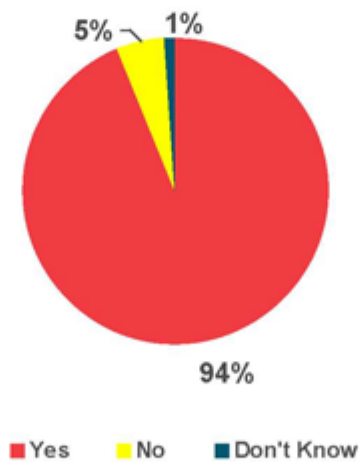
Q5b1. Please fill out the chart below. Please think about 2008 gross charges to your cancer program by service category.
 Q5b2. Please fill out the chart below. Please think about 2008 cancer program expenses by service category.



[Go back](#)

Table 7. Nearly all of the programs offer financial counseling.

Financial Counseling Offered
Percent of Respondents (n=84)



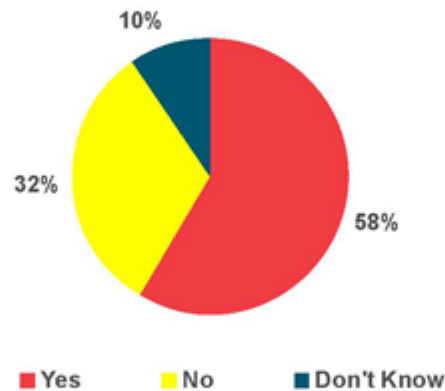
Q2g. Does your program offer financial counseling to patients and families?

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Table 8. Around one-half of respondents use reimbursement specialists.

Used Reimbursement Specialists
Percent of Respondents (n=84)



Q8d. How would you characterize the overall financial status of your cancer program? (SELECT ONE RESPONSE.)

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Table 9. Respondents using reimbursement specialists are more likely to characterize their programs' financial status as very good.

Volume and Cost Information

		Use Reimbursement Specialists			Total
		Yes	No	Don't Know	
Financial Status	Very Good	49%	37%	25%	43%
	Good	31%	48%	13%	35%
	Poor	8%	7%	0%	7%
	Don't Know	12%	7%	63%	16%
	Total	58%	32%	10%	

Q8c. How would you characterize the overall financial status of your cancer program? (SELECT ONE RESPONSE.)
 Q8d. Have you used reimbursement specialists?




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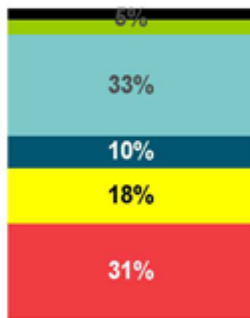
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Table 10. Patients with Medicare + supplemental decreased as a percentage of the payer mix in Year 2 compared to Year 1.

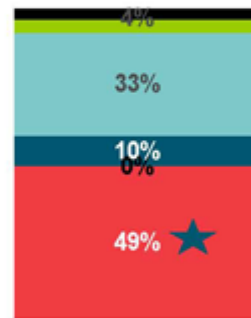
Volume and Cost Information

Mean Total Billed Charges for Cancer Program in Fiscal 2008 (n=40) = \$52,088,959
Range=\$17,722 to \$310,000,000

Average % Volume Based on Charges



Year 2 (n=54)



Year 1 (n=70)

★ Significant difference Year 1 vs. Year 2 (p<.05)

■ Medicare with supplemental ■ Medicare without supplemental ■ Medicaid ■ Commercial/HMO ■ Charity care ■ Self pay

Q8a.
Q8b.

What were the total billed charges for your cancer program in fiscal year 2008?
Please fill out the chart below. Please think about annual billed charges for your total cancer center in the 2008 fiscal year.

Don't know: n=30

[Go back](#)

Table 11. Successfully competing: Respondents face three competing cancer programs in their market areas, reported average market share of 43 percent.

Cancer Programs in Market Area

	Mean	Min	Max
Mean number of cancer programs in market area (n=75)	3.3	0	15
Mean number of Hospital-based programs (n=67)	2.1	0	7
Mean number of Community-based programs (n=67)	1.0	0	12
Mean number of University hospital settings (n=67)	0.5	0	3
Average program market share (n=51)	43%	5%	90%

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? RANGE 0 to 99
 2 Community-based (medical office) programs? RANGE 0 to 99
 3 University hospital settings? RANGE 0 to 99
 Q1o. What is your program's approximate market share overall, for those outpatient cancer services that you offer?



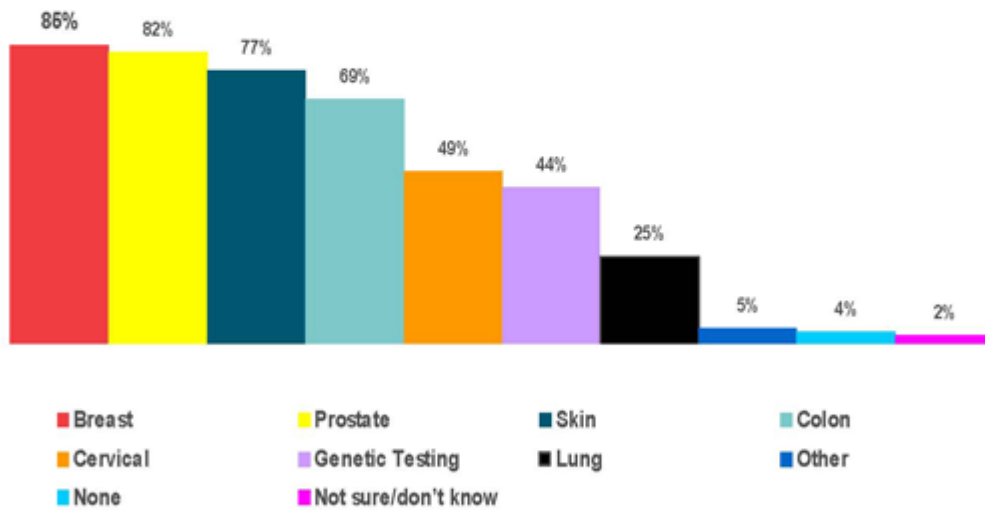

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Table 12. The majority of programs offer breast, prostate, skin, and colon cancer screening; only 25 percent offer lung cancer screening.

Cancer Screening Programs Provided
Percent of Respondents (n=84)



Q11. Which of the following kinds of cancer screening programs do you provide? (SELECT ALL THAT ARE PROVIDED)

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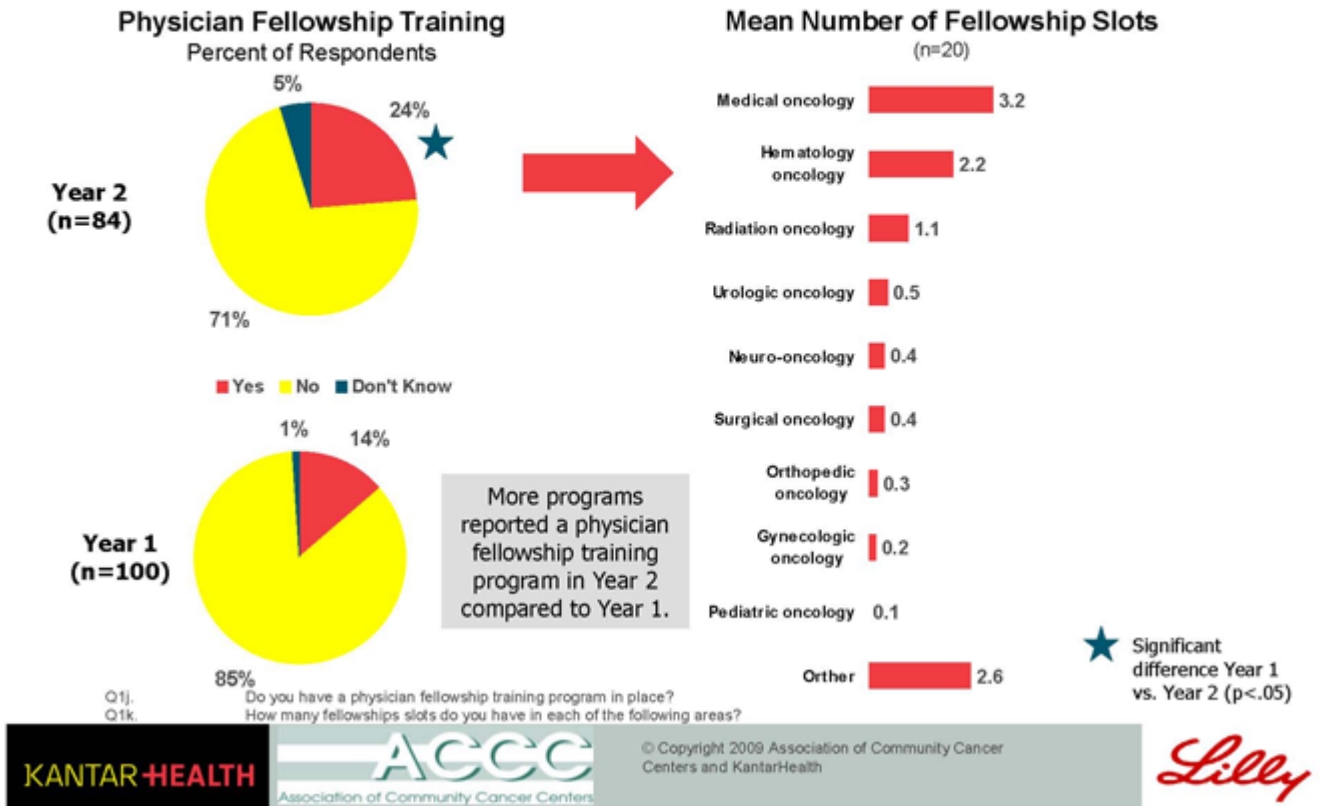
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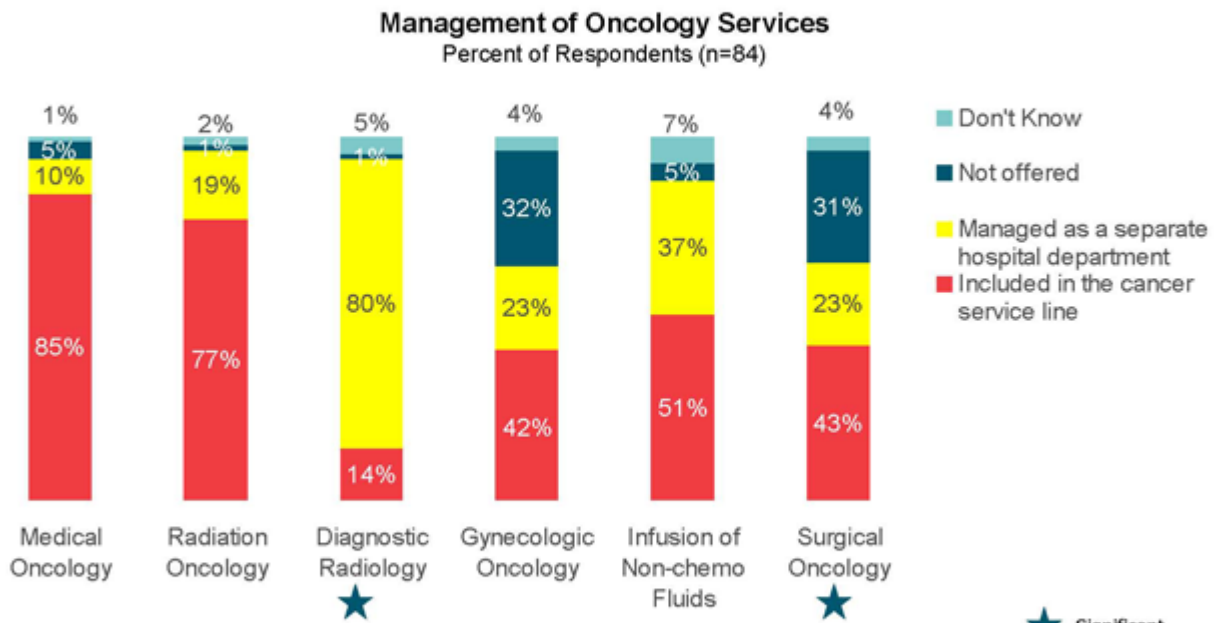
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Table 13. 24 percent (up from 14 percent in Year 1) of programs surveyed have physician fellowship training; medical and hematology oncology dominate.



[Go back](#)

Table 14. Scope of services managed: The majority of programs include medical and radiation oncology in their cancer service line.

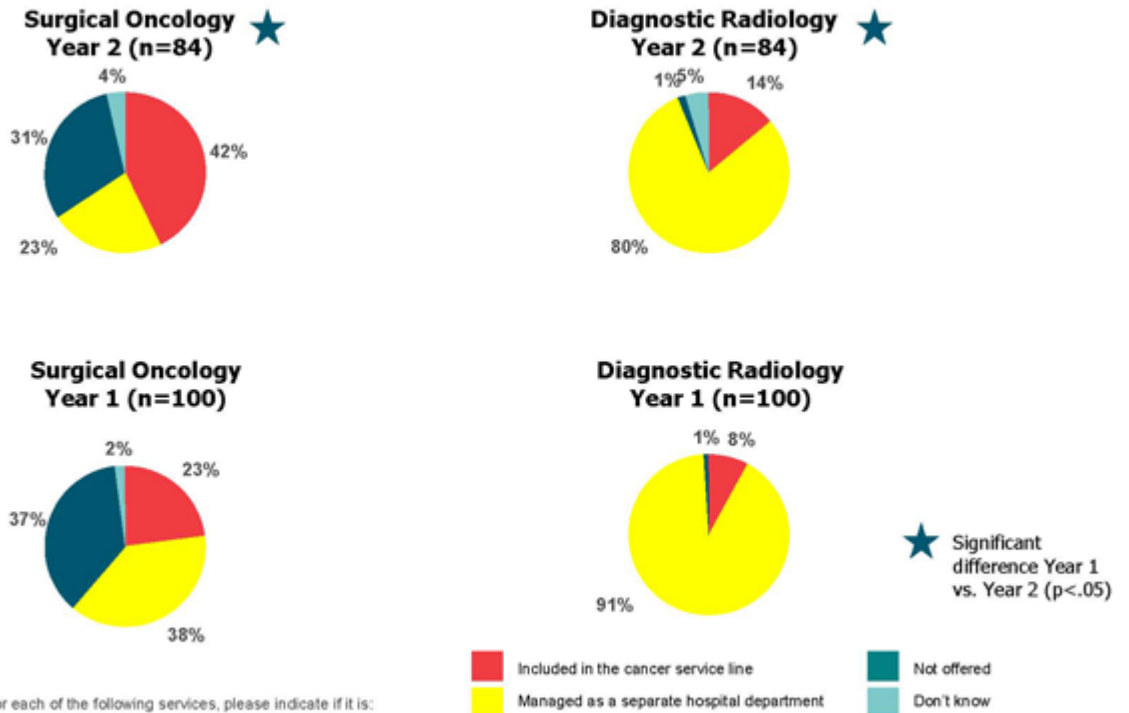


Q1L. For each of the following services, please indicate if it is:

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Table 15. In Year 2, diagnostic radiology and surgical oncology were more likely to be included in the cancer service line compared to Year 1.



Q1L. For each of the following services, please indicate if it is:

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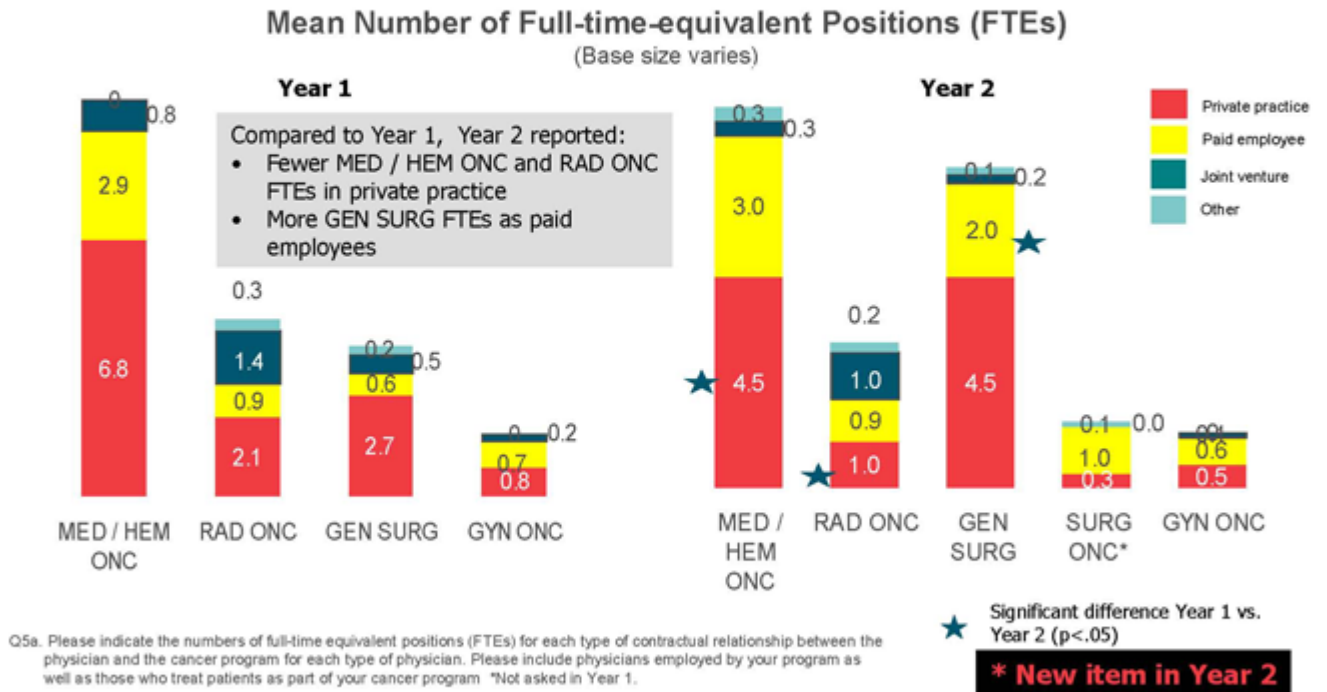


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Table 16. Relationships pivotal: Most programs rely heavily on private practice physicians, but less so in Year 2 vs. Year 1.



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.

[Go back](#)

Table 17. About one-half of respondents have med/hem oncologists who are private practice or paid employees of the hospital.

Number of Respondents (out of 84) Reporting Presence of Each Type of Full-time-equivalent Positions (FTEs)

	Med/ Hem Oncologist	Radiation Oncologist	General Surgeon	Certified Surgical Oncologist	Gynecologic Oncologist
Private practice	47	28	43	15	17
Paid employee of hospital/medical school	42	22	23	18	27
Professional service contract	10	35	6	1	6
Joint Venture (not paid by hospital)	4	6	1	2	1

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. Physicians who are part time should be counted as partial FTEs. Please include physicians employed by your program as well as those who treat patients as part of your cancer program




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**Table 18. Nursing and administrative staff account for the most FTEs.
Mean Number of Full-Time-Equivalent Positions (FTEs) in 2008 Fiscal Year**

	Mean	Min	Max
Number of total nursing (n=74)	15.8	1	70
Number of RN s with oncology nursing certification (n=78)	10.2	0	67
Number of administrative staff (receptionists, other clerical, Hospital information system) (n=69)	8.4	0	48
Number of RNs focused on chemotherapy administration (n=75)	7.9	0	40
Number of radiation oncology technicians (n=74)	7.1	0	50
Number of non-physician diagnostic radiology (n=48)	6.7	0	90
Number of clinical research personnel (n=79)	4.6	0	80
Number of non-physician laboratory staff (n=60)	4.2	0	70
Number of dosimetry personnel (n=74)	2.4	0	8
Number of medical physicists (n=76)	2.1	0	7
Number of billing and collection (dedicated to facility whether or not physically present) (n=53)	1.9	0	21
Total number of pharmacists supporting the cancer center (n=75)	1.7	0	10
Number of senior administrative / executive management staff for clinic (n=76)	1.7	0	7
Number of oncology coders / billing coders (dedicated to facility whether or not physically present) (n=87)	1.5	0	8
Number of physician extenders (i.e., RNP / PA, clinical nurse specialists) (n=79)	1.6	0	22
Number of patient navigators (n=81)	1.6	0	9
Number of rehabilitation / wellness personnel (n=83)	1.4	0	30
Number of pharmacy technicians (n=70)	1.3	0	5
Number of oncology social workers or other individuals focused on financial counseling (n=78)	1.2	0	5
Number of psychologists / social workers focused on mental health counseling (n=77)	1.1	0	4
Number of LPNs in this cancer program (n=77)	0.7	0	6
Number of nutritionists or dietitians (n=76)	0.7	0	4
Number of non-mental health (e.g., case managers, etc.) (n=73)	0.6	0	10
Number of survivorship personnel (n=77)	0.6	0	7
Number of genetic counselors (n=78)	0.5	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.


[Go back](#)

Table 19. Director is the most commonly reported title of senior program managers.

Title of Cancer Program's Senior Manager
Percent of Respondents (n=84)



Q2d. What is the title of the senior cancer program manager? (SELECT ONE)

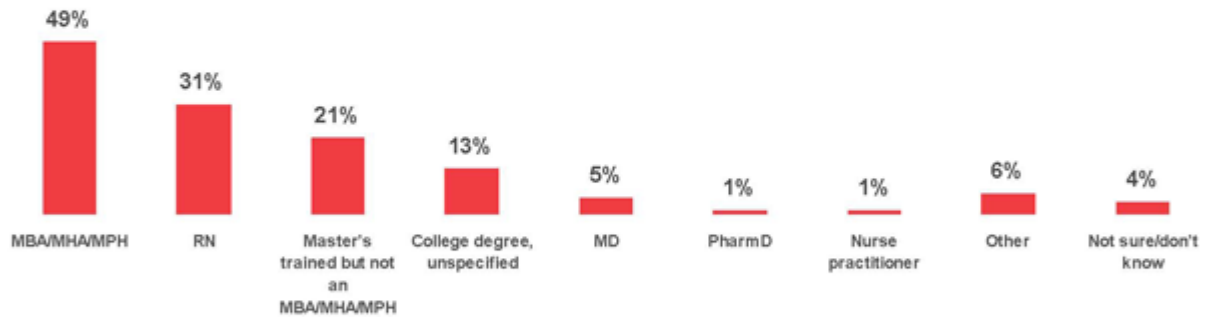
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Table 20. Most senior managers hold masters degrees with a business focus.

Academic Training of Cancer Program's Senior Manager
Percent of Respondents (n=84)



Q2e. What is the academic training of this senior cancer program manager? (SELECT ALL THAT APPLY)



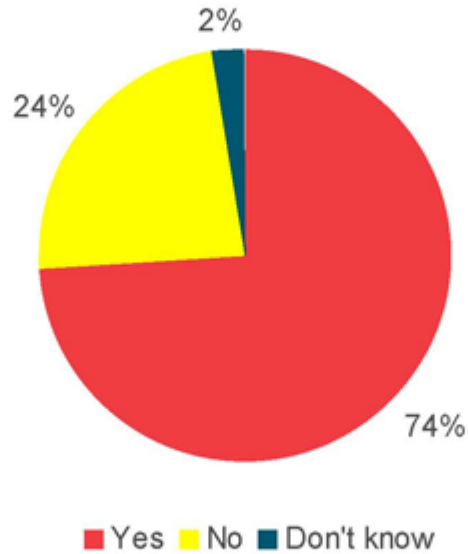

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Table 21. Dedication and Specialization: 74 percent report that the service line manager is dedicated to the cancer program.

Cancer Program's Senior Manager Fully Dedicated to Program
Percent of Respondents (n=84)



Q2b.

Is the cancer program's senior manager fully dedicated to the cancer program?

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Table 22. Pharmacy, lab, and radiology were frequently mentioned services other than cancer reporting to the same manager.



Q2c. What other service lines or services report to the same manager? (SELECT ALL THAT APPLY)



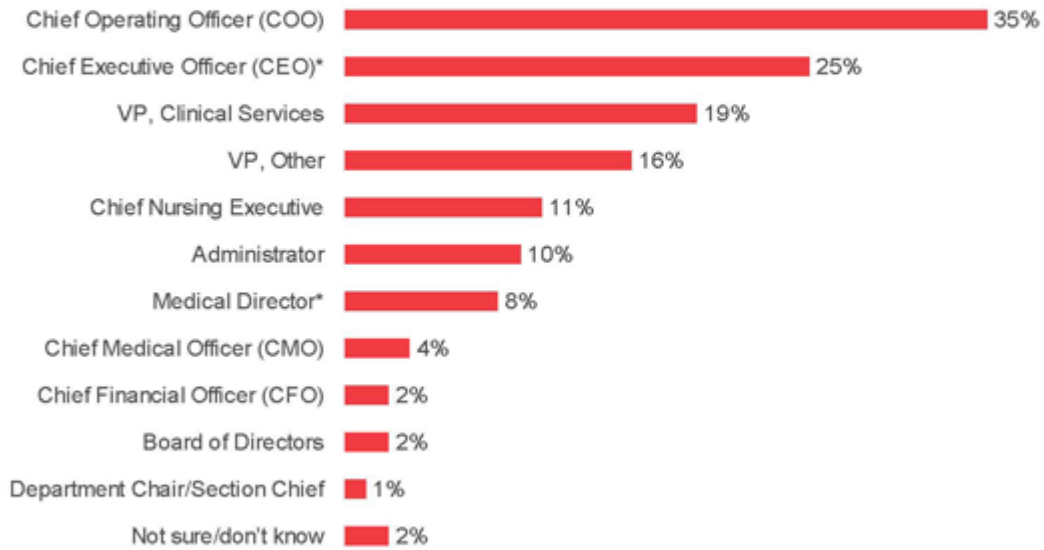
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Table 23. Reporting lines: Service managers report to COO or VP.

Executives to Which The Cancer Program's Senior Manager Reports
Percent of Respondents (n=84)



Q2a

To what executive(s) does the cancer program's senior manager report? (SELECT ALL THAT APPLY.)

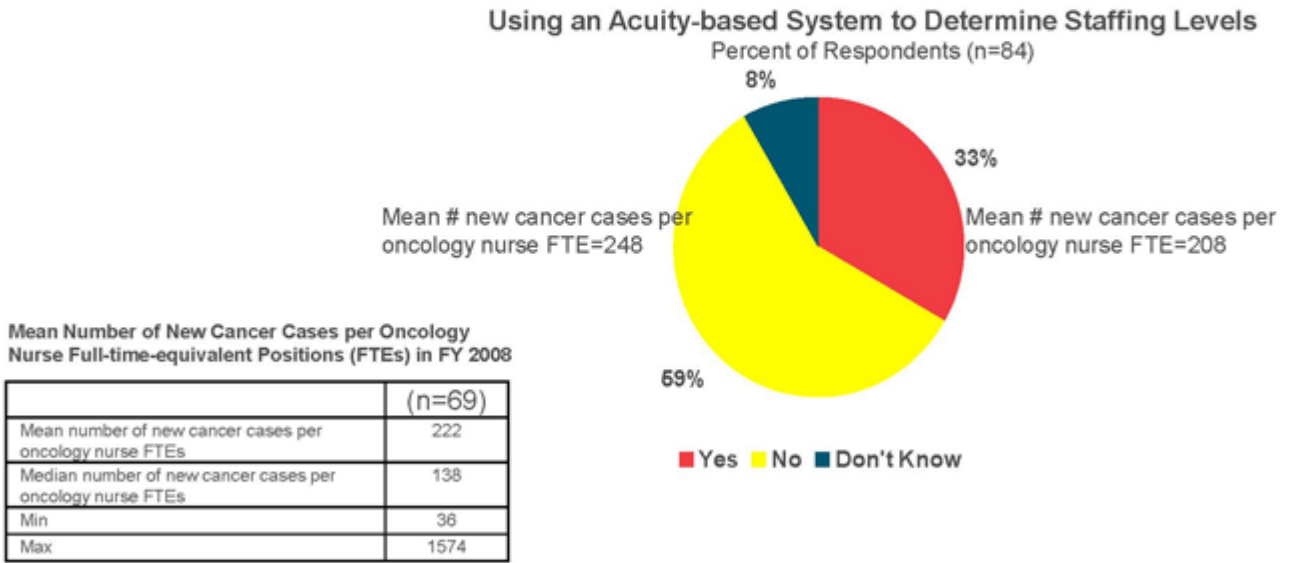
***New item in Year 2**



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Table 24. One in three of respondents report using an acuity-based system to determine staffing levels; those using an acuity-based system have fewer oncology nurse FTEs per case.

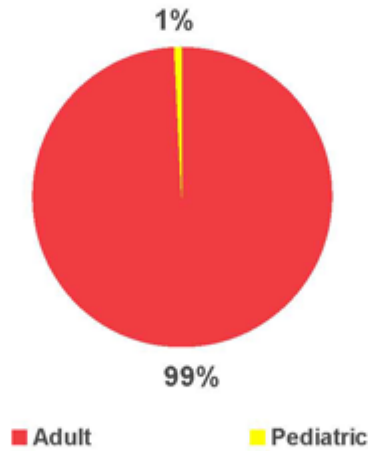


Q7u. Are you using an acuity-based system to determine staffing levels?

[Go back](#)

Table 25. Responding programs focus on adult patient populations.

Type of Patient Visits to Clinic
Average % of Visits (n=79)



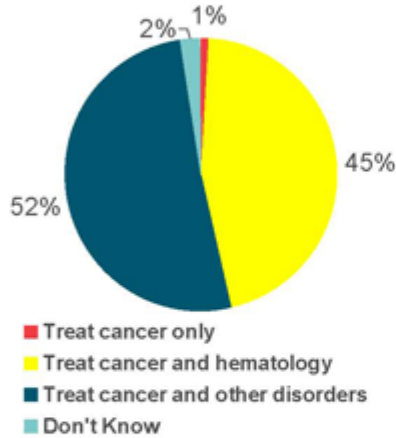
Q8b. What percentage of patient visits in this clinic are pediatric vs. adult?

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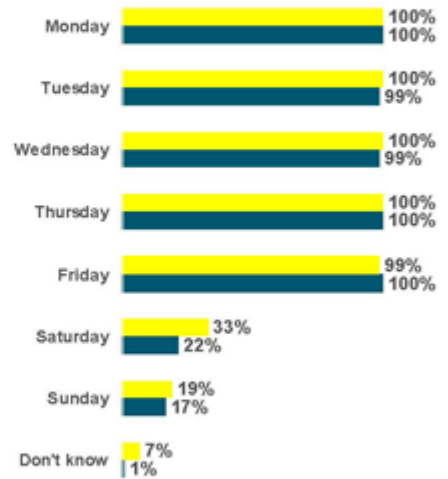
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Table 26. Dedication and Specialization: Half of programs infuse only cancer/hematology drugs, most treat Monday through Friday only

Infusion Center Dedicated to Cancer
Percent of Respondents (n=84)



Days of Week Chemo Administered
Percent of Respondents (n=84)



Q6a.
Q6g.

Is the infusion center dedicated to cancer?
Which days of the week are chemotherapy administered in this infusion center?

[Go back](#)

Table 27. Programs reported daily rates of 5 infusion patients per chair and 6 per FTE nurse.

New

Mean Number of Infusion Patients

	Mean	Min	Max
Mean number of infusion patients per chair per day (n=77)	5.2	1	60
Mean number of infusion patients per FTE nurse per day (n=77)	6.1	1	16

Q711.
Q712.

In 2008 what was the number of infusion patients per chair per day?
In 2008 what was the number of infusion patients per FTE nurse per day?




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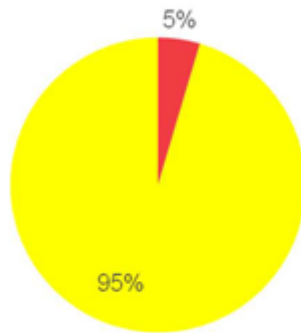


[Go back](#)

Table 28. Pharmacy does the mixing: Regardless of mixing pharmacy's location, pharmacy personnel reportedly dominates chemotherapy mixing.

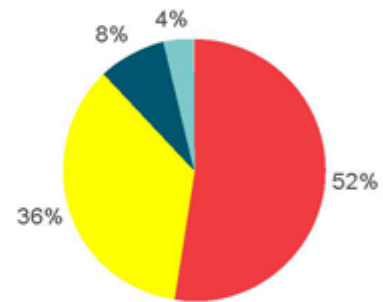
Chemotherapy Infusion Mixing

Average Percent Mixed by:
Percent of Respondents (n=79)



■ Nurse ■ Pharmacist

Location of Mixing Pharmacy
Percent of Respondents (n=84)



■ Infusion Center
■ Hospital Pharmacy
■ Other
■ Don't Know

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

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Table 29. Hospitals with dedicated pharmacies are less likely to restrict access to injectables.

Drug Acquisition Programs
Percent of Respondents (n=84)

		Dedicated Pharmacy in Ambulatory Outpatient Services			Total
		Yes	No	Don't Know	
Restrict Access to any Injectables	Yes	30%	19%	0%	25%
	No	48%	42%	0%	44%
	Don't Know	22%	39%	100%	31%
	Total	55%	43%	2%	

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 program?

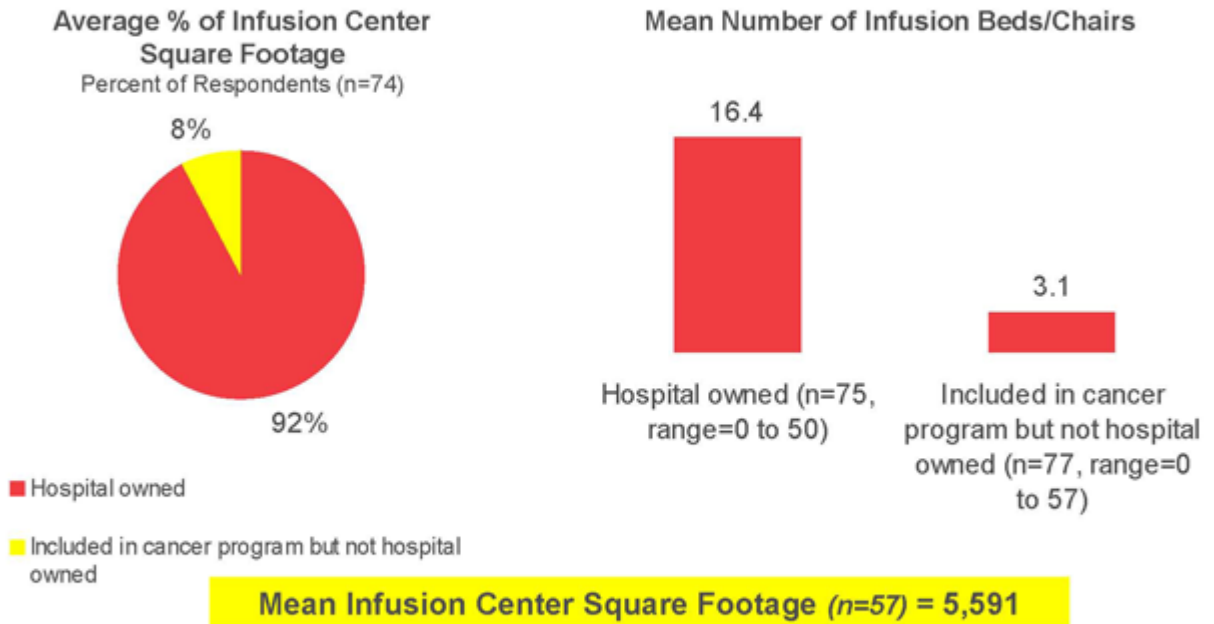



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Table 30. Clear ownership: Hospitals own the majority of space and beds included in programs.



Q8e. What is the square footage of your infusion center (including both adult and pediatric chairs/beds)?
Q8f. What percent of the total square footage falls into each of these two categories?
Q8d. How many of the IV infusion chairs/beds in your infusion center fall into each of the following types?

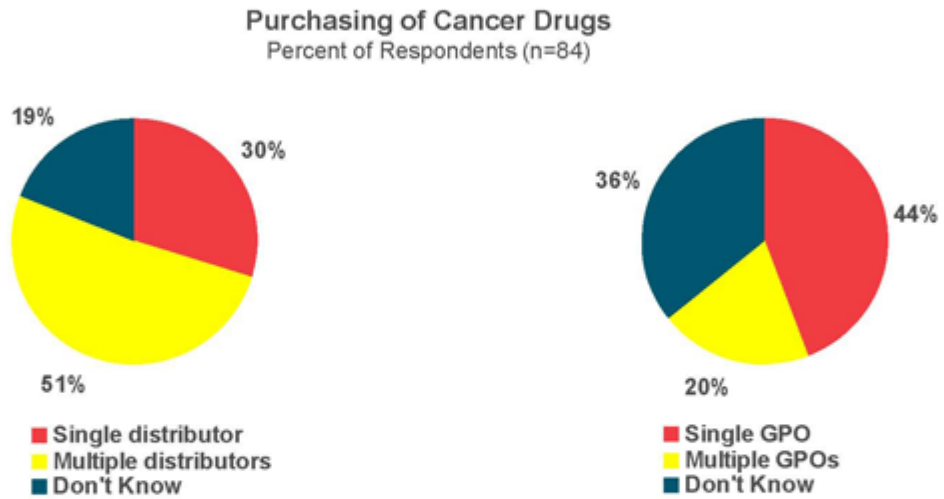


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Table 31. Most programs purchase cancer drugs through multiple distributors, but a single GPO.



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

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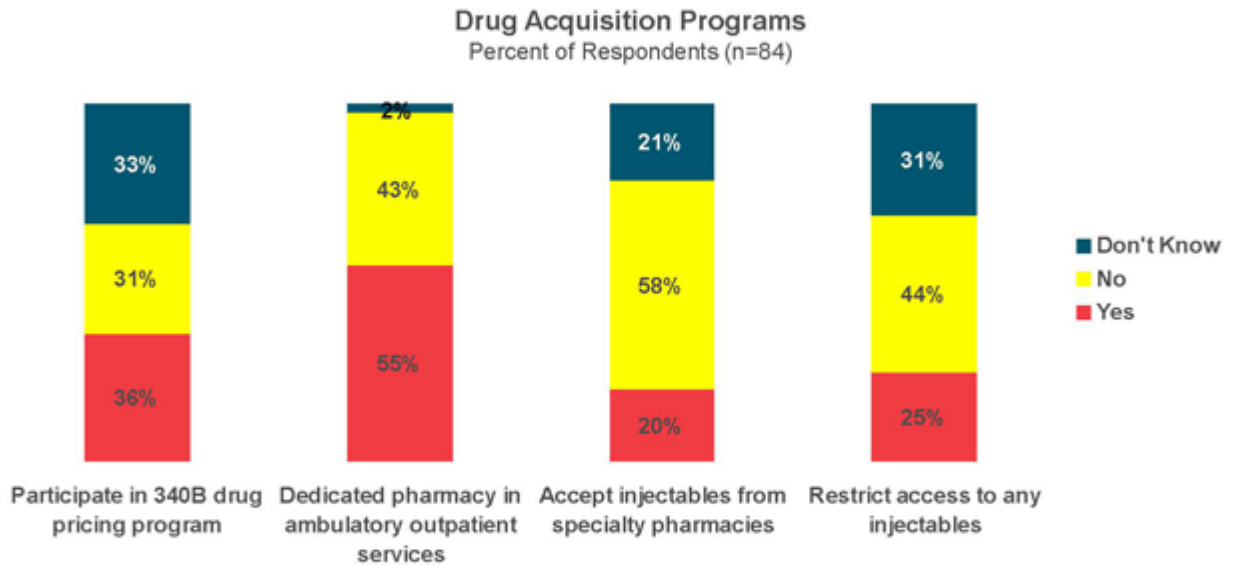
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Table 32. Most respondents' programs do not participate in alternative acquisition programs.

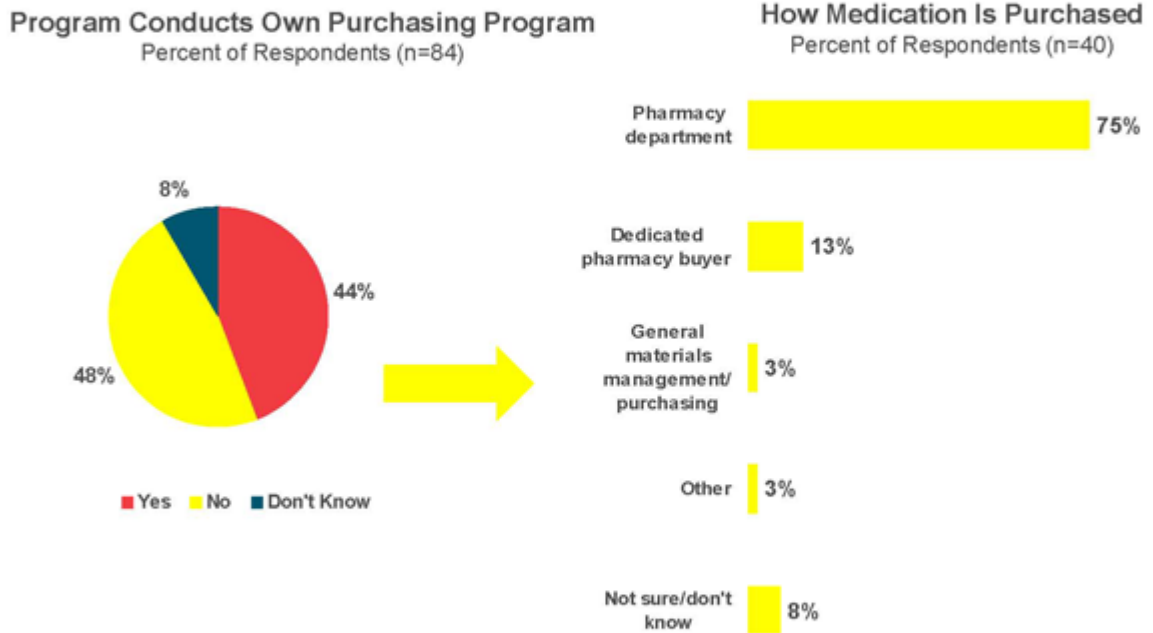


Q3c. Does your program participate in the 340B (Public Health Services) drug pricing program?
 Q3d. Does your program have a dedicated pharmacy in your ambulatory outpatient services?
 Q3f. Does your program accept injectable drugs supplied by specialty pharmacies (who mail you the drug and bill the health plan directly)?
 Q3g. Does your program restrict access to any injectable cancer drugs from use in the cancer program?



[Go back](#)

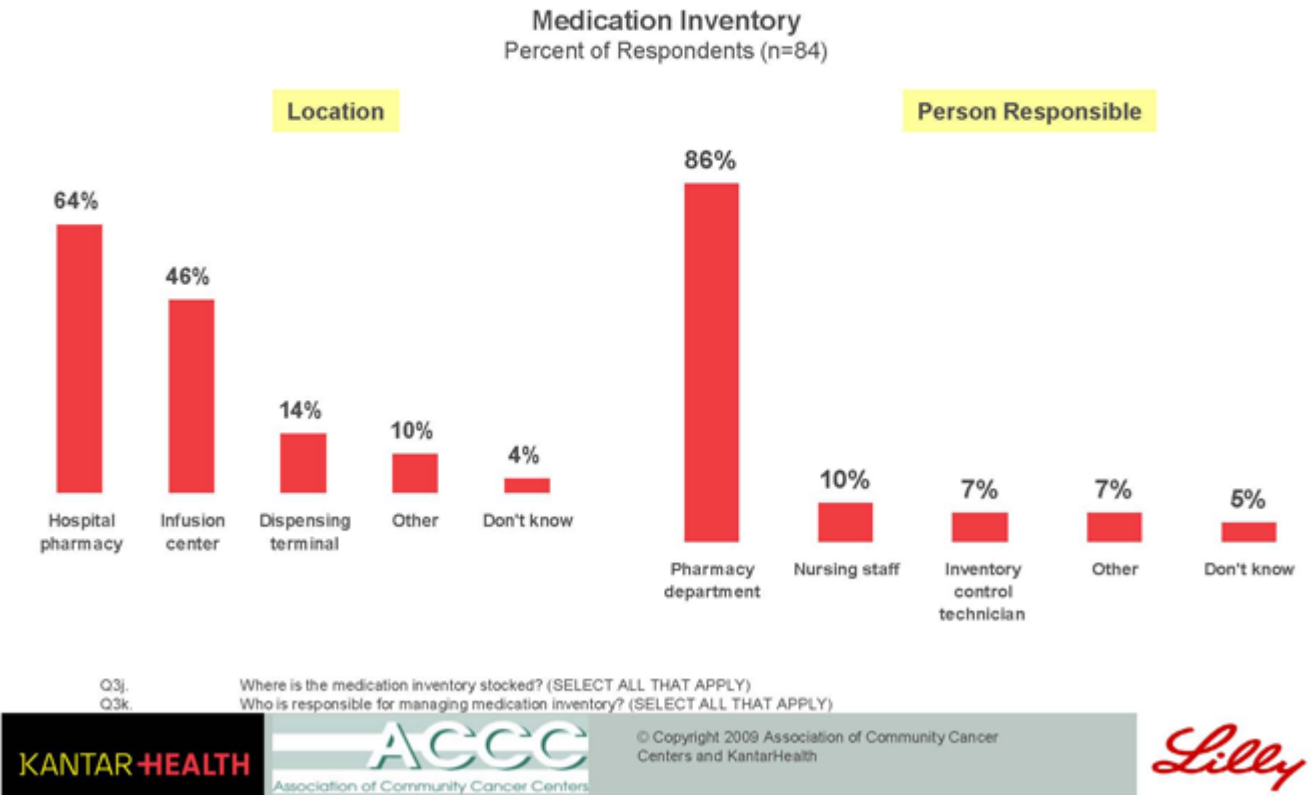
Table 33. Most programs report purchasing medication through the pharmacy department rather than conducting their own purchasing program.



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?

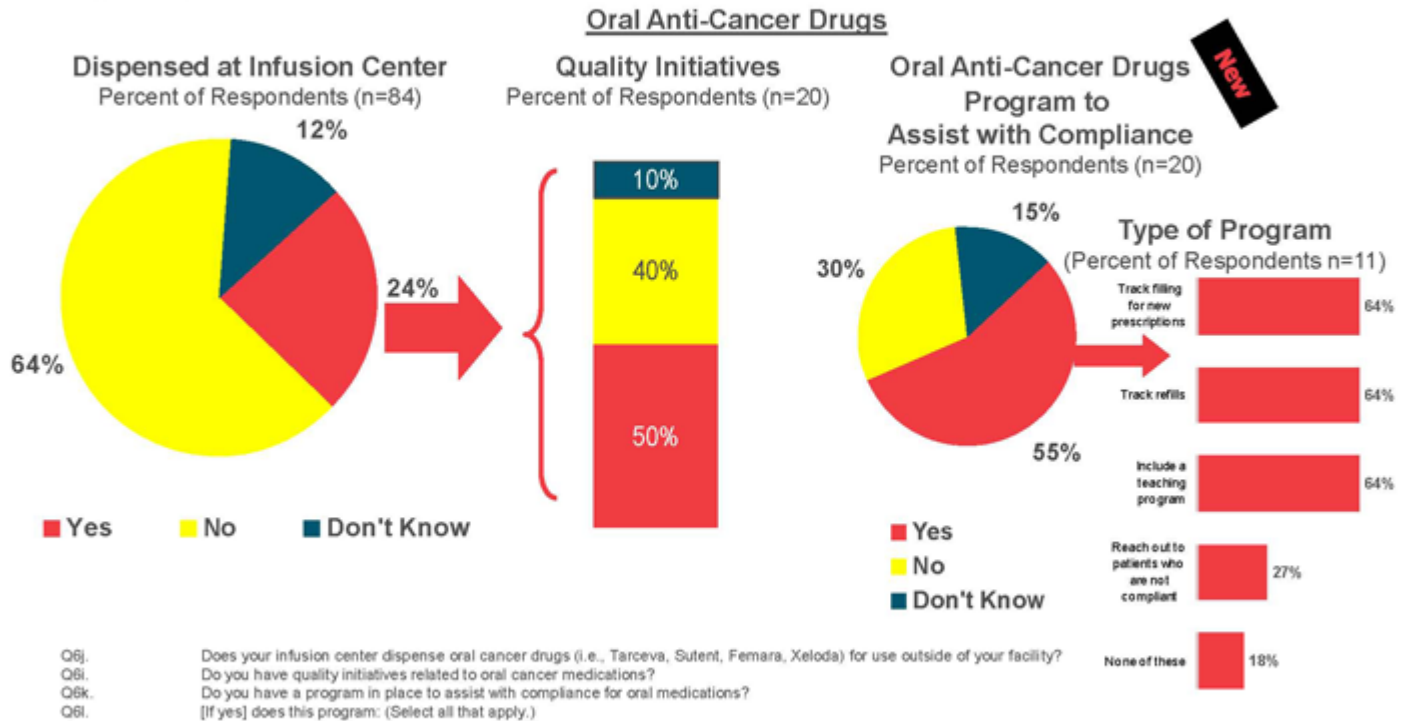
[Go back](#)

Table 34. Medication is typically stocked in the hospital pharmacy with the pharmacy department responsible for managing the inventory.



[Go back](#)

Table 35. Oral anti-cancer agents remain unpopular: Only 24 percent of programs dispense oral anti-cancer drugs; half of dispensers have quality initiatives related to orals.



Q6j. Does your infusion center dispense oral cancer drugs (i.e., Tarceva, Sutent, Femara, Xeloda) for use outside of your facility?
 Q6i. Do you have quality initiatives related to oral cancer medications?
 Q6k. Do you have a program in place to assist with compliance for oral medications?
 Q6l. [If yes] does this program: (Select all that apply.)

[Go back](#)

Table 36. The majority of infusion centers do *not* have a retail pharmacy.

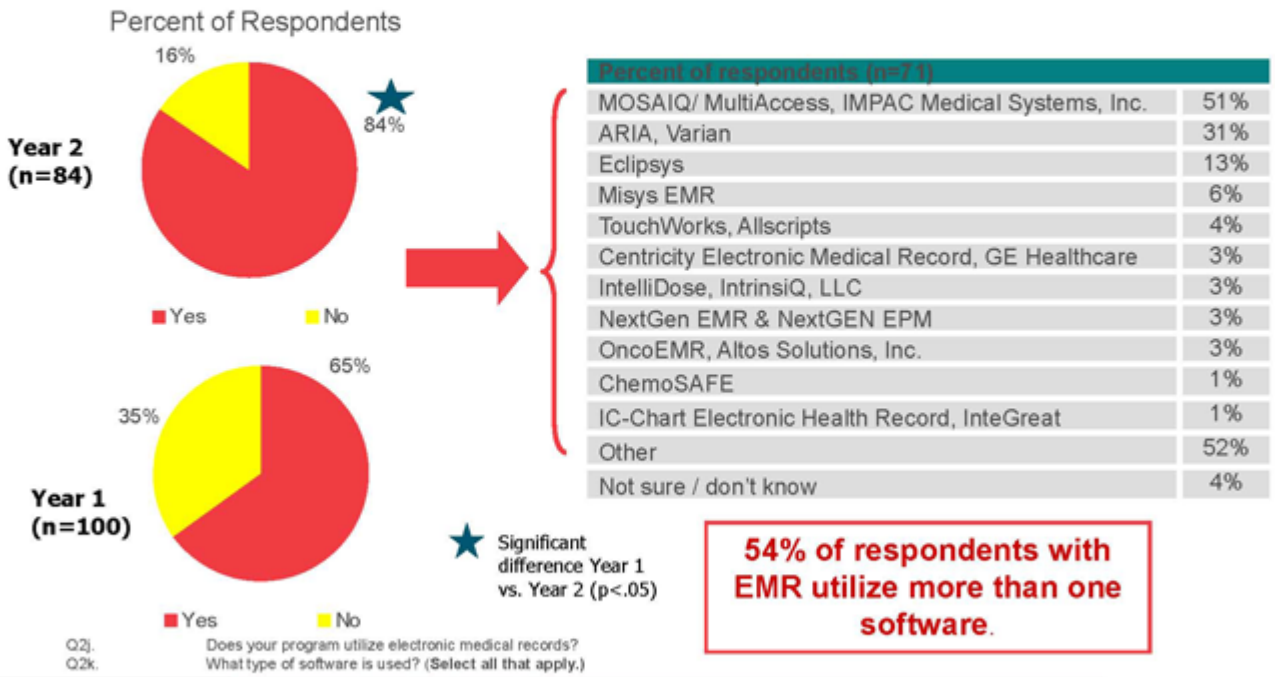


Q8j. Does your infusion center have a retail pharmacy?

[Go back](#)

Table 37. EMR use is increasing (Year 1 to Year 2) but not universal; IMPAC and Varian appear to be approaching “industry standard” status.

Utilization of Electronic Medical Records



[Go back](#)

Table 38. Year-to-year comparison of community practices considering partnering with hospitals.

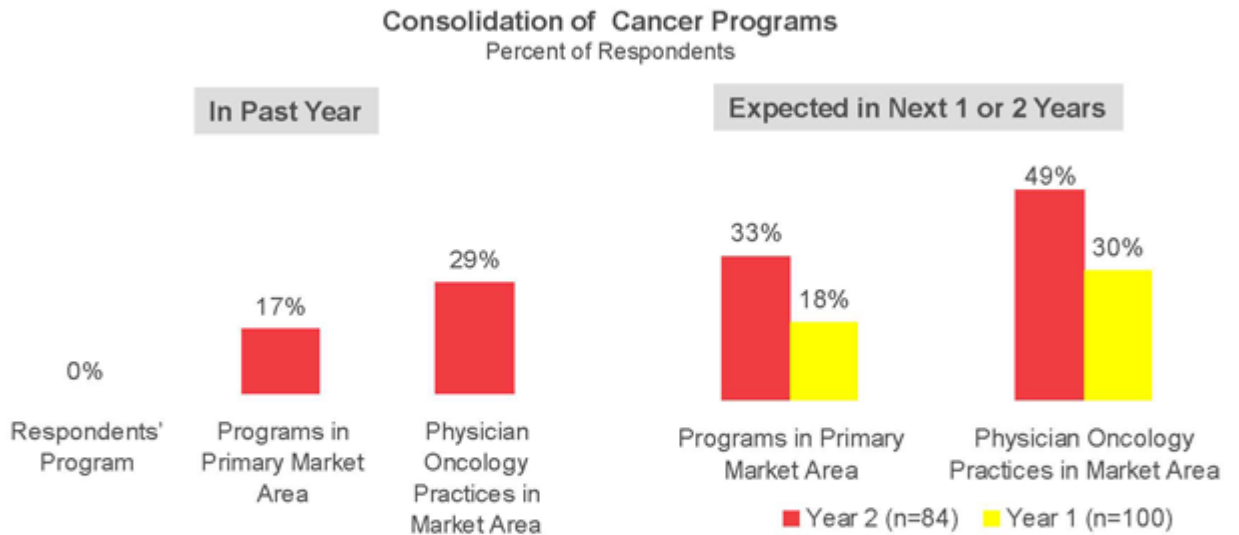


Source: MattsonJack DaVinci: Oncology Market Access U.S. 2009; Annual Practice Manager Surveys, 2006, 2008, 2009




[Go back](#)

Table 39. Ongoing consolidation: Community practices are consolidating faster, but hospitals are also in play - accelerating in Year 2.



Q1p. Within the last year has your program:
 Merged with another cancer program?
 Acquired another cancer program (or part of another program)?
 Affiliated with another cancer program?

Q1q. In your primary market area in the last year has there been consolidation (merger, acquisition) of cancer programs?
 Q1r. In your primary market area, in the next one or two years do you anticipate consolidation of cancer programs?
 Q1s. In your primary market area in the last year has there been consolidation of physician oncology practices?
 Q1t. In your primary market area, in the next one or two years do you anticipate consolidation of physician oncology practices?



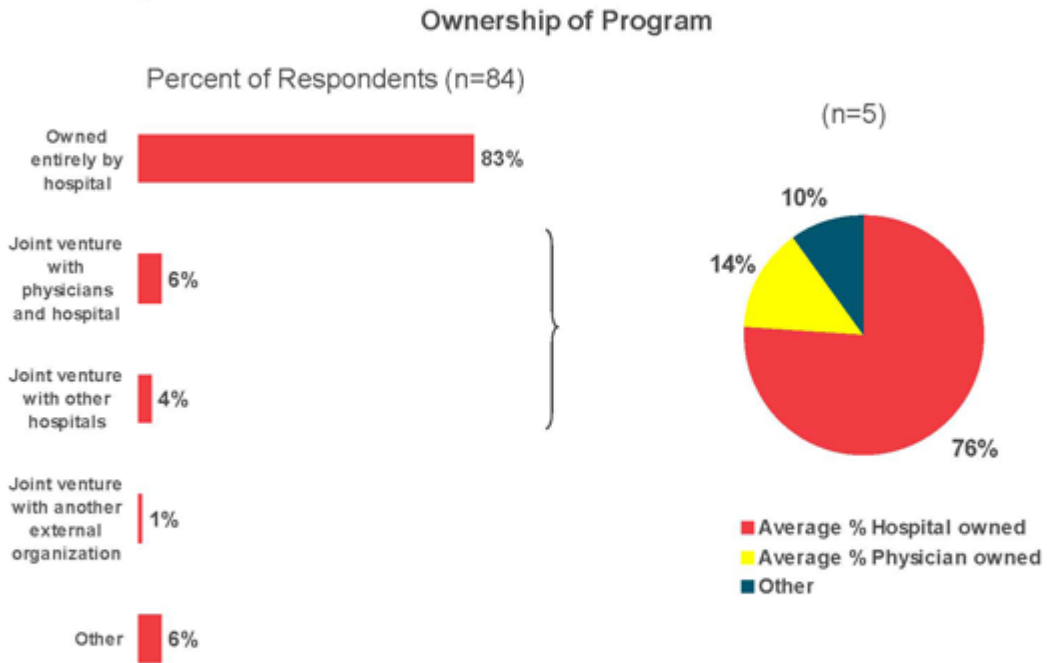


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[Go back](#)

Table 40. Most programs are owned entirely by the hospital; hospitals are majority owners in JVs.



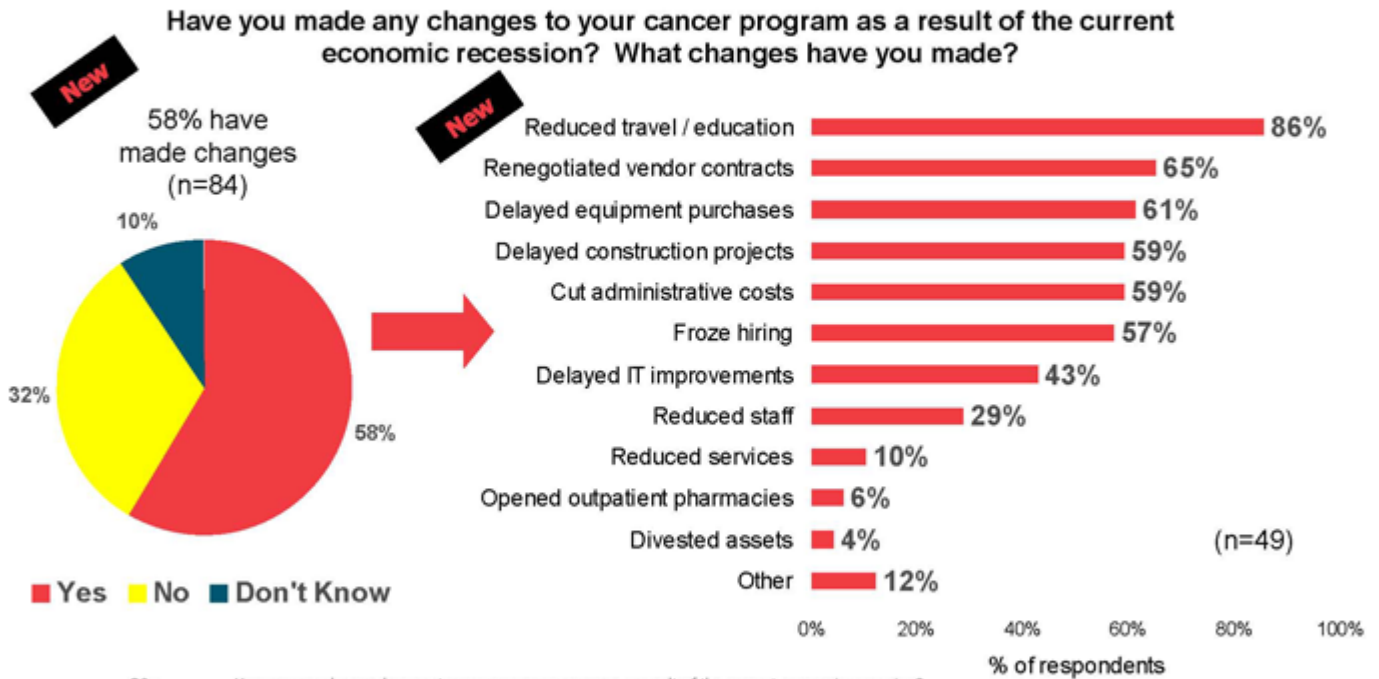
Q2h. Which of the following best describes the ownership of your program? (SELECT ONLY ONE)
Q2i. What percent of your program is owned by each of the following?

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[Go back](#)

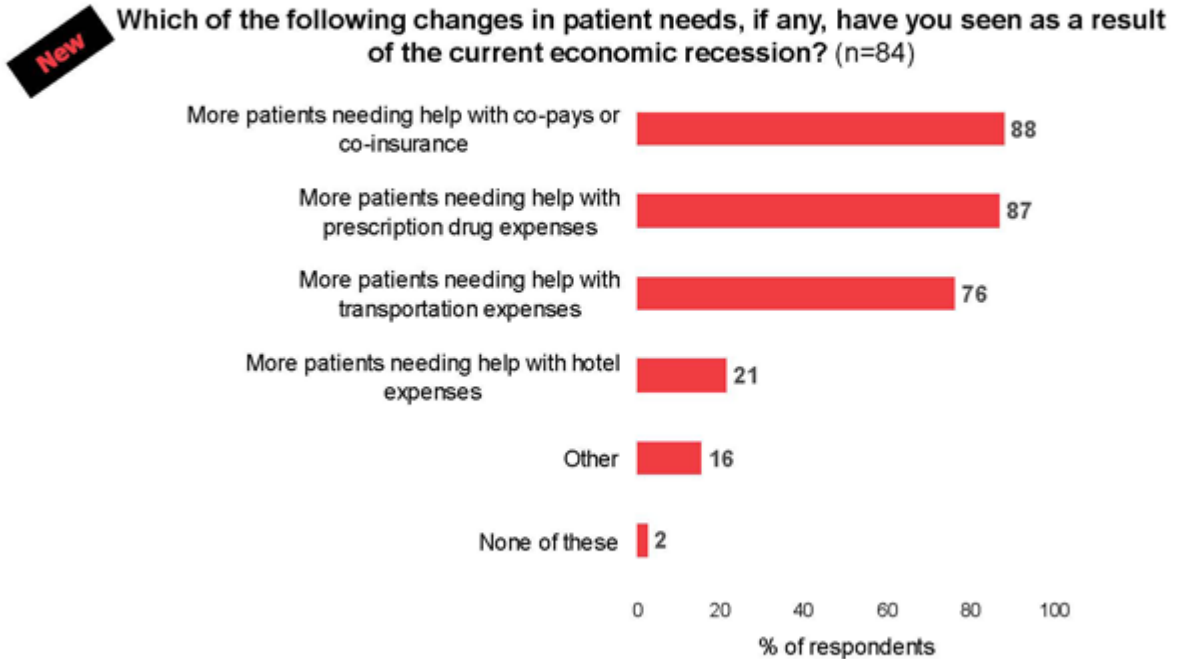
Table 41. Cancer programs felt the current economic recession.



Q9a. Have you made any changes to your cancer program as a result of the current economic recession?
Q9b. [If yes] Which if the following changes have you made? MAY SELECT MORE THAN ONE

[Go back](#)

Table 42. Cancer programs are seeing more patients who need help affording their medication.



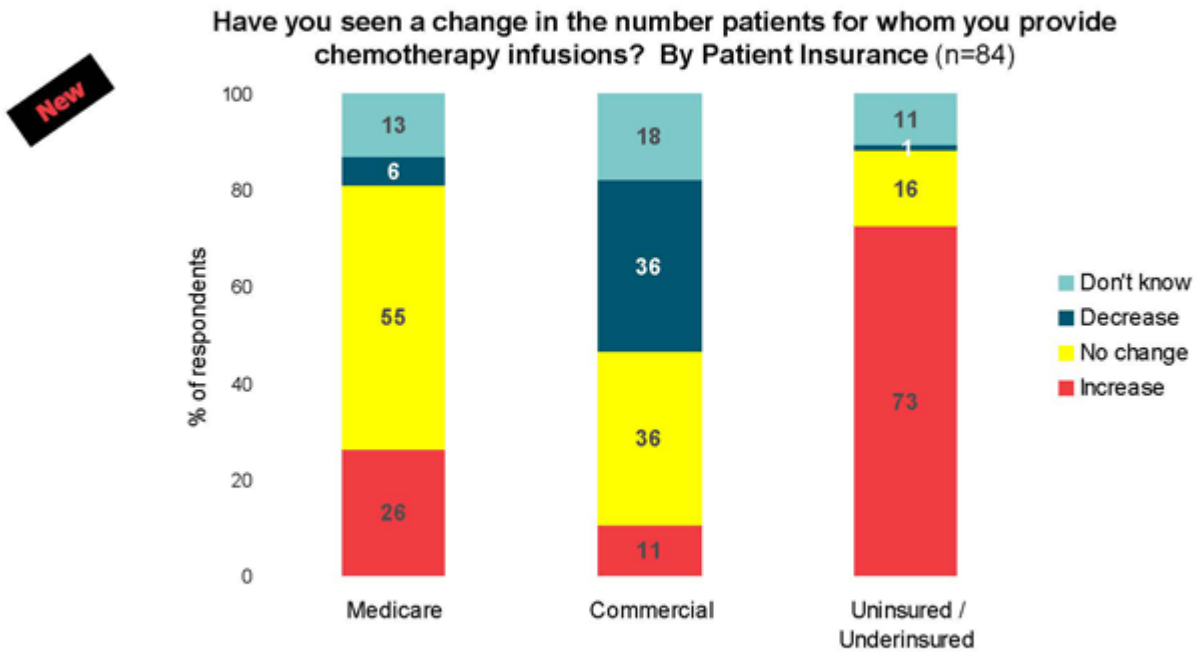
Q9C. Which of the following changes in patient needs, if any, have you seen as a result of the current economic recession?






[Go back](#)

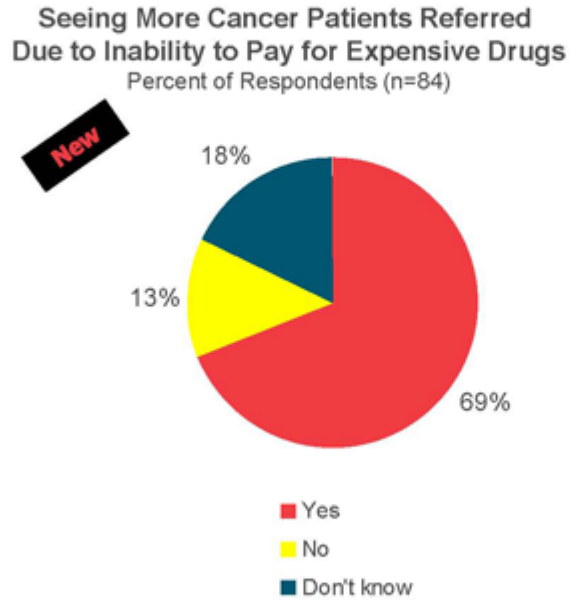
Table 43. Cancer programs have seen an increase in the number of uninsured / underinsured chemotherapy patients.



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?

[Go back](#)

Table 44. Programs are seeing an increase in patients referred due to inability to pay for expensive drugs.

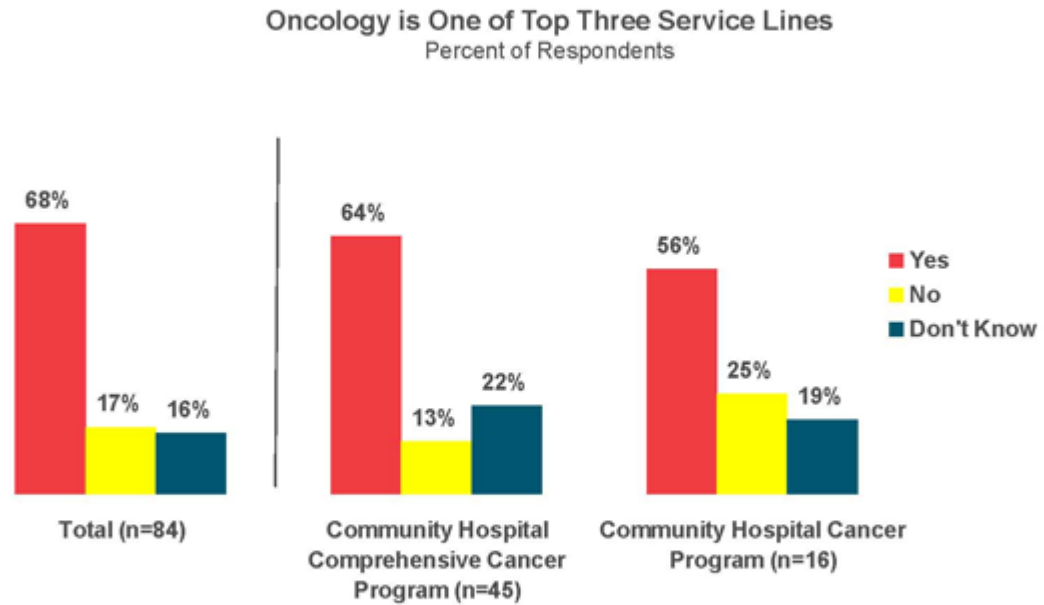


Q8I2. Compared to last year, are you seeing more patients referred to your cancer program for expensive drugs that they are unable to pay for?

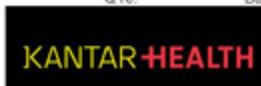


[Go back](#)

Table 45. Oncology is one of top three service lines for most responding hospitals.



Q1e. Based on billed charges, is oncology one of the top 3 service lines in the hospital / institution?

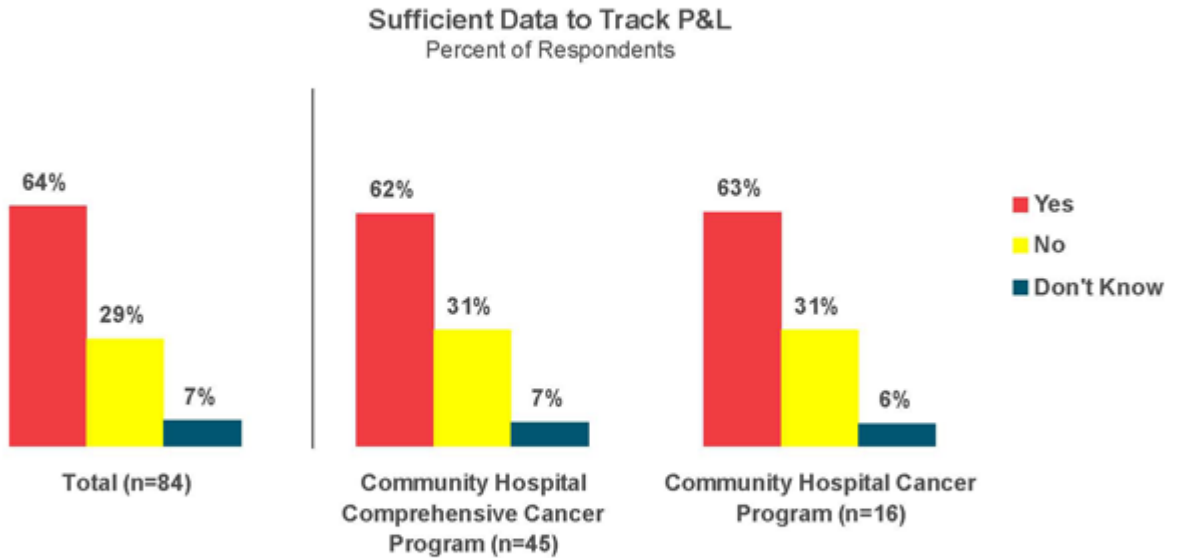


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[Go back](#)

Table 46. Two-thirds of respondents report sufficient data to track P&L; comprehensive programs are more likely to have sufficient data.



Q1f. Do you have sufficient data to track Profit & Loss of the Oncology program?

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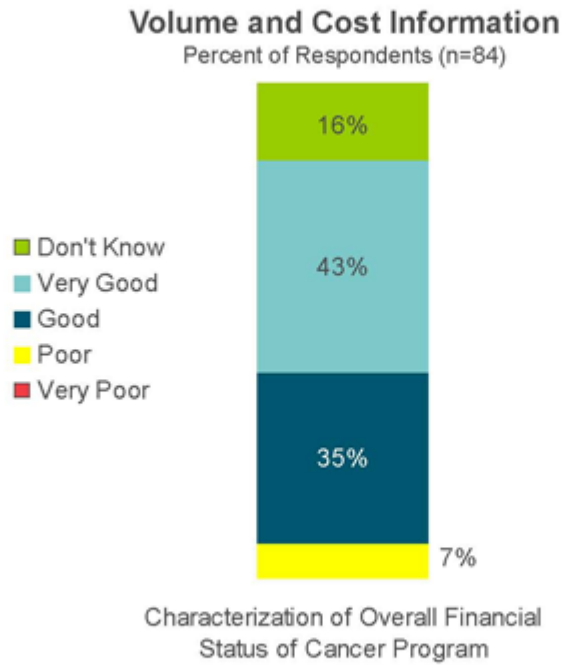
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[Go back](#)

Table 47. Most respondents characterize their programs' financial status as good or very good.

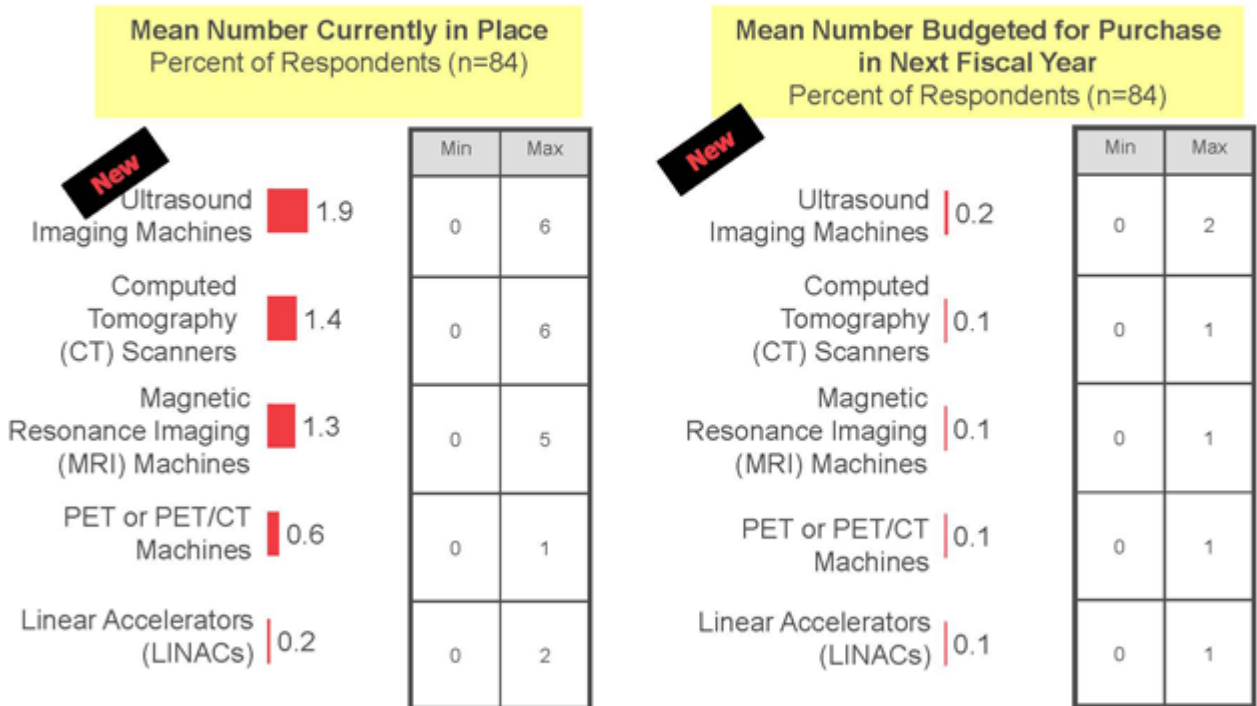


Q8c. How would you characterize the overall financial status of your cancer program? (SELECT ONE RESPONSE.)



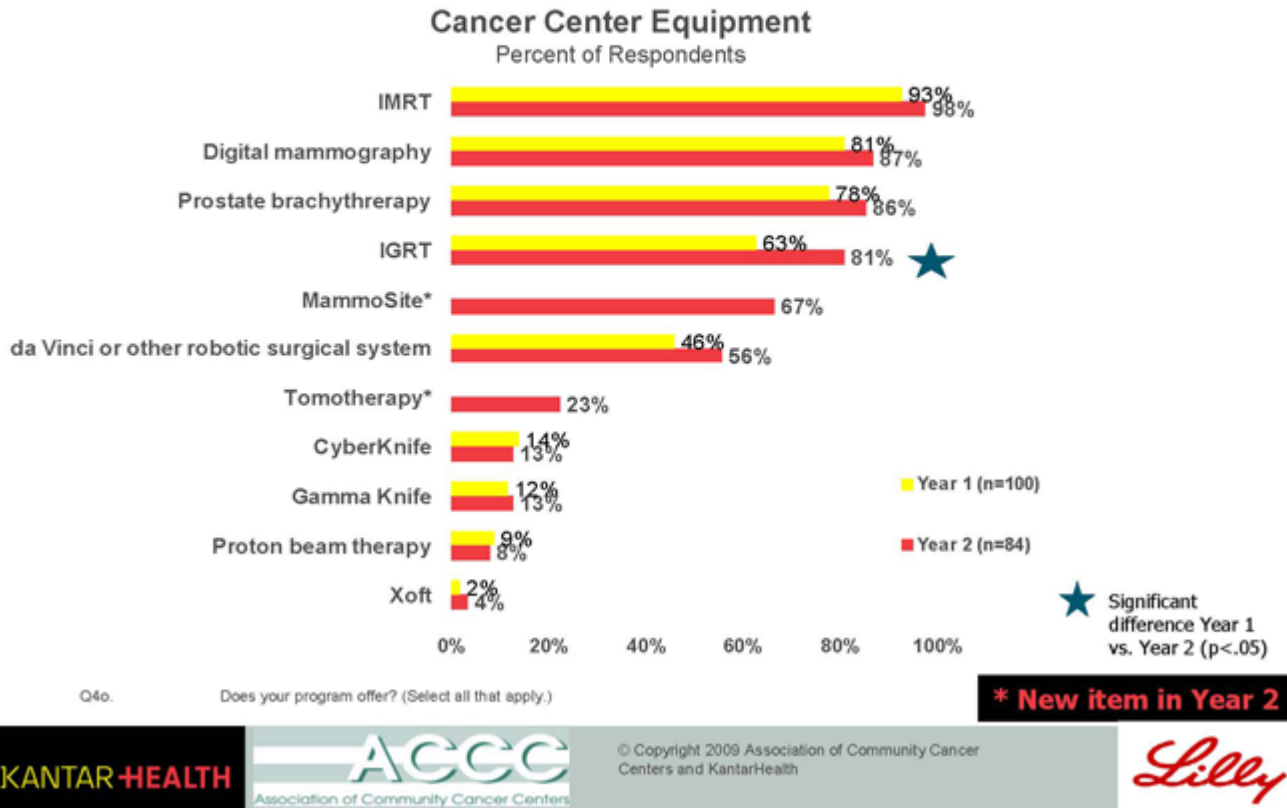
[Go back](#)

Table 48. The ratio of existing to budgeted equipment indicates freezing equipment purchase plans.



[Go back](#)

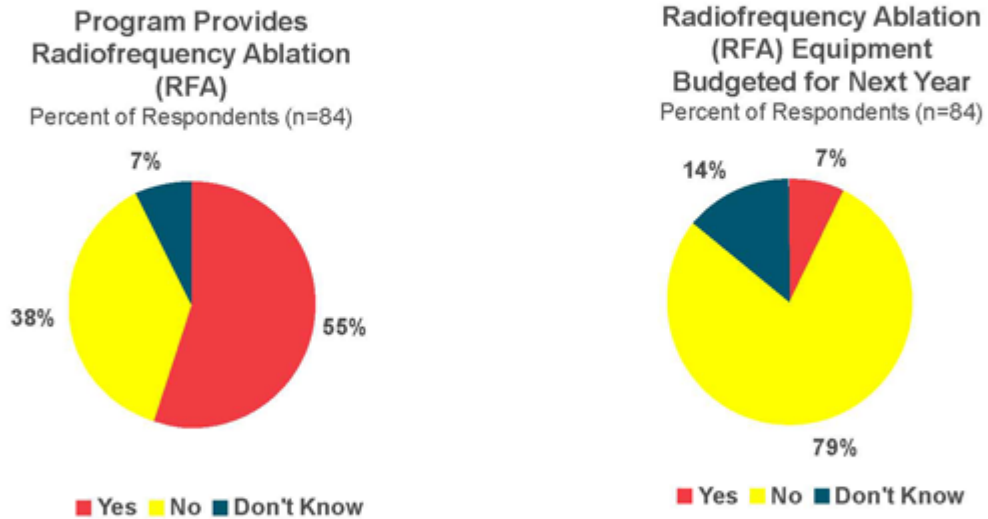
Table 49. The majority of programs offer IMRT, digital mammography, and prostate brachytherapy; those offering IGRT have increased (Year 1 to Year 2).



[Go back](#)

Table 50. More than one half of programs report providing RFA; only 7% of programs report RFA equipment budgeted for next year.

Cancer Center Equipment



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

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