



Chief Justice Roberts concluded that the individual mandate is the imposition of a tax on those who do not have insurance

U.S. Supreme Court Rules on PPACA – More Uncertainty and Complexity for Oncology Leaders



SPECIAL PRESIDENT'S MESSAGE

Linda Weller-Ferris, PhD, ACE President

Centura Health System, Centura Health Leader for Oncology Services, State of Colorado

When the much-anticipated Supreme Court ruling on the constitutionality of the 2010 Patient Protections and Affordable Care Act (Affordable Care Act or ACA) was read, there was widespread confusion and misinterpretation at first. Watching CNN report quickly (in error) that the court had ruled ACA as unconstitutional only highlights the complexity of the ruling, with some provisions standing and others being reversed, in part.

The Ruling

Chief Justice John G. Roberts delivered the opinion of the Court with regard to the constitutional challenges to two provisions of ACA, The Individual Mandate and the Medicaid Expansion, and if the ACT stood:

1) **The Individual Mandate:** The key provision that requires Americans to maintain "minimum essential" health insurance was ruled as constitutional and will begin in 2014 for those who are NOT exempted, or who don't have an employer or government program. If individuals do not comply with the mandate, then there will be a penalty paid to the Internal Revenue Service with an individual's taxes.

In reading the decision, the debates were clear:

A) The constitutionality question centered on if the individual Mandate was a "penalty" or a "tax" and this became the centerpiece of the constitutional argument. ACA described the payment for not maintaining health insurance as a **penalty**, not as a **tax**. Chief Justice ruled that the Constitution allows Congress the power to regulate Commerce, but the individual mandate is not a valid exercise of the power of Congress under the Commerce Clause. The labeling of the payment as a penalty, and not a tax, does not hold by way of the Constitution. The penalty "compels" individuals to become active in commerce by purchasing a product. To quote the majority, "The Framers [of the Constitution] knew the difference between doing something and doing nothing. They gave Congress the power to "Regulate Commerce." [pp 16–27]. Chief Justice Roberts concluded that the individual mandate is the imposition of a tax on those who do not have insurance, and while not constitutional under the

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Radiation and Prostate Cancer – Dilemma and Decisions

Eva Huddleston, BS, R.T.(R)(T), Consultant, The Oncology Group

Controversies over screening and treatment for early stage prostate disease are not the only debates going on in prostate cancer care today. Physicians and radiation oncology leaders planning to expand their prostate treatment service lines must also assess the clinical (i.e. outcomes, side effects and biochemical control) and financial (i.e. cost versus reimbursement) aspects of the available radiation-based treatment modalities.

Radiation to the prostate is commonly delivered using an external source with techniques like 3D conformal therapy, intensity modulated radiation therapy (IMRT), stereotactic body radiation therapy (SBRT) or proton beam therapy. Another possibility, brachytherapy, delivers radiation internally by implanting low or high dose radioactive sources directly into the patient's prostate tissue.

IMRT, currently considered a standard of care for prostate cancer treatment, is reimbursed by most, if not all, payers

when submitted with a prostate cancer diagnosis code. Due to the lack of long-term comparative clinical data regarding efficacy, many payers consider SBRT and proton beam therapy investigational for prostate cancer and reimburse them only under special considerations. Medicare payers detail their conditions of coverage in the form of Local Coverage Determinations, which can be found in the Medicare Coverage Database located at www.cms.gov/medicare-coverage-database. Wisconsin Physician Service (WPS), the current Medicare Administrative Contractor (MAC) for IA, KS, MO and NE (and in the implementation process for IN and MI), outlines their specific criteria for proton beam therapy reimbursement of prostate cancer. The following excerpt, obtained from www.cms.gov on June 27, 2012, is from the WPS Proton Beam Therapy policy:

This section defines conditions that are still under

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Commerce Clause, the mandate could be upheld because it is the power of the Congress to “lay and collect Taxes.” [Article I, 8, clause 1; pp 33-44.] The taxation was upheld because: 1) It is not an extremely high dollar amount; 2) It is a willful violation and not an unlawful conduct; and 3) It is collected by the IRS, through normal taxing authority.

2) The Medicaid Expansion: Twenty-six States, several individuals, and the National Federation of Independent Business brought suit in the Federal District Court challenging the Medicaid expansion. The current Medicaid program offers federal funds to States to assist pregnant women, children, needy families, the elderly, blind, and disabled in securing medical care. At the heart of the debate is that ACA forced the States to expand the Medicaid programs to meet the health care needs of non-elderly populations with income that was below 133% of the poverty level. While the States would receive expanded federal funds, it would have dramatically increased the number of individuals that the States would have to cover in the Medicaid program – by approximately 32 million Americans. Under ACA, if the States refused to comply with the added Medicaid coverage, they would lose federal funding for **all of its federal Medicaid funds**. The Supreme Court ruled that this was a Constitutional violation. The ruling stated that “The Constitution does not give Congress the authority to require the States to regulate.” In stronger language, it was ruled that “Congress may use its spending power to create incentives for the States to act in accordance with federal policies. But when “pressure turns into compulsion,” *Steward Machine Co v. Davis*, 301 U.S. 548, 590 (1937), the legislation runs contrary to our system of federalism.”

[567 U.S. _ (2012), p 47]

3) The Act Stands: The Courts also concluded that “The question here is whether Congress would have wanted the rest of the Act to stand, had it known that States would have a genuine choice whether to participate in the new Medicaid expansion. Unless it is evident, that the answer is no, we must leave the rest of the Act intact.” [567 U.S. _ (2012), p 57.]

The Dissent

To be sure, dissenting Justices Scalia, Kennedy, Thomas and Alito view the majority ruling on the individual mandate as far-reaching, with strong language: “It threatens that order because it gives such expansive meaning to the Commerce Clause that all private conduct (including failure to act) becomes subject to federal control, effectively destroying the Constitution’s division of governmental powers.” [Scalia, Kennedy, Thomas, and Alito, JJ, dissenting, p 14.] With regard to the definitions of penalty or a tax, the dissenting Justices wrote that “[A] tax is an enforced contribution to provide for the support of government; a penalty is an exaction imposed by statute as punishment for an unlawful act.” [Scalia, Kennedy, Thomas, and Alito, JJ, dissenting, p 18.]

The Supreme Court writes, “We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation’s elected leaders. We ask only whether Congress had the power under the Constitution to enact the challenged provisions.” [567 U.S._2012, p 3]. The Courts also expressed its respect of the independent power of the States to check the power of the federal government, stating that “By denying any one govern-

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ment complete jurisdiction over all the concerns of public life, federalism protects the liberty of the individual from arbitrary power." [National Federation of Independent Business v. Sebelius, opinion of Roberts, C.J., p 4.]

Reactions to the Supreme Court Ruling

The Democrats have hailed this as a "striking victory". The House Republicans, of course, have already held another vote on July 10th again repealing the ACA. This will clearly not hold under the Democrat-controlled Senate. President Obama continues to deliver speeches declaring this "a victory for the people all over this country whose lives are more secure because of this law." [Vicini, Reuters, 6/28; Kim, Politico, 6/28; New York Times, 6/28.]

Others are really pleased... Take the immediate ACS CAN volunteer letter that talked about no longer fearing that she would not be able to afford medical insurance coverage because of her cancer history. And that children surviving cancer will no longer face lifetime limits. And dependents under 26-years of age can stay on their parents' health insurance. These are good things. The press release by the National Association of Public Hospitals and Health Systems also endorsed the individual mandate and reinforced the law, because, overall PPACA "promotes innovation, preventive care, and community-based collaborations." NAPH urged states to participate in the Medicaid expansion, since this is now optional. They estimated that more than 27 million people without insurance might not get the option of participating in Medicaid in 2014, if the States opt out. [www.naph.org, Press Release of 6/28/2012].

The American Hospital Association endorsed the ruling as giving hospital's "clarity" to continue their reform efforts. [www.advisory.com/Daily-Briefing/2012/06/28/How-health-industries-are-reacting-to-ruling]. In its press release, Rich Umbdenstock, President and CEO of AHA, indicated that the healthcare industry will continue to transform the delivery of healthcare and focus on implementing "better coordinated, high-quality care." Meanwhile, the Wall Street Journal indicated that hospitals will continue their plans for IT infrastructure-building, consolidations, and a focus on outpatient services.

Uncertainty and Troubled Waters Ahead

Not so fast... There is still huge uncertainty ahead for healthcare leaders and the future of PPACA. The Medicaid expansion is extremely tenuous, because of the uncertainty of States accepting the expansion. As of July 5th, the Advisory Board reported that five States will not participate, including Florida,

Louisiana, Mississippi, South Carolina, and Wisconsin. Six States have also declared that they are strongly considering not participating, including Iowa, Missouri, Nebraska, Nevada, New Jersey, and Texas. Three States are leaning toward participating, including Arkansas, Oregon, and Rhode Island. The ten States that have declared participation include California, Connecticut, Delaware, District of Columbia, Hawaii, Illinois, Maryland, Massachusetts, Minnesota, Vermont, and Washington.

That leaves 26 States undecided, including Alabama, Alaska, Arizona, Colorado, Georgia, Idaho, Indiana, Kansas, Kentucky, Maine, Michigan, Montana, New Hampshire, New Mexico, New York, North Carolina, North Dakota, Ohio, Oklahoman, Pennsylvania, South Dakota, Tennessee, Utah, Virginia, West Virginia, and Wyoming. The States clearly fear bankruptcy, tax increases for their citizens and businesses, and a negative impact on their business base. They also object on ideological grounds. Many Governors view the Medicaid expansion as a "massive entitlement expansion" under Obamacare, and fear that current residents who are eligible, but not enrolled, would add additional financial exposure. The States also know that the economic recovery is limping along, there are looming expiration of tax cuts and mandated Medicare and defense cuts. It's not a rosy picture for State Governors.

More to Come after November Elections

With this ruling, we now know that as of today, under the leadership of President Obama, healthcare and oncology leaders will march forward with plans to meet the provisions of the law. At least... until November, when, if there is an election of a Republican President and the Democrats lose control of the Senate, it's a new day. PPACA may be rescinded. There may be major undoing of major provision of PPACA. Insurance exchange subsidies may disappear. The PPACA may be defunded, rendering the law mute. The full insurance expansion will be limited. Then too, some of the popular provisions may stand.

What Do We Know and What Are Oncology Leaders Doing About It?

- We, as oncology leaders, are going about our work. Regardless of the impact of health care reform, we are preparing for the increase in cancer incidence of more than 45% from 2010 to 2030. This equates to an increase of 1.6 million cancer patients in 2010 to 2.3 million cancer patients in 2030. This growth is projected to result in a 61% to 70% increase in cancer incidence for older adults 65 years of age, compared with an 11%

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increase for younger adults. [Smith BD, Smith GL, Hurria A, et al. *Future of cancer incidence in the United States: burdens upon an aging, changing nation.* J Clin Oncology, 2009; 27: 2758-2765.]

- We are designing programs to provide surveillance and deliver ongoing care plans for the large volume of cancer survivors. Currently, the rate of cancer survivors is approximately 8.5 times the number of newly diagnosed cases. In 2012, there were 1.64MM newly diagnosed cases and more than 13MM cancer survivors. To put this in perspective, cancer incidence grew 60+% between 1975 and 2008, while cancer survivors grew more than 230%.
- We are building capacity, fine-tuning our long-term strategic plans and projections. We are assessing the cancer burden for our hospitals, including the assets, technologies, physical facilities, staffing, electronic health records, and physician alignment strategies to ensure that we will have the capabilities to care for these cancer patients and survivors.
- We are ensuring that Electronic Health Records are meeting meaningful use guidelines, and that our quality reporting and cost accounting systems are robust enough to meet the coming reporting requirements by CMS and our payers. We are focused on preparing for Medicare's readmissions penalties and the Value-Based Purchasing Program.
- We are standardizing our clinical care pathways, redesigning our inpatient care and ED utilization models for our cancer patients.
- We are focused on the potential financial impact of the Medicaid expansion, and what is occurring in our states.

- We are watching how payers are grappling with extreme uncertainty now. We are also witnessing our commercial payers move towards population-risk contracting.
- We are assessing the evolution of Fee-for-Service into ACOs, and bundled payment contracting strategies—from volume-based to value-based care delivery. We are witnessing the decelerating price growth, continued cost pressures, shifting payer mixes, and a deteriorating case mix. We are working to maintain sustainable margins, which, in the long run, will be achieved through breaking-even with Medicare patients.
- We are developing our healthy neighborhoods, aligning with and maximizing our primary care physician relationships.
- Oncologists are focused on meeting the Medicare quality standards and now believe that there will be greater and greater value-based revenue stream with the commercial payers. They are aligning with hospitals in record numbers.
- Last, our cancer care providers are also assessing how well they are caring for their patients throughout the episode of care and care continuum, following evidence-based guidelines, and functioning more effectively in a multidisciplinary team.

Until November, we work and wait for the next wave of change based on the election. Stay tuned and be sure to vote! ■

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investigation and would be covered when part of a clinical trial, registry or both.

1. Unresectable lung cancers and upper abdominal/peri-diaphragmatic cancers.

2. Advanced stage, unresectable pelvic tumors including those with peri-aortic nodes or malignant lesions of the cervix

3. Technically un-resectable left breast tumors

4. Unresectable pancreatic and adrenal tumors

5. Skin cancer with macroscopic perineural/cranial nerve invasion of skull base

6. Unresectable Malignant lesions of the liver, biliary tract, anal canal and rectum

7. Prostate Cancer, Non-Metastatic.

There is as yet no good comparative data to determine whether or not Proton Beam Therapy for prostate cancer is superior, inferior, or equivalent to external beam radiation, IMRT, or brachytherapy in terms of safety or efficacy.

The prostate cancer should be locally contained and not be an advanced prostate cancer (i.e. T3 or T4 where the tumor has spread through the capsule or has invaded seminal vesicles or other structures) and not any N disease (i.e. no spread to lymph nodes or there has been spread to the pelvic lymph nodes). Note: spread into pelvic lymph nodes is considered metastatic disease.

Coverage and payments of Proton Beam Therapy for prostate cancer will require:

a. Physician documentation of patient selection criteria (stage and other factors as represented in the NCCN guidelines);

b. Documentation and verification that the patient was informed of the range of therapy choices, including risks and benefits.

Other factors considered favorable for coverage include enrollment of the patient in an appropriate clinical registry for planned assessment and publication, clinical trials.

In April of 2010, the Medicare Evidence Development and Coverage Advisory Committee (MedCAC) convened a meeting to discuss available data on the risks, benefits and outcomes of radiation therapy techniques, such as external beam and brachytherapy, used in the treatment of prostate cancer. During this meeting, committee members presented a technology assessment, prepared by the Evidence-Based Practice Center at Tufts Medical Center, to a panel of 15 physicians. The Evidence-Based Practice Centers, contracted to the Agency for Healthcare Research and Quality (AHRQ), conducts technology assessments and write evidence reports when requested by the Centers for Medicare and Medicaid Services (CMS). In the technology assessment, it was stated that due to the long clinical course of prostate cancer patients, commonly measured in decades, most studies have focused on short-term effects and biochemical control rather than long-term efficacy outcomes like metastases and disease-specific mortality.¹

One such short-term study, published by Zelefsky et al², compared 132-nonrandomized patients treated to 81 Gy with either 3D or IMRT and found fewer GI and GU toxicities for the IMRT patients. Other studies have support-

ed the findings that patients treated with IMRT develop fewer toxicities than those treated with 3D conformal therapy, leading to the acceptance of IMRT, which costs more per course of therapy than 3D, as a standard of care for prostate treatments. Preliminary findings of a study published by Dr. Jay P. Ciezki³ indicated that both low and high dose brachytherapy offer better rectal sparing than 3D and less GU toxicity than IMRT with the added benefit of being the least expensive of the three modalities.

SBRT and proton beam therapy are becoming more readily available and study results of the biochemical control and toxicity rates for these modalities have begun to appear in scientific journals. A study published in the January 2012 issue of the *International Journal of Radiation Oncology-Biology-Physics* compared the biochemical failure rates of 196 patients who received a mix of photon and proton beam therapy with the failure rates of 203 patients with similar disease stage who received brachytherapy treatment. This study found that both sets of patients had comparable biochemical failure rates.⁴ In addition, new studies are being conducted to compare these modalities to more standard forms of radiation treatment. In April 2012, an international multi-arm randomized trial was set to accept its first patient; one arm of the study was designed to compare biochemical disease-free survival rates of patients treated with a course of standard radiation therapy to those who received SBRT over a 5-year period. In May 2012, Massachusetts General Hospital also announced that they would be launching a study in June 2012 to compare the effectiveness of standard radiation to proton beam therapy.

With so many treatment options available, coupled with variances in reimbursement, the results of these studies and others like them will play an important role in decision making regarding appropriate radiation therapy treatment options for patients with prostate cancer. Study findings concerning efficacy, outcomes and biochemical control will enable physicians, patients and payers to make educated well-informed decisions concerning the available radiation based treatment options for prostate cancer. In addition, cancer program administrators will need to stay informed to ensure they understand any possible clinical or reimbursement ramifications triggered by study results. ■

...most studies have focused on short-term effects and biochemical control rather than long-term efficacy outcomes...

References

1. Agency for Healthcare Research and Quality. (2010, August 13). GeneralInformation. Retrieved April 4, 2012, from Centers for Medicare & Medicaid Services: www.cms.gov/coveragegeninfo/downloads/id69ta.pdf
2. Zelefsky MF, F.Z. (2000). Clinical experience with intensity modulated radiation therapy (IMRT) in prostate cancer. *Radiotherapy & Oncology*, 241-249.
3. Ciezki J, R.C. (2012). Long-term toxicity and associated cost of initial treatment and subsequent toxicity-related intervention for patients treated with prostatectomy, external beam radiotherapy or brachytherapy. *Genitourinary Cancers Symposium*. San Francisco.
4. Coen, J. J., Zietman, A. L., Rossi, C. J., Grocela, J. A., Efstathiou, J. A., Yan Yan, et al. (2012). Comparison of high-dose proton radiotherapy and brachytherapy in localized prostate cancer: a case-matched analysis. *International Journal of Radiation Oncology-Biology-Physics*, e25-e31.

Eva Huddleston, BS, R.T. (R) (T), is a consultant with The Oncology Group. Eva has over 20 years experience in the oncology field including an extensive background in radiation oncology. The Oncology Group, LLC, is one of the premier cancer program strategic planning firms in the US, providing customized solutions to assist in the development, growth or enhancement of cancer services.

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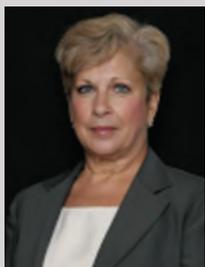
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SPOTLIGHT ON OMC GROUP'S EXPERTS - SUSAN SHAFER, MT, CMM, CPC, RMC



Susan Shafer is a Senior Consultant with Oncology Management Consulting Group and brings over 25 years of experience in the healthcare field. Sue served for well over two and a half decades as practice administrator of a very active and successful oncology practice in Pennsylvania and continues to provide sales and technical support for a medical billing software program. Her responsibilities included oversight of all operations including staffing, purchasing, billing and collections, and payer contract negotiations. She also enjoys considerable experience in practice management of a free standing radiology facility as well as family practice. Susan has also specialized in instituting Physician Quality Reporting Initiative (PQRI), Quality Oncology Practice Initiative (QOPI), and E-prescribe programs into practices. Specific areas of her focus for OMC Group include billing, coding, and accounts

receivable management, lost receivables and inventory management of chemotherapeutic agents to avert revenue loss.

Susan is one of the original founders and board members of the Premier Oncology Hematology Manager's Society (formerly Pennsylvania Hematology Oncology Manager's Society). She is also a former member of the Easton Hospital Office Manager's Steering Committee and since 2005 she has been a member of Amgen's Office Manager's speaker board.

Sue is a certified Medical Technologist, Certified Medical Manager with the Professional Association of Health Care Office Managers, Certified Professional Coder with the Academy of Professional Coders, and Registered Medical Coder with The American Association of Registered Health Care Professionals

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Blueprint for Development of a Lung Cancer Center of Excellence

By *Kate Canterbury, Senior Managing Associate and Consultant, Oncology Solutions, LLC*

With the constant changes in today's healthcare environment, patients are becoming increasingly savvy when choosing their oncology physician care team. National organizations are now focusing on disease-specific program accreditations and certifications such as the National Accreditation Program for Breast Centers (NAPBC), the Joint Commission's Disease Specific Care Certification in Lung Cancer, and BlueCross BlueShield's Blue Distinction Centers for Complex and Rare Cancers. For a cancer program to differentiate itself from market competitors, it is necessary to focus on expanding and improving service delivery at the disease-site level. Lung Centers of Excellence (COEs) are programs structured to provide the highest levels of physician expertise, diagnostic and treatment capabilities, and supportive care services available to lung patients. Suggested framework for the development of lung COEs is presented below.

Components of a Lung Center of Excellence

Multidisciplinary Care and Physician Expertise

■ **Pulmonology (Including Interventional)** – Pulmonology services are a critical component of any Lung COE, but can be a rate-limiting-factor for many lung programs if there is a lack of committed outpatient pulmonology support. Many pulmonologists are primarily focused on the delivery of critical care services, leaving little capacity for the outpatient diagnostic services required to appropriately work-up lung patients. Additionally, COEs include interventional pulmonologists who perform aggressive interventional procedures in the airways and chest cavity, including endobronchial ultrasound-guided transbronchial or fine needle aspirations (EBUS-TBNA and EBUS-FNA). A team of researchers from Leiden University Medical Center recently conducted an evaluation of mediastinal staging methods in non-small cell lung cancer (NSCLC). This trial showed that staging with EBUS-FNA and EBUS-TBNA could eliminate the need for a mediastinoscopy in a significant number of patients, allowing for a far less invasive approach with reduced morbidity. A combined approach, with mediastinoscopy reserved for those patients with negative findings from EBUS-FNA and EBUS-TBNA, also resulted in superior sensitivity and negative predictive value over mediastinoscopy alone.¹

SuperDimension is also emerging as a leader in the field of diagnostic technology providing minimally invasive access to lesions deep in the lungs as well as mediastinal lymph nodes. Engaging physicians who are trained to utilize SuperDimension will only strengthen the diagnostic capabilities of a lung COE.

■ **Radiology (Including Interventional)** – Highly-skilled radiologists who can accurately evaluate lung disease in a timely manner can elevate a lung program. Specifically, interventional radiologists can provide surgically ineligible patients with minimally invasive procedures to reduce their pain and improve their quality of life. These procedures might include radiofrequency ablation, cryoablation, and chemoembolization.²

■ **Pathology** – Most lung COEs include pathologists specifically trained in the evaluation of lung diseases. These physicians provide vital support to the treating physicians when diagnosing cancers; during surgical procedures; and in follow-up. Timely and accurate specimen evaluations are a critical component of lung COEs.

■ **Dedicated Thoracic Surgery** – Research studies suggest that lung patients treated by thoracic surgeons are more appropriately assessed for comorbidities and serious preoperative risk factors. Thoracic surgeons have

superior long-term outcomes and lower lengths of stay.³ Minimally-invasive treatment capabilities, such as video-assisted thoracic surgery (VATS), are critical components of lung COEs, serving as a differentiator from competitors and a less-invasive surgical option for the patient. Patients are seeking out this capability and many believe that utilization of these techniques will become standard of care for most lung patients.

■ **Anesthesia** – An emerging feature in lung COEs is development of a thoracic-trained anesthesiology team, including both anesthesiologists and CRNAs. Dr. Phillip Hartigan, a well-known anesthesiologist from Brigham and Women's Hospital specializing in thoracic anesthesia, recently published the *Practical Handbook of Thoracic Anesthesia* in response to fellow anesthesiologists looking to develop internal thoracic anesthesia expertise. Dr. Hartigan addresses strategies to improve patient care, specifically by shortening recovery times and improving technical capabilities during complicated, advanced thoracic surgical procedures.

■ **Medical and Radiation Oncology** – Integration of medical and radiation oncology into the patient care team is essential to any program and a "must-have" for lung COEs. Both physician groups will play key roles in the treatment experience for the patient. For medical oncology, adjuvant therapy can be a vital component of the treatment plan. In order to identify eligible candidates, there must be seamless communication between physician specialties. For those patients who are not candidates for surgery, stereotactic body radiation therapy (SBRT) may be used as a treatment modality. SBRT is a treatment technology that should be offered by any lung COE. Again, all decisions should be made under the umbrella of delivering multidisciplinary care.

Key Program Components

■ **Dedicated Lung Tumor Conference and Multidisciplinary Care** – A multidisciplinary approach to treatment is a major component of most lung COEs. An example of this approach is the utilization of a tumor conference dedicated to the presentation of lung cancer cases with physician representation from the aforementioned specialties. As with most tumor conferences, physicians discuss each patient and work collaboratively to make treatment recommendations. This team approach improves coordination of care and communication among the medical professionals involved in the continuum of care. National advocacy organizations are guiding patients to choose their treatment centers based upon whether the program embraces multidisciplinary care.⁴

■ **Patient Navigation** – Patients diagnosed with lung cancer require a significant number of procedures and/or physician consultations to establish a comprehensive diagnosis. Many patient navigators work with these patients and their physician care team to assist with scheduling and to identify and attempt to overcome any barriers that may be preventing patients from receiving appropriate care. Patient navigators are an important link between the physician, patient and all other patient care services. Additional roles of a lung navigator might include planning multidisciplinary tumor conferences, tracking quality indicators and providing patient and community education. There have been few studies published around the impact of patient navigation on the continuum of care, but a recent study published in *CA: A Cancer Journal for Clinicians* validated that the strongest evidence to date for the effectiveness of patient navigation is the improvements in cancer screening and outcomes related to cancer diagnostic services.⁵ Lung patient navigators

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Development of a Lung Cancer Center of Excellence

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who assist with implementation of lung screening programs and the resulting workup pathways are vital to the success of any lung COE.

■ **Smoking Cessation Program** – The Lung Cancer Alliance (LCA) believes that a well developed smoking cessation program is a vital component to any lung screening program and/or comprehensive lung cancer program. LCA’s *National Framework for Lung Cancer Screening Excellence: Guiding Principles for Lung Cancer Screening Excellence* states that comprehensive programs “will include a comprehensive smoking cessation program in its screening and continuum of care program based on best practices and clinical evidence”. Most programs chose to provide nicotine replacement therapy (NRT) in combination with regular smoking cessation counseling sessions.

■ **Lung Screening Program** – Results from the recent National Lung Cancer Screening Trial (NLST) show that screening with low-dose helical computed tomography (CT) can significantly reduce mortality in persons at high-risk for lung cancer. The study, funded by the National Cancer Institute, included 53,454 persons (aged 55-74 years) at high risk for lung cancer from 33 US medical centers. Patients were randomly assigned to CT (N = 26,722) or to chest x-ray (N = 26,732) screening, and data was collected for lung cancer cases and deaths through December 2009.⁶

The screening rate positive for lung cancer was 24.2% with low-dose CT and 6.9% with chest radiographs. A total of 247 deaths per 100,000 person-years occurred in the CT screening group compared with 309 with chest radiography, representing a 20.0% relative reduction of death from lung cancer with the use of CT screening. Death from any cause was reduced by 6.7% with the CT screening.⁷ The National Comprehensive Cancer Network (NCCN) recently developed new screening and follow-up guidelines based on these findings.⁸ Since the release of these findings, lung cancer screening programs, utilizing low dose CT capabilities, are being planned and implemented across the country in community hospitals of all sizes, academic/university based hospitals and comprehensive cancer centers. The table below provides benchmarking data on the cost to patients of a lung cancer screening CT.

TABLE 1: Examples of Lung Screening CT Patient Costs

Somerset Medical Center	\$225
Providence Portland Medical Center	\$350
St. Joseph Hospital of Orange	\$125
Lehigh Valley Hospital	\$350
Piedmont Hospital of Atlanta	\$300
WellStar	\$199 for one person; \$299 for one person & spouse
Emory Hospital	\$275

■ **Lung Clinic or Pathway for Work-Up of Lung Patients** – There are many successful approaches to implementation of a lung clinic or appropriate patient work-up process. Some programs chose to implement true multidisciplinary care (MDC) clinics, others choose “virtual” MDC clinics, and some focus on a seamless referral process to regional pulmonology groups. The following are examples of successful implementations of each of these approaches.

Example #1: WellStar Health System – True MDC Clinic

- Unique Physician Expertise – Minimally-invasive thoracic surgery, interventional pulmonology and radiology.
- WellStar is a participant in the I-ELCAP study and has developed a robust lung cancer screening program which now utilizes the NCCN Lung Cancer Screening Guidelines to determine patient eligibility. There is a seamless process established for referral into the WellStar

MDC Clinic, known as the Specialty Teams and Treatment (STAT) Clinic.

- The lung patient navigator is a critical component of the STAT Clinic. The navigator is responsible for conducting patient intake and referral screening; ensuring referral to appropriate diagnostic services and other appropriate pre-visit testing; managing the actual patient visit; and then preparing for resulting multidisciplinary discussion of the patient’s treatment plan. During the patient’s visit to the STAT Clinic, they meet with the appropriate physicians; the physicians meet to discuss the treatment plan; and the recommended plan is delivered to the patient. Services are provided at one location over a three to four hour period⁹.

Example #2: Christiana Care – “Virtual” MDC Clinic

- Unique Physician Expertise – Minimally-invasive thoracic surgery, interventional pulmonology and radiology.
- Christiana Care is a participant in the I-ELCAP study and has developed a robust lung cancer screening program which now utilizes the NCCN Lung Cancer Screening Guidelines to determine patient eligibility.
- A lung patient navigator assists with preparing patients (collection and scheduling of appropriate tests and diagnostic scans) for the “virtual” MDC clinic in which patients initially see the thoracic surgeon. The patients are then discussed in a multidisciplinary tumor conference with representation from surgery, medical oncology, and radiation oncology. After the conference is complete, the thoracic surgeon follow-ups with the patient to explain the recommended treatment plan. The patient is then seen by the medical oncologists and/or radiation oncologists, as necessary. In this model, the patient is required to meet with each physician separately, but the offices are located in one building.

Example #3: Inova Health System, Fairfax Hospital – Referral to Regional Pulmonology Groups

- Unique Physician Expertise – Minimally-invasive thoracic surgery, interventional pulmonology and radiology, thoracic pathology and anesthesiology, and specialized medical and radiation oncology.
- Inova Fairfax hospital has chosen to implement a lung cancer screening program utilizing the NCCN Lung Cancer Screening Guidelines to determine patient eligibility.
- A lung patient navigator assists with the appropriate work-up of suspected lung cancer patients by working with primary care physicians and three local pulmonology groups.

■ **Lung-Specific Clinical Research Protocols** – To position a program as a center of excellence, patients must have access to national lung-specific clinical trials. Physicians should be actively involved in building research partnerships with national entities such as the NCI and NIH. Additionally, the multidisciplinary team of physicians should meet regularly to evaluate the lung program’s clinical trial menu to ensure that the research needs of their patient population are being met.

■ **Palliative Care** – Palliative care services are being uniquely integrated into lung COEs across the country. A study published in the *New England Journal of Medicine* proved that patients with metastatic non-small cell lung cancer receiving early palliative care experienced significant quality of life improvements and less aggressive care at the end of life with longer survival.¹⁰ In February 2012, the American Society of Clinical Oncology (ASCO) released a provisional clinical option that patients with metastatic non-small cell lung cancer should be offered concurrent palliative care and standard

Continued on page 10 >

Development of a Lung Cancer Center of Excellence

> Continued from page 9

oncologic care at initial diagnosis.¹¹ The provision of palliative care services is a priority of the NCI's Community Cancer Centers Program whereby best practices are shared among sites in order to appropriately develop palliative care services for both the patient and the physician.

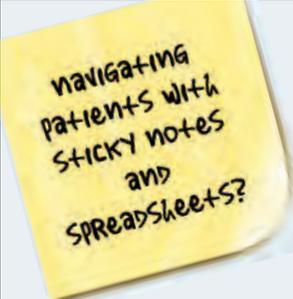
Importance of Developing a Lung Center of Excellence

There are many paths an oncology program can take when developing their lung cancer program, but superior physician expertise, cutting-edge diagnostic and treatment capabilities, and comprehensive supportive care services are the pieces of a program that can significantly impact patient care. Patients are seeking experts in lung cancer care who work together in a multidisciplinary environment to determine the most appropriate and personalized treatment plan. To attract these types of educated patients, oncology programs will find that the best approach involves elevation of their lung program to "center of excellence" status which includes integration of the aforementioned components. ■

Kate Canterbury, MPA, is a consultant with Oncology Solutions, LLC, bringing extensive experience in public health policy and tumor-specific specialization. Oncology Solutions, LLC, founded in 1973, is the largest independent, oncology-specific consulting firm. Our experienced professionals provide a full range of strategic, programmatic, and financial services to help health care organizations of all types and sizes to advance their cancer programs. For more information visit www.oncologysolutions.com

References

1. Annema JT, van Meerbeeck JP, Rintoul RC, et al. "Mediastinoscopy vs endosonography for mediastinal nodal staging of lung cancer: a randomized trial." *JAMA*, 2010.
2. Society of Interventional Radiology Website: <http://www.sirweb.org/patients/lung-cancer/>
3. Ellis MC, Diggs BS, Vetto JT, Schipper PH. "Intraoperative oncologic staging and outcomes for lung cancer resection vary by surgeon specialty." *Annals of Thoracic Surgery*, December 2011.
4. Lung Cancer Alliance Website: <http://www.lungcanceralliance.org/get-information/what-if-i-am-diagnosed/where-do-i-find-the-best-care/>
5. Paskett, E., Harrop, J., Wells, K. "Patient navigation: an update on the state of the science." *CA: A Cancer Journal for Clinicians*, June 2011.
6. The National Lung Screening Trial Research Team. "Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening." *NEJM*, August 4, 2011.
7. The National Lung Screening Trial Research Team. "Reduced Lung-Cancer Mortality with Low-Dose Computed Tomographic Screening." *NEJM*, August 4, 2011.
8. "NCCN Guidelines for Detection, Prevention, and Risk Reduction: Lung Cancer Screening." http://www.nccn.org/professionals/physician_gls/f_guidelines.asp#detection
9. WellStar STAT Cancer Clinic Website: <http://cancer.wellstar.org/stat-cancer-clinic/>
10. Temel, J., Greer, J., et al. "Early palliative care for patients with metastatic non-small cell lung cancer." *New England Journal of Medicine*, August 19, 2010.
11. "American Society of Clinical Oncology Provisional Clinical Opinion: The Integration of Palliative Care into Standard Oncology Care." *Journal of Clinical Oncology*, February 2012.



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Rising Costs of Cancer Care

By Marsha Fountain, RN, MSN, President, The Oncology Group; and Karen Gilden, Executive VP, The Oncology Group

“**Unsustainable Cancer Costs**” read a *Bloomberg News* headline last month. The news story quoted an expert panel assembled by *The Lancet Oncology* medical journal, saying, “Cancer treatment costs are rising at such a rapid rate that they threaten to become ‘unsustainable’ even for rich countries.”¹ Cancer care costs, estimated in 2009 to be \$286B worldwide (1/2 of which are pegged to cancer treatment, with another 50% calculated as “lost production”) could not be sustained at that level. The Bloomberg story attributes the rise to the world population aging (leading to more cancer cases, as the century unfolds), higher costs for drugs and new technologies, and to “overuse of tests and expensive diagnostics.”²

Long a source of concern, cancer care costs are related to the cost per case and to the multiplier effect caused by the increasing number of cancer patients predicted as the US and world populations age. Dubbed the “Silver Tsunami” by some social scientists and economists, the facts show a marked increase in the number (and percentage) of US individuals 65 and older. The number of people 65 and older in the US will double between 2010 and 2050;³ US population is expected to grow by 19% between 2010 and 2030; However, cancer patient volume is expected to increase 45%, or more.⁴

Cancer care costs span the scope of inpatient and outpatient services, and are not limited, as some believe, to the costs associated with directly treating patients with chemotherapy, radiation oncology, and surgery. For example, a recent JAMA study reported that diagnostic imaging accounts for over 10% of ALL cancer care costs. Furthermore, diagnostic imaging costs for cancer patients grew between 1%-5% per year between 1999 and 2006. Moreover, diagnostic imaging costs, as a portion of a cancer patient’s overall cost of treatment, increased from 5.1% in 1999 to 10.3% by 2006.⁵

Clinical and technological advances on the horizon add hope for cancer patients while concomitantly adding associated cost to the system. Clinicians expect their near-term future treatment arsenals to include personalized treatments specific to a certain patient, rather than a certain type of cancer; more targeted therapies; less invasive (but not necessarily less expensive) procedures; increased screening; and patients requesting more support services (such as patient navigators and complementary medicine therapies). Add to this, the realities of health care payment reform, and the mix could become volatile – with institutions, and cancer programs, dealing with reduced payments per patient and increased patient numbers. It could be the old saw, “making up the loss through volume”.

Experts and healthcare observers note other factors leading to the current increase in cancer care costs include reimbursement models that affect doctors’ incentives for using certain treatments or diagnostic procedures. While experts exhort “patients, insurers, policymakers, drug companies and the health industry . . . to work together to lower costs without compromising care,”⁶ expect the real work to control costs to land on cancer center leaders, oncologists (across all modalities), and staff.

Specifically, expect cancer care reimbursement to occupy a prominent position on payors’ radar screens. Most importantly, CMS (as the major payor for cancer care) will no doubt, redouble their scrutiny of costs. Payment recovery auditors are becoming more aggressive in pursuing intended or non-intended overpayments for all services, but could potentially focus on cancer care services. The Recovery Audit Programs (such as CMS or OIG) post their findings on their websites. For example, in 2010 in one region, over \$1 million dollars was recovered related to IV chemotherapy infusion.⁷

The upcoming patient influx, coupled with granular level interest in cancer services costs requires each institution take steps to ensure their programs

rest on solid financial foundations. While quality cancer care is the ultimate goal, without appropriate revenue, quality could be at risk. It is inherent on the cancer program leaders (both administrative and physician) to determine where cost is occurring and if there are ways to safely reduce cost or ensure appropriate revenue.

Steps to take could include:

1. Accurately calculating the costs of cancer care (by tumor site and stage, by physician(s), by modality and diagnostics). Most programs can “estimate” their costs of care, but few have rigorously calculated their institution’s exact costs.
2. Benchmark your institution’s costs to national averages.
3. Work with affiliated physicians to define “best care” – is it guidelines based; is there wide latitude for individual physician choice (of drug, of surgical procedure, of f/u care, etc.); is it based on comparative effectiveness research? Drill down what this institution’s physicians define as measurable clinical quality. For these decisions may guide cost/benefit ratio discussions that could affect reimbursement incentives your physicians may respond to.
4. Determine which functional departments delivering care to your cancer patients add the most costs to the total cancer patient final bill. And monitor this particular department’s costs to determine if they are rising or remaining stable.
5. Operate with exquisite revenue cycle monitoring. Now is not the time to “leave money on the table”, or to neglect to re-bill for denied charges. Conduct audits to ensure the physicians, their staffs, and the institutional departments are billing and receiving revenue for all provided services. And remain hyper vigilant that coders and billers comply with all relevant billing regulations.
6. Consider partnering with community agencies, practitioners, and groups to broaden the cancer program’s supportive care services, without taking on development and operations costs. Off load those to the partner, and enable the partner to charge for them, as the community economy will bear. ■

References

1. Bloomberg news (accessioned online Sept 27, 2011 at 2:44 pm). Cancer Cost Swells, Risks Becoming ‘Unsustainable,’ Lancet Says By Kristen Hallam - Sep 26, 2011 5:58 AM CT <http://www.bloomberg.com/news/2011-09-26/cancer-cost-swells-risks-becoming-unsustainable-lancet-says.html>
2. Bloomberg news (accessioned online Sept 27, 2011 at 2:44 pm). Cancer Cost Swells, Risks Becoming ‘Unsustainable,’ Lancet Says By Kristen Hallam - Sep 26, 2011 5:58 AM CT <http://www.bloomberg.com/news/2011-09-26/cancer-cost-swells-risks-becoming-unsustainable-lancet-says.html>
3. UAB New Archive (accessed online Oct. 13, 2011 at 5:18). Beware the silver tsunami – the boomers turn 65 in 2011. <http://main.uab.edu/Sites/MediaRelations/articles/82818>
4. Smith BD, Smith GL, Hurria A, Hortobagyi G, Buchholz TA. Future of Cancer Incidence in the United States: Burdens Upon an Aging, Changing Nation. *Journal of Clinical Oncology* 2009; Vol 27 No 17: 2758-2765
5. Dinan MA, Curtis LH, Hammil BC, Patz, EF, Abernethy AP, Shea AM, Schulman KA. Changes in the use of Diagnostic Imaging Among Medicare Beneficiaries with Cancer, 1999-2006. *JAMA* 2010; Vol 303 Number 16 1625-1631
6. Bloomberg news (accessioned online Sept 27, 2011 at 2:44 pm). Cancer Cost Swells, Risks Becoming ‘Unsustainable,’ Lancet Says By Kristen Hallam - Sep 26, 2011 5:58 AM CT <http://www.bloomberg.com/news/2011-09-26/cancer-cost-swells-risks-becoming-unsustainable-lancet-says.html>
7. <https://www.cms.gov/Recovery-Audit-Program/Downloads/FY2010ReportCongress.pdf>

World Class Cancer Care, Closer to Home

Academic medical centers still dominate teaching and research, but a growing number of suburban and rural facilities are offering more comprehensive, high-quality oncology services

By Sharon Lleva-Carter and Richard J. Couturier

Perhaps no medical diagnosis is more devastating and life-altering than a diagnosis of cancer. Nearly 1.6 million Americans received that bad news in 2011, according to American Cancer Society estimates.

When a cancer diagnosis is delivered, the natural reaction of most patients and families is to try to do everything humanly possible to beat the disease. Typically, that includes demanding the very best cancer care they can possibly find. One might assume that has driven many patients to large academic medical centers with dedicated, high-profile cancer programs.

And why not? When lives are at stake, it seems logical to choose facilities that offer a level of knowledge, expertise and technological resources that community hospitals might lack. Yet, in reality, 85 percent of cancer patients are diagnosed and receive initial treatment in community hospitals, according to the National Cancer Institute (NCI). In part, that is because unless patients happen to live nearby, seeking treatment at academic medical centers often means long commutes or even the need to set up temporary residence in the area. In addition, trying to navigate a massive medical center campus in an unfamiliar city can be highly stressful – and that’s about the last thing needed by cancer patients. Studies suggest that stress can weaken the immune system and lead to impaired health or healing.

In the past, cancer centers were out of reach for many smaller hospitals due to both the costs of specialized facilities and equipment, and the difficulty of recruiting and retaining experienced oncologists. Now local hospitals increasingly have the option to partner with large, academic medical centers to provide local care, rather than recruiting independent community oncologists. These affiliations can provide access to a more structured, proven and marketable program.

But are cancer patients who seek treatment close to home relegated to second-class care? Increasingly, the answer is a resounding “no.” Many community cancer centers have significantly narrowed the gap in terms of the quality of care, while offering the added comfort and convenience of a familiar local institution closer to home.

Growing Demand, Growing Momentum

The number of new cancer cases in the United States will increase 45 percent by 2030, fueled by an aging, increasingly diverse population. That is according to research published by the Journal of Clinical Oncology in 2009. That study by the University of Texas M.D. Anderson Cancer Center projected that there will be 2.3 million new cases of cancer in 2030, up from slightly less than 1.6 million in 2011. The number of cases among minorities will double and cases among seniors will rise by two thirds. In fact, by age 70 or older, men have a 1 in 3 chance of getting cancer and women have a 1 in 4 chance, according to the American Cancer Society.

Meanwhile, a recent study by the American Association of Medical Colleges and the American Society of Clinical Oncologists found that the nation will face a shortage of 2,550 to 4,080 oncologists by 2020. Clearly, the demand for cancer care will continue to increase, with a growing chasm between supply and demand. Perhaps that is part of the reason momentum is growing for community cancer care centers.

Another initiative that has put local cancer centers in the spotlight is the Community Cancer Centers Program. Launched by the NCI in 2007, the pro-



The Baylor Charles A. Sammons Cancer Center draws patients to Dallas from around the world. But patients who would prefer to seek treatment closer to home can increasingly find top-quality cancer care at smaller, community based clinics. (Photo courtesy Duke Realty)

gram is designed to create a network of community cancer centers that supports research, enhances access to care and increases quality for more Americans. The goals of the program, which is ongoing, are to:

- Reduce cancer healthcare disparities
- Draw more patients into clinical trials in community-based hospitals
- Prepare facilities for standardizing the collection and storage of voluntarily donated biological specimens for cancer research
- Link facilities to national computer networks that support basic, clinical and population-based cancer research
- Improve the overall quality of care
- Improve survivorship, palliative care services and patient advocacy

In addition to the NCI program, healthcare reform seems likely to increase demand for cancer care. The Association of Community Cancer Centers (ACCC) predicts that reform will have these implications:

- Patients and survivors with existing insurance will have more adequate coverage, including no lifetime limits, fewer annual limits, no rescissions, retiree reinsurance, first dollar coverage of screenings and other preventive services
- More insurance options will be available for cancer patients and survivors
- Subsidized high-risk pools will be formed that offer age-adjusted standard premiums
- Dependents up to age 26 will have access to their parents’ plans
- Patients will have improved information about the value of available options and more standardized information
- There will be some pressure on insurers to keep premium increases more moderate

The transition to personalized medicine will be another powerful driver of demand for new cancer care services. Oncology care of the future will be both standardized and personalized – standardized in terms of protocols to more consistently deliver quality care; personalized in terms of treatment

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programs tailored to specific types and stages of cancer, as well as patients' own health records, medical histories, and even their biology and DNA.

In addition to growing demand, there is usually a compelling business case for community cancer centers. Cancer treatment programs tend to be one of the most profitable service lines providers offer.

Indeed, most community cancer centers successfully weathered the recession and are on a firm financial footing. In a survey released by the ACCC in July 2010, 78 percent of the 84 community cancer centers that responded characterized their program's financial status as "good" or "very good."

Peaceful Coexistence

There is an important role for both community cancer centers and large academic medical centers (AMCs), according to Donna Bowers, Vice President of Oncology Services for Dallas-based Baylor Health Care System.

"Community cancer centers really complement large academic cancer centers," Ms. Bowers says. "AMCs do bench research best. Community and regional cancer centers are most known for translational research and clinical care. However, the shortage of providers in smaller communities can present a problem, especially when people need daily care such as radiation therapy."

There are many benefits to community cancer centers, says Dr. Steven Paulson, Chairman and President of Texas Oncology in Dallas.

"Large cancer centers are better at dealing with unusual types of cancer, but the physicians who work there might be more interested in research than in treating patients," Dr. Paulson says. "Community cancer centers are designed to be more accessible to the average patient.

"AMCs and community cancer centers peacefully coexist in most markets. Care is also similar at both types of facilities: there isn't much evidence that patient outcomes are any better at AMCs than at community cancer centers."

Where to Begin

Cancer centers both large and small have limits when it comes to the amount of capital available for their development. So it is vital for providers to approach each project with clear objectives and realistic expectations regarding what is possible in terms of their business plan and financial position. Likewise, it is important to develop projections regarding the potential market share that the new facility can reasonably capture in light of services offered by potentially competing facilities.

Local hospitals might find themselves partnering with big, academic centers to provide care, rather than recruiting independent, community oncologists. Other hospitals will continue to have community oncologists but, as noted above, many will affiliate with an established program. Additionally, some community oncologists will form large groups that will participate in research and clinical trials and will partner with academia to provide cutting-edge care that they also take to the community.

Regardless of the operational structure, it is vital to assemble the right team from the start to guide the design and construction of the cancer center. In addition to the facility owners, administrators and potential partners, the team should incorporate the perspectives and input of stakeholders such as physicians, nursing staff, technicians and cancer survivors. Those healthcare professionals should be joined by key vendors including the developer or program manager, architect, and general contractor or construction manager.

How to Pay for It

Community hospitals with inadequate access to capital – or which simply prefer to put their money into new technologies and other investments in their core business of healthcare delivery – might find it worthwhile to explore partnering with a third-party healthcare real estate firm with experience developing cancer care centers. Such a firm can serve as a long-term partner and advisor, determining what resources are needed and developing a plan with appropriate strategies that will meet the hospital's needs. The developer also can provide access to a wide range of financing alternatives that will not burden its client's balance sheet.

In addition, third-party developers that are skilled in the new philosophy of cancer care can assist with the selection of like-minded architects, contractors and other partners. They can provide a professional, dedicated management team which will be responsible for the day-to-day operation of the complex medical space, and they can provide leasing expertise, including negotiating with physicians for independent leases.

Healthcare executives note that there are many strategic reasons to use a third-party developer. "Having a third party finance and own a healthcare facility really helps ensure compliance with the Stark laws against self-referrals," notes Ms. Bowers of Baylor Health Care System.

"Days cash on hand is an important metric that is closely watched by credit agencies," adds Wes Huff, Director of Real Estate for Baylor Health Care System. "Even if a System can pay for a new facility using cash and debt, it might choose to preserve cash by using an outside vendor.

"Most healthcare professionals are not interested in being real estate developers. Third-party firms that develop, finance and manage a facility can bring flexibility and creativity when it comes to marketing the space, which is good for the Healthcare System and the Healthcare tenants".

What to Include

Much has been learned in recent years about ways to contribute to improved patient outcomes through cancer center design. Natural materials like wood and stone, soothing colors, natural light, exterior views, water features, positive distractions like artwork and patterns, and healing gardens have become de rigueur design elements because they provide comfort, reduce stress and are believed to promote healing.

Many of those elements were pioneered by the cancer programs of large academic medical centers. But the concepts of healing environments are also being extended to community cancer centers.

Beyond design elements, here are the components that can potentially be housed in a comprehensive cancer center:

- Radiation oncology, with technology options including linear accelerators, CyberKnife systems and proton beam therapy
- Chemotherapy and infusion therapy
- Diagnostic imaging
- Urgent care
- Clinics, including general oncology, general outpatient follow up, transplant, multi-disciplinary for additional healthcare needs and physician offices
- Palliative care (which focuses on relieving the pain, symptoms and stress of cancer)
- Research and clinic trials

"...developers that are skilled in the new philosophy of cancer care can assist with the selection of like-minded architects, contractors and other partners."

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World Class Cancer Care, Closer to Home

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- Surgery, inpatient and outpatient
- Inpatient beds
- Support space, such as administrative offices, full laboratories and pathology, and space for information technology (IT), research, and fellowships and publications

Clearly, only large academic cancer centers are likely to include the bulk of what is on this list. For example, with a price tag of \$125 million to \$200 million or more, proton beam therapy centers are out of reach for all but the largest, most well-funded institutions. Nor would most community cancer centers be likely to include transplants, research and clinical trials, or integrated inpatient and outpatient services.

However, community cancer centers can establish viable programs on a much smaller scale that can satisfy most of the demand for services in their market areas. Components can be strategically selected based on the programs' objectives, scope and possible academic affiliations.

Baylor's Hub and Spoke Model

Baylor Health Care System epitomizes the trend of offering cancer care in both the AMC and community setting. On one hand, the system boasts what is arguably one of the most comprehensive cancer care facilities in the nation, the \$150 million, 10-story, 459,717 square foot Baylor Charles A. Sammons Cancer Center at Baylor University Medical Center in Dallas. The huge outpatient building, which was developed by Duke Realty, opened in March 2011 and offers treatments for every type of cancer and includes nearly every item described above.

Yet, at the same time, Baylor operates eight other smaller, community based cancers centers, bringing cancer care to Dallas suburbs and small Texas towns ranging from Carrollton to Waxahachie.

Thus the size and scale of cancer centers can vary widely. While some academic cancer centers including the flagship Baylor facility can approach 500,000 square feet, a successful community cancer center can consist of as little as 7,500 square feet. Locations can be on-campus or can be freestanding and community-based.

Most community cancer centers should also be able to rival academic cancer centers in terms of the amenities mentioned above, albeit on a smaller scale. Those amenities can include:

- convenient parking
- chapels or areas for meditation
- complimentary retail, such as cafés, restaurants and other types of food services, as well as shops offering products related to image and wellness, such as wigs, prosthetics, dietary supplements, books, gifts and greeting cards
- healing gardens and walks, and other outdoor spaces
- conference and education spaces, such as spaces for libraries, education, psychological counseling, nutrition counseling and support groups
- pharmacies
- phlebotomy and lab services

Community Centers' Growing Role

Despite the need for more community based cancer centers, healthcare executives say they must continue to focus on cutting costs. "The need to reduce costs can put a damper on new facilities, but there are still some facilities that have to be built," says Mr. Huff of Baylor Health Care System. "Some are built as a long-term defensive move to defend market share; others are built as a short-term bid to increase revenues. When it comes to the latter type, at Baylor we're building as fast as we can. We want to better serve our patients while seizing the opportunity to maximize our most profitable operations."

No matter how providers design their new oncology facilities, how they structure their programs and what amenities they offer, one thing is certain: community based facilities will play an increasingly prominent role in the future of cancer care. ■

Sharon Lleva-Carter is Executive Director, Duke Realty (previously Director, Design & Construction, Northwestern Memorial Hospital). Richard J. Couturier is Vice President, Development-South/West, Duke Realty. For more information, please visit www.dukerealty.com/healthcare.

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ACE MEMBER SNAPSHOT

ASSOCIATION
of CANCER
EXECUTIVES

Northwestern Lake Forest Hospital
Lake Forest, IL

- **Director Oncology Service Line:** Karlina Peal, MBA
- **How long have you been an oncology executive?** 12 years
- **What type of organizational model is the center?** Comprehensive community cancer center
- **Annual new cancer cases:** 700
- **Number of locations:** Two locations currently working on integrating into the Academic Center (NLFH Northwestern Lake Forest Hospital joined NMH Northwestern Memorial Hospital in Feb 2010)
- **Physician environment:** effective today 7/2/2012, Rad Onc physicians employed by NMFF Northwestern Medical Faculty Foundation; Med Onc- still private practice
- **Accreditations:** ACR/ASTRO Radiation Oncology; Commission on Cancer w/6 commendations, NAPBC, JCAHO
- **Unique or recently developed programs/services:** Recently opened a new comprehensive Cancer Center off site from the hospital to include: Infusion/chemotherapy, Radiation Oncology and supportive oncology services. Across both campuses recently developed cancer survivorship/networking groups, wig boutique for cancer center and wigs on wheels in the Inpatient setting. Complimentary and Integrative medicine services such as: yoga, nutrition and massage for cancer patients. Heighten the awareness of the tumor registry to patients and services at our organization.
- **Lessons learned:** Try to engage the staff early on to create a team approach, trust and engagement. Network with colleagues on what has worked and what you might be able to adapt in your facility.
- **Contact information:** Karlina M. Peal, 847-535-6135; 660 N. Westmoreland Rd. Lake Forest, IL 60045



3 QUESTIONS
WITH AN ACE MEMBER



Brian E. McCagh, FACHE
*Executive Director – Oncology Services
Sandra & Malcolm Berman Cancer Institute; Greater
Baltimore Medical Center, Baltimore, MD*

Stats: Cancer Executive for 20 years. ACE Member for 17 years; served on several committees and on the Board of Directors, including President for two terms. Education: BA from Wheeling Jesuit University, 1968; MBA in Healthcare Administration, George Washington University, 1974

What keeps you up at night?

- Growing physician alignment concerns and challenges
- Shrinking reimbursement and shifting payor mix
- Increasing cost reduction pressures
- Deteriorating case mix with our aging population
- Increasing cost of high technology, including IT

What are some of the biggest challenges you face?

- Selecting the best of breed oncology-specific EMR solution
- Creating a meaningful financial dashboard for the oncology service line
- Increasing competition in the regional market
- Gaining funding support for major capital equipment needs

Any advice for new cancer executives?

- Clearly assess your cancer program's strengths, weaknesses, opportunities and threats
- Focus on Patients First and Service Excellence
- Develop a strong business plan with realistic and measurable goals; track and report progress made against established goals
- Establish a meaningful oncology program dashboard report; report findings to executives on a monthly basis
- Establish an executive oncology leadership council consisting of both clinical and administrative leadership
- Keep your executive team informed... focusing on the FACTS that impact your cancer program
- Create a Patient & Family Advisory Council and involve them in decision making that impacts services offered to your cancer patients. ■



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ACE Welcome New Members

As of August 1, 2012

■ **Theresa Chandler**

Director

The Regional Medical Center
3000 St. Matthews
Orangeburg, SC 29115
803-395-4710
tpchandler@regmed.com

■ **Michael Cretaro**

Chief Radiation & Information Systems

Hematology-Oncology Associates of CNY
5008 Brittonfield Pkwy
E Syracuse, NY 13057
315-472-7504
mcretaro@hoacny.com

■ **Linda Friel-Stone, BA, CTR**

Cancer Program Coordinator

Nyack Hospital
160 North Midland Hospital
Nyack, NY 10960
8453482595
frielstonel@nyackhospital.org

■ **Kudzi Muchaka, MA, MBA, MPA**

Director

California Cancer Center
7257 N. Fresno Street
Fresno, CA 93720
559.451.3671
kmuchaka@communitymedical.org

■ **Betsy Mullenix**

Grant Cooepr Healthcare

One North Brentwood
St. Louis, MO 63105
314-726-5291 x145
mullenix@grantcooper.com

■ **Jason Rife**

ECG Management Consultants

100 Cambridge Street
Suite 2001
Boston, MA 02114
617-227-0100
jrife@ecgmc.com

■ **Kathleen Spears, PhD, MHA**

President & CEO

Cancer Support Community Central
Indiana
5150 West 71st Street
Indianapolis, IN 46268
317-257-1505
Kathleen@cancersupportindy.org

■ **Jane Tozer**

Director

Physician Resource Management, Inc.
28175 Haggerty Road
Suite 119
Novi, MI 48377
248-549-4057
jtozer@oprservices.com

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ACE 19TH ANNUAL MEETING
January 23–26, 2013
San Antonio, TX

