Association of Community Cancer Centers

Trends in Community Cancer Centers
A survey of ACCC membership

Full Report

2013

ACCC
Association of Community Cancer Centers

The Center for Provider Education
ACCC

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 to help guide 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 4 of the survey, a joint project between ACCC and Lilly.

The consulting firm of Oncology Reimbursement Management, Carmel, Ind., collected responses, conducted follow-up interviews, and analyzed results.

Contents

Section 1. Key Findings

Year 4 of ACCC's annual *Trends in Community Cancer Centers* survey finds:

- The vast majority of cancer programs indicate that they feel good to very good about their financial health and are able to manage costs while improving revenues.
- Cancer programs continue to see consolidations (acquisitions, affiliations, and mergers) in their marketplace. Consolidation is both a means by which to achieve good financial performance and a result of good financial performance.
- Affordability of care is a growing concern for patients. Many cancer programs continue to see an increase in the number of indigent and underinsured patients.
- Cancer programs know that Accountable Care Organizations (ACOs) deserve their attention, but the majority are watching and waiting while other cancer programs start to experiment.
- Demonstrating quality in the delivery of cancer care is challenging, complex, and resource intensive. Although quality is a metric that the vast majority of cancer programs are interested in measuring, they see this goal as a difficult journey in which they are only in the initial stages.

The future is toward larger entities—whether it's physician practices merging or multi-site health systems, more sophisticated resources, and coming to terms with the impact of cost of care on both patients (insured, underinsured, and uninsured) and providers. It is a transformative time in healthcare—and the oncology landscape is continuing to change with the times.

In Their Own Words: What Respondents Said

"There is more financial stability this year, and we know the rules of the game."

"The 340B is a tremendous program that helps us level the playing field with the independent private practices."

"Most hospitals don't have the systems in place to get specific financials for oncology. The consequence of this deficiency is that expansions and/or positions become harder to justify. You need to capture specifics so you can prove the income your program is generating either directly or indirectly."

"As the Affordable Care Act nears implementation and as sequestration nears reality, there will be a tighter squeeze on our cancer program financially and increased concern among patients that their care will be impacted."

"My three tips for measuring quality cancer care: Make certain your program is integrated into the Quality and Safety Program of your health system. Develop quality indicators with physicians' input. Do not keep the successes internal to the program. Share them."

Section 2. Methodology

In August 2012 an ACCC Steering Committee approved questions and scope of research for its annual survey of community hospital cancer programs, which is conducted within ACCC's Center for Provider Education and under the direction of ACCC Executive Director Christian Downs, JD, MHA, and ACCC Senior Director of Programs and Meetings Lu Anne Bankert. Year 4 of the survey was launched through an Internet-based data collection conducted between November 27, 2012, and January 13, 2013. Emails were sent to 679 ACCC members. Ninety-eight members completed the online survey. Participants answered questions on such topics as consolidation, expansion, clinical technology, human resources, and financial health. The consulting firm of Oncology Reimbursement Management, Carmel, Ind., collected responses, conducted follow-up interviews in February 2013, and analyzed results. Seven cancer programs participated in one-on-one follow-up phone interviews.

Key preliminary findings of the survey were released on Friday, March 8, 2013, at the ACCC 39th Annual National Meeting. A summary of final findings will mail with the July/August 2013 *Oncology Issues*.

Steering Committee members include: Dorene J. Fankhauser, RN, MS, Mount Carmel Network Cancer Program; Brendan Fitzpatrick, MBA, Alamance Cancer Center; Thomas A. Gallo, MS, Virginia Cancer Institute, Inc.; Luana R. Lamkin, RN, MPH, Mountain States Tumor Institute; Becky L. DeKay, MBA, Feist-Weiller Cancer Center; and Virginia T. Vaitones, MSW, OSW-C, Pen Bay Medical Center.

Section 3. Participant Characteristics

Section 3.1. Respondent Profile

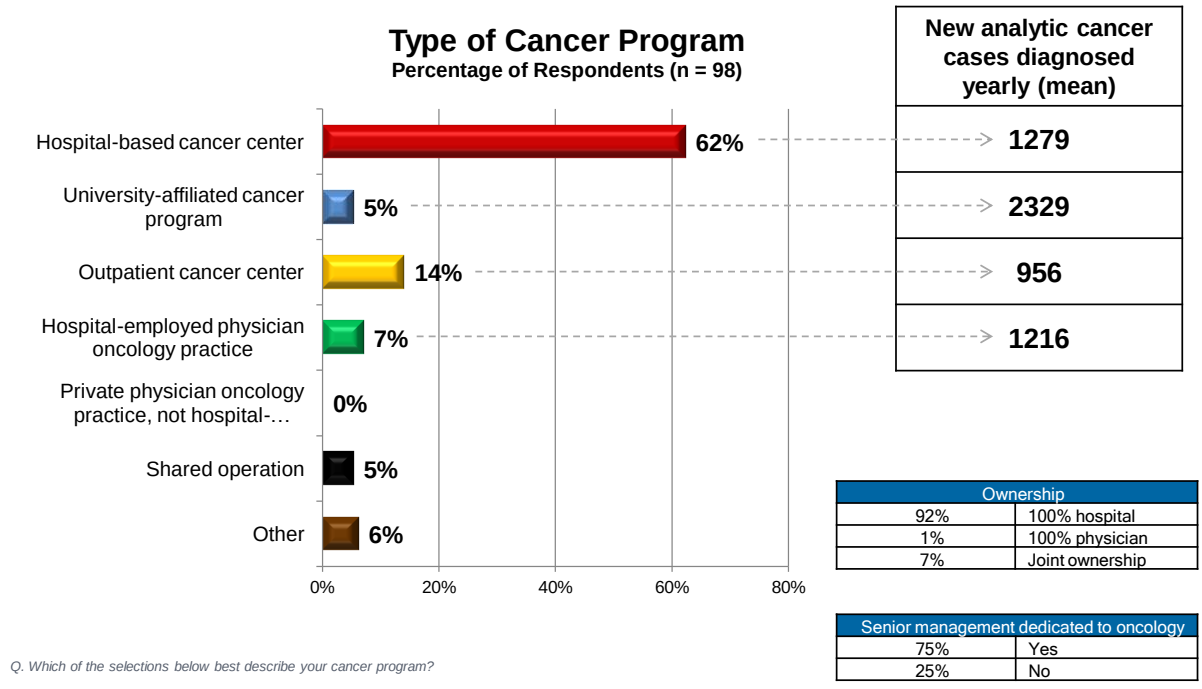
Ninety-eight cancer programs submitted responses to the survey. Of these, 62 percent are hospital-based cancer programs.

The mean number of new analytic cancer cases diagnosed yearly at these hospital-based cancer programs is 1,279, while university-affiliated cancer programs (5 percent of respondents) see considerably more new analytic cancer cases (2,329/mean) (Table 1).

Fourteen percent of respondents are outpatient cancer centers, while 7 percent are hospital-employed physician oncology practices. The remainder includes "shared operation" cancer programs and "other," such as freestanding cancer programs.

Table 1.

Responses represent 98 institutions – two-thirds of which are community hospital-based or university-affiliated cancer programs.



Ninety-two percent of responding programs are owned entirely by the hospital, which is similar to Year 3 Survey's finding of 91 percent. Seven percent are joint ventures with physicians and the hospitals, again similar to Year 3 Survey's finding of 8 percent. One percent is owned by physicians alone.

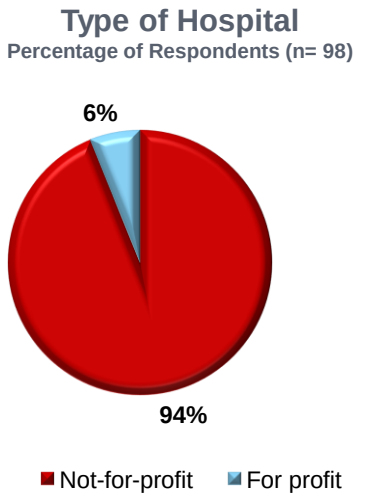
Seventy-five percent of cancer programs report that their service line manager is fully dedicated to their program.

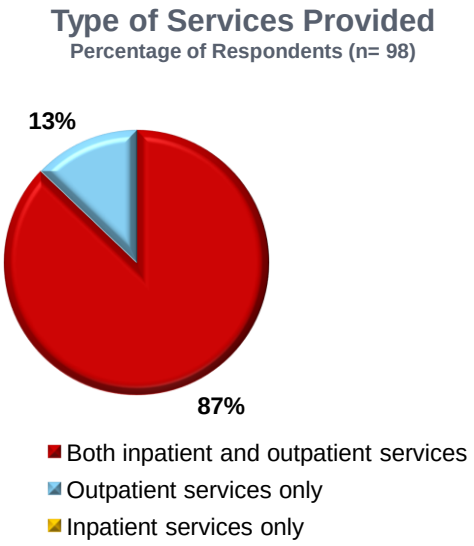
Most programs focus on adult patient populations. Pediatric patients represent a very small percent of clinic volume (not shown in table). The vast majority of programs (81 percent) treat adult cancer patients. Another 16 percent of programs had a small number (1-10 percent) of pediatric patients. In only 3 percent of responding programs did pediatric patients comprise more than 10 percent of the cancer patients.

Consistent with years past, nearly all respondents (94 percent) describe their program as not-for-profit, providing both inpatient and outpatient services (Table 2).

Table 2.

Respondents are not-for-profit hospitals that generally provide both inpatient and outpatient services.





Q. Which of the following best describes your cancer program?
Q. Which of the following does your program provide?

Section 3.2. Number of Patients

Fifty percent of responding programs saw 1,000 cancer patients or less in 2011 (Table 3), while an equal percentage saw more than 1,000 cancer patients. The mean number of cancer patients seen in 2011 was 4,593 with 40 respondents.

Table 3.

Number of Cancer Patients Seen in 2011

Patients Seen	Percentage of Institutions
0 - 500	30%
501 – 1,000	20%
1,001 – 5,000	28%
5,001 – 10,000	10%
> 10,000	12%

Q: In 2011 how many patients entered your cancer program?

40 hospitals responded

Section 3.3. Service Lines

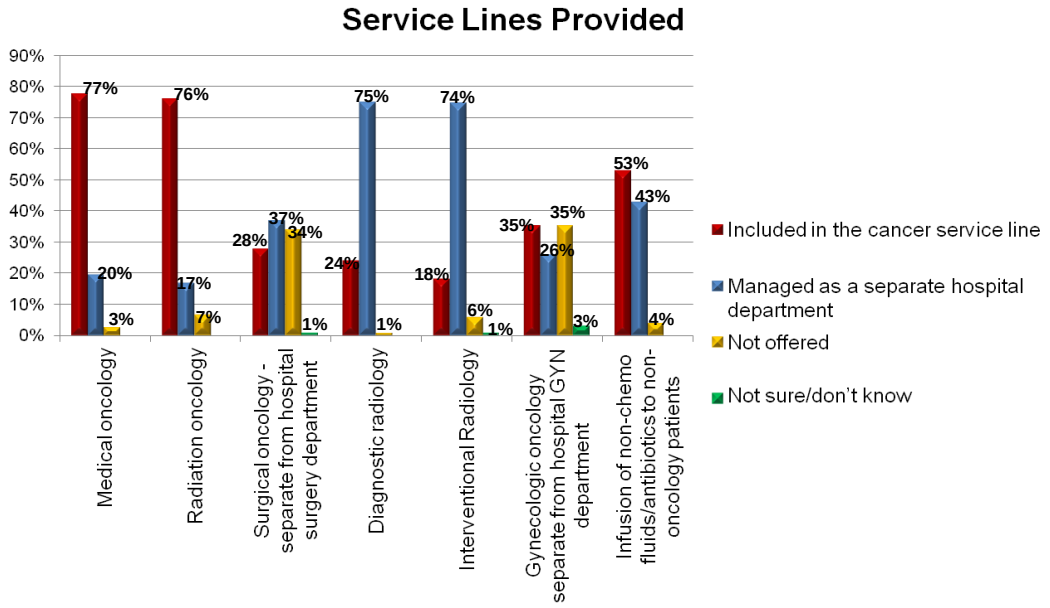
Cancer programs continue to offer an array of service lines.

Almost 80 percent of reporting institutions include medical and radiation oncology in their cancer service line, whereas more than 70 percent of respondents report that diagnostic radiology and interventional radiology service lines are managed as their own separate department line (Table 4). Slightly more institutions (53 percent) manage infusion services of non-chemotherapy drugs as part of the cancer service line rather than as a separate department.

Note: 21 percent of respondents indicate they do not offer medical or radiation oncology in their cancer service line compared to just 5 percent of programs in the Year 1 Survey. We might assume that they misread the question. Or, as we noted last year, it may be that the lines between care settings appear to be blurring. Our assumption is that their patients may be seeing medical oncologists in private practices "affiliated" with but "separate" from the hospital. 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.

Table 4.

Essentially all institutions offer medical and radiation oncology services – and two-thirds offer surgical and gynecologic oncology services.

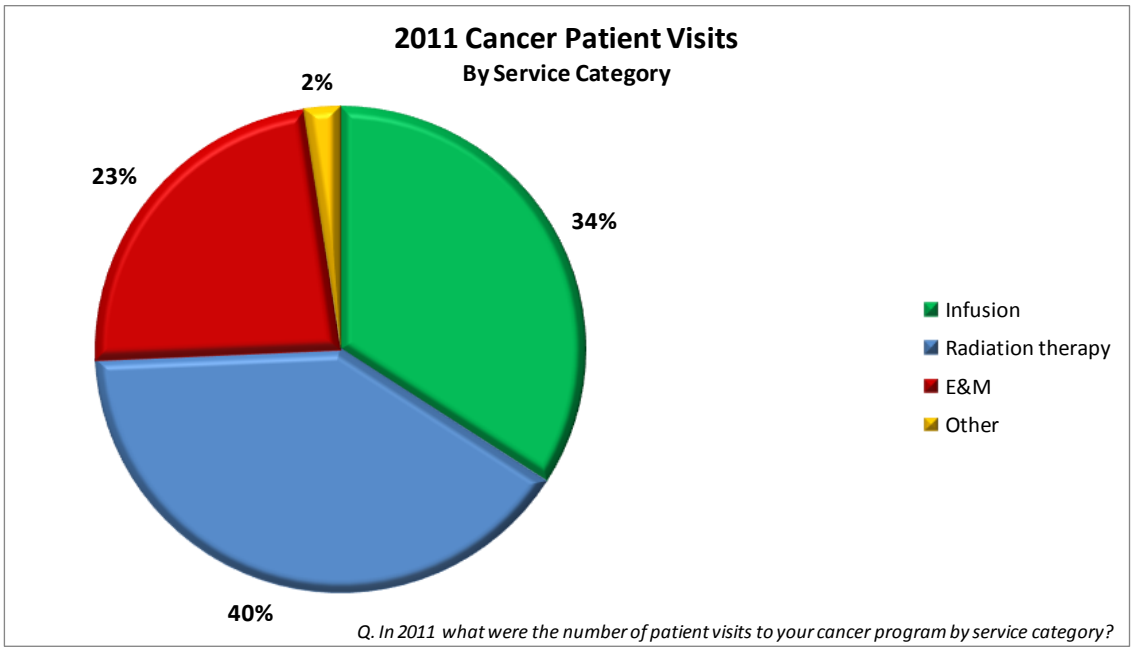


Q. For each of the following services, please indicate the level of offering.

A greater percentage of patient visits (40 percent) were for radiation therapy compared to infusion (34 percent) or E&M (23 percent) (Table 5). In Year 3 Survey, patient visits were balanced more closely across infusion, radiation therapy, and E&M.

Table 5.

More cancer patient visits were for radiation therapy than for infusion or E&M.

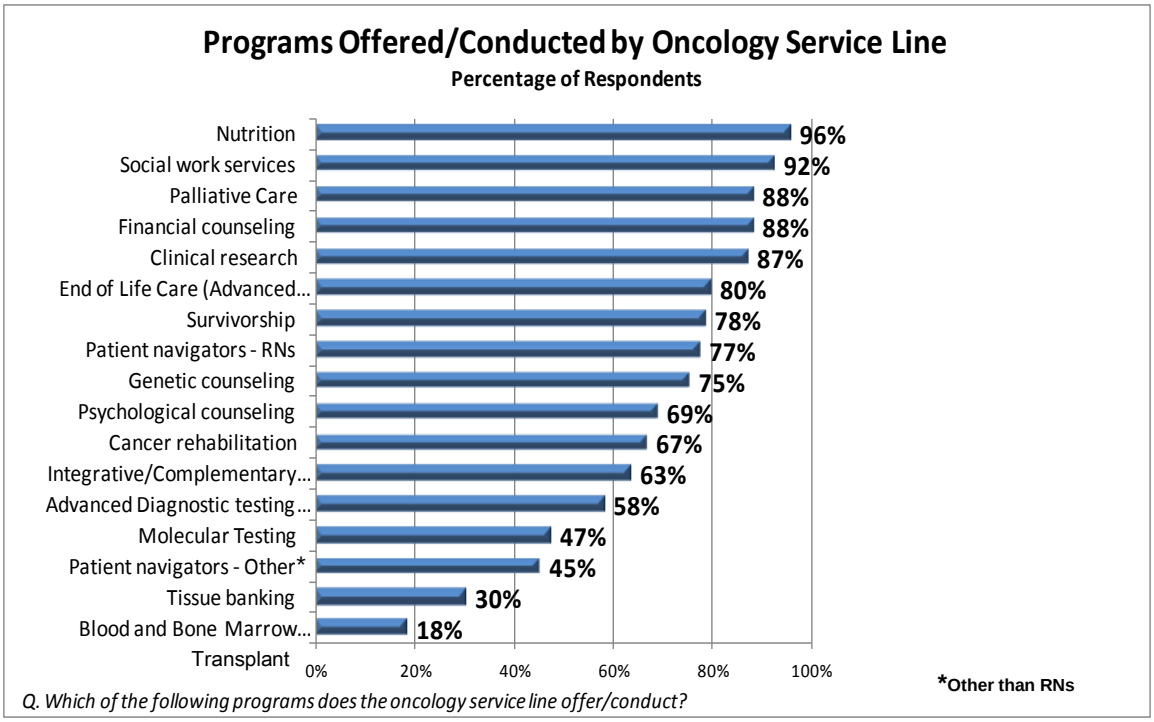


Section 3.4. Cancer Program Services

Most, but not all, programs offer the services that are required by the Commission on Cancer, including survivorship (78 percent), RN patient navigators (77 percent), genetic counseling (75 percent), psychological counseling (69 percent), and cancer rehabilitation (67 percent).

Table 6.

Cancer programs continue to offer a full range of services.



Eighty-seven percent of programs report participation in clinical research.

Almost one in three offer tissue banking, compared to one in five in last year's survey.

Most cancer programs (88 percent) offer financial counseling.

See Appendix for sources of funding for each service.

Section 3.5. Social Media

Three of four cancer programs use Facebook to market their program; one in three is on both YouTube and Twitter. More than half (57 percent) report success in using social media to build an online community, and 80 percent plan to continue to use social media in the next one to two years. One in three respondents accesses the ACCC Facebook page.

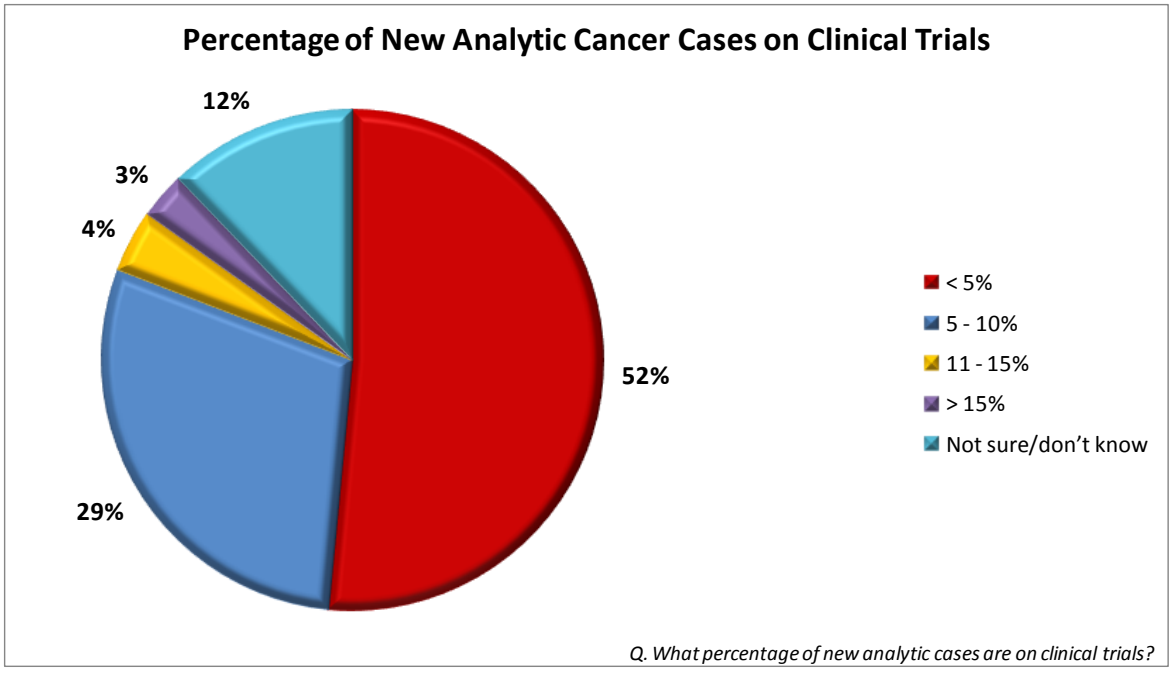
Section 3.6. Clinical Trials

Although most responding cancer programs conduct clinical trials, the majority (52 percent) enroll less than 5 percent of their new analytic cancer cases and almost one-third (29 percent) enroll just 5 to 10 percent of their new analytic cancer cases (Table 7). There are numerous barriers to participation in clinical trials from trial design, to timeliness, to patient resistance, to poor communications.

Tools and processes for screening patients, obtaining informed consent, and complying with the trial requirements are critical to effective accrual. Providers require the knowledge, tools, and inclination to educate patients about clinical trials as a treatment option when available.

Table 7.

Enrollment in clinical trials remains low.



Section 3.7. Participation in Accountable Care Organizations

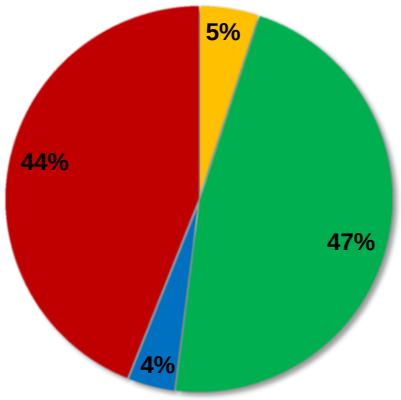
Cancer programs are acutely aware of Accountable Care Organizations (ACOs). ACOs agree to manage all of the healthcare needs for a defined population in a specific period; they are required to report on utilization, cost, and quality of care.

Just 5 percent of programs report that they participate in an ACO. Almost half of the respondents plan to participate, even though the details about cancer program participation remain to be determined. Most cancer programs stated that it is their belief that their hospital will be part of an ACO, causing them to have a relationship with the ACO. Their concerns center around the cost parameters in oncology and the practice of oncology, which are very different from primary care – the basis for the ACO model.

Table 8.

Participation in ACOs remains low, although ACOs are top-of-mind for most hospitals. Most are not jumping into the CMS pilots because of the complexity and resource-intensive nature of ACOs.

Participation in Accountable Care Organizations



- Already participating in an ACO
- Yes, plan to participate
- No, do not plan to participate
- Not sure/don't know

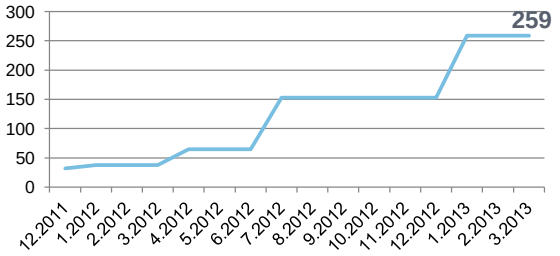
Q. Does your program have plans to participate in an Accountable Care Organization in the future?

"This is much bigger than just cancer."

"We are still very much trying to figure ACOs out. It starts by looking at them from the hospital's perspective, and then from the cancer perspective, as appropriate."

"We want to understand the leading edge of ideas, but be cautious in what we implement. We don't want to be the first to invest money in ACOs."

ACOs Approved By CMS



Source : CMS

Section 3.8. Primary Service Area

Cancer care remains a competitive business. The majority of hospital-based not-for-profit cancer programs have 1 to 5 competitors in their marketplace, while hospital-based for profit cancer programs have far fewer.

Table 9.

Not-for-profit cancer centers tend to have more competition within their primary markets.

Competing Cancer Programs	Hospital-based For Profit	Hospital-based Not-For-Profit	Community-Based (Medical Office) Program	University Hospital Setting
0	67%	20%	36%	57%
1	23%	34%	33%	32%
2	5%	19%	17%	6%
3 -5	6%	23%	7%	4%
6 -10	0%	4%	7%	0%
> 10	0%	1%	0%	0%
	100%	100%	100%	100%

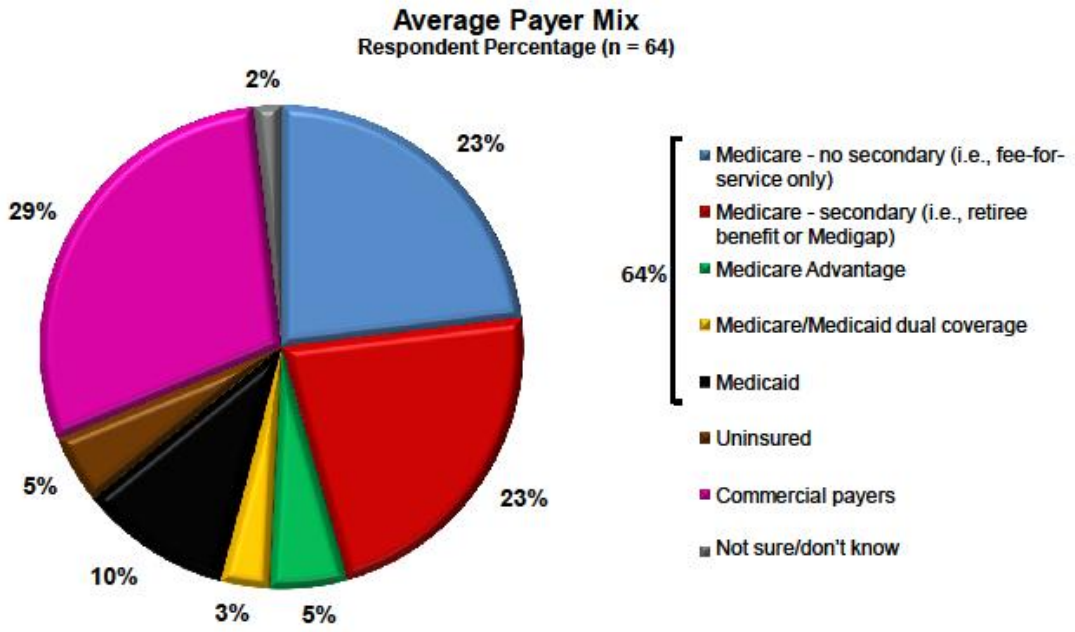
How many other cancer programs (of all types) exist within your primary market area?

Section 3.9. Payer Mix

Public payers predominate within responding cancer programs. Respondents indicate that 64 percent of their patients are under public insurance; 46 percent are covered by Medicare, equally divided between Medicare with a secondary insurance and Medicare with no secondary insurance. Five percent of their patients are covered under Medicare Advantage, while just 3 percent have Medicare/Medicaid dual coverage. One in ten patients is covered by Medicaid. Commercial insurance makes up 29 percent of the payer mix. Five percent are uninsured. (Note: Average Payer Mix in Table 10 below refers to total respondents' mean percentage for each type of insurance.)

Table 10.

Almost two-thirds of the average hospital's patients are under public insurance, where reimbursement rates are low and patient co-pays are often not collected.



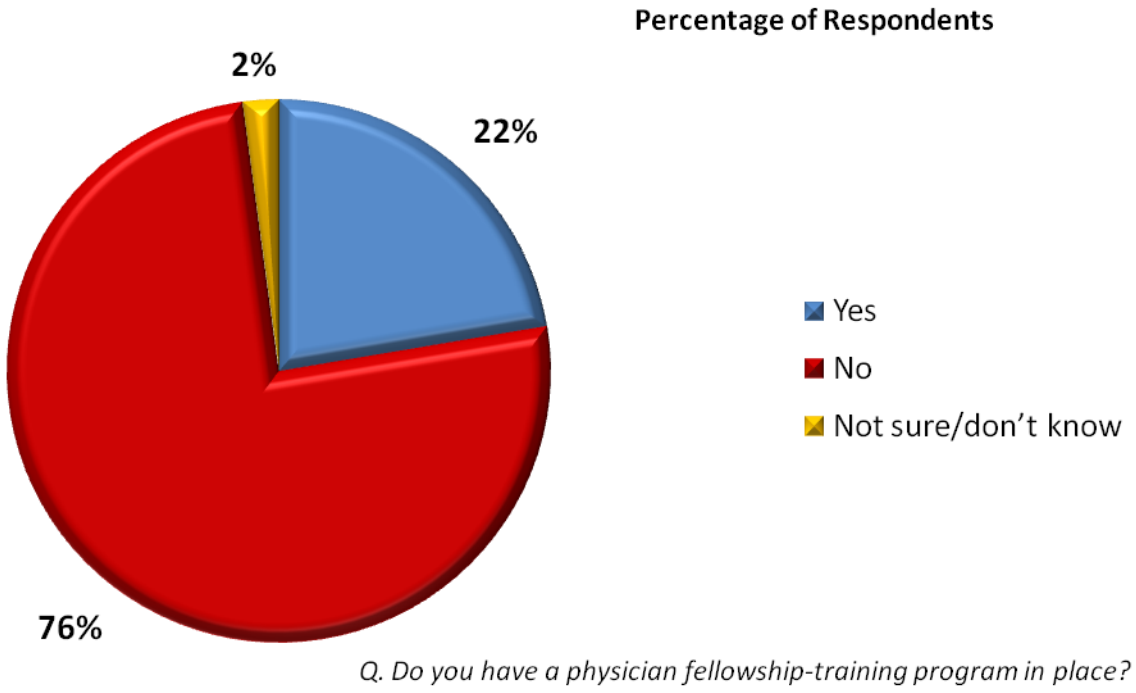
Q. Please allocate the percentage of patients with each of the following types of insurance being treated by your program

Section 3.10. Fellowship Training Programs

Consistent with previous surveys, most cancer programs that responded to the survey tend not to have residency and fellowship programs. Just 22 percent of respondents have a residency program or fellowship program affiliated with the cancer program.

Table 11.

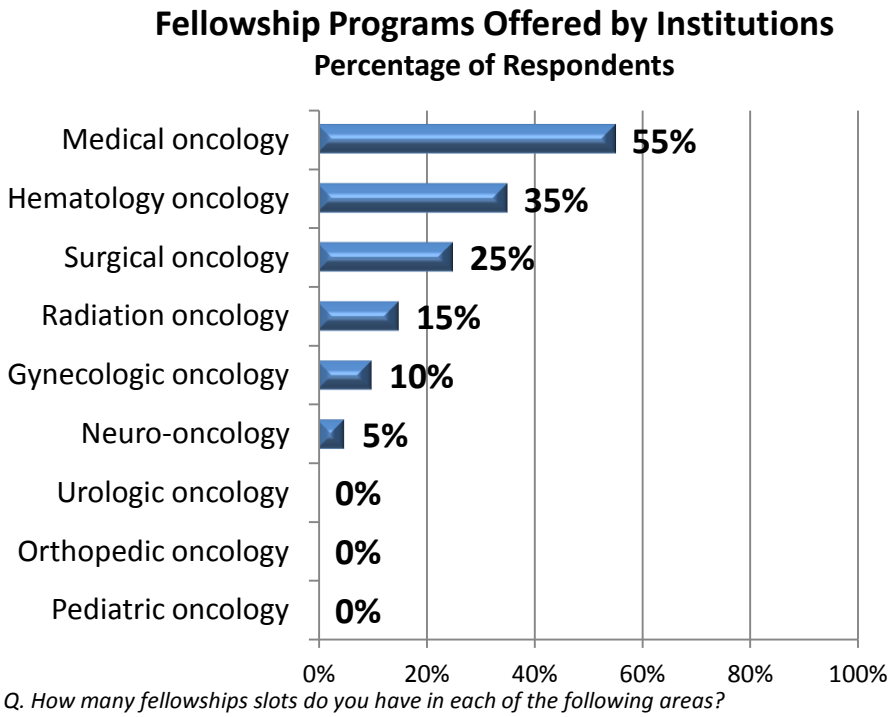
Institutions with a fellowship training program in place



Q. Do you have a physician fellowship-training program in place?

Table 12.

Fellowship programs by specialty



Q. How many fellowships slots do you have in each of the following areas?

Of the 22 percent of respondents that have fellowship and/or residency programs, medical and hematology oncology have the most slots.

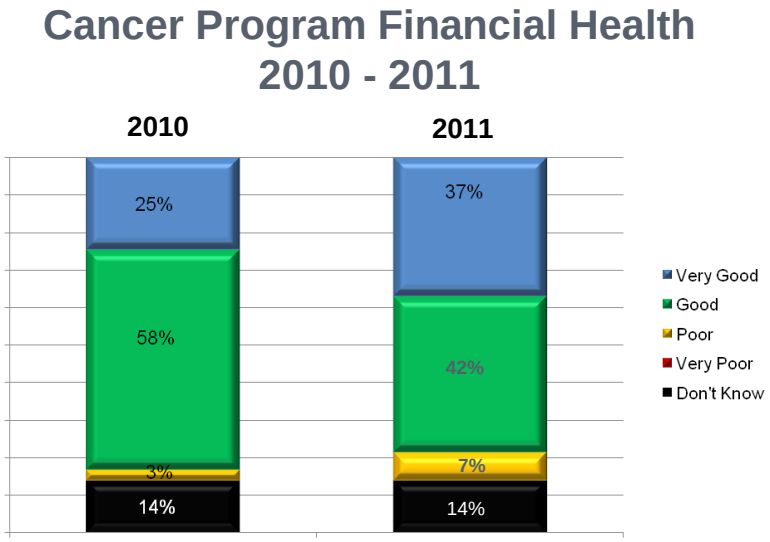
Section 4. Financial Status and Capital Equipment

Section 4.1. Overall Financial Status of Programs

Cancer programs were asked to compare their financial health in 2010 with that in 2011. Almost 80 percent of respondents report their program's financial status as good to very good in 2011 (Table 13), a slight drop from the 83 percent who rate their program's financial health as good to very good in 2010. More respondents (37 percent) report very good financial health in 2011 compared to 25 percent in 2010. This better bottom line may be due to more consolidation with oncology practices and a clearer understanding of the current and near-future reimbursement climate.

Table 13.

Cancer programs are positive about their financial position today. Many see multiple ways they can grow revenues and manage costs in the near future.



"By acquiring the community oncology practice, we now not only get the uninsured, but we also get the insured patients."

"During the last couple of years radiation oncology protocols were under review, which led to a lot of weeping, wailing, and gnashing of teeth around IMRT. The cuts weren't as bad as we expected."

"Cancer care is recognized as doing well within our institution. There is more stability this year, and we know the rules of the game."

Q. How would you characterize the overall financial status of your cancer program in 2010 versus 2011?

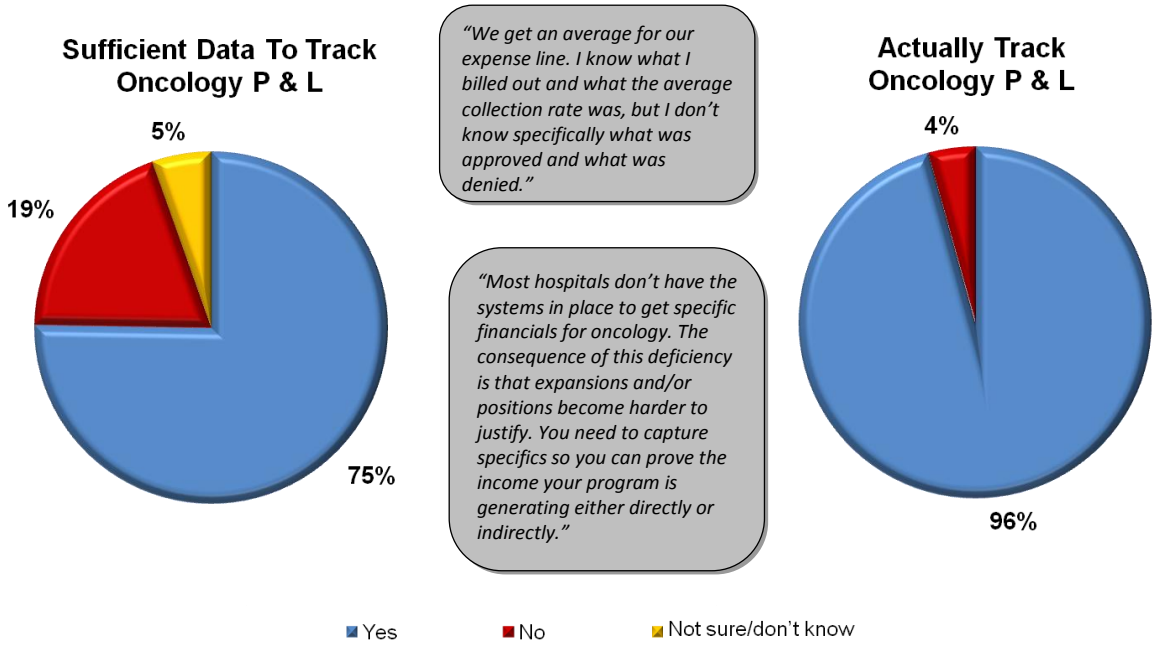
In this year's survey, 75 percent of respondents report that they do have sufficient data to track profit and loss (Table 14). Of those that do have sufficient data to track oncology P&L, almost all actually track it.

A number of administrators stated that they need more real-time and granular data since their current tracking system uses trending data over time. "Most hospitals don't have the systems in place to get specific financials for oncology," wrote one respondent. Unlike a community oncology practice setting, which tracks the economics of the practice with very specific cost information, hospital-based cancer programs may not have all the data they need to make business decisions.

Still, the percentage of respondents (75 percent) that have such tracking data is higher than in previous years' surveys, which had been fairly consistent at 63 to 66 percent over the previous three years of surveys.

Table 14.

While cancer programs have information that can track profits and losses, most programs only see a portion of the cancer care picture within their institution.



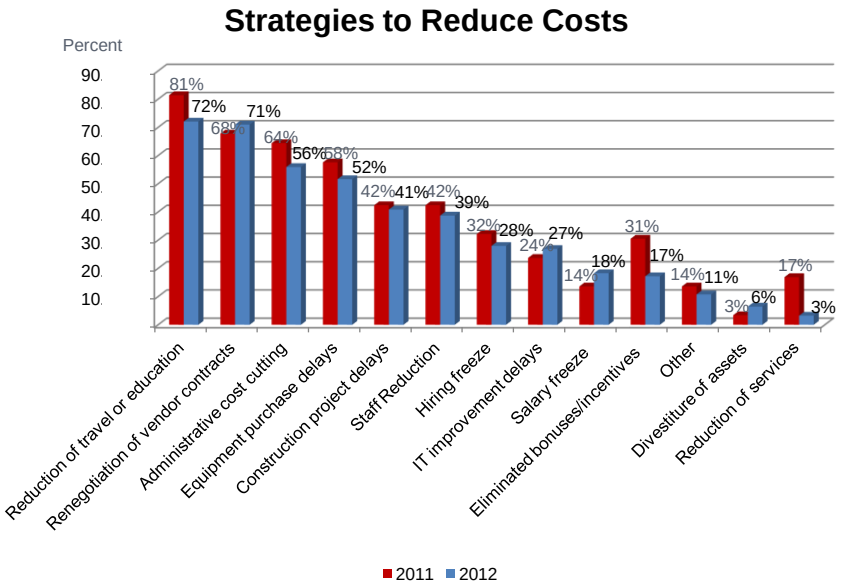
Q. Do you have sufficient data to track the Profit & Loss of the oncology program?
Q. Do you track the Profit & Loss of the oncology program?

Section 4.2. Strategies to Control Costs

Cost containment and cost reduction are key elements in maintaining financial stability within a cancer program. This year's survey results are consistent with Year 3 Survey results.

Table 15.

Cost reduction strategies vary by institution.



"Cost reduction strategies usually start as a hospital-wide initiative, and every area gets the same directives. If oncology services are driving growth and profits, we need to fight for a different approach."

"2012 looks a lot like 2011 because we have been trimming costs for some years now, and there is only so much that can be done without affecting revenues and retention."

Q. Which of the following strategies is your institution using to reduce costs?

Key strategies to reduce costs include reducing travel and conferences, renegotiating vendor contracts, cutting administration, and delaying capital expenditures.

Reducing costs through people management can impact retention and employee morale and are used less frequently than other cost-reduction strategies. Less than one-third of respondents report hiring freezes or elimination of bonuses or incentives, and fewer still report salary freezes.

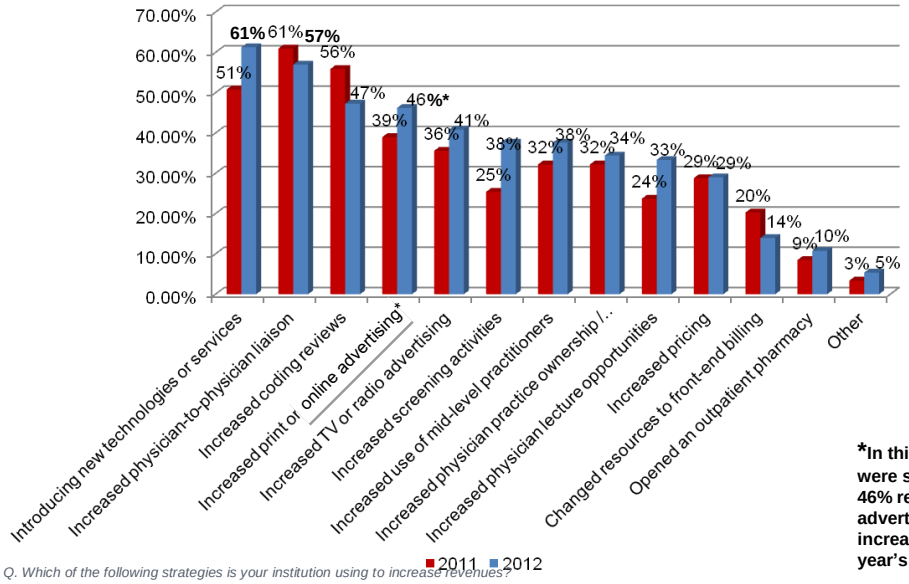
Section 4.3. Strategies to Increase Revenue

The addition of new technology and new service lines continues to be part of most cancer programs' revenue strategy. Sixty-one percent of institutions report introducing new technologies and service lines—up from 51 percent in Survey Year 3.

Table 16.

New technologies and services offer additional revenue streams to hospitals. These new technologies often work hand in hand with a hospital's strategy to capture higher share of patients within their market.

Strategies to Increase Revenues



"Varian had a recent system update that caused us to upgrade our radiation platform such that our radiation services and revenues increased."

***In this year's survey, print and online were separated into two questions. 46% represents increasing print advertising only. 39% of respondents increased online advertising in this year's survey.**

Q. Which of the following strategies is your institution using to increase revenues?

Fifty-seven percent of institutions used their physician-to-physician liaison strategy to help increase their revenue. 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 and help capture a higher share of patients within the market.

Additional strategies to boost revenue include increased coding reviews, increased advertising, increased screening activities, and increased use of mid-level practitioners.

Section 4.4. Capital Equipment Expansion and Replacement Plans

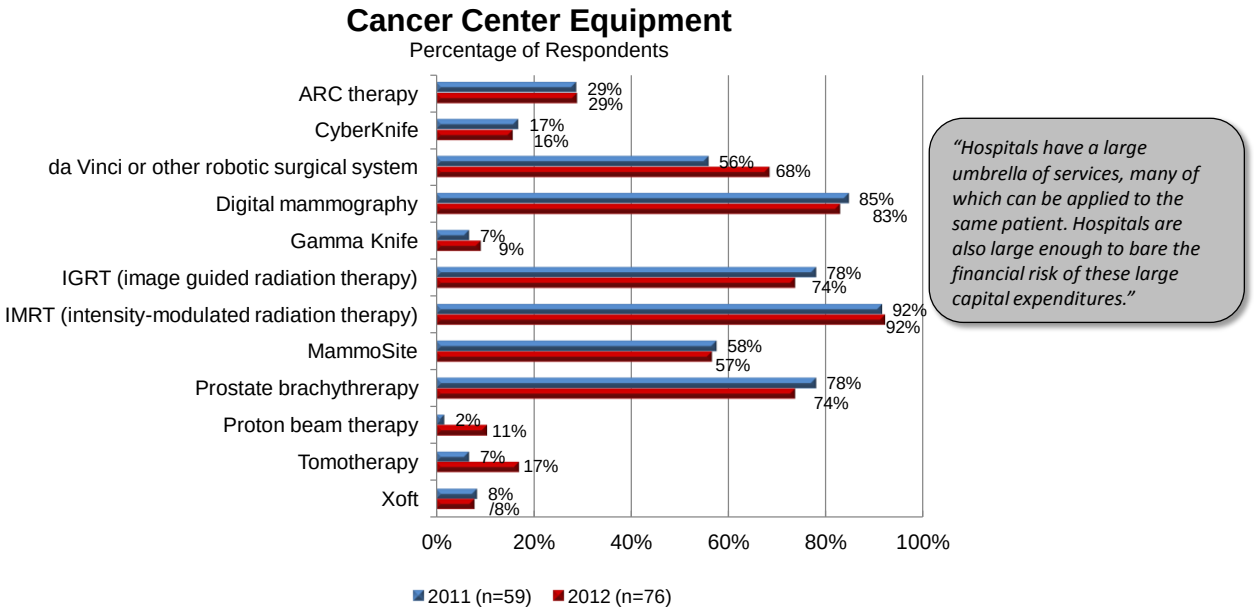
Ninety-two percent of responding cancer programs offer IMRT, consistent with last year's survey results, and 83 percent offer digital mammography. In the current survey, da Vinci and other robotic surgical systems jumped to 68 percent of programs offering the services, up from 56 percent in the previous survey. Proton beam therapy showed a jump from 2 to 11 percent.

Forty-two percent of respondents indicated their program offers radiofrequency ablation (RFA) (not shown in table), and 4 percent have included equipment for RFA within their budgets for next fiscal year.

Use of specialized services by patients can lead to the use of other services within the cancer program as well.

Table 17.

Technologies, such as robotic surgery, proton beam therapy and tomotherapy, are increasing because they not only lead to additional revenues from the service itself, but often can lead to the use of other patient services as well.

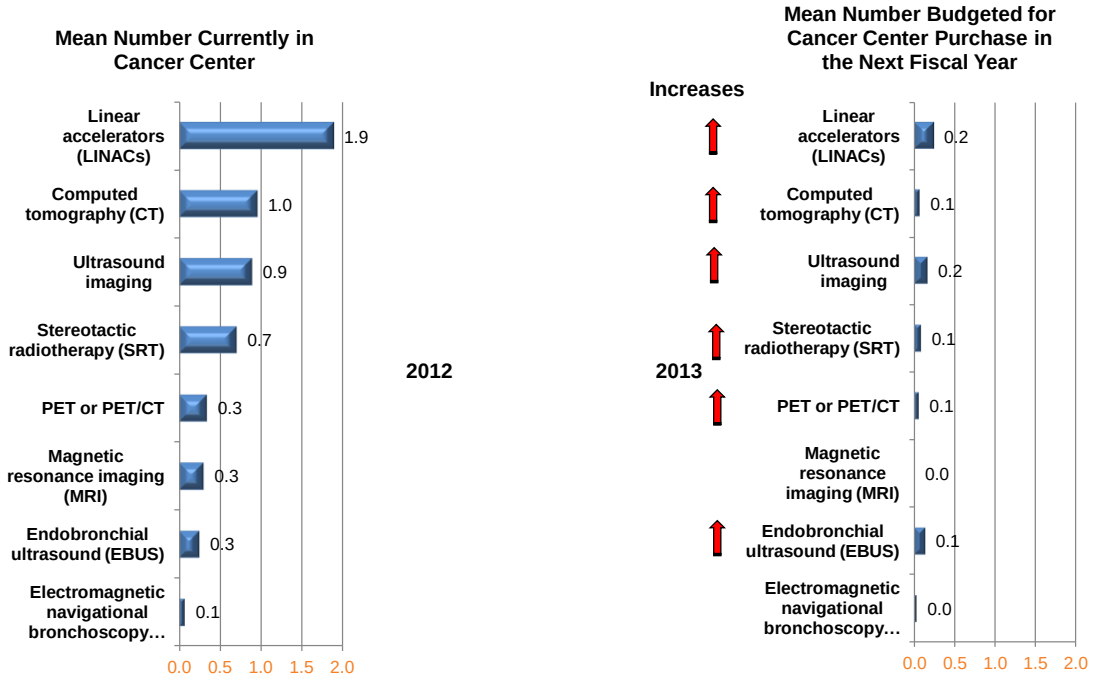


"Hospitals have a large umbrella of services, many of which can be applied to the same patient. Hospitals are also large enough to bare the financial risk of these large capital expenditures."

Q. Which of the following does your program offer?

Table 18.

Purchasing additional capital equipment that expands services can certainly increase revenues, but whether the equipment purchase stays in the budget and is actually purchased depend on many factors.



Q. How many of the following equipment is available in the cancer center?
Q. How many are budgeted for next year?

Purchasing additional capital equipment and technology is a sign of a healthy business. This year's study shows that cancer programs are, on average, anticipating increased capital equipment purchases in the next fiscal year. For example, the mean number of linear accelerators is 1.9 within reporting institutions. The mean number budgeted for purchase in 2013 is 0.2, an increase of 10 percent.

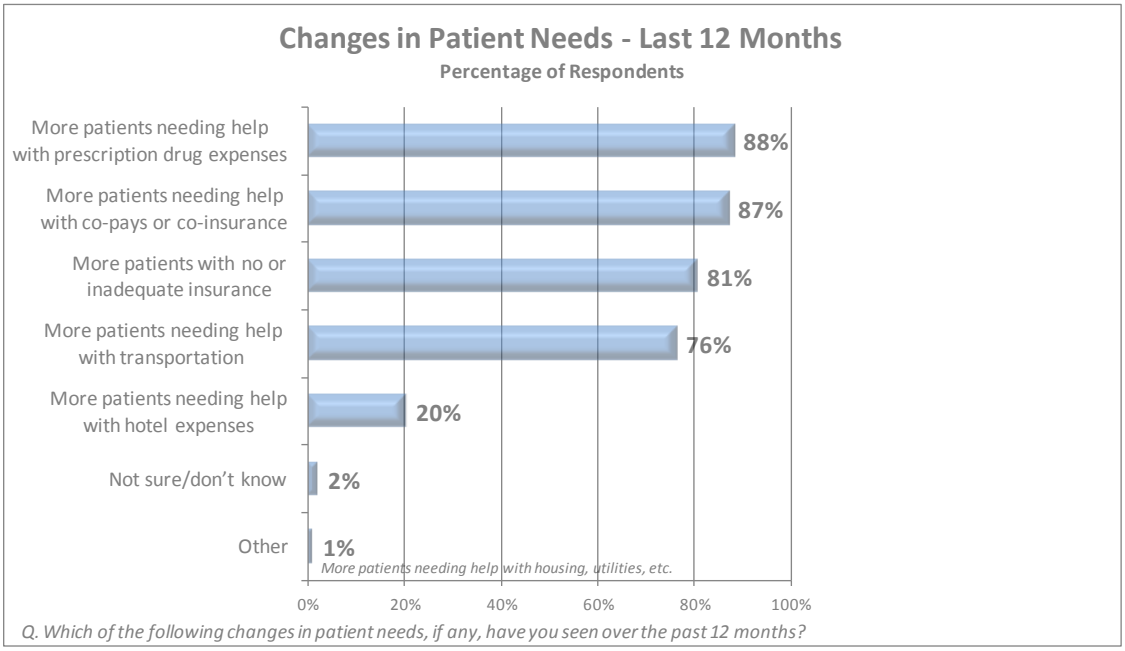
Section 5. Impact of the Economy on Patients

Section 5.1. Changes in Patient Needs

Within a slow-growth economic environment and higher than usual unemployment, respondents report that more patients need help with prescription drug expenses and with co-pays or co-insurance (Table 19). At the same time, cancer programs report seeing more patients with no or inadequate insurance.

Table 19.

Many patients are still seeking help with expenses and insurance.



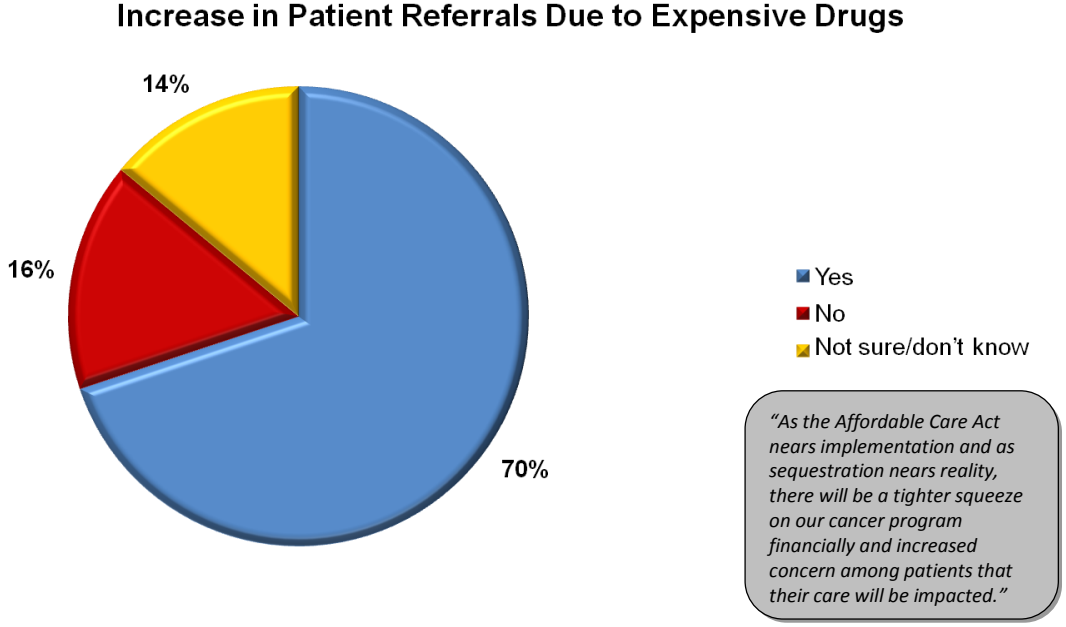
The trend, however, seems to be slightly fewer patients in need than last year.

Percentage of Programs Reporting Patients Needing More…

	Year 3	Year 4
Help with Prescription Drug Expenses	90%	88%
Help with Co-pays and Coinsurance	95%	87%
Help with Transportation Expenses	80%	76%
Help with Hotel Expenses	31%	20%

Table 20.

Hospitals continue to be the safety net for patients without adequate insurance/resources to pay for their cancer therapy.



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

Seventy percent of respondents to this year's survey (Table 20) state that they are seeing more patients referred from oncology practices to the hospital-based cancer program for expensive drugs that the patients are unable to pay for. Some community-based practices may be unwilling to take the risk of not being reimbursed for services, according to some administrator respondents.

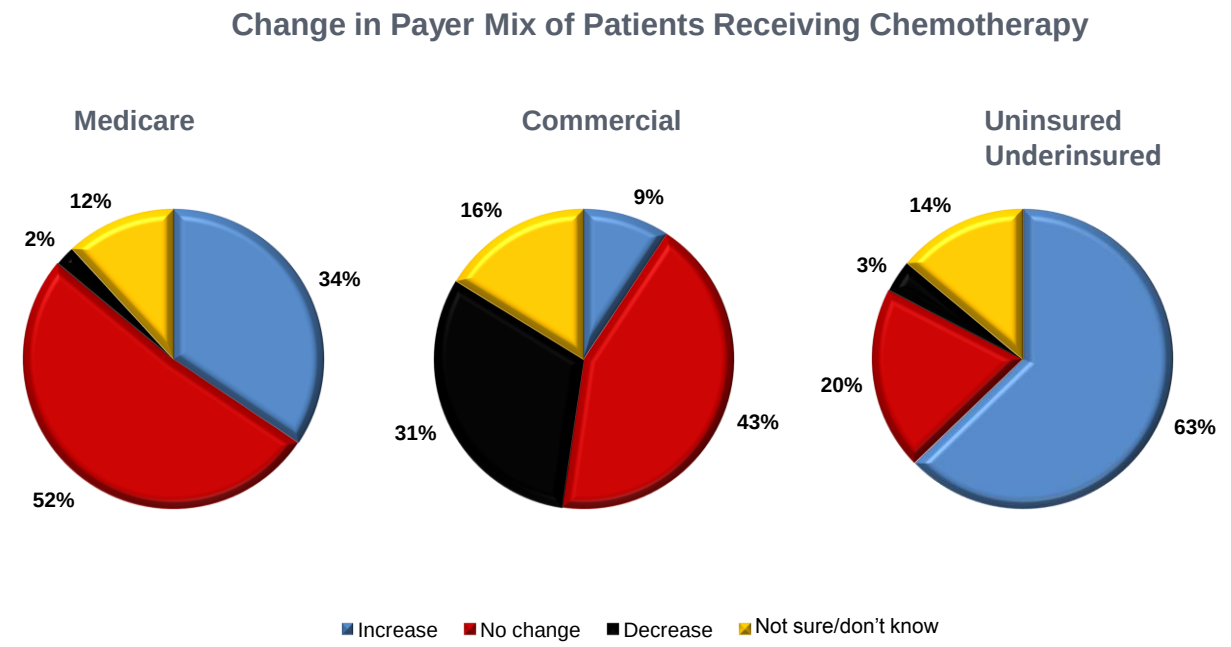
Again, the trend is downward in terms of referrals based on inability to pay for cancer drugs. In last year's survey, 83 percent of respondents saw more patients referred based on an inability to pay for cancer drugs.

Note that most cancer programs (88 percent) offer financial counseling to their patients (Table 6, page 11).

Thirty-four percent of respondents (Table 21) indicate that they are seeing an increase in the number of patients in Medicare who receive chemotherapy. At the same time, 31 percent report a decrease in commercial payer chemotherapy infusions, and 63 percent report an increase in the number of uninsured and underinsured cancer patients receiving chemotherapy.

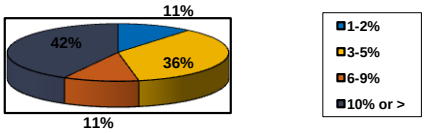
Table 21.

Respondents note a decrease in the number of patients without commercial insurance and an increase in the number of uninsured/underinsured. Once the ACA is implemented in 2014, these percentages may change.

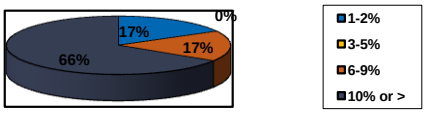


Q. Have you seen a change in the number of Medicare patients for whom you provide chemotherapy infusions?
Q. Have you seen a change in the number of commercially insured patients for whom you provide chemotherapy infusions?
Q. Have you seen a change in the number of uninsured or underinsured patients for whom you provide chemotherapy infusions?

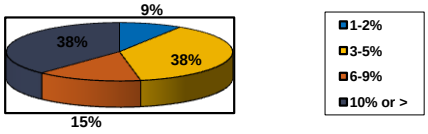
By What Percentage Has the Number of Medicare Patients Increased?



By What Percentage Has the Number of Uninsured Patients Increased?



By What Percentage Has the Number of Commercially Insured Patients Decreased?



Note that two-thirds of those who responded saw a 10 percent or greater increase in the number of uninsured or underinsured patients receiving chemotherapy.

When asked to which programs they refer needy patients, 62 percent responded to pharmaceutical-sponsored programs, 20 percent to not-for-profit programs such as NeedyMeds, and 16 percent to advocacy organizations, such as the Patient Advocate Foundation.

As we look at decreasing numbers of patients within commercial payer plans and increasing numbers of uninsured, we can hope that implementation of the Affordable Care Act in 2014 may reverse the trends.

Section 6. Consolidation

When asked if their oncology program has merged, affiliated, or acquired another cancer program, 19 percent reported consolidation through affiliation, 10 percent through acquisition, and 5 percent through merger in the past year.

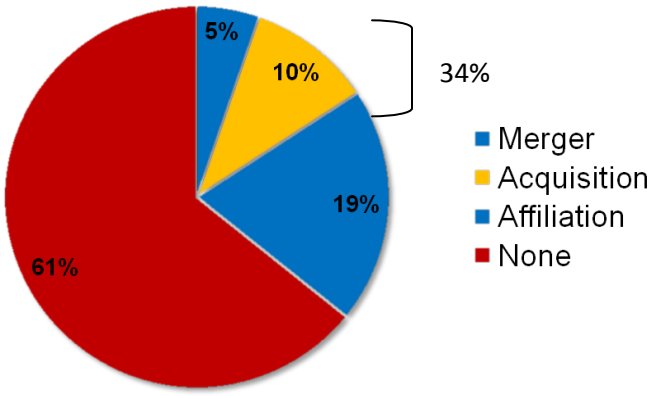
Table 22.

Consolidation continues. One out of every three respondents were involved in a merger, acquisition or affiliation of cancer programs in just the last year alone.

Programs Involved in Mergers, Acquisitions, and Affiliations
2012
Percent Respondents (n = 93)

"We have counted 720 individuals steps (and are still counting) that it takes to integrate a community practice into a hospital, which includes everything from people to processes to IT."

"I think the predominant centers treating cancer patients in a few years will be hospitals and very large community practices, because they will be the only organizations able to handle the risks and complexities given where cancer care is headed."



Q. Within the last year has your program merged with another cancer program?
Q. Within the last year has your program affiliated with another cancer program?
Q. Within the last year has your program acquired another cancer program (or part of another program)?

When cancer programs were asked if they have seen consolidation of cancer programs in their primary market area over the last year, 30 percent answered yes (Table 23). Forty-two percent of respondents have seen consolidation of physician practices in their primary market area.

When asked if they expect consolidation in the next one or two years, 40 percent answered that they expect consolidation of cancer programs and 46 percent expect consolidation of physician practices.

Table 23.

Consolidation: Mergers and Acquisitions in Primary Marketplace

Present - Last Year

Type	Yes	No	Don't Know
Cancer Programs	30%	67%	3%
Physician Offices	42%	52%	6%

Future – Next 1-2 Years

Type	Yes	No	Don't Know
Cancer Programs	40%	46%	14%
Physician Offices	46%	41%	13%

Hospital Respondents = 92

Section 7. Staffing

7.1. Physician Staffing

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. The mean number of FTE medical/hematologic oncologists in Survey Year 4 jumped to 5.1 (Table 24) compared to 2.9 in Survey Year 3, while the mean number of FTEs in professional service contracts fell from 1.4 last year to 0.7 in this year's survey. Mean number of FTE radiation oncologists jumped to 1.8 in this year's survey from 0.9 in Survey Year 3.

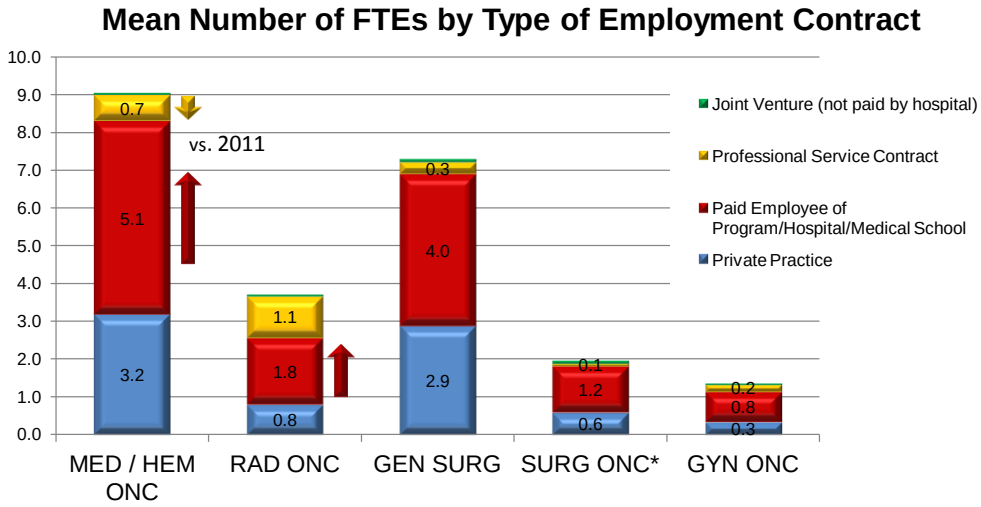
Survey results show that the majority (57 percent) of medical oncologists are employees of the hospital and 36 percent are in private practice (not shown in table). The remaining 7 percent have a professional service contract with the hospital.

Forty-eight percent of radiation oncologists are paid employees of the hospital. Another 30 percent have a professional service contract with the hospital, and only 22 percent are in private practice.

The trend is for the hospitals to have physicians as paid employees. There are extremely few joint ventures.

Table 24.

Consistent with hospital acquisitions, the number of oncologists and radiologists that are hospital employees is growing, while the number of service contracts is declining.



Q. Please indicate the number of full-time equivalent positions (FTEs) for each type of contractual relationship between the physician and the cancer program/hospital for each type of physician

As office-based physicians continue to create arrangements with hospitals, two forces are at work: financial pressures and a demographic shift.

Increasingly expensive anticancer therapies and more patients who are uninsured or underinsured continue to squeeze physician practices financially. With reimbursement decreasing in the physician office setting, joining forces with the hospital may provide opportunities to continue to provide community-based care in the physician office. Accountable Care Organizations (ACOs) may be accelerating the shift in site of service. Currently many of the approved ACOs are hospital-centric systems.

Another driver of change is a demographic trend in favor of employment. Younger healthcare providers, in general, are comfortable with hospital employment. This is a different scenario from 10-15 years ago, when providers seemed to have more entrepreneurial interest in establishing their own practices.

How Are Programs Supporting Community Oncologists Who Are *Not* Paid Employees?

	Last Year	This Year
↓ Medical director fees	55%	48%
↓ Clinical research support	51%	46%
↓ Leased space in or adjacent to hospital	45%	28%
↑ Lease employees from the hospital	6%	7%
←→Increased pay for on-call services to hospital	6%	6%
←→ Partnering on equipment purchases	4%	4%

Section 7.2. Nurse Staffing

Nursing accounts for 24 percent of the non-physician staff in responding cancer programs. The mean number of FTE nurses is 17.5 (Table 25).

Section 7.3. 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 (Table 25). See Appendix for percent of hospital staff by FTE position.

Table 25.

Hospital Staffing

FTEs	Respondents	Mean FTEs
RN in total	60	17.5
RN with oncology nursing certification	61	11.2
Nurses focused on chemotherapy administration	61	10.1
Administrative staff	55	8.2
Non-physician diagnostic radiology	42	5.9
Radiation oncology technician	62	5.9
Non-physician laboratory staff	50	3.7
Billing and collection	47	3.0
Clinical research personnel	60	2.5
Nurse patient navigators	62	2.0
Dosimetry personnel	62	2.0
Medical physicist	62	1.9
Pharmacists supporting the cancer center	60	1.6
Senior administrative/executive management staff	63	1.5
Nurse practitioners	61	1.3
Oncology coders/billing coders	56	1.3
Physician extenders	62	1.2
Pharmacy technician	51	1.2
Lay person patient navigators	62	1.0
Psychologist or social workers focused on mental health	56	1.0
Oncology social worker or other focused on financials	58	1.0
Rehabilitation/wellness personnel	50	0.9
Nutritionists or dietitians	58	0.8
Genetic counselor	61	0.6
Non-mental health (e.g., case managers)	58	0.6
Survivorship personnel	61	0.5
Social worker patient navigators	62	0.4

Section 7.4. Staffing Acuity Systems

In this year's survey one out of three (33 percent of respondents) indicate using an acuity-based system to determine staffing levels, compared to 20 percent in last year's survey and 36 percent in the first year of the survey. Such systems can decrease turnaround times, improve patient flow, and make a difference in operations.

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.

Section 8. Infusion Center and Pharmacy

Section 8.1. Infusion Center

The mean numbers of infusion beds/chairs are 20 (hospital-owned) and 1 (included in the cancer program but not hospital-owned). This number continues to grow from 17.9 (hospital-owned) and 2.9 (included in the cancer program but not hospital-owned) in last year's survey.

Table 26.

Number of Infusion Chairs

Number of Infusion Chairs/ Hospital	Percentage of Hospitals
0-10	15%
11 - 20	42%
21 – 30	24%
31 – 40	13%
41 - 50	4%
> 50	1%

78 hospitals responded

The average FTE nurse to patient ratio in the infusion center is 1:4. The mean number of FTE nurses per infusion patient per day is 1:5.

Programs report daily rates of an average of 8.2 infusion patients per chair per day. This is a significant jump from last year's survey when reported daily rates averaged 5.5 infusion patients per chair per day. Consolidation of the marketplace may explain some of this increase.

Thirty-eight percent of respondents are looking to expand their infusion services, down from 46 percent in last year's survey, and 32 percent plan to expand to a satellite facility. 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.

The majority of cancer programs report administering chemotherapy Monday through Friday, probably the most efficient use of both personnel and equipment.

Table 27.

Hospital Infusion Days

Infusion Days/Week	Percentage of Hospital Utilizing
4 Days	3%
Monday – Friday (5 Days)	81%
Monday – Saturday (6 Days)	6%
Monday – Sunday (7 Days)	10%

78 hospitals responded

When asked if the infusion center restricts access to any injectable cancer drugs, preventing or limiting their use, almost half (49 percent) answered no, while 26 percent said yes, and 25 percent did not know.

When asked if the infusion center treats cancer patients as well as patients with other disorders, 63 percent responded yes.

This year's survey	**Percentage**
Cancer only	4
Cancer and hematology	29
Cancer and other disorders	63
Don't know	4

Last year's survey	Percentage
Cancer only	2
Cancer and hematology	15
Cancer and other disorders	78
Don't know	5

Section 8.2. Pharmacy

Sixty-eight percent of respondents report having a dedicated pharmacy in ambulatory outpatient services.

Most respondents (77 percent) report that pharmacy personnel mix chemotherapy drugs, not nurses. Two percent are mixed by nursing, while 8 percent of respondents report a combination of pharmacy personnel and nursing mix chemotherapy drugs. 13 percent of respondents do not know who mixes chemotherapy drugs.

About half of mixing pharmacies are located in the infusion center, while 36 percent are located in the hospital pharmacy. Most often (61 percent), mixing occurs in the infusion center, followed by the hospital pharmacy (32 percent). Just 2 percent mix in other locations and 5 percent do not know where mixing takes place.

Who bills for infused drugs? Mostly (88 percent) hospitals, followed by the physician practice (9 percent), with 3 percent of respondents not knowing. In last year's survey respondents reported that hospitals accounted for 76 percent of billing, followed by the physician practices (19 percent), with 5 percent not knowing.

For 72 percent of programs, the drug budget resides in the pharmacy, compared to 21 percent in the oncology program budget.

Most medication purchasing (88 percent) is done by the pharmacy department. Just 8 percent is conducted by general materials management or hospital purchasing.

48 percent of programs report purchasing their drugs through multiple distributors, up slightly from last year's survey (42 percent).

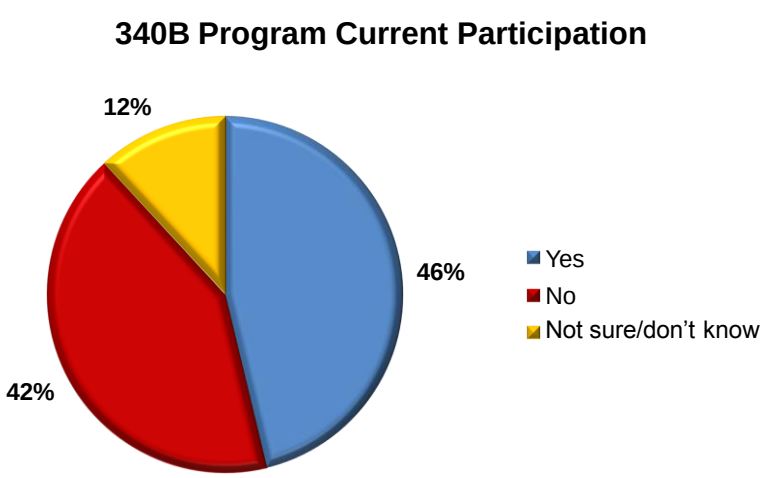
One in four programs accepts injectable drugs supplied by specialty pharmacies, down from one in three in last year's survey (Table 32, page 40). (A sizable percentage of respondents, 20 percent in this year's survey, were not sure.) Accepting injectables from specialty pharmacies presents challenges for cancer programs with regard to operations, reimbursement, patient safety and institutional liability.

Section 8.3. Participation in the 340B Drug Discount Program

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. Some respondents report an increase of local oncology practices seeking affiliation in order to access the economic benefits of the program.

Table 28.

While 94 percent of responding institutions are not-for-profit, less than half participate in the 340B Program. Participation will likely grow as the Affordable Care Act funds millions more Medicaid patients beginning in 2014.



"340B is a tremendous program that helps us level the playing field with the independent private practices. These are the same practices that refer the indigent patients to hospitals."

"The 340B program is a black hole inside of our pharmacy department. We know it's a good program for the hospital, but that is about the extent of it."

Q. Are you participating in the 340B Drug Discount Program?

Participation in the 340B Drug Discount Program among survey respondents is at 46 percent, the same percentage as in last year's survey. All those currently participating in the 340B Program plan to continue their participation in the future.

Although 340B Program administration can be difficult at first, ACCC members note that administration becomes easier once the program is up and running.

In general, growth in the number of 340B hospital sites has accelerated over the past three years. (For more information about the growth of 340B hospital sites, see note in Appendix, page 52, within this report.) The rapid growth in the last three years is due to the change in the legislation that allowed 340B entities to contract with more than one pharmacy. We would anticipate participation to grow due to

increased awareness about the program and the fact that the Affordable Care Act will fund millions of additional Medicaid lives in 2014.

Section 8.4. Use of Reimbursement Specialists

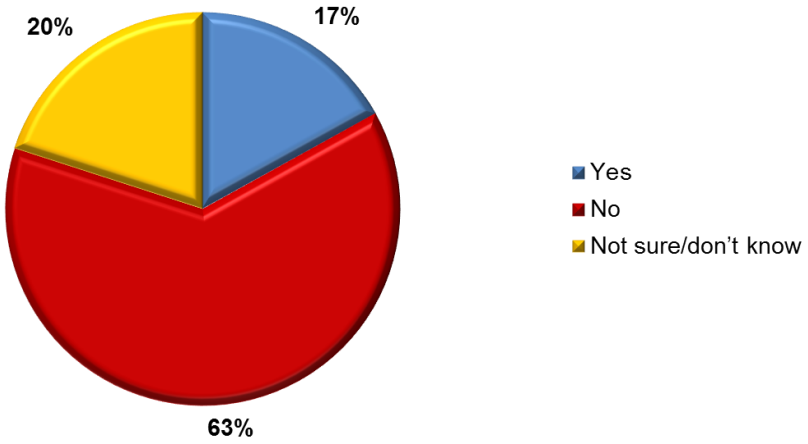
Sixty-three percent of respondents do *not* use commercial reimbursement specialists within their organizations (Table 29), suggesting a missed opportunity to ensure full payment for services. Just 17 percent do utilize reimbursement specialists.

To improve the percentage of claims that are submitted correctly and help ensure proper (and full) reimbursement for services provided, cancer programs must increase coding reviews, ensure that charges are supported by correct documentation, confirm that all services are billed, ensure that any service they provide is fully reimbursed, and research denials.

Table 29.

Because of how most hospitals are organized, often there is a lack of communication and coordination between the cancer program and billing that can lead to missed opportunities for coverage and reimbursement.

Use of Commercial Reimbursement Specialists



"Many hospitals have this kind of culture where there is this big bucket of money that allows us to manage our budgets in a way that does not always have to be efficient."

"Systems aren't geared for specific financials, and therefore it is often hard to get the necessary feedback that would drive change – like denials."

Q. Have you used commercial reimbursement specialists?

The use of commercial reimbursement specialists is much higher within the private practice setting. As more consolidation takes place in the marketplace and as more physician practices establish relationships with hospitals, it will be interesting to keep a close watch on the utilization of reimbursement specialists within the cancer program setting.

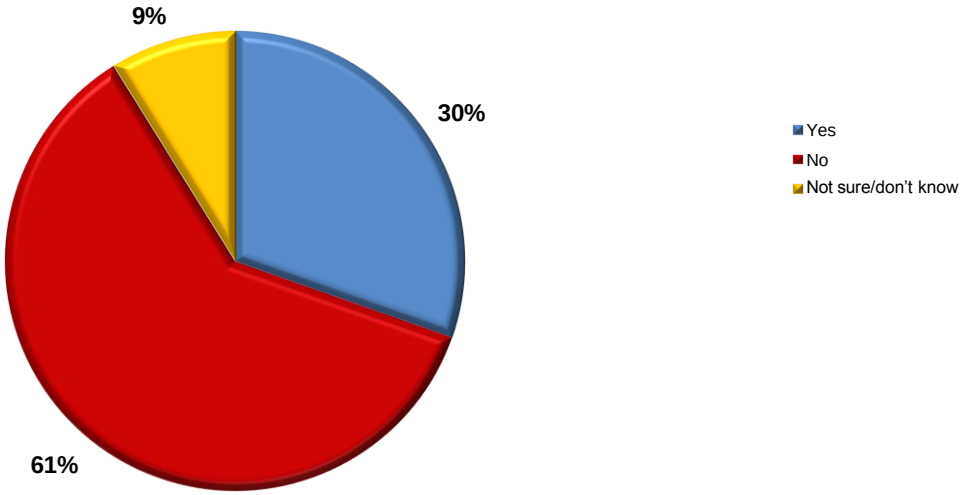
Section 8.5. Oral Cancer Drugs

About one-third of infusion centers (30 percent) dispense oral cancer drugs (Table 30), similar to the 31 percent in last year's survey.

Table 30.

Only 1 in 3 cancer programs dispenses oral cancer medications for use outside the facility.

Percentage of Dispensers of Oral Cancer Medications



Q. Does your program dispense oral cancer drugs (eg, Tarceva, Sutent, Femara, Xeloda) for use outside of your facility?

With a growing number of oral cancer compounds, cancer programs would seem a likely place to incorporate outpatient pharmacies on the facility site to dispense oral agents. However, the trend is to contract with retail pharmacies rather than invest in an onsite pharmacy to dispense oral cancer medications.

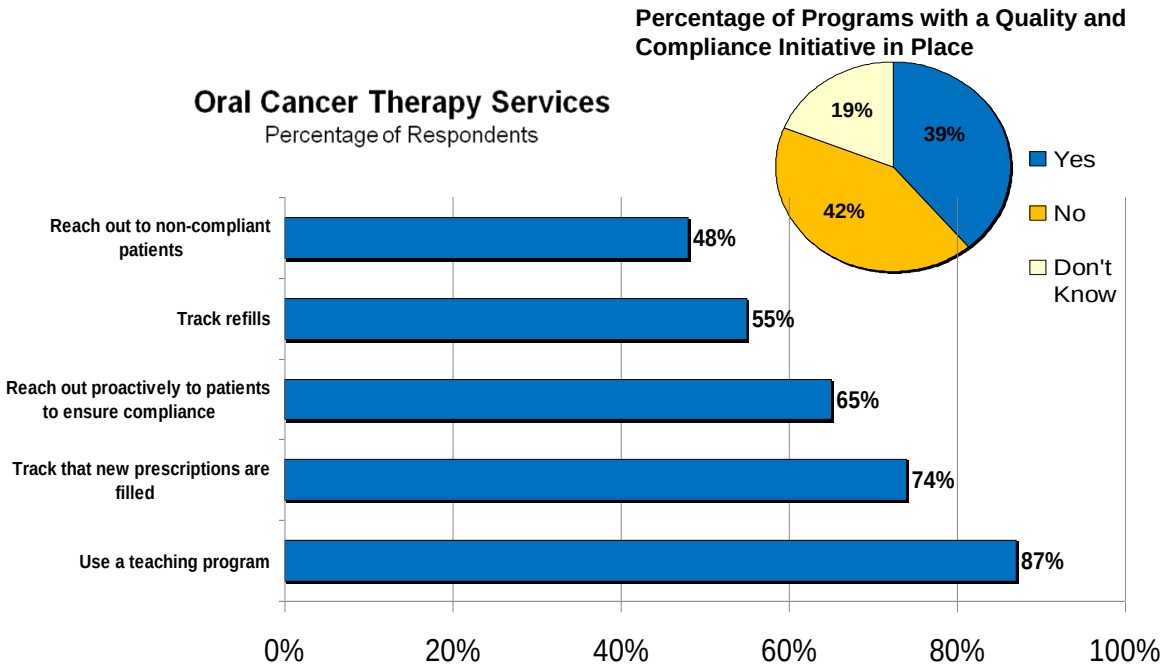
When asked if the hospital has a contract with a commercial payer that reimburses for oral cancer drugs that are dispensed, just 4 percent replied yes, while 69 percent said no and 27 percent were not sure.

While just 39 percent of programs have compliance programs in place for medications (Table 31), the percentage is higher than 24 percent in last year's survey.

A teaching program for patients is used by 87 percent of those with quality and compliance initiatives in place, while 74 percent track that new prescriptions are filled.

Table 31.

Teaching programs and tracking that new prescriptions are filled top the list of quality and compliance initiatives in place to help patients on oral cancer medications.



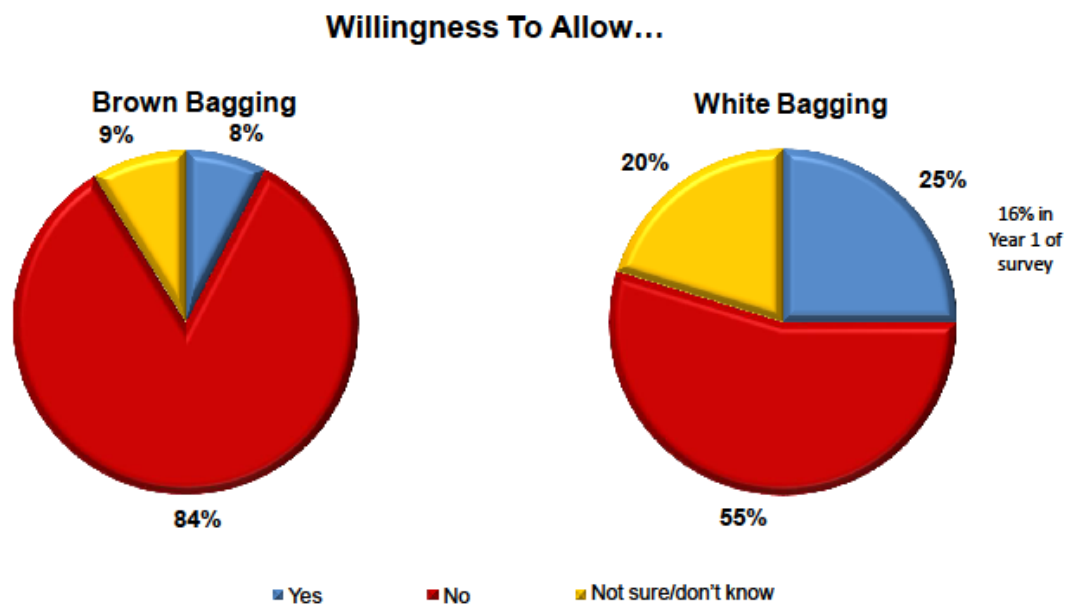
Q. Do you have quality/compliance initiatives related to oral cancer medications that you employ with patients?
Q. Which of the following services does this quality/compliance program: provide?

Section 8.6. Acquisition of Injectables through Specialty Pharmacy

"White bagging" is the practice of having patient-specific medications or supplies delivered directly to the practice setting (hospital outpatient infusion center or physician office) by specialty pharmacies for use by a specific patient. Acquisition of injectables from specialty pharmacies has increased over the last few years. In year 1 of the survey only 16 percent of cancer programs allowed specialty pharmacies to white bag or provide the medication. In this year's survey that number is up to 25 percent. Twenty percent of respondents are unsure about their institution's status.

Table 32.

Accepting product from specialty pharmacies is a growing trend, and not limited to just community practices. Hospitals have seen growth driven by payers over the 4 years of this survey.



Q. Do you accept patient-provided/patient-delivered drugs for infusion?
Q. Does your program accept injectable drugs supplied by specialty pharmacies

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.

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.

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. Just 8 percent of reporting programs allow brown bagging.

Section 9. EMR Systems

The use of electronic medical records (EMRs) is increasing, but is still not universal in community cancer programs. In the Year 4 Survey, 79 percent of respondents report utilization of EMRs, which is similar to 78 percent in last year's survey. Nearly two-thirds of programs report having two or more EMR software systems in place.

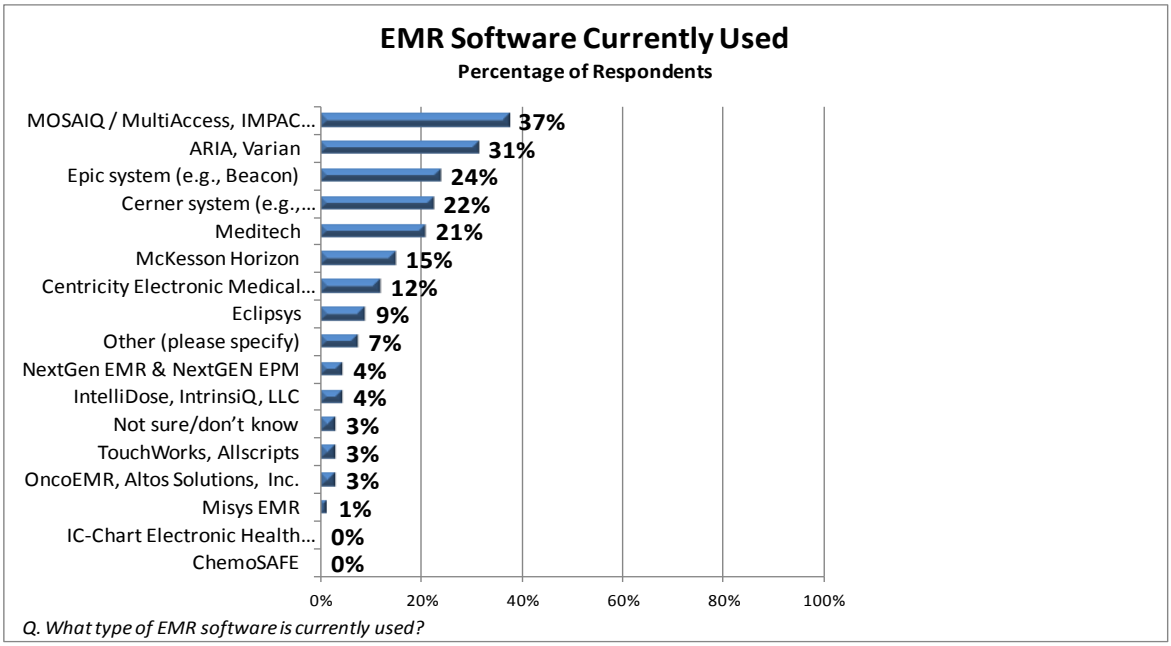
Twenty-three percent of cancer programs report they are in the process of implementing EMR/EHR systems. Four of every five programs that are in the process of implementing a system are either replacing or adding to an existing system.

Of those adding or replacing a system nearly 70 percent are implementing the Epic system.

MOSAIQ and Varian's ARIA are the most frequently used EMR software (Table 33). Radiation oncology departments frequently need separate EMR systems because their needs are not met by whatever system the chemotherapy operations are using.

Table 33.

Cancer programs use a wide variety of EMR software.



EMR use allows transparent and accountable reporting on delivered care as well as:

- 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.

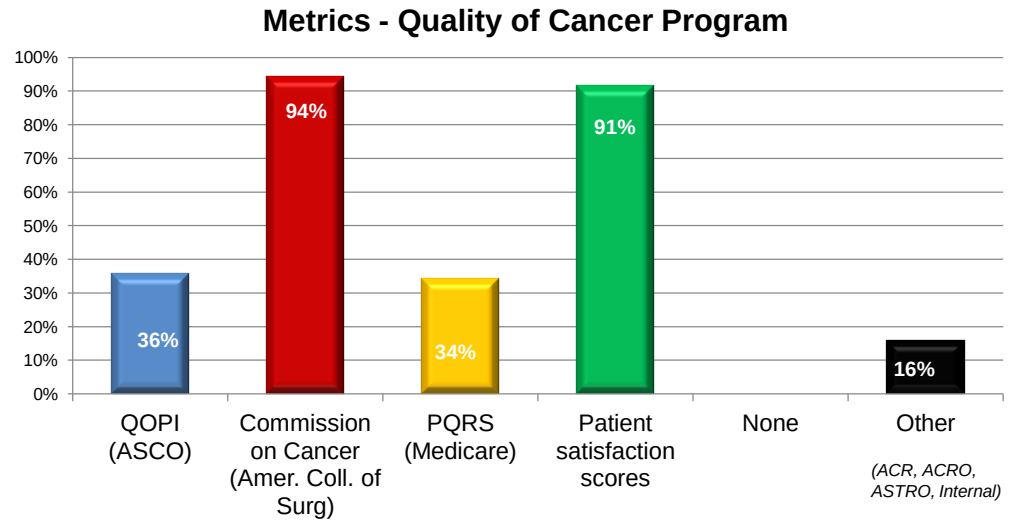
Section 10. Quality Metrics: Improving the Patient Experience

Although most cancer center programs report that they measure quality care, many also report that they are only beginning the process.

Commission on Cancer standards (94 percent) and patient satisfaction scores (91 percent) are high on the list of metrics that cancer programs use to measure quality care (Table 34). Thirty-six percent of respondents use the Quality Oncology Practice Initiative (QOPI) and 34 percent use the Physician Quality Reporting System (PQRS).

Table 34.

All hospitals measure quality in some way, and most standardize on what will lead to meaningful accreditation and better patient experiences.



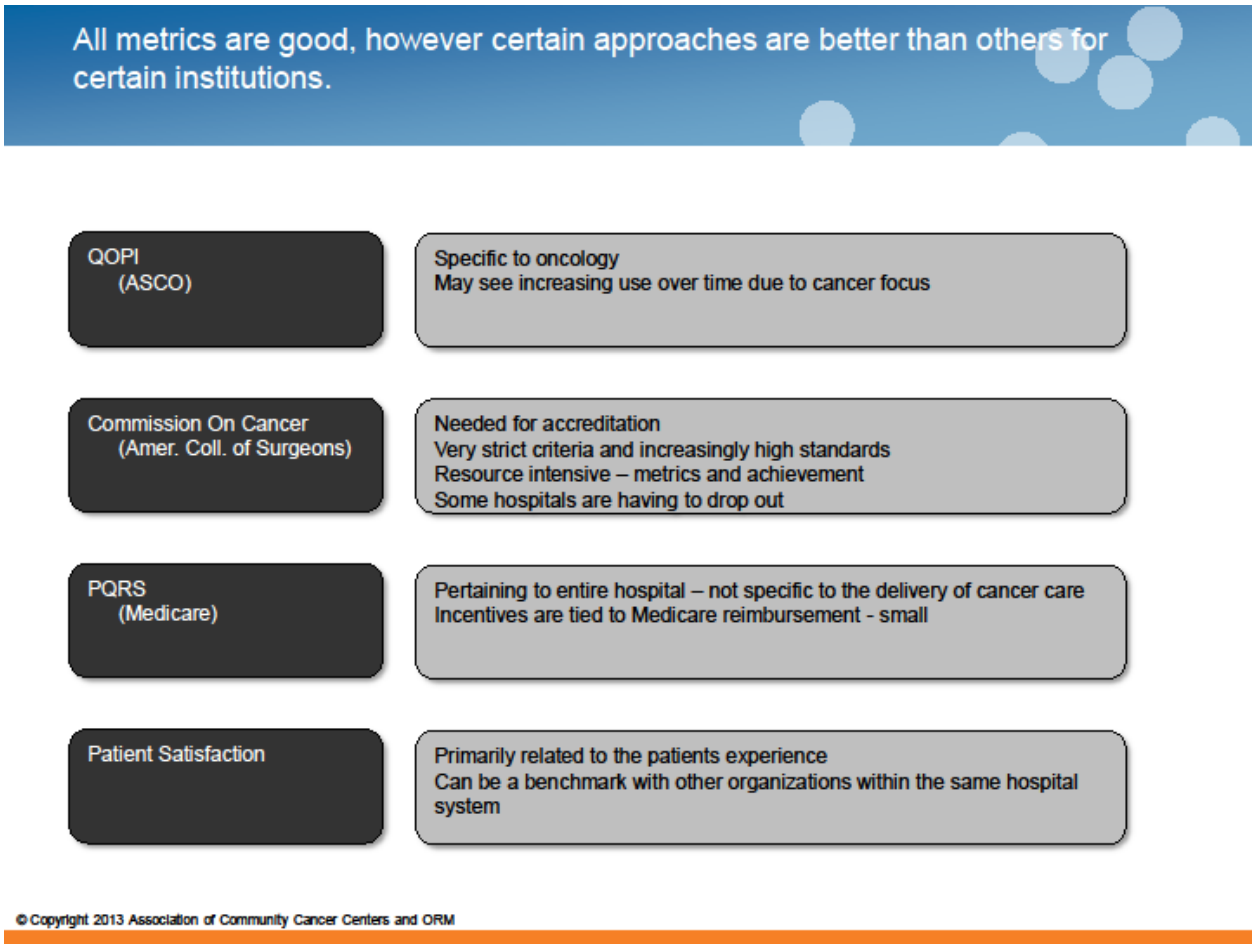
Q. What current metric(s) do you utilize to measure and track the quality of your cancer program(s)?

A fragmented healthcare system and inadequate connectivity of data systems mean that providers are looking at options such as nurse navigators and high-tech data collection to determine quality cancer care. Survival is no longer the sole element in determining quality.

At the same time, patients are demanding more data and user-friendly tools to assess the quality of their care. Patient-Centered Outcomes Research Institute (PCQRI) information is likely to strengthen the role of patients in cancer care decision making. Patients are interested in dimensions beyond survival

rates, including side effects of various treatment options and their impact on quality of life and functional status.

Table 35.



Most respondents (91 percent) are looking for guidance with regard to quality measures (Table 36).

Most institutions believe that establishing a program to measure quality of care is a journey that they must take and embrace.

Table 36.

Yet cancer programs recognize this is a journey that many have recently started, and are looking for guidance on improvements, particularly from those involved in the same journey.

Quality Metrics - Best Practice Sharing

"There is a lot to figure out regarding measuring quality appropriately, but unfortunately not a lot of experts in the area."

Yes
No

"My three tips for measuring quality cancer care: Make certain your program is integrated into the Quality and Safety Program of your health system. Develop quality indicators with physicians' input. Do not keep the successes internal to the program. Share them."

Q. Would you (or someone at your program) be interested in being part of a peer network related to measuring the quality of cancer care delivery in hospitals, for the purposes of sharing best practices?

Section 11. Appendix

Percent of Hospital Staffing by Position (FTEs)

	0	1 - 5	6 - 10	11 - 20	21 - 30	31 - 40	41 - 50	51 - 75	76 - 100	> 100
Non-physician diagnostic radiology	64%	14%	7%	10%	0%	0%	2%	0%	2%	0%
Radiation oncology technicians	13%	37%	37%	13%	0%	0%	0%	0%	0%	0%
Dosimetry personnel	11%	85%	3%	0%	0%	0%	0%	0%	0%	0%
Medical physicists	11%	84%	5%	0%	0%	0%	0%	0%	0%	0%
Physician extenders (i.e., RNP / PA, CNS)	52%	44%	5%	0%	0%	0%	0%	0%	0%	0%
Nurse practitioners	43%	56%	0%	2%	0%	0%	0%	0%	0%	0%
RN with oncology nursing certification	2%	46%	31%	8%	3%	2%	5%	2%	2%	0%
RNs in total	0%	15%	38%	23%	10%	2%	5%	3%	3%	0%
Pharmacists supporting the cancer center	13%	85%	2%	0%	0%	0%	0%	0%	0%	0%
Pharmacy technicians	20%	80%	0%	0%	0%	0%	0%	0%	0%	0%
Psychologists or social workers focused on mental health counseling	30%	66%	4%	0%	0%	0%	0%	0%	0%	0%
Oncology social workers or others focused on financial counseling	26%	74%	0%	0%	0%	0%	0%	0%	0%	0%
Non-mental health (e.g., case managers, etc.)	67%	33%	0%	0%	0%	0%	0%	0%	0%	0%
Non-physician laboratory staff	40%	56%	0%	0%	0%	2%	0%	0%	2%	0%
Genetic counselors	51%	49%	0%	0%	0%	0%	0%	0%	0%	0%
Rehabilitation / wellness personnel	68%	30%	0%	0%	2%	0%	0%	0%	0%	0%
Nutritionists or dietitians	16%	84%	0%	0%	0%	0%	0%	0%	0%	0%
Administrative staff (excludes billing and collections)	0%	58%	24%	15%	0%	0%	2%	0%	0%	2%
Billing and collection	32%	60%	4%	2%	0%	2%	0%	0%	0%	0%
Senior administrative / executive management staff for clinic	5%	92%	2%	2%	0%	0%	0%	0%	0%	0%
Clinical research personnel	17%	75%	5%	3%	0%	0%	0%	0%	0%	0%
Survivorship personnel	57%	41%	2%	0%	0%	0%	0%	0%	0%	0%

Percent of Hospital Staffing by Position (FTEs)

	0	1 - 5	6 - 10	11 - 20	21 - 30	31 - 40	41 - 50	51 - 75	76 - 100	> 100
Nurses focused on chemotherapy administration	5%	39%	34%	15%	2%	0%	2%	2%	0%	2%
Oncology coders / billing coders (dedicated to facility whether or not physically present)	34%	63%	4%	0%	0%	0%	0%	0%	0%	0%
Nurse patient navigators	21%	69%	10%	0%	0%	0%	0%	0%	0%	0%
Social worker patient navigators	73%	27%	0%	0%	0%	0%	0%	0%	0%	0%
Lay person patient navigators	74%	23%	2%	0%	0%	2%	0%	0%	0%	0%

Total Billed Charges in Fiscal Year 2011

Percentage	$
28%	< $5 mil
10%	$ 5 – 15 mil
10%	$16 – 25 mil
21%	$26 – 50 mil
14%	$51 – 100 mil
14%	$100 – 200 mil
3%	> $200 mil

What were the total billed charges for your cancer program in fiscal year 2011?

29 hospitals responded

Percentage of Annual Billed Charges for Cancer Center in 2011 by Payer

Medicare with Supplemental	29%
Medicare without Supplemental	15%
Medicaid	10%
Commercial & HMOs	28%
Charity Pay	4%
Self Pay	6%
Not sure	8%

2011 Expenses and Gross Service Charges

2011 Expenses	
Drugs	37%
Support staff	31%
Supplies	10%
Facility costs	7%
Other	5%
Not sure	10%

2011 Gross Service Charges	
Radiation services	27%
Drugs	26%
Drug administration	21%
Laboratory	5%
E&M services	4%
Not sure	17%

How Are The Following Services Funded?

Source of Funding	Genetic Counseling	Tissue Banking	Social Work Services	Psychological Counseling	Nutrition
General Operating Funds	71%	57%	91%	78%	91%
Endowment	3%	0%	1%	2%	1%
Philanthropy	4%	4%	2%	3%	3%
Grants	4%	21%	3%	2%	0%
State Funding	0%	4%	1%	0%	0%
Trial Sponsors	0%	29%	0%	0%	0%
Patient Pays	33%	4%	3%	22%	9%
Insurance	39%	4%	5%	30%	13%
Not Sure/Don't Know	3%	24%	0%	8%	0%

Q: Which of the following programs does the oncology service line offer/conduct? Select all that apply AND FOR EACH SERVICE LINE SELECTED, also select ALL the funding Sources?

Note that percentages do not total 100 percent because respondents were asked to list all sources of funding.

How Are The Following Services Funded?

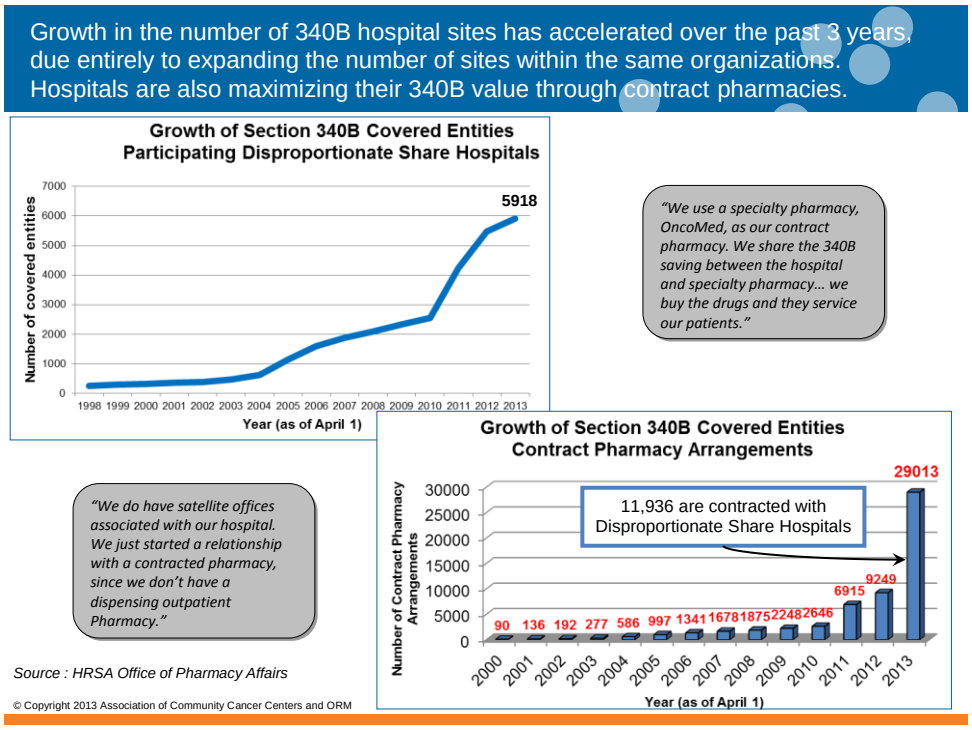
Source of Funding	Cancer Rehabili-tation	Bone & Bone Marrow Transplantation	Financial Counseling	Molecular Testing	Advanced Diagnostic Testing
General Operating Funds	66%	65%	91%	41%	91%
Endowment	3%	0%	0%	2%	1%
Philanthropy	6%	6%	0%	2%	3%
Grants	5%	0%	2%	5%	0%
State Funding	0%	0%	0%	0%	0%
Trial Sponsors	0%	6%	0%	7%	0%
Patient Pays	29%	18%	1%	52%	9%
Insurance	42%	59%	1%	82%	13%
Not Sure/Don't Know	8%	65%	1%	23%	0%

Q: Which of the following programs does the oncology service line offer/conduct? Select all that apply AND FOR EACH SERVICE LINE SELECTED, also select ALL the funding Sources?

How Are The Following Services Funded?

Source of Funding	End-of-Life Care (Advanced Care)	Palliative Care
General Operating Funds	78%	78%
Endowment	4%	2%
Philanthropy	3%	10%
Grants	1%	2%
State Funding	1%	0%
Trial Sponsors	0%	0%
Patient Pays	12%	23%
Insurance	15%	33%
Not Sure/Don't Know	7%	1%

Q: Which of the following programs does the oncology service line offer/conduct? Select all that apply AND FOR EACH SERVICE LINE SELECTED, also select ALL the funding Sources?



The Office of Pharmacy Affairs within the Health Resources and Services Administration *(*HRSA*),* an agency of the U.S. Department of Health and Human Services, reports growth in the number of hospital sites qualifying to be 340B eligible sites. That number has grown from 1,000 sites in 2005 to 5,918 sites in 2013.

Also shown above is the growth in the number of contracted pharmacies, which has increased from 2005 at 997 pharmacies to 29,013 contracted pharmacies in 2013. The rapid growth in the last three years is due to the change in the legislation that allowed 340B entities to contract with more than one pharmacy. Almost 12,000 of the 29,013 pharmacies are contracted with disproportionate share hospitals, which may provide additional access for needy patients to retail drugs at the 340B price.