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Enhancing Cancer Care With Technology
28 Physician Compensation: Designing the “Best-Fit” Plan
A framework to evaluate and redesign compensation plans for oncologists.
By Matthew R. Sturm

36 Social Media and Your Cancer Program
Social media—done right—can help build your brand, improve customer service, and expand your market reach.
By Kat Gerlich

44 Survivorship Midwest Style
Launched in 2008, this survivorship program has already developed treatment summary and survivor care plans, a survivor “network,” informal self-help friendship groups, and more.
By Sandra Carbone

DEPARTMENTS

2 From the Editor | In With the New
3 President’s Message | The Journey Together
4 Fast Facts | Top cancers linked with bankruptcy, and more
6 Issues | ACCC testifies before HOP Panel (formerly the APC Panel), and more
12 Coding & Billing | The ABC’s of CSW Billing
15 Member Profile | Good Samaritan Cancer Center, Kearney, Nebraska
18 Tools | Approved cancer drugs, and more
49 Action | GE joins as sponsor of 2012 ACCC Innovator Awards, and more
51 Professional Opportunities
52 1st Person | Leigh and Joshua in Wonderland

Cover photo by Rene Samseining, courtesy of Getty Images
FROM THE EDITOR

In With the New

BY CHRISTIAN DOWNS, JD, MHA

I was cleaning my attic last week and came across copies of *Newsweek* magazine from the 1980s. It was fun to thumb through the old issues. Some things never change. Democrats and Republicans were fighting over taxes. The Middle East was in turmoil. The U.S. was concerned about the cost of healthcare—under the DRG prospective payment system. Anyone remember that? But there were aspects of the magazine that are now completely different. In the 1980s, there were no ads for computers or software, financial services, and, shockingly, lifestyle pharmaceuticals.

On Monday, knowing I had to write this column, I dug up an old edition of *Oncology Issues*. I thought I’d have a similar experience. But I didn’t—not even close. Unlike *Newsweek*, everything about ACCC’s journal was different, including its title. ACCC’s journal wasn’t even called *Oncology Issues* until the summer of 1988. It truly surprised me how much the journal had evolved. Some common themes remain, such as the desire to deliver the best care possible for patients. But what really what took me aback was the complexity and sophistication of the challenges we face today. And the four feature articles in this edition of *Oncology Issues* prove my point.

Our cover article discusses the issue of accreditation, and not just one accreditation, but all the accreditations your program is being asked to consider. How do today’s community cancer centers “juggle” these multiple accreditations? Toni Hare helps by providing practical strategies, such as ensuring consistent communication; putting together an involved Cancer Committee; educating your cancer registrars; and developing overarching goals, a scorecard, and planning tools.

Our second feature involves the complex and sensitive topic of physician compensation. With new relationships evolving between hospitals and physicians and physicians and payers, author Matthew Sturm provides a framework to evaluate and redesign compensation plans for today’s oncologists.

Our next article, “Social Media and Your Cancer Program,” is a topic that did not even exist 10 years ago. But social media is here to stay. So learn how social media—done right—can help build your brand, improve customer service, and expand your market reach.

In our last feature article, Sandra Carbone writes about a cancer survivorship program, launched in 2008, that has already developed treatment summary and survivor care plans, a survivor “network,” and informal self-help friendship groups. It’s hard to believe that comprehensive survivorship programs weren’t really on the radar for most community cancer centers even 10 years ago.

As we all know, change is inevitable. It can be challenging, but it can also bring about innovation and improvement. In my last column I wrote about the 2012 redesign of ACCC’s journal. The first issue is in your hands right now. And throughout the year, I’m going to call out a new feature and ask for your comments (see box at right). Today, as we unveil the latest iteration of *Oncology Issues*, I can’t help but wonder what people will think of our journal 10 or even 20 years from now. Whatever it looks like in the future, I’m confident *Oncology Issues* will continue to evolve and grow to meet the needs of ACCC’s membership.
We are a part of the greatest specialty in medicine: Oncology. When you dig through the many distractions and obstacles to care, at the end of the day it is still a remarkable and rewarding position that our patients entrust to us. They ask us to care for them at a most vulnerable time in their lives, and happily we are able to celebrate with more and more of them through survivorship than ever before.

At the same time, we are seeing evolutionary change in our care setting and practices due to enormous economic pressures. Among the stressors are the high cost of technology, decreasing reimbursement, increasing regulation, increasing cost of treatment, and increasing patient volumes—many of whom may be uninsured or underinsured. It is anticipated that the overall demand for oncology services will increase by over 40 percent by the year 2020.

We will likely need revolutionary changes in our care settings to meet the need. Already we are in an era of mergers and consolidations that are making private practice community oncology a dwindling entity. Will this shift help or compound the challenges of meeting the upcoming care demands? Will the changes that occur be evolutionary or revolutionary?

While these challenges are framed by uncertainty, we do know that oncology care providers have always been a resourceful group. We have worked through the challenges of the past decades and have managed to dramatically improve the quality and science of the care we deliver. I have no doubt that we will continue down that same path.

Over the past three decades, ACCC has been a vital resource in that journey, and the Association will continue to offer resources, support, and answers to the entire cancer team no matter what the future brings. ACCC's ever-expanding educational programs and advocacy efforts will help us through the changes—whether evolutionary or revolutionary—that lie ahead.

For the journey ahead, I am grateful for ACCC. What a wonderful and unique organization we have! Members who are passionate about great cancer care. Staff who are passionate about providing the education and advocacy work to make all of our programs and institutions thrive, and an organization that values the work and input of the entire cancer team. It is with more than a tinge of sadness that I become “Past President” of this unique organization. I thank you for allowing me the opportunity of personal and professional growth in leading ACCC over the past year. I have enjoyed every moment.

Now it is time to look forward to the future and all we can do with ACCC. Let’s make cancer care better together.
Tell Us What You Think! Like the journal redesign? Finding the information and tools you need? Let us know by taking our annual survey at: www.surveymonkey.com/s/LJKPS5H.

New ACCC Video Demonstrates Value of Membership
“ACCC: Together We Can Achieve Excellence” illustrates how you can improve patient care, efficiencies, and your bottom line by using ACCC programs and services. Learn more at: www.youtube.com/user/ACCCvision.

“Strategies for Nutrition & Supportive Care Need of Patients with Head and Neck Cancer” and “Nutrition—Symptom Management.”
Learn more at: www.accc-cancer.org/nutrition.

“Oncology Nutrition: What’s the Point?”, “Developing a Culture of Nutrition at a Community Cancer Center,” and “Optimizing Enteral Nutrition for Oncology Patients.”
Learn more at: www.accc-cancer.org/nutrition.

PODCASTS

WEBINARS

$$$$ of Cancer
Patients with cancer often bear higher cost burdens compared to patients with other chronic conditions. An AHRQ study showed that a higher proportion of nonelderly patients with cancer face a high burden of treatment costs (13.4 percent) compared to those with other chronic conditions (9.7 percent) and those without chronic conditions (4.4 percent). High out-of-pocket healthcare costs can deter patients with cancer from seeking care and may affect treatment costs, notes study author Didem S.M. Bernard, PhD.


Top 5 Cancers Linked with Personal Bankruptcy (in order of risk)

1. Lung
2. Thyroid
3. Leukemia and lymphoma
4. Uterine
5. Colorectal

What did the U.S. spend on healthcare in 2010?

$8,402 per person


Did You Know Choosing a 5-star Rated Hospital Could Save Your Life?

🌟 Patients have, on average, a 73% lower risk of death at a 5-star hospital compared to a 1-star hospital, and a 63% lower chance of experiencing a complication.

🌟 If all Medicare patients from 2008 through 2010 had been treated at 5-star hospitals, 240,040 lives could potentially have been saved.

🌟 Eighty percent of patients visiting HealthGrades.com are concerned about the quality of hospital care in their community; 42% believe their chance of death or complication is higher in some hospitals in their community.

Source: http://topcities.healthgrades.com/ratings

What is Causing Our Country’s Drug Shortages?

- **Product quality issues (particulate, contamination, impurities, etc.):** 54%
- **Delays and capacity issues:** 21%
- **Discontinuations:** 11%
- **Raw material issues:** 5%
- **Increase in demand due to other shortage:** 4%
- **Loss of manufacturing site:** 3%
- **Component problems and/or shortage:** 2%

Source: www.fda.gov./AboutFDA/Transparency/Basics/ucm272223.htm
ACCC Testifies Before Newly Renamed HOP Panel

On Feb. 27, 2012, ACCC testified before the new Hospital Outpatient Payment (HOP) Panel (formerly the Ambulatory Payment Classification (APC) Panel). The panel has been renamed and expanded in order to accommodate its new duties to make recommendations to the Centers for Medicare & Medicaid Services (CMS) on appropriate levels of supervision. The panel will add five new members to ensure representation from all hospitals, including Critical Access Hospitals (CAHs) and rural hospitals. Ernest Anderson, Jr., MS, RPh, testified before the HOP Panel on behalf of ACCC. His testimony focused on drug reimbursement and pharmacy overhead costs in the hospital outpatient department.

ACCC has testified on this topic in the past, often with the APC Panel agreeing with ACCC’s recommendations. This year, ACCC also discussed the role that drug shortages and REMS compliance play in the pharmacy department in addition to the other costs incurred in drug preparation.

In the 2012 Hospital Outpatient Prospective Payment System (HOPPS) final rule, CMS reduced drug reimbursement to ASP+4 percent, down from ASP+5 percent in 2011. ACCC asked the panel to recommend to CMS to increase reimbursement under the HOPPS to at least ASP+6 percent in 2013. ACCC will also follow up its testimony with meetings with CMS staff in the coming months.

ACCC Responds to CMS Policies on CED

On Jan. 20, 2012, ACCC submitted comments to CMS about the agency’s Coverage with Evidence Development (CED) policies. ACCC expressed its belief that continued clinical research is essential to further improve patient care and must be a priority for all stakeholders involved in cancer care, including CMS. Accordingly, ACCC strongly urged CMS to ensure that CED does not restrict beneficiary access to appropriate care or impede innovation that will ultimately benefit Medicare beneficiaries.

New Drug Shortage Legislation Introduced

Jan. 31, 2012, U.S. Representatives John Carney (D-Del.) and Larry Bucshon (R-Ind.) introduced the Drug Shortage Prevention Act of 2012 (H.R. 3839). The legislation would strengthen the Food and Drug Administration’s ability to take into account critical shortage issues in the approval and regulation process, and calls for a study on the feasibility of a national contingency plan to address critical drug shortages.

ACCC also supports H.R. 2245 and S. 296, companion bills that shift the requirement of reporting drug shortages from physicians to the manufacturing companies. Each of these bills has been referred to subcommittees for further action. ACCC will keep you updated on their progress.

Report Finds Cancer Screening Below Target Rates

According to a report released by the Centers for Disease Control (CDC) and the National Cancer Institute (NCI) Jan. 26, 2012, U.S. cancer screening rates for breast, cervical, and colorectal cancers remain below target levels set by federal officials in the Healthy People 2020 initiative. Overall, the breast cancer screening rate was 72.4 percent (below Healthy People 2020 target of 81.1 percent), cervical cancer screening was 83 percent (below the target of 93 percent), and colorectal cancer screening was 58.6 percent (below the target of 70.5 percent). The study also identifies disparities in cancer screening rates among Asian and Hispanic populations. The report is available in the Jan. 27 issue of the CDC’s Morbidity and Mortality Weekly Report (MMWR 2012;61:41-45), available online at http://www.cdc.gov/mmwr.

Pioneer ACOs Announced

32 health care organizations from across the country will participate in the Pioneer Accountable Care Organization (ACOs) Model. For the full list of organizations see link: http://innovations.cms.gov/files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf.
**Indication**

YERVOY (ipilimumab) is indicated for the treatment of unresectable or metastatic melanoma.¹

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**Important Safety Information**

**WARNING: IMMUNE-MEDIATED ADVERSE REACTIONS**

YERVOY can result in severe and fatal immune-mediated adverse reactions due to T-cell activation and proliferation. These immune-mediated reactions may involve any organ system; however, the most common severe immune-mediated adverse reactions are enterocolitis, hepatitis, dermatitis (including toxic epidermal necrolysis), neuropathy, and endocrinopathy. The majority of these immune-mediated reactions initially manifested during treatment; however, a minority occurred weeks to months after discontinuation of YERVOY.

Assess patients for signs and symptoms of enterocolitis, dermatitis, neuropathy, and endocrinopathy and evaluate clinical chemistries including liver function tests (LFTs) and thyroid function tests at baseline and before each dose.

Permanently discontinue YERVOY and initiate systemic high-dose corticosteroid therapy for severe immune-mediated reactions.

---

**REFERENCES**


Important Safety Information (cont)

Recommended Dose Modifications
Withhold dose for any moderate immune-mediated adverse reactions or for symptomatic endocrinopathy until return to baseline, improvement to mild severity, or complete resolution, and patient is receiving <7.5 mg prednisone or equivalent per day.

Permanently discontinue YERVOY for any of the following:
- Persistent moderate adverse reactions or inability to reduce corticosteroid dose to 7.5 mg prednisone or equivalent per day
- Failure to complete full treatment course within 16 weeks from administration of first dose
- Severe or life-threatening adverse reactions, including any of the following
  - Colitis with abdominal pain, fever, ileus, or peritoneal signs; increase in stool frequency (≥7 over baseline), stool incontinence, need for intravenous hydration for >24 hours, gastrointestinal hemorrhage, and gastrointestinal perforation
  - AST or ALT >5 x the upper limit of normal (ULN) or total bilirubin >3 x the ULN
  - Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full-thickness dermal ulceration or necrotic, bullous, or hemorrhagic manifestations
  - Severe motor or sensory neuropathy, Guillain-Barré syndrome, or myasthenia gravis
  - Severe immune-mediated reactions involving any organ system
  - Immune-mediated ocular disease which is unresponsive to topical immunosuppressive therapy

Immune-mediated Enterocolitis:
- In the pivotal Phase 3 study in YERVOY-treated patients, severe, life-threatening or fatal (diarrhea of ≥7 stools above baseline, fever, ileus, peritoneal signs; Grade 3-5) immune-mediated enterocolitis occurred in 34 (7%) and moderate (diarrhea with up to 6 stools above baseline, abdominal pain, mucus or blood in stool; Grade 2) enterocolitis occurred in 28 (5%) patients
- Across all YERVOY-treated patients (n=511), 5 (1%) developed intestinal perforation, 4 (0.8%) died as a result of complications, and 26 (5%) were hospitalized for severe enterocolitis
- Infliximab was administered to 5 of 62 (8%) patients with moderate, severe, or life-threatening immune-mediated enterocolitis following inadequate response to corticosteroids
- Monitor patients for signs and symptoms of enterocolitis (such as diarrhea, abdominal pain, mucus or blood in stool, with or without fever) and bowel perforation (such as peritoneal signs and ileus). In symptomatic patients, rule out infectious etiologies and consider endoscopic evaluation for persistent or severe symptoms
- Permanently discontinue YERVOY in patients with severe enterocolitis and initiate systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent). Upon improvement to ≤Grade 1, initiate corticosteroid taper and continue over at least 1 month. In clinical trials, rapid corticosteroid tapering resulted in recurrence or worsening symptoms of enterocolitis in some patients
- Withhold YERVOY for moderate enterocolitis; administer anti-diarrheal treatment and, if persistent for >1 week, initiate systemic corticosteroids (0.5 mg/kg/day prednisone or equivalent)

Immune-mediated Hepatitis:
- In the pivotal Phase 3 study in YERVOY-treated patients, severe, life-threatening, or fatal hepatotoxicity (AST or ALT elevations >5x the ULN or total bilirubin elevations >3x the ULN; Grade 3–5) occurred in 8 (2%) patients, with fatal hepatic failure in 0.2% and hospitalization in 0.4%
- 13 (2.5%) additional YERVOY-treated patients experienced moderate hepatotoxicity manifested by LFT abnormalities (AST or ALT elevations >2.5x but ≤5x the ULN or total bilirubin elevation >1.5x but ≤3x the ULN; Grade 2)
- Monitor LFTs (hepatic transaminase and bilirubin levels) and assess patients for signs and symptoms of hepatotoxicity before each dose of YERVOY. In patients with hepatotoxicity, rule out infectious or malignant causes and increase frequency of LFT monitoring until resolution
- Permanently discontinue YERVOY in patients with Grade 3-5 hepatotoxicity and administer systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent). When LFTs showed sustained improvement or return to baseline, initiate corticosteroid tapering and continue for 1 month. Across the clinical development program for YERVOY, mycophenolate treatment has been administered in patients with persistent severe hepatitis despite high-dose corticosteroids
- Withhold YERVOY in patients with Grade 2 hepatotoxicity

Immune-mediated Dermatitis:
- In the pivotal Phase 3 study in YERVOY-treated patients, severe, life-threatening or fatal immune-mediated dermatitis (e.g., Stevens-Johnson syndrome, toxic epidermal necrolysis, or rash complicated by full thickness dermal ulceration, or necrotic, bullous, or hemorrhagic manifestations; Grade 3–5) occurred in 13 (2.5%) patients
  - 1 (0.2%) patient died as a result of toxic epidermal necrolysis
  - 1 additional patient required hospitalization for severe dermatitis
- There were 63 (12%) YERVOY-treated patients with moderate (Grade 2) dermatitis
- Monitor patients for signs and symptoms of dermatitis such as rash and pruritus. Unless an alternate etiology has been identified, signs or symptoms of dermatitis should be considered immune-mediated
- Permanently discontinue YERVOY in patients with severe, life-threatening, or fatal immune-mediated dermatitis (Grade 3-5). Administer systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent). When dermatitis is controlled, corticosteroid tapering should occur over a period of at least 1 month. Withhold YERVOY in patients with moderate to severe signs and symptoms

Please see brief summary of Full Prescribing Information, including Boxed WARNING regarding immune-mediated adverse reactions, on the following spread.
Immune-mediated Endocrinopathies:
- In the pivotal Phase 3 study in YERVOY-treated patients, 1 case of fatal Guillain-Barré syndrome and 1 case of severe (Grade 3) peripheral motor neuropathy were reported.
- Across the clinical development program of YERVOY, myasthenia gravis and additional cases of Guillain-Barré syndrome have been reported.
- Monitor for symptoms of motor or sensory neuropathy such as unilateral or bilateral weakness, sensory alterations, or paresthesia. Permanently discontinue YERVOY in patients with severe neuropathy (interfering with daily activities) such as Guillain-Barré-like syndromes.
- Institute medical intervention as appropriate for management of severe neuropathy. Consider initiation of systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent) for severe neuropathies. Withhold YERVOY in patients with moderate neuropathy (not interfering with daily activities).
- Moderate endocrinopathy (requiring hormone replacement or medical intervention; Grade 2) occurred in 12 (2.3%) YERVOY-treated patients and consisted of hyperthyroidism, adrenal insufficiency, hypopituitarism, and 1 case each of hyperthyroidism and hypothyroidism.
- Median time to onset of moderate to severe immune-mediated endocrinopathy was 11 weeks and ranged up to 19.3 weeks after the initiation of YERVOY.
- Monitor patients for clinical signs and symptoms of hypophysitis, adrenal insufficiency (including adrenal crisis), and hyper- or hypothyroidism.
- Patients may present with fatigue, headache, mental status changes, abdominal pain, unusual bowel habits, and hypotension, or nonspecific symptoms which may resemble other causes such as brain metastasis or underlying disease. Unless an alternate etiology has been identified, signs or symptoms should be considered immune-mediated.
- Monitor thyroid function tests and clinical chemistries at the start of treatment, before each dose, and as clinically indicated based on symptoms. In a limited number of patients, hypophysitis was diagnosed by imaging studies through enlargement of the pituitary gland.
- Withhold YERVOY in symptomatic patients. Initiate systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent) and initiate appropriate hormone replacement therapy. Long-term hormone replacement therapy may be necessary.

Other Immune-mediated Adverse Reactions, Including Ocular Manifestations:
- In the pivotal Phase 3 study in YERVOY-treated patients, clinically significant immune-mediated adverse reactions also reported with <1% incidence were: myocarditis, angiopathy, temporal arteritis, vasculitis, polymyalgia rheumatica, conjunctivitis, blepharitis, episcleritis, scleritis, leukocytoclastic vasculitis, erythema multiforme, psoriasis, pancreatitis, arthritis, and autoimmune thyroiditis.
- Permanently discontinue YERVOY for clinically significant or severe immune-mediated adverse reactions. Initiate systemic corticosteroids (1-2 mg/kg/day of prednisone or equivalent) for severe immune-mediated adverse reactions.
- Administer corticosteroid eye drops for uveitis, iritis, or episcleritis. Permanently discontinue YERVOY for immune-mediated ocular disease unresponsive to local immunosuppressive therapy.

Pregnancy & Nursing:
- YERVOY is classified as pregnancy category C. There are no adequate and well-controlled studies of YERVOY in pregnant women. Use YERVOY during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Human IgG1 is known to cross the placental barrier and YERVOY is an IgG1; therefore, YERVOY has the potential to be transmitted from the mother to the developing fetus.
- It is not known whether YERVOY is secreted in human milk. Because many drugs are secreted in human milk and because of the potential for serious adverse reactions in nursing infants from YERVOY, a decision should be made whether to discontinue nursing or to discontinue YERVOY.

Common Adverse Reactions:
- The most common adverse reactions (≥5%) in patients who received YERVOY at 3 mg/kg were fatigue (41%), diarrhea (32%), pruritus (31%), rash (29%), and colitis (8%).
peritoneal signs; Grade 3–5) immune-mediated enterocolitis occurred in 34 (7%) YERVOY-treated patients, [See Boxed Warning]

• Advise nursing mothers not to breast-feed while taking YERVOY. See MEDICATION GUIDE

Indications and Usage

YERVOY (ipilimumab) is indicated for the treatment of unresectable or metastatic melanoma.

CONTRAINDICATIONS

None.

Warnings and Precautions

YERVOY can result in severe and fatal immune-mediated reactions due to T-cell activation and proliferation.

Immune-mediated Enterocolitis

In Study 1, severe, life-threatening, or fatal diarrhea (7 of 9 or more stools above baseline, fever, ileus, perianal signs; Grade 3–5) immune-mediated enterocolitis occurred in 34 (7%) YERVOY-treated patients, and death (diarrhea with up to 6 stools above baseline, abdominal pain, mucus or blood in stool; Grade 2) enterocolitis occurred in 28 (5%) YERVOY-treated patients. Across all YERVOY-treated patients (n=511), 5 (1%) patients developed intestinal perforation, 4 (0.8%) patients died as a result of complications, and 26 (5%) patients were hospitalized for severe enterocolitis. The median time to onset was 7 days (range 1.6–13.4) and 6.3 weeks (range 0.3–18.0) after the initiation of YERVOY for patients with Grade 3–5 enterocolitis and with Grade 2 enterocolitis, respectively.

Twenty-nine patients (5%) with Grade 3–5 enterocolitis were treated with high-dose (>40 mg prednisone equivalent per day) corticosteroids, with a median dose of 80 mg/day of prednisone or equivalent; the median duration of treatment was 2.3 weeks (ranging up to 13.9 weeks) followed by corticosteroid taper. Of the 28 patients with moderate enterocolitis, 46% were not treated with systemic corticosteroids, 29% were treated with <40 mg prednisone equivalent per day for a median duration of 5.1 weeks, and 25% were treated with high-dose corticosteroids for a median of 10 days prior to corticosteroid taper. Infliximab was administered to 5 of the 62 patients (8%) with moderate, severe, or life-threatening immune-mediated enterocolitis following inadequate response to corticosteroids. The median time to onset of moderate, severe, or life-threatening immune-mediated enterocolitis was 11 weeks and ranged up to 30.9 weeks.

Of the 21 patients with moderate to severe-life-threatening enterocolitis, 17 patients required long-term hormone replacement therapy including, most commonly, adrenal hormones (n=10) and thyroid hormones (n=13).

Monitor patients for clinical signs and symptoms of hypophysitis, adrenal insufficiency (including adrenal crisis), and hyper- or hypothyroidism. Patients may present with fatigue, headache, mental status changes, abdominal pain, unusual bowel habits, and hypotension, or nonspecific symptoms which may resemble other causes such as brain metastasis or underlying disease. Unless an alternate etiology has been identified, signs or symptoms of endocrinopathies should be considered immune-mediated.

Monitor thyroid function tests and clinical chemistry at the start of treatment, before each dose, and as clinically indicated based on symptoms. In a limited number of patients, hypophysitis was diagnosed by imaging studies through enlargement of the pituitary gland.

Without YERVOY dosing in symptomatic patients. Initiate systemic corticosteroids at a dose of 1 to 2 mg/kg/day of prednisone or equivalent, and initiate appropriate hormone replacement therapy. [See Dosage and Administration (2.2) in Full Prescribing Information]

Other Immune-mediated Adverse Reactions, Including Ocular Manifestations

The following clinically significant immune-mediated adverse reactions were seen in less than 1% of YERVOY-treated patients in Study 1: nephritis, pneumonitis, meningitis, pericarditis, uveitis, iritis, and hemolytic anemia.

Across the clinical development program for YERVOY, the following likely immune-mediated adverse reactions were also reported with less than 1% incidence: myocarditis, angioedema, temporal arteritis, vasculitis, polymyalgia rheumatica, conjunctivitis, papillitis, epiphiitis, dermatitis, leukocytoclastic vasculitis, erythema multiforme, psoriasis, panarteritis, arthritis, and autoimmune thyroiditis.

Permanently discontinue YERVOY for clinically significant or severe immune-mediated adverse reactions. Initiate systemic corticosteroids at a dose of 1 to 2 mg/kg/day prednisone or equivalent for severe immune-mediated adverse reactions.

Monitor corticosteroid eye drops to patients who develop uveitis, iritis, or epiphiitis. Permanently discontinue YERVOY for immune-mediated ocular disease that is unresponsive to local immunosuppressive therapy. [See Dosage and Administration (2.2) in Full Prescribing Information]

Adverse Reactions

The following adverse reactions are discussed in greater detail in other sections of the labeling.

• Immune-mediated enterocolitis [see Warnings and Precautions].
• Immune-mediated hepatitis [see Warnings and Precautions].
• Immune-mediated dermatitis [see Warnings and Precautions].
• Immune-mediated nephropathies [see Warnings and Precautions].
• Immune-mediated endocrinopathies [see Warnings and Precautions].
• Other immune-mediated adverse reactions, including ocular manifestations [see Warnings and Precautions].
Clinical Trials Experience

Because clinical trials are conducted under widely varying conditions, the adverse reaction rates observed cannot be directly compared with rates in other clinical trials or experience with therapeutics in the same class and may not reflect the rates observed in clinical practice.

The clinical development program excluded patients with active autoimmune disease or those receiving systemic immunosuppression for organ transplantation. Exposure to YERVOY (ipilimumab) 3 mg/kg for four doses given by intravenous infusion in previously treated patients with unresectable or metastatic melanoma was assessed in a randomized, double-blind clinical study (Study 1). [See Clinical Studies (16) in Full Prescribing Information] One hundred thirty-one patients (median age 57 years, 60% male) received YERVOY as a single agent, 380 patients (median age 56 years, 61% male) received YERVOY with an investigational gp100 peptide vaccine (gp100), and 132 patients (median age 57 years, 54% male) received gp100 peptide vaccine alone. Patients in the study received a median of 4 doses (range 1 to 4 doses); YERVOY was discontinued for adverse reactions in 10% of patients.

The most common adverse reactions (>5%) in patients who received YERVOY at 3 mg/kg were fatigue, diarrhea, pruritus, rash, and colitis.

Table 1 presents selected adverse reactions from Study 1, which occurred in at least 5% of patients in the YERVOY-containing arms and with at least 5% increased incidence over the control gp100 arm for all-grade events and at least 1% incidence over the control group for Grade 3–5 events.

Table 2 presents the per-patient incidence of severe, life-threatening, or fatal immune-mediated adverse reactions from Study 1.

### Table 1: Selected Adverse Reactions in Study 1

<table>
<thead>
<tr>
<th>System Organ Class/Preferred Term</th>
<th>Percentage (%) of Patients</th>
<th>YERVOY 3 mg/kg</th>
<th>YERVOY gp100</th>
<th>YERVOY gp100 n=131</th>
<th>YERVOY gp100 n=380</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gastrointestinal Disorders</td>
<td>Any Grade or Any Grade 3–5</td>
<td>36%</td>
<td>4%</td>
<td>20%</td>
<td>4%</td>
</tr>
<tr>
<td>Diarrhea</td>
<td>Any Grade or Any Grade 3–5</td>
<td>32%</td>
<td>5%</td>
<td>27%</td>
<td>5%</td>
</tr>
<tr>
<td>Collitis</td>
<td>Any Grade or Any Grade 3–5</td>
<td>8%</td>
<td>3%</td>
<td>5%</td>
<td>2%</td>
</tr>
<tr>
<td>Skin and Subcutaneous Tissue Disorders</td>
<td>Any Grade or Any Grade 3–5</td>
<td>31%</td>
<td>0%</td>
<td>21%</td>
<td>&lt;1%</td>
</tr>
<tr>
<td>Pruritus</td>
<td>Any Grade or Any Grade 3–5</td>
<td>29%</td>
<td>2%</td>
<td>0%</td>
<td>25%</td>
</tr>
<tr>
<td>Rash</td>
<td>Any Grade or Any Grade 3–5</td>
<td>29%</td>
<td>2%</td>
<td>0%</td>
<td>25%</td>
</tr>
<tr>
<td>General Disorders and Administration Site Conditions</td>
<td>Any Grade or Any Grade 3–5</td>
<td>41%</td>
<td>7%</td>
<td>3%</td>
<td>41%</td>
</tr>
</tbody>
</table>

* Incidences presented in this table are based on reports of adverse events regardless of causality.

### Table 2: Severe to Fetal Immune-mediated Adverse Reactions in Study 1

<table>
<thead>
<tr>
<th>Immune-mediated Adverse Reaction</th>
<th>Percentage (%) of Patients</th>
<th>YERVOY 3 mg/kg</th>
<th>YERVOY gp100</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any Immune-mediated Adverse Reaction</td>
<td>15%</td>
<td>12%</td>
<td></td>
</tr>
<tr>
<td>Enterocolitis (a,b)</td>
<td>7%</td>
<td>7%</td>
<td></td>
</tr>
<tr>
<td>Hepatotoxicity (a)</td>
<td>7%</td>
<td>2%</td>
<td></td>
</tr>
<tr>
<td>Dermatitis (a)</td>
<td>2%</td>
<td>3%</td>
<td></td>
</tr>
<tr>
<td>Neutropenia (a)</td>
<td>1%</td>
<td>&lt;1%</td>
<td></td>
</tr>
<tr>
<td>Endocrinopathy</td>
<td>1%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Hypoprolactinemia</td>
<td>4%</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>0%</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>

* a Including fatal outcome.
* b Including intestinal perforation.
* c underlying etiology not established.

### Immune-mediated Hepatitis

Immune-mediated hepatitis is a rare, severe, and potentially fatal side effect seen in patients treated with YERVOY. It may occur at any time during treatment and can be fatal. Patients may experience symptoms such as fever, nausea, vomiting, or jaundice. Treatment may include withdrawal of YERVOY and initiation of corticosteroid therapy, such as prednisone 1 to 2 mg/kg/day or equivalent per day. In a subset of patients, mycophenolate treatment may be considered. The risk of immune-mediated hepatitis increases with higher doses of YERVOY. The incidence and severity of hepatitis can be reduced by careful monitoring and prompt initiation of appropriate treatment.

### Immune-mediated Enterocolitis

Immune-mediated enterocolitis is a side effect that can occur in patients treated with YERVOY. It may be characterized by diarrhea, abdominal pain, and fever. Treatment may involve discontinuation of YERVOY and initiation of systemic corticosteroids at a dose of 1 to 2 mg/kg/day or equivalent per day. In some cases, mycophenolate treatment may be considered. The risk of immune-mediated enterocolitis increases with higher doses of YERVOY. The incidence and severity of enterocolitis can be reduced by careful monitoring and prompt initiation of appropriate treatment.

### Drug Interactions

No formal drug-drug interaction studies have been conducted with YERVOY (ipilimumab).

### USE IN SPECIFIC POPULATIONS

#### Pregnancy

Pregnancy Category C

There are no adequate and well-controlled studies of YERVOY in pregnant women. Use YERVOY during pregnancy only if the potential benefit justifies the potential risk to the fetus.

In a combined study of embryo-fetal and peri-natal/postnatal development, severe toxicities including increased incidences of third-trimester abortion, stillbirth, premature delivery, low birth weight, and infant mortality occurred following intravenous administration of ipilimumab to pregnant cynomolgus monkeys every 21 days from the onset of organogenesis through parturition at doses of 3.6 or 7.2 times the recommended human dose of 3 mg/kg by AUC. [See Nonclinical Toxicology (13.2) in Full Prescribing Information]

In genetically engineered mice in which the gene for CTLA-4 has been deleted (a “knockout mouse”), offspring lacking CTLA-4 were born apparently healthy, but died within 3–4 weeks due to multi-organ inflammation and damage by lymphocytes.

Human IgG1 is known to cross the placental barrier and ipilimumab is an IgG1; therefore, ipilimumab has the potential to be transmitted from the mother to the developing fetus.

#### Nursing Mothers

It is not known whether ipilimumab is secreted in human milk. Because many drugs are secreted in human milk and because of the potential for serious adverse reactions in nursing infants from YERVOY, a decision should be made whether to discontinue nursing or to discontinue YERVOY, taking into account the importance of YERVOY to the mother.

### Pediatric Use

Safety and effectiveness of YERVOY have not been established in pediatric patients.

### Geriatric Use

Of the 511 patients treated with YERVOY at 3 mg/kg, 28% were 65 years and over. No overall differences in safety or efficacy were reported between the elderly patients (65 years and over) and younger patients (less than 65 years).

### Renal Impairment

No formal studies of YERVOY in patients with renal impairment have been conducted. [See Clinical Pharmacology (12.3) in Full Prescribing Information]

### Hepatic Impairment

No formal studies of YERVOY in patients with hepatic impairment have been conducted. [See Clinical Pharmacology (12.3) in Full Prescribing Information]

### OVERDOSAGE

There is no information on overdosage with YERVOY.

### PATIENT COUNSELING INFORMATION

#### See MEDICATION GUIDE in Full Prescribing Information.

- Inform patients of the potential risk of immune-mediated adverse reactions.
- Advise patients to read the YERVOY Medication Guide before each YERVOY infusion.
- Advise women that YERVOY may cause fetal harm.
- Advise nursing mothers not to breast-feed while taking YERVOY.

Manufactured by: Bristol-Myers Squibb Company Princeton, NJ 08543 USA

Bristol-Myers Squibb
Princeton, NJ 08543 U.S.A.

1281558A2 IF-80001A-03-11 Issued: March 2011
A clinical social worker (CSW) is a practitioner trained, educated, and licensed at the graduate level, with a master’s degree or higher in social work, to provide mental health services for individuals, families, and groups. Some states have licensing requirements, and these practitioners are referred to as licensed clinical social workers (LCSWs).

The profession of clinical social work originated in the 1920s, and the role of social workers shifted over time with increasing attention on individual social adjustment. By the mid-20th Century, psychiatric social work was an accepted area of practice and laid the foundation for what would be labeled “clinical social work” in the 1970s.

Of the four core mental health professions, social workers comprise the largest group of clinically trained practitioners in the United States. In addition, social workers are more likely than psychologists and psychiatrists to work in rural communities.1

Cancer Center Social Work
A cancer center social worker typically provides psychosocial services to patients, families, and caregivers facing the impact of a cancer diagnosis. Social workers are knowledgeable about the psychosocial, emotional, and financial issues that cancer patients may confront. Oncology social workers help facilitate the patient’s adjustment to cancer and can help patients navigate the healthcare system. In addition, oncology social workers are knowledgeable about local resources, pharmaceutical and non-pharmaceutical patient assistance programs, and government programs and can assist patients and their families in accessing this support. In many cancer programs, the clinical social worker coordinates and/or facilitates patient and caregiver support groups.

The clinical social worker is generally part of a multidisciplinary team that works together to meet the needs of the cancer patient and/or family. The CSW may be primarily responsible for managing practical issues, such as transportation, housing, financial assistance, and language or cultural barriers to treatment or ancillary services. While the primary assistance provided by the social worker may be providing education related to the disease process, discussion of treatment decisions, and support with coping skills, the CSW may also provide and document individual and family counseling sessions.

Reimbursement
For purposes of Medicare reimbursement, a clinical social worker is an individual who possesses a master’s degree or doctorate in social work, has performed at least two years of supervised clinical social work, and either:
1. Is licensed or certified as a clinical social worker by the State in which the services are performed, or
2. If the State does not have a licensing or certification process, has completed at least two years or 3,000 hours of post-master’s degree supervised clinical social work practice under the supervision of a master’s level social worker in an appropriate setting, such as a hospital, skilled nursing facility (SNF), or clinic.

In addition, covered services include those that the CSW is legally authorized to perform under State law or regulation to diagnose and treat mental illnesses. Services provided to beneficiaries that are inpatient or in a partial hospitalization program are considered to be Medicare Part A expenses, while services performed in a physician’s office, outpatient hospital, hospice, or community mental health center can be billed by the CSW to Medicare Part B. Mental health services provided to a skilled nursing home patient may be Part A or Part B, depending on the nature of the patient’s admission to the SNF.

Covered therapeutic services are reimbursed as follows:
• The payment for CSW services is based on 80 percent of the lesser of 1) the actual charge, or 2) 75 percent of the physician fee schedule.
• Professional services billed outpatient in a Critical Access Hospital (CAH) are reimbursed at 115 percent of the allowed amount (75 percent of the physician fee schedule). The CAH is required to append HCPCS Level II modifier AJ (clinical social worker) to the professional charges.
• The annual Medicare Part B deductible and 20 percent coinsurance apply to CSW services.

Covered clinical social worker services in the hospital outpatient setting are reimbursed by Medicare Part B, regardless of whether the CSW is employed by the hospital or practices independently. However, clinical social workers cannot bill Medicare directly for outpatient services;
“Managing the costs of cancer treatment is difficult for many patients and families coping with cancer, and may cause distress and worry and make it more challenging to follow their doctors’ prescribed treatment course,” said Carolyn Messner, president of the Association of Oncology Social Work (AOSW). AOSW was formed in 1984 and is dedicated to the enhancement of psychosocial services to people with cancer and their families to help them cope with the practical, financial, emotional, and social concerns of living with cancer.

the hospital must file the Medicare claim and identify the social worker with a specific provider number. The CSW cannot generally charge for evaluation and management (E/M) services, psychological testing, or procedure codes that include medical management. Therapeutic services that can generally be billed by a CSW include individual psychotherapy, group therapy, and family therapy (procedure codes 90804–90899).

Remember that payers other than Medicare may have different limitations on the number of sessions or hours reimbursed per patient per calendar year or fiscal year.

Component of Hospital Clinic Visit

There are two parts to every outpatient hospital visit 1) the professional component that reports the physician’s service and 2) the technical and facility component used to report the services of hospital ancillary staff, room, and overhead costs, collectively called the hospital resources.

Since the implementation of the Medicare Hospital Outpatient Prospective Payment System (HOPPS) in August 2000, hospitals have been coding clinic visits using the same E/M procedure codes as those reported by physician offices. When assigned by the hospital, however, these codes have entirely different definitions. Physician reporting relates to CPT® definitions based on complexity of history, examination, and medical decision-making. In contrast, hospital reporting of a technical visit service takes into account the intensity of facility resources used by hospital staff on the day of a patient encounter with the physician.

Medicare holds each facility accountable for following its own system for assigning the different levels of clinic visit codes. As long as the services furnished are documented and medically necessary and the facility is following its own system, which reasonably relates the intensity of hospital resources to the different code levels, Medicare assumes that the hospital is in compliance with these reporting requirements. Therefore, Medicare has only two requirements:

- The services must be documented and medically necessary, and
- The mapping should reasonably reflect the intensity of the hospital’s technical resources.

While the CSW cannot bill for clinic visits, management services, or non-psychotherapy procedures, all resources expended by the hospital in an outpatient department can be used to report a facility clinic visit (technical service). This visit includes social worker services relating to patient education, navigation, or other services that include direct face-to-face patient contact. For example, if the hospital employs a point system or other methodology to track resource utilization for purposes of billing the clinic visit, appropriate credit can be given for the services of the CSW on the date of a technical clinic visit. Remember that the clinic visit is the technical component of a face-to-face physician evaluation and management service in the outpatient department. Hospital clinic visit codes include:

- New patient visits (99201–99205)
- Established patient visits (99211–99215).

To recap: clinical social workers cannot bill separately for services provided to an individual patient that are not considered individual, group, or family therapy. However, the CSW can be considered part of the hospital resources that contribute to the level of the technical clinic visit service on the day the patient is evaluated by the physician in the hospital outpatient department.


References


Additional Resources


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SPOTLIGHT ON OMC GROUP’S EXPERTS - ELAINE KLOOS, RN, NE-BC, MBA

Elaine Kloos is a Senior Consultant with Oncology Management Consulting Group and brings over 25 years of experience in healthcare administration. Elaine also enjoys over 20 years of expertise in Oncology Administration and Women’s Breast Health Services with specific areas of focus in clinical service line development, comprehensive breast care centers, strategic planning, revenue cycle analysis as well as facility design and project management. As a Registered Nurse, Elaine adds significant clinical expertise to the OMC Group and is expert in clinical operations, patient satisfaction, radiation oncology equipment selection, new program development as well as JCAHO, ACoS, ACR and ACRO accreditation processes. She has served as an Oncology Service Line Director and Vice President for numerous healthcare systems and community based hospitals and her oncology experience includes oversight for inpatient medical and GYN oncology, radiation oncology, outpatient chemotherapy infusion, medical and GYN oncology physician practices, comprehensive breast centers, high-risk breast cancer and high-risk colon cancer programs, clinical research, community outreach, and cancer registry. Among her major areas of proficiency are revenue cycle analysis of the oncology service line (both medical oncology and radiation oncology), strategic planning, market analysis and positioning, operational efficiency, new program development and facility design.
Good Samaritan Cancer Center
Kearney, Nebraska

Quality care centered on the patient

Good Samaritan Cancer Center in Kearney, Nebraska, is an example of a community-based cancer program that not only provides quality care for the region it serves, but as a National Cancer Institute Community Cancer Centers Program (NCCCP) site also contributes to efforts aimed at improving cancer care nationwide.

Accredited by the American College of Surgeons Commission on Cancer (CoC) since 1982, Good Samaritan Cancer Center has been an NCCCP site since 2007. Sponsored by Catholic Health Initiatives (CHI), Good Samaritan Hospital is a regional referral center. The Good Samaritan Cancer Center service area covers a population of nearly 350,000 that includes central Nebraska and northern Kansas. The cancer center provides comprehensive cancer care in a patient-centered, healing environment. Services include:

- Infusion therapy
- Radiation therapy
- Genetic counseling
- Patient navigation
- A patient resource library
- Support groups
- Access to a wide range of clinical trials

Like many community-based cancer programs serving semi-rural areas, Good Samaritan Cancer Center cares for patients who often have to travel long distances to receive cancer treatment. Through its NCCCP participation, the cancer center is working to improve access to care for both the rural population and the region’s underserved.

In 2004 a new one-story cancer center with a Varian 21EX linear accelerator was constructed on the hospital campus. Then, in 2007, the facility was expanded to accommodate a new Varian Trilogy linear accelerator with on-board imaging. Today Good Samaritan Cancer Center offers the latest radiation oncology treatment options including IMRT, IGRT with respiratory gating, stereotactic radiosurgery/radiotherapy (SRS/SRT), high and low dose rate brachytherapy, MammoSite, and a prostate seed implant program.

Visitors arriving at the cancer center enter into a spacious light-filled lobby and reception area. Conveniently located off the lobby are the patient resource library, a conference room, and a playroom for children. The

Vital Statistics
- Hospital bed size: 287
- Number of new analytics cases seen in 2010: 500

Selected Support Services
- Survivorship Program
- Dedicated Oncology Dietitian
- Oncology Exercise and Rehabilitation Program
- Integrated Care (yoga, massage therapy, acupuncture)
- Pastoral Care and Palliative Care

The Latest Treatment Options

Gathered in the Healing Garden, Good Samaritan staff sport “Kearney Tackles Cancer” tee-shirts.
library features a touch-screen computer from CancerHelp® that is pre-populated with cancer education information, including publications from the National Cancer Institute. Visitors can view videos, search for information, and download and print out materials on topics of interest. Information is available in English and Spanish and is updated monthly. The search function allows staff to use an English-language menu to find Spanish-language materials.

A hallway, with views of the tranquil healing garden, leads to radiation oncology services (on the right) and the infusion area (on the left). Outpatient infusion services, staffed by oncology-certified nurses, are available Monday-Friday and on weekends by appointment. The infusion area has eight private rooms comfortably furnished with TV, DVD players, and phones. Patients have a choice of receiving treatment in a bed or recliner. Snacks, refreshments, and meals are available.

An RN multidisciplinary care coordinator schedules the cancer center’s bi-weekly breast cancer multidisciplinary conferences and the monthly neuro-oncology multidisciplinary conferences. General cancer conferences are held twice per month.

Support Services
Good Samaritan Cancer Center offers a range of support services to patients and their families, including smoking cessation counseling; genetics counseling; support groups, such as a breast cancer support group, “A Time to Heal” rehabilitation program, and “Life After Cancer—Surviving to Thriving”; and a telephone support group in collaboration with the local Leukemia & Lymphoma Society. The cancer center has an RN breast health specialist and a second RN coordinator who focuses primarily on assisting rural and underserved patients.

Exceptional Access to Clinical Trials
Clinical trials are the key to advancements in the understanding and treatment of cancer. As a regionally coordinated NCCCP site, Good Samaritan Cancer Center is working with two other CHI facilities in Nebraska—Saint Elizabeth Cancer Institute in Lincoln and Saint Francis Cancer Treatment Center in Grand Island—to increase awareness of and access to clinical trials statewide. The cancer center is also affiliated with the Southwest Oncology Group (SWOG), the Radiation Therapy Oncology Group (RTOG), and is a member of the NCI’s Cancer Trials Support Unit (CTSU). In 2010 Good Samaritan Cancer Center accrued 150 patients to clinical trials, an accrual rate of approximately 30 percent.

Quality Reporting
Good Samaritan Cancer Center not only shares quality reporting information on its website, the cancer center also served as a beta site for the Commission on Cancer’s Rapid Quality Reporting System (RQRS), a reporting and quality improvement tool that has been developed to help CoC-accredited cancer programs promote evidence-based care at the local level.

Regional Collaboration
Participation in the NCCCP has allowed Good Samaritan Cancer Center to improve outreach both within the CHI health system’s Nebraska locations and across the region. A primary focus of the cancer center’s NCCCP work has been outreach to the rural population and the area’s Hispanic population. Through the NCCCP project, efforts include patient navigation, outreach services, and clinical trial recruitment to increase access for underserved populations.

The three CHI Nebraska NCCCP pilot sites have collaborated to conduct both professional education programs and patient education and support programs via telehealth. They have also collaborated to distribute newsletters and participate in monthly NCCCP conference calls. Outreach nurses from the three CHI Nebraska NCCCP pilot sites also work collaboratively both in program development and in outreach efforts.

Good Samaritan Cancer Center is also working with the Nebraska Library Association to help provide reputable information on cancer to the region’s rural population. The project, a collaborative effort between the Nebraska Cancer Control Plan and Good Samaritan Cancer Center, involves developing a cancer resource section within select local libraries. The cancer center has launched a pilot outreach effort in five community libraries that agreed to develop a dedicated space within the library for cancer information that is then provided by various health organizations. The library director or outreach staff then spread the word to local physicians that this vetted patient information is available at the local library.

Community Connections
In the current economic environment, many community cancer centers are seeing an increase in patients needing assistance with the costs of cancer care. Over the past three years, efforts by local high school and college students and the community have raised $75,000 through the “Kearney Tackles Cancer” campaign. Annual tee shirt sales and a fundraising BBQ event generate most of the monies raised. The fundraiser was initiated by a group of high school students who wanted to start a program that would benefit the community and honor a teacher who had cancer. The funds raised go to the Good Samaritan Hospital Foundation and are administered by advocates to cancer patients in need.

“Even though we are a smaller community hospital, we provide a wide range of services to help the people of our region. Our staff is very experienced and highly qualified, and we are very lucky to have them. Oncology is very much a service program that involves people, and our people are our biggest asset,” said Connie Wittman, RN, MN, AOCN, MHA, director of oncology services.
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TOOLS

APPROVED DRUGS

- Genentech (www.gene.com), a member of the Roche Group, announced the Food and Drug Administration (FDA) has approved Erivedge™ (vismodegib) capsules for the treatment of adults with metastatic basal cell carcinoma (BCC) or with locally advanced BCC that has recurred following surgery or who are not candidates for surgery, and who are not candidates for radiation. Vismodegib inhibits the Hedgehog pathway, an important embryonic developmental pathway. Reproductive toxicity studies in rats demonstrated that vismodegib exposure during organogenesis results in embryo-fetal death at higher exposures and severe birth defects at exposures within the range achieved with the recommended human dose.

  The recommended dose and schedule for vismodegib is 150 mg orally daily.

- The FDA has granted regular approval for Gleevec™ (imatinib mesylate tablets) (Novartis Pharmaceuticals, www.novartis.com) for the adjuvant treatment of adult patients following complete gross resection of Kit (CD117) positive gastrointestinal stromal tumors (GIST). Accelerated approval for this indication was granted in December 2008. Labeling is also revised to include the results of a randomized trial demonstrating that recurrence-free survival (RFS) and overall survival (OS) were improved by continuing adjuvant imatinib therapy to 36 months.

  The recommended dose of imatinib for adjuvant treatment is 400 mg/day administered with meals daily for three years. The optimal duration of treatment is not known.

- The FDA has approved Inlyta (axitinib tablets) (Pfizer, Inc. www.pfizer.com), a kinase inhibitor, for the treatment of patients with advanced renal cell carcinoma (RCC) after failure of one prior systemic therapy. The approval is based on data from the Phase III AXIS trial, which demonstrated that Inlyta significantly extended progression free survival (PFS) [HR=0.67, 0.54-0.81, P<0.0001] with a median PFS of 6.7 months (95% CI: 6.3,8.6) compared with 4.7 months (95% CI: 4.6,5.6) for those treated with sorafenib, a current standard of care for this patient population. This improvement in PFS was greater in the cytokine-pretreated subgroup compared to the sunitinib-pretreated subgroup.

- The FDA approved glucarpidase injection (Voraxaze®) (BTG International Ltd., www.btgplc.com) for the treatment of toxic plasma methotrexate concentrations (> 1μmol/L) in patients with delayed methotrexate clearance due to impaired renal function. Glucarpidase is not indicated for use in patients who exhibit the expected clearance of methotrexate (plasma methotrexate concentrations within 2 standard deviations of the mean methotrexate excretion curve specific for the dose of methotrexate administered) or those with normal or mildly impaired renal function because of the potential risk of subtherapeutic exposure to methotrexate.

- Millennium: The Takeda Oncology Company (www.millennium.com) announced that the FDA has approved a supplemental new drug application for Velcade® (bortezomib), which updates the label to include the subcutaneous method of administration in all approved indications: multiple myeloma and mantle cell lymphoma after at least one prior therapy.

DRUGS IN THE NEWS

- Pinnacle Biologics, Inc. (www.pinnaclebiologics.com) announced that the company has received orphan drug designation for Photofrin® (porfimer sodium) as adjuvant therapy to surgery in treatment of malignant pleural mesothelioma.

- ZIOPHARM Oncology, Inc. (www.ziopharm.com) announced that the FDA has accepted its investigational new drug application (INDA) for the oral dosing of palfosfamide (Zymafos® or ZIO-201). Palfosfamide is a novel DNA cross-linker in class with bendamustine, ifosfamide, and cyclophosphamide.

- Circadian Technologies Ltd. (www.circadian.com.au) announced that the company’s wholly-owned subsidiary, Vegenics Pty Ltd., has received approval
for its INDA to initiate clinical trials of VGX-100 in cancer patients with solid tumors. The first Phase I trial will study VGX-100 in patients with a variety of late-stage cancers. VGX-100 is a human antibody that acts against the human VEGF-C protein. Treatment for cancers, particularly glioblastoma and metastatic colorectal cancers, are the first target indications for VGX-100.

**DEVICES IN THE NEWS**

- Hologic, Inc. ([www.hologic.com](http://www.hologic.com)) announced FDA approval of the company’s Cervista HTA (high throughput automation) System for use with Hologic’s previously approved human papillomavirus (HPV) HR test. The company’s HPV HR test uses Hologic’s proprietary Invader technology to detect 14 high-risk types of HPV that are associated with cervical cancer and precancerous lesions.

- Varian Medical Systems ([www.varian.com](http://www.varian.com)) announced updated control software, which received FDA 510(k) clearance in November, that adds a High Intensity Mode to the company’s Clinac® and Trilogy® machines, enabling dose delivery rates of up to 2400 monitor units per minute—double their former highest output. Varian also received FDA clearance for the Pivotal™ Care Solution Prone Breast Treatment, an innovation that allows patients to be treated on their stomachs rather than their backs.

- The FDA has granted Royal Phillips Electronics ([www.healthcare.philips.com/us_en/](http://www.healthcare.philips.com/us_en/)) 510(k) clearance for the company’s first commercially available whole body positron emission tomography/magnetic resonance (PET/MR) imaging system, the Ingenuity TF PET/MR.

- MIM Software Inc. ([www.mimsoftware.com](http://www.mimsoftware.com)) announced that Mobile MIM™ has received its second FDA 510(k) clearance for release of its new version, Mobile MIM 3.0. Mobile MIM is now cleared for diagnostic X-ray and ultrasound viewing, as well as radiation treatment plan review and approval. Mobile MIM 3.0 is available on the Apple® App Store(™).

- The FDA has granted Translational Sciences Corporation ([www.transcicorp.com](http://www.transcicorp.com)) 510(k) clearance for commercialization of the company’s OncoTrac™ medical imaging software. OncoTrac is designed for efficient quantitative assessment of treatment response of metastatic tumors, including breast, lung, colorectal, prostate, and lymphoma. OncoTrac products provide a structured workflow solution for cancer practitioners and researchers to report precise measurement of solid and metastatic tumors for routine clinical care and cancer drug trials. As a vendor-neutral platform, OncoTrac software architecture is suitable for use in daily radiology practice, and can be easily integrated into most existing PACS environments without any product customization.

- RaySearch Laboratories AB ([www.raysearchlabs.com](http://www.raysearchlabs.com)) announced that version 2.5 of the company’s RayStation® treatment planning system has been released for clinical use in the U.S. and Europe. RayStation 2.5 includes all of RaySearch’s optimization algorithms for VMAT, IMRT, and 3D-CRT along with a comprehensive set of tools for traditional 3D-CRT planning. The new version includes improvements of RaySearch’s unique multi-criteria optimization (MCO) solution for IMRT.

- Veran Medical Technologies ([www.veranmedical.com](http://www.veranmedical.com)) announced the release of its SPIN Drive™ platform upgrade for bi-planar virtual fluoroscopy view used to navigate multiple planes simultaneously. This advancement enables physicians to view the location of the Always-On Tip Tracked™ instrument in a fluoro-like view without any radiation being delivered to the patient, physician, or staff.

- The FDA has granted Konica Minolta Medical Imaging USA ([www.konicaminolta.com/medicalusa](http://www.konicaminolta.com/medicalusa)) 510(k) clearance for the company’s Xpress CR Digital Mammography upgrade. The clearance specifically applies to the company’s CP1M 18 x 24 and 24 x 30 cassettes and the use of the CS 3 control station with the REGIUS 190 and 210 readers. 

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**EP Tracker Now Available**

Fulcrum Methods ([www.fulcrummethods.com](http://www.fulcrummethods.com)) announced release of EP Tracker™, a SaaS-based (software-as-a-service-based) interactive tool that helps centrally administer the lifelong process of individual EP registration and reporting and attestation. Hospitals, healthcare systems, and medical groups can use EP Tracker to ensure affiliated eligible professionals (EPs) have properly registered for and successfully completed requirements to qualify for meaningful use incentives. The tool tracks EP funds receipt by year and program, EP funds flow, and EP funds assignment. EP Tracker was developed and designed in conjunction with users of Fulcrum Methods’ Meaningful Use Assessment Tool.
Multiple Cancer Program Accreditations

Mastering the Juggling Act

BY TONI HARE, RHIT, CTR
Juggling is a skill I have never mastered. In fact, it’s something very few people even attempt. Yet, hospitals and healthcare systems nationwide are doing just that—juggling multiple treatment guidelines, industry standards, quality measures, and hospital-specific pathways that are the result of a transitioning healthcare system. As payers back away from transactional-based pay and towards a pay-for-performance model, hospitals are required to provide validation of the patient care and quality outcomes they provide to their communities.

The increased attention to industry standards has impacted cancer programs as well. From the cancer program administrator, to the Cancer Committee and the cancer registrar, comprehensive changes to standards are affecting data collection, utilization, and analysis. But the changes don’t stop there. As healthcare consumers become more discerning, community cancer centers are feeling the pressure to meet and exceed the evolving standards of many different organizations, such as the Commission on Cancer (CoC), The Joint Commission’s Disease-Specific Certification, the National Accreditation Program for Breast Centers (NAPBC), and the Quality Oncology Practice Initiative (QOPI) from the American Society of Clinical Oncology (ASCO).

In addition to managing multiple accreditations from multiple accrediting agencies, this year cancer programs also have a new set of patient-centered CoC Standards to implement. More than 1,500 hospitals, freestanding cancer centers, and cancer program networks nationwide are currently accredited by the CoC, and as of January 1, 2012, all CoC-accredited programs and those programs seeking accreditation are now required to implement the new CoC 2012 standards. The new standards work to:

- Coordinate and integrate care across boundaries of the healthcare system
- Provide information, communication, and education that people need and want
- Guarantee physical comfort, emotional support, and the involvement of family and friends.

As a CoC-trained Consultant, I sense the trepidation in my clients’ questions, concerns, and comments regarding the new CoC standards—Will I need to hire more staff? How can I afford to hire a nurse navigator? Will my Cancer Committee understand what we have to do? How can I do more without additional resources?

This article highlights ways cancer programs can manage multiple and ever-changing cancer program standards. In other words, the article aims to answer the question—how can a cancer program effectively juggle multiple accreditations, while making the most of current internal resources?

To answer this question, cancer program leadership needs to analyze and assess the internal resources available to ensure each resource is being fully utilized. I typically ask questions that uncover the systemic and collaborative approach of the cancer program:

- Is the cancer registry acting as a strategic partner to the cancer care team?
- Is the Cancer Committee aware of the latest standards?
- Is there a shared vision within the cancer program?
- Is that shared vision supported by senior leadership?
- Are there adequate and useful communication tools to promote a successful feedback loop?

For example, I often find the cancer registry to be an underutilized resource. While many cancer programs realize the benefit of a strategic partnership with the cancer registry, others are simply not aware of the powerful potential provided by educated cancer registrars. As a cancer program and cancer registry consultant, my career has been dedicated to assisting cancer programs to become more efficient and effective. Together with my team of compliance experts, I have come up with six steps to mastering the juggling act of multiple accreditations.

**Step 1**

Stop asking, “What does the standard say?” and start asking, “What is the right thing to do?”

Palliative care, survivorship, patient navigation, continuum of care, and psychosocial screening aren’t just buzzwords in today’s standards, they are important components of a multidisciplinary approach to patient care that includes the family, as well as the physical and emotional aspects of care. It’s not the
standard that guides us to enhance care; it’s the concept that patient-centered quality care is the right thing to do.

More often than not, I find clients who focus on the large-scale changes to standards get more overwhelmed than necessary. Most clients are already performing in compliance with new standards. They understand what’s right; they may just not completely understand how to incorporate it into the Cancer Committee activities. In many cases, their actions may need to be formalized, tweaked, documented, discussed, or validated to be compliant with the new standard.

So, my first step is to help clients realize the standards aren’t groundbreaking. Instead, these new standards help community cancer centers solidify and validate that appropriate care is being provided. Of course, corrections, changes, and new processes may be added here and there, but, in my experience, it is easier to first identify what a client is doing right, and build from there.

By shifting your perspective from semantics to ethics, the standards for each accreditation will start to become interwoven, and identifying similar logic, overlapping requirements, and where gained efficiencies can be realized will become easier. For example, cancer registrars at CoC-accredited cancer programs already collect stage, prognostic indicators, and treatment information for the assessment of treatment planning standards. That information then can be used for both CoC and NAPBC quality outcome studies. Another example is the overlap in the NAPBC and the CoC standards to develop a process to monitor physician use of the American Joint Committee on Cancer (AJCC) or other appropriate staging in treatment planning. Both accrediting agencies require that this process be developed, so communication between the two oversight committees is essential to reduce redundant activities.

Illustrate the changes to standards, the overlapping requirements, and the overarching objectives.

As a consultant, I find it easiest to explain how to manage multiple accreditations efficiently by creating a matrix that illustrates this information. A scorecard or dashboard can serve the same purpose. Basically, the matrix needs to outline each CoC standard, and map it to a correlating NAPBC standard or disease-specific measure and then provide detail of what information needs to be captured and by whom. In most instances, the cancer registry plays an important role.

A matrix or diagram that connects the dots for everyone in the cancer program is very helpful in explaining what you are doing, why you are doing it, and how you are doing it. For example, The Joint Commission disease-specific certification for breast, colorectal, lung, pancreatic, prostate, or renal cancer does not come with a clear set of quality indicators; it is up to the cancer center to determine what those indicators are and how they will be collected and measured. By having an informed and educated taskforce or subcommittee in charge of this certification process, the resulting quality indicators should be aligned with the overarching goals and objectives of the cancer program and the hospital. The matrix can then start to pinpoint exactly what information needs to be collected, in what time period, and where the information can be found.

It’s true that someone needs to have an intimate understanding of each of the accreditations or certifications in order to put this kind of matrix together. As a result, it seems to work best if one person from the Cancer Committee is charged with this task and that person can request assistance as needed.

However, more work and change can be hard to swallow. Applying for additional accreditations needs to be an objective or goal that is shared not only within the cancer center, but also with the hospital senior leadership. So, prior to moving forward with additional accreditations, make sure they fit with the goals of the hospital and that your senior leadership understands the who, what, where, when, why, and how.

Realize the connection between CP3R and NAPBC.

It’s important to realize the universal nature of these standards. For example, both the Commission on Cancer’s National Quality Forum (NQF)-endorsed, evidence-based quality care measures, which are reported through the Cancer Program Practice Profile Report (CP3R), and certain NAPBC standards require the utilization of quality measures endorsed by the NQF. So by design, meeting the requirements of CP3R also positions a cancer center to be on the right track to comply with certain NAPBC standards.

However, before applying for the NAPBC accreditation, your cancer center must exhibit an extreme focus on breast health; it must have a multidisciplinary approach, with oncologists, radiologists, surgeons, pathologists, nurses, and other healthcare professionals all working in concert to efficiently guide patients through a cohesive system of comprehensive breast care.
Applying for additional accreditations needs to be an objective or goal that is shared not only within the cancer center, but also with the hospital senior leadership.

A common misstep is when a community cancer center wants to be NAPBC accredited, but has not taken any of the necessary steps to plan and prepare for this survey process. While commonalities exist between the CPR and NAPBC, and while you can most definitely realize time savings from accurate, timely, and complete cancer data collected in the registry, your breast program needs to be multidisciplinary in structure and focused on the diagnosis and treatment of patients with diseases of the breast.

**step 4**

*Get the Cancer Committee aware, educated, and involved.*

The Cancer Committee is the governing body that directly affects and validates patient care. It has the responsibility and accountability for cancer program activities. In some situations, a cancer center may decide to apply for NAPBC or a Joint Commission disease-specific certification and form a leadership team without the involvement of the Cancer Committee. This decision can result in duplicative action, competing objectives, and inefficiencies when preparing for multiple surveys. Prevent these types of challenges by creating a collaborative effort with the Cancer Committee in support of all cancer care quality initiatives. Therefore, the Cancer Committee is one of the first places to start when considering applying for an accreditation. By leveraging the involvement of dedicated and knowledgeable Cancer Committee members, cancer centers can efficiently and effectively juggle multiple accreditations.

For example, the HERS Breast Center at Mayo Clinic Health System in Eau Claire, Wisconsin, created a Breast Program Leadership Committee of key leadership and care providers dedicated to breast cancer in order to achieve two significant accreditations:

- The Breast Imaging Center of Excellence by the Commission on Quality and Safety
- The Commission on Breast Imaging of the American College of Radiology.

“After achieving these accreditations for our Breast Center, the NAPBC accreditation was a logical next step,” said Barb Eidahl, RN, director of oncology at Mayo Clinic Health System in Eau Claire. “A committee of Breast Program Leadership already existed and the knowledge and resources required to apply for NAPBC had already been pulled together. We were also able to streamline our meetings by scheduling the Breast Program Leadership meeting to occur directly after the quarterly Cancer Committee meetings. That way the members of the Cancer Committee who were also on the Breast Program Leadership committee were already in the right place,” Eidahl said.

**step 5**

*Invest in the cancer registry.*

Bottom line, the cancer registry is your data mine. It’s up to you to mine the data and turn it into information that can be used to set objectives related to accreditation, cancer care, patient outcomes, reimbursement, and business decisions. Specifically, cancer registry information can be used to:

- Establish population trends and stage of disease
- Identify physician referral patterns
- Determine hospital outmigration patterns
- Enhance and monitor existing cancer program services
- Assist in resource and equipment allocation
- Populate oncology scorecards.

By setting accreditation objectives, the team of registrars can identify upfront the data to be collected, and can determine an efficient process for collecting any necessary additional data items outside of the Facility Oncology Registry Data Standards (FORDS). By working collaboratively with your team of registrars, you can streamline the process to prepare for and achieve accreditation with multiple guidelines, and get more from your current resources.

For example, suspecting an issue with physician and patient referrals, Denise Clark, director of oncology at the...
A CASE STUDY

Ohio Health’s Riverside Methodist Hospital is an organization that is successfully managing multiple accreditations. An ACCC Cancer Program member, Riverside has been CoC accredited for 28 years. In 2005 the hospital achieved The Joint Commission’s disease-specific certification for lung cancer and, in 2009 achieved NAPBC accreditation for breast cancer. Riverside’s cancer program exemplifies the comprehensive, collaborative approach necessary to enhance quality of care and achieve additional accreditations, while maximizing the internal resources available. The cancer registry at Riverside is a well-used, reliable data source, and the Cancer Committee, originally developed to assist the hospital achieve CoC accreditation, plays an important role in the oversight of the entire cancer program. A look at Riverside’s operations reveals that mastering the art of juggling multiple accreditations is not so difficult after all.

The Cancer Committee

For Riverside Methodist Hospital the first step in effectively managing multiple accreditations was to make the process the responsibility of subcommittees of the larger Cancer Committee. Upon agreement, smaller subcommittees with a disease-specific focus were established to support the additional accreditations (i.e., The Joint Commission’s disease-specific certification for lung cancer and NAPBC’s accreditation for breast cancer). The Cancer Committee was familiar with the CoC Standards and understood the importance of accreditation—from both the hospital and patient perspectives. Because of this understanding, the subcommittees were able to benefit from what had been done for the CoC accreditation, and then work to drill down to more specific quality measures and data elements for lung and breast cancer.

According to Anna Hensley, MBA, RT(T), director of Cancer Services at Riverside Methodist Hospital, the collaboration between the Cancer Committee and subcommittees for the lung certification and breast accreditation increased efficiencies and allowed for goals and objectives to be overarching and consistent throughout the cancer program.

“The key is to not reinvent the wheel for each quality measure or initiative in the cancer program,” Hensley said. “By having clarity on the goals and objectives of the hospital and of the cancer program, committees can be clear with one another and work in harmony to meet multiple accreditations, while streamlining processes and avoiding duplicative work.”

Annually, Riverside’s Cancer Committee agrees on goals that are aligned with the overall goals of the organization. Each subcommittee can then develop goals that will work to support and advance the overarching goals of the oncology program. The subcommittees report to the Cancer Committee on a regular basis, providing updates on goal status and requesting support for any barriers that may have come up.

The Riverside Cancer Services Cancer Management Team.

The Cancer Registrar

Another important component, Hensley explained, was involving the cancer registrar very early in the process. “By adding a cancer registrar to the multidisciplinary subcommittees, you can be assured that not only is the quality measure meaningful to cancer patients, but also that it is realistic to measure.”

For example, for the NAPBC accreditation, the cancer registrar worked very closely with the physicians; she had a good understanding of how the data was captured and the steps required to capture additional and concurrent data. In some situations, the information necessary to measure a specific quality metric was simply too time intensive for what the outcome may have meant to the cancer program. And the cancer registrar helped Riverside’s subcommittee make this determination.

The Joint Commission Disease-Specific Certification

At the point Riverside applied for The Joint Commission’s disease-specific certification for lung cancer, the cancer program had already been working to achieve improved processes and outcomes for lung cancer. Given that there are no nationally recognized quality indicators for lung cancer, the cancer center formed a lung subcommittee that developed very specific criteria to measure using Riverside’s lung cancer dashboard. After applying for The Joint Commission’s certification, this subcommittee of specialists worked in conjunction with a Joint Commission surveyor to refine the final metrics that would be used for The Joint Commission’s lung-specific certification process.

NAPBC Accreditation

At the same time the lung subcommittee was managing The Joint Commission survey process, a breast cancer subcommittee was managing the process for NAPBC.

The decision to move forward with additional certifications and accreditations needs to be thoroughly evaluated. While there can be a benefit to the quality of care, the actual accreditation can be expensive in terms of application costs and resource costs. A hospital needs to be prepared to dedicate a variety of resources and there has to be physician and staff buy-in. Riverside’s decision to move forward with NAPBC accreditation was
discussed and agreed on easily because the cancer program was 
already submitting to the CoC’s CPIR and had already imple-
mented a breast navigation program.

“We were on the right track, so the next step was form-
ing a team dedicated to breast cancer care,” Hensley said. 
Riverside’s NAPBC subcommittee consisted of a breast sur-
geon, radiation oncologist, medical oncologist, pathologist, 
radiologist, breast navigators, administrative staff, and more.

Planning & Goal Setting

To increase awareness of all quality measures being tracked at 
Riverside, Hensley, in collaboration with her team, implement-
ed a Quality Scorecard that serves as the measurement tool for 
clinical indicators for all accreditations. As the director of the 
cancer program, Hensley made herself accountable for updat-
ing and posting this scorecard in a centralized location. “The 
scorecard is very helpful. It’s easy to read, and is used to keep 
all stakeholders across the board involved and aware of the 
quality initiatives happening at Riverside,” Hensley said.

The scorecard is a highly utilized communication tool at 
Riverside. Metrics on the scorecard serve as agenda items for 
the Cancer Committee, are frequently discussed in the sub-
committees for disease-specific certifications, and are present-
ed by Hensley to hospital senior leadership quarterly.

“Because the clinical indicators on the scorecard actually 
roll up into the hospital’s Process Improvement Committee’s 

scorecard, the hospital leadership at Riverside understands 
the importance and relevance of these accreditations,” Hens-
ley explained. “Also, the cancer program leadership, includ-
ing the Cancer Committee, understands how these accredit-
a tions fit into the bigger picture goals and objectives of the 
hospital,” Hensley said.

The scorecard (Figure 1, below) identifies several clinical 
indicators tracked by Riverside. It is organized by ac-
creditation and tracks each data set by a year-to-date com-
parison, target, current status, and monthly progress of 
each clinical indicator.

Additionally, having a point person to manage the multiple 
timelines, dashboards, and goal deployment documents helps 
keep all of the teams on the right path. Riverside maintains a 
shared calendar of studies being performed, unique data be-
ing collected, and important survey dates so that the entire 
team can quickly see a snapshot of what’s going on in their 
cancer program.

Overall, Riverside Methodist Hospital has been success-
ful at managing ever-changing and multiple accreditations 
because of their ability to communicate, identify meaningful 
and realistic clinical indicators, and plan and leverage exist-
ing internal resources. Their commitment to quality cancer 
registry data and their ability to utilize a very involved Cancer 
Committee has been valuable in the process of successfully 
applying for additional certifications and accreditations.

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**Figure 1. Riverside Methodist Hospital, Cancer Services, Quality Scorecard FY12: Sample Clinical Indicators**

<table>
<thead>
<tr>
<th>QUALITY MEASURES</th>
<th>FY12 YTD</th>
<th>TARGET</th>
<th>STATUS</th>
<th>JUL-11</th>
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<tbody>
<tr>
<td><strong>CoC Accreditation Performance Measures</strong></td>
<td></td>
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<tr>
<td>Chemotherapy administration</td>
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<tr>
<td>Pain satisfaction (Press Ganey quarterly percentile, any unit, ICD-9 cancer diagnosis code)</td>
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<td>Chemo extravasations</td>
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<td>Planned vs. given dose (Radiation Oncology)</td>
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<tr>
<td>Patients accrued to clinical trials</td>
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<tr>
<td>Percent of patients seen by navigator</td>
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<tr>
<td><strong>The Joint Commission Disease-Specific Certification Performance Measures</strong></td>
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<tr>
<td>Social work evaluation for Radiation Oncology patients (Outpatient)</td>
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<tr>
<td>Documentation of patient education (Outpatient)</td>
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<tr>
<td>Nutrition consult for inpatients (Inpatient)</td>
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<tr>
<td>Multimodal therapy—Stage III cancer evaluated for chemotherapy/ radiation therapy (Inpatient)</td>
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<tr>
<td>Lung cancer lymph node dissection rate</td>
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<tr>
<td><strong>NAPBC Accreditation Performance Measures</strong></td>
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<tr>
<td>Breast—days detection to diagnosis</td>
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<td></td>
</tr>
<tr>
<td>Breast—days abnormal mammography to final pathology</td>
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Indiana University West, used the registry to evaluate where and why patients were being referred. “By using the new 2010 class of case coding structure, our cancer registrars created a special study of the top three primary sites by type of treatment and location of treatment,” explained Clark. “This [study] allowed us to perform a needs assessment for radiation oncology patients.”

The needs assessment at Indiana University West will also be used to help evaluate equipment allocation, physician, and patient referral patterns; ensure appropriate services are provided to their patients; and serve as a benchmark for an awareness campaign targeting patients within a specific zip code and informing them of options at Indiana University West.

step 6

Don’t re-invent the wheel; instead look to hospitals that juggle multiple accreditations well for tips, tools, and techniques.

One tip I know many hospitals would share is their partnership with the American Cancer Society (ACS). Specifically, community cancer centers can benefit from two ACS programs: the Patient Navigator Program and the Collaborative Action Plan. The ACS Patient Navigator Program, initiated in 2001, partners with hospitals and treatment centers to provide trained patient navigators to help patients, families, and caregivers navigate the many systems needed during the cancer journey. These patient navigators can provide information on the following:

- Information on clinical trials
- Questions to ask the doctor
- Day-to-day help
- Emotional support
- Prescription and medical supply assistance
- Travel assistance
- Lodging through Hope Lodge.

The long-standing relationship between ACS and CoC (since the 1930s) has led the CoC to develop standards regarding information about the availability of clinical trials, support services, and prevention and early detection programs. Today, ACS supports CoC hospitals by providing a dedicated Collaborative Action Plan and an ACS staff partner to the hospital. This staff member is in frequent communication with the Cancer Liaison Physician (CLP), present at Cancer Committee, and can provide the Collaborative Action Plan.

On the Association of Community Centers’ MyNetwork members-only online community, the

Just as the act of juggling requires an intense and unrelenting focus on each and every ball in the air simultaneously, a cancer program’s ability to manage multiple accreditations also requires an intensity and a never-ending focus on multiple facets of patient care at one time.

ACCCExchange Listserv, is also a good source for ACCC members to have open dialogue on various topics, including how to implement tools, such as a scorecard or matrix, to help all members of the cancer program stay on the same page.

Why Even Attempt the Juggling Act?

Consistent communication, an involved Cancer Committee, educated cancer registrars, overarching goals, a scorecard, and planning allow cancer programs to effectively and efficiently juggle multiple accreditations. But what’s most significant about organizations that are successfully juggling multiple accreditations isn’t the stamp of approval from the accrediting agency every two or three years, it’s the outcome. Facilities that strive to achieve multiple accreditations are in essence striving for continuous enhancements to quality of care and improved patient outcomes. These cancer programs know what it means to set and closely monitor quality clinical data that is relevant and meaningful to patient-centered cancer care.

Just as the act of juggling requires an intense and unrelenting focus on each and every ball in the air simultaneously, a cancer program’s ability to manage multiple accreditations also requires an intense and never-ending focus on multiple facets of patient care at one time. [1]

—Toni Hare, RHIT, CTR, is a Commission on Cancer-trained Consultant, and leads CHAMPS Oncology, a Cleveland-based cancer registry and cancer program consulting and management company. For more information, visit: www.champsoncology.com.

References

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Physician Compensation:
Designing the “Best-Fit” Plan

BY MATTHEW R. STURM, MBA

Physician compensation is a fundamental element of employing oncologists; yet, compensation planning can be a challenging and politically divisive process, especially as the number and diversity of stakeholders increase. For healthcare systems or multispecialty groups, understanding the nuances of the oncology care delivery model is of key importance. For example, administrators must understand how programmatic features—such as clinical research, multidisciplinary care, and the presence or absence of a patient navigation program—impact oncologists.

All physician practice groups (single specialty, multispecialty, and health system-employed) must consider not only their desired outcomes from the compensation plan and the culture that the plan will foster, but also how the plan will align with the evolving healthcare landscape and payment models (e.g., accountable care organizations, bundled payments, value-based reimbursement). This article presents a framework to evaluate and redesign compensation plans for oncologists.

The Importance of a Compensation Plan
A physician practice group’s compensation plan speaks volumes about an organization’s culture—whether a healthcare system or an independent medical group. Paychecks are often viewed as a reflection of the value a group places on a physician’s contribution. Moreover, the compensation plan—intentionally or not—serves as a beacon for the behaviors and activities that the group values (e.g., clinical productivity, research, multidisciplinary care, adherence to clinical pathways). Therefore, for the long-term success of the organization, the compensation plan must be thoughtfully designed to foster the desired group culture. This plan is especially important for oncology practices, where numerous factors affect group success; these elements should be carefully incorporated into the compensation plan in a balanced manner.

Not surprisingly, altering the compensation formula is a risky enterprise because income will be redistributed in ways that are sure to upset at least some members of the practice. Everyone will have legitimate arguments for why he or she should earn more; many will question the data, process, and outcome; and no one will be completely satisfied with the results. Throughout the compensation planning process, the needs and interests of the practice as a whole must be balanced with those of individual oncologists. As Figure 1 (below) shows, opportunities exist to reach an acceptable compromise, despite disparate preferences.

The objective of a compensation planning project is to develop a plan that both rewards desired activities and incorporates the group’s unique characteristics, ideologies, and strategic goals. Many oncology practices use a three-phase approach to compensation planning: Assessment, Design, and Implementation.

Internal Assessment
Start the planning process with a detailed assessment of your current physician compensation plan. Look at the oncologists’ performance compared to internal and external benchmarks. The process will ultimately result in the development of plan redesign goals that will guide efforts in the Design phase.

The internal assessment consists of a review of relative group compensation performance and a questionnaire for, or a series of interviews with, the oncologists.

Group Data. Use an analysis of current compensation and production data from the oncologists to assess the impact of the current compensation plan in terms of the group’s goals. This analysis may include graphs of compensation and production data for all oncologists (by specialty) in the practice.

Figure 1. Physician Compensation Outcomes
Review the data for key trends, issues, and concerns. Then answer these two questions.

- Are there significant outliers above or below the trendline? If so, identify why?
- What is the shape of the compensation per work RVU to work RVU trendline? A flat line indicates no incremental incentives for production. A line with a positive slope indicates incremental incentives for production. A line with a negative slope indicates incremental disincentives for production. Ideally, the trendline will have a positive slope.

As noted above, the market is evolving toward new, less production-driven physician payment models. So, evaluate the characteristics of your current physician compensation plan. Specifically, look at what percentage of an oncologist’s compensation is tied to nonproduction-based measures, such as:

- Group citizenship (e.g., governance participation, committee participation, peer review, specific work outcomes, staff surveys)
- Quality
- Multidisciplinary care
- Adherence to clinical pathways
- Outreach efforts
- Participation in clinical research.

Compare your findings to market trends. In 2012, it is appropriate for oncology practices to target allocating 10 to 20 percent of physician compensation using nonproduction-based measures.

**Physician Input.** During the initial assessment phase, the practice may ask for input from the oncologists (via survey or interview) on compensation plan design. The objective is to identify the practice’s goals for the plan and areas of satisfaction and/or dissatisfaction with the current plan, as well as to get feedback on potential modifications (e.g., incentives for multidisciplinary care and/or compliance with clinical pathways).

**External Assessment**

During the external assessment, the practice may compare its compensation and production data to national and regional benchmarks such as those available from MGMA (Medical Group Management Association), AMGA (American Medical Group Association), and other surveys. Potential questions include:

- Is the practice’s production in line with the benchmarks? If not, why?
- Is the practice’s compensation in line with the benchmarks? If not, why?
- Are there any specialties that vary significantly from the benchmarks? If so, why?

The objective of a compensation planning project is to develop a plan that both rewards desired activities and incorporates the group’s unique characteristics, ideologies, and strategic goals.
UNIQUE ISSUES FOR HEALTHCARE SYSTEMS

In addition to the general compensation considerations discussed in this article, healthcare systems employing oncologists face some unique issues.

Infusion Suite Services
Medical oncology practices that heavily use non-physician providers for the management of infusion services will need to consider how productivity and expense will impact their compensation model. In particular, non-physician productivity will impact overall compensation, as under an employment model if infusion services are transitioned to a hospital-based billing model (in which infusion therapy is a designated health service), physicians will no longer receive credit for this revenue or RVU production. Depending on the magnitude of non-physician activity, it may be important to structure an arrangement that allows for physicians’ continued management of infusion services.

Increasingly, hospitals are opting to create agreements that compensate physicians for management of the infusion suite. Several options are available, depending on the particulars of an arrangement. Many opt for a fixed-fee stipend that compensates physicians for services related to infusion suite management. Others incorporate a payment per work RVU premium that reflects incremental compensation associated with management services. An alternate but similar approach to this last option is addition of a work RVU credit for clinical services that correlates to infusion management activity. Regardless of the approach, to ensure that the program is compliant with the Stark Law and Anti-Kickback Statute, hospitals need to be cautious in developing their preferred methodology to ensure that payment is in no way tied to hospital-based volume growth. As such, legal review is advisable when designing such a compensation model.

Service Incentives
Hospitals generally recognize that production-driven plans will need to evolve to reflect changing practice patterns, economics, and the rising emphasis on non-productivity performance indicators. However, some hospitals are reluctant to get too far ahead of reimbursement changes. Production-based compensation plans (typically measured in work RVUs) continue to be the favored methodology for hospitals, and they often use productivity tiers that disproportionately reward high producers and provide strong incentives for high levels of production. These plans reflect the current economics of physician payment, which is still based almost entirely on clinical work measures.

Although hospitals typically incorporate some type of performance or quality bonus into their compensation models, the measures are often not based on stretch goals (e.g., performance goals that require a significant change or improvement) because defining, valuing, tracking, and measuring outcomes can prove difficult. Yet, doing so can be very helpful in executing service line strategies; as such, more institutions are starting to incorporate these incentives and make them a larger portion of total compensation (see Table 1, left, for examples).

Use of service incentives, such as those identified in Table 2 (page 32), in physician compensation models is an emerging trend that will continue to grow, particularly in light of ongoing healthcare reform efforts that emphasize patient outcomes and episode-based care.

Surgical Oncology Call Coverage Restrictions
With increasing subspecialization of surgical oncologists, many physicians are no longer clinically or personally willing to cover general surgery call. If the hospital’s current emergency department (ED) call coverage arrangement or medical staff bylaws require the physicians to take call, the healthcare system may consider providing additional funding to compensate general surgeons for surgical oncology call. It may also be in the hospital’s interest to eliminate any of the surgical oncologists’ ED call coverage duties to allow them more time to focus on oncology service line advancement.
Table 2. Potential Oncology Compensation Incentives

<table>
<thead>
<tr>
<th>INCENTIVE</th>
<th>PERFORMANCE METRICS</th>
<th>FREQUENCY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work Effort</td>
<td>Charges, net revenues, RVUs, panel size, visit and encounters, and office hours and availability</td>
<td>High</td>
</tr>
<tr>
<td>Quality</td>
<td>Healthcare Effectiveness Data and Information Set (HEDIS) Indicators and readmission and infection rates</td>
<td>Moderate and Growing</td>
</tr>
<tr>
<td>Medical Management</td>
<td>Inpatient stays per thousand, ambulatory visits per thousand, and selective utilization rates (e.g., ER visits, MRIs)</td>
<td>Low</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>Satisfaction surveys, complaints and compliments, and panel retention</td>
<td>Low</td>
</tr>
<tr>
<td>and/or Provider Satisfaction</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group Citizenship</td>
<td>Review, specific work group outcomes, and staff surveys</td>
<td>Medium</td>
</tr>
</tbody>
</table>

continued from page 30

Goals & Objectives
Based on oncologist feedback, draft a set of goals and objectives for the revised compensation plan, addressing such issues as:

- How the compensation plan will compare with market trends.
- Behaviors the plan will encourage (e.g., clinical productivity, research, multidisciplinary care, adherence to clinical pathways).
- The acceptable level of administrative burden to operate the plan.
- How the plan will be used as a recruiting and retention tool.
- How the plan will enable the practice to prepare for new payment models.

With assessment of the current compensation plan completed and goals for the revised plan determined the design phase begins. This process typically involves two parts: developing a conceptual method and testing the method.

The Conceptual Method
In developing and selecting a conceptual method, the goal is to design a compensation method that addresses:

- The practice’s goals and objectives
- Any inequity issues identified in the assessment phase.

As mentioned previously, oncology practices today have a unique opportunity to begin developing a compensation model that will propel the practice into the future of evolving payment models. Historically, production measures have dominated most oncology compensation plans. Today, however, many oncology groups are rebalancing their incentives between production and quality. This effort has been aided by the adoption of electronic health records (EHRs) and the increasing availability of reportable information. Thus, many oncology practices are beginning to reserve 10 to 20 percent of the total dollars earmarked for incentive payments in the compensation plan for quality initiatives.

Organizations can choose from many different performance metrics to incentivize oncologists. Table 2 (at left) summarizes the pros and cons of the most common incentives, as well as the frequency of their use.

The primary performance indicators used to calculate the incentive portion of a physician’s compensation, as identified by respondents in ECG’s 2010 compensation and production survey, which included 63 provider organizations, representing 6,847 physicians in 64 specialties, is illustrated in Figure 2 (below).

As illustrated in Table 1, work RVUs remain the most common productivity payment metric today, in large part because they focus on the professional work of the physician, which correlates with current payment models. However, for the first time in ECG’s 12-year survey history, quality was noted as a key performance indicator. See Table 3 (at right) for a comparison of typical productivity metrics and their advantages and disadvantages.

The amount of variability within a compensation system will determine the range of income potential for the oncologists, as the five compensation systems shown in Figure 3 demonstrate (at right).

As mentioned above, incentive payments for oncologists may be tied to a combination of production- and nonproduction-based measures. Thus, a practice must decide both what incentive metrics to use and what percentage of compensation will be at risk for the oncologists. Options include the following models.

Figure 2. Compensation Incentive Performance Measures
Table 3. Potential Oncology Compensation Incentives

<table>
<thead>
<tr>
<th>VARIABLE</th>
<th>ADVANTAGES</th>
<th>DISADVANTAGES</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVUs</td>
<td>–Most accurate measure of physician effort&lt;br&gt;–Payer-blind&lt;br&gt;–Consistent comparison of physician productivity</td>
<td>–Divorced from the economics of the practice&lt;br&gt;–Many do not understand proposed changes to the RVU system&lt;br&gt;–Some do not believe that RVUs are a true indicator of productivity</td>
</tr>
<tr>
<td>Collections</td>
<td>–Direct measure of cash inflow&lt;br&gt;–Aligned with financial strategy</td>
<td>–Affected by payer mix and effectiveness of billing and collections office&lt;br&gt;–Likely will disadvantage medical oncologists employed by hospitals, as chemotherapy is a designated health service and therefore cannot be credited to the physician</td>
</tr>
<tr>
<td>Gross Charges</td>
<td>–Aligned with financial strategy</td>
<td>–Influence by fee schedules, which can vary widely and are not necessarily representative of productivity or reimbursement&lt;br&gt;–Likely will disadvantage medical oncologists employed by hospitals, as chemotherapy is a designated health service and therefore cannot be credited to the physician</td>
</tr>
<tr>
<td>Visits and Patient Encounters</td>
<td>–Direct measure of cash inflow&lt;br&gt;–Aligned with financial strategy</td>
<td>–Not meaningful for procedural specialties&lt;br&gt;–No consideration of acuity or length of visit</td>
</tr>
</tbody>
</table>

**Figure 3. Range of Oncology Compensation Models**

Base Salary. The salary model (Figure 4a, page 34) is uncommon except for newly-recruited oncologists. This model provides the same level of income regardless of a physician’s performance, and therefore, offers little incentive to maintain or increase performance. However, in select cases, such as when the practice asks oncologists to participate in activities that may otherwise inhibit their income-generating ability, the salary model may be warranted. In such instances, the use of a salary should be kept only to the applicable time engaged in the activity, and every effort should be made to transition the payment model to one based on quantifiable performance measures.

Base Salary with Incentive. This model (Figure 4b, page 34) limits an oncologist’s downside risk by placing a floor on compensation levels and providing additional income for performance above the threshold. Setting the base salary is critically important in determining the meaningfulness of the incentive. The base salary with incentive model tends to underpay high performers and overpay lower performers because the base salary limits variability within the model.

Flat Incentive. This model (Figure 4c, page 34) includes no base compensation; thus, earnings depend entirely on performance compared to the metrics set out in the compensation plan. Typically, performance is tracked relative to a 12-month rolling period so that income levels are fairly predictable. This model offers a much stronger incentive for performance with much greater compensation available to higher performers.

Tiered Incentive. This model (Figure 4d, page 34) provides oncologists with significant incentive to maintain or increase performance. The tiered incentive model exposes lower-performing physicians to considerable downside income risk.

Tiered Incentive Plus Bonus. Similar to the tiered model, the tiered incentive plus bonus model (Figure 4e, page 34) includes an additional incentive to reach the thresholds. This model is more commonly used when performance is clustered below desired levels. The bonus provides added encouragement to push beyond current levels of performance.
Testing the Conceptual Method

Once a conceptual method is agreed on, develop a financial model to test the model’s impact on physician income levels using historic data. This step will not only help to understand the implications of the method but also later help to “sell” the method to the practice. Testing the method typically involves the following tasks:

- **Quantifying the Variables.** Assign values to the compensation drivers (e.g., determine the amount to be paid for each work RVU and compensation for achieving various quality or group citizenship metrics).
- **Developing Financial Projections.** After determining the values of the model variables, test the financial impact of the new compensation plan on the oncologists using data from the most recently ended fiscal year.
- **Revising the Model.** Based on feedback from the practice, revise the model. This process is iterative. Several revisions may be needed to develop a plan that captures the goals of the practice.

Addressing Complications

Many factors complicate the design and administration of a physician compensation plan. The plan should effectively address the following issues in a manner that reflects the practice’s culture:

- **Ancillary or Outside Revenue.** How will this revenue be allocated among group members (e.g., equal shares, based on use, based on ownership)?
- **Capitation Revenue.** How are capitation revenues distributed among the practice? How are incentives weighted for productivity versus efficiency?
- **Part-Time Providers.** How does the plan handle part-time providers? Is their productivity “normalized”?
- **Shared Practices.** Do physicians in a shared practice share the compensation, or are they each treated as a part-time physician?
- **Midlevel Production.** Does midlevel provider (e.g., NP or ARNP) production count toward a physician’s productivity?

Compensation Models

![Figure 4a. Base Salary Model](image)

![Figure 4b. Base Salary with Incentive Model](image)

![Figure 4c. Flat Incentive Model](image)

![Figure 4d. Tiered Incentive Model](image)

![Figure 4e. Tiered Incentive Plus Bonus Model](image)
• **New Physicians.** Will the practice provide income guarantees? If so, for how long?

• **Plan Draws and Reconciliations.** Over what period does the plan “draw” from, and when is the draw reconciled with actual production?

• **Nonclinical Duties.** How will physicians be compensated for nonclinical duties (e.g., practice management responsibilities, outreach staffing, clinical research)?

• **Expense Management.** How will physicians be incentivized to manage expenses in their clinic?

### Implementing the Plan

With the proposed new compensation plan agreed to by the practice, planning for the transition from the existing plan to the new one will begin. Typically, this process involves careful documentation of the details of the agreed-upon plan, development of necessary tools and processes to administer the plan, and possibly a period of “shadow” reporting (i.e., tracking and reporting a physician’s performance under the new model prior to implementation).

Below are some keys to successful compensation plan design for an oncology practice. These specific tactics may help organizations avoid difficult situations.

• **Physician Direction.** Recruit opinion leaders to assist in the design of the compensation plan.

• **Market Relevance.** Pay competitive income for competitive work effort.

• **Flexibility.** Adopt a compensation plan that flexes with the market annually.

• **Transition.** Compensation plan design must include analysis of the impact transition to the new structure, and may require temporary income protection.

Once a conceptual method is agreed on, develop a financial model to test the model’s impact on physician income levels using historic data. This step will not only help to understand the implications of the method but also later help to “sell” the method to the practice.

• **Communication.** Communicate fully and frequently to all physicians.

• **Simplicity and Objectivity.** Establish understandable, objective, and measurable incentives.

• **Alignment of Incentives.** Align physician and organization incentives.

• **Respect for Culture.** Respect the differences in the decision-making process and organizational style within the oncology practice.

• **Resistance to Making Special Deals.** Once the planning process is complete, stay true to the decisions that were made during the process.

—Matthew R. Sturm, MBA, is senior manager, ECG Management Consultants, Inc. For more information, visit: www.ecgmc.com.
Social Media and Your Cancer Program

BY KAT GERLICH
POSITIVE WORD OF MOUTH IS A POWERFUL MARKET INFLUENCER.

And today’s digital platforms provide community cancer centers the opportunity to generate and nurture word of mouth exponentially, behooving practices to consider digital channels as part of their overall growth strategy. With careful planning, a minimum investment of time, and circumvention of potential pitfalls, community cancer centers and oncology practices can realize strong ROI (return on investment) in terms of increased patient pull-through by developing a social media presence.

Healthcare & the Internet

Searching for healthcare has become the third most popular use of the Internet, spawning the growth of virtual communities focused on topics from nutrition to cancer. Nearly 60 percent of all adults in the U.S. have looked online for health information, using search engines, the blogosphere, and social media. Unpaid adult caregivers, friends, and/or family members are those most likely to look online for health information. Women ages 35–54 in the role of unpaid caregiver comprise the largest segment using social media for health information. Social media sites such as Facebook, Twitter, and YouTube are becoming trusted sources of information on a myriad of topics, including cancer care. In fact, patients and caregivers are increasingly relying on virtual sources to inform their healthcare decision-making process. See Figure 1, page 38, for type of medical information Internet users seek.

With those statistics in mind, ask yourself this question—How does my cancer center or oncology practice use digital platforms to support informed patient decisions regarding cancer, cancer treatment, and choice of providers?

Today less than one-quarter of U.S. hospitals use social networking tools, and fewer still fully embrace digital media to connect and interact with their target audiences. If your cancer center or practice is included in this statistic, now is the time to develop a strong “virtual voice” that can help:

• Build your credibility as a recognized authority
• Support your differentiated brand
• Boost the number of patients who choose you as their provider.

Build a Foundation

To be successful, your digital voice must be built on a strong foundation that includes a written marketing plan, an in-depth Web presence, and improved patient processes.

Developing your marketing plan. A deep dive into marketing plan development is, of necessity, reserved for a separate discussion. In short, your marketing plan is an overview of your market landscape, detailing the strategies and programs you will employ to achieve the current year’s goals. Objectives are built around your mission statement, which reflects what your cancer program or oncology practice does. Your marketing plan objectives are a summary of your target opportunities in terms of cancer incidences, disease sites, and/or specific patient populations. Relative to your area of specialization and competitive environment, your marketing plan should answer these questions:

• Who are your specific target population(s), and what are your growth goals relative to these groups?
• Why would (or should) your target population(s) choose you as their cancer care provider?
Your website is your “hub,” virtually representing your cancer program or practice 24 hours a day, every day of the year.

- What unique benefits does your cancer program offer?
- Which of your unique benefits are strong enough to stand as a differentiating platform?
- What promise(s) are implied to your patients and referring physicians within your differentiating statements, and how will you deliver on these promises?
- What marketing mix (traditional and/or digital) affords you the most productive communications with your target population(s)?

Next, you will need to develop a realistic step-by-step implementation timeline, secure any necessary training and tools, and delegate responsibilities for executing your marketing plan.

Optimizing your website. Your website is your “hub,” virtually representing your cancer program or practice 24 hours a day, every day of the year. Much of your digital strategy will ultimately drive traffic through this virtual doorway into your cancer center program. To achieve success, you must first:

- Identify your target audience(s)
- Conduct research to determine their needs
- Fill your website with as much content (relevant to identified audience needs) as you can.

That said, great content accomplishes nothing unless it is read by your target audience. Of the thousands of websites listed in response to online queries, you want yours to be among the first to appear so it is most likely to be visited via click-throughs. Optimize your website to elevate your search engine results ranking for improved visibility by:

- Identifying 50 to 100 keyword phrases
- Establishing relevancy by organizing content around pages dedicated to two to three specific keyword phrases
- Having your webmaster incorporate your keywords into meta tags and alternative text
- Building authority via credible inbound links (i.e., links from an external webpage back to your website or webpage).

Improving your patient processes. Map out every touchpoint in your patient experience, and discuss how each member of your team can exceed expectations based on your brand differentiation. Ensure that your cancer center or oncology practice is sufficiently staffed. Further, staff should be aware of referral protocols and have access to resources that enable consistent communications for every encounter with patients, other staff, and referring physicians. Periodically, review your systems for optimal flow and maximum efficiency. Consistently delivering beyond the implied promise of your competitive differentiators will naturally generate positive word of mouth from your patients that can grow exponentially via virtual communities.

Phase 1: Explore Social Media Options

More than a tool, social media require strategic planning, consistent attention, and long-term commitment to reach goals. Simply put, social media done poorly can be far worse than refraining from the activity altogether. To achieve success, plan to dedicate at least one hour daily to your social media efforts. While you can choose from a plethora of social media platforms, consider Facebook, Twitter, and/or YouTube as good launching points. In fact, one survey indicates that about 94 percent of all Americans who rely on social networking for health information turn to Facebook.²

Each social media platform has its own style and protocols. Become acquainted with the platform and its users through exploration. Locate and subscribe to blogs and forums of interest. Find online communities and follow conversations based on topics or keywords in your area of specialization. Evaluate the quality of blogs and networks relevant to your cancer center or oncology practice and its services by observing the type of content or questions that stimulate interaction via posted responses and clickthroughs.

Designate a staff member to create a profile at www.facebook.com. Click on “Pages” in the left-side navigation on the profile page, then the “Create a Page” button and select the type of page. Your cancer center or oncology practice can now begin to build an official Facebook Brand page. You may choose not to have default applications, such as Photos, Links, Events, Notes, and Video, show on your page. Working with a third-party application or your web designer, develop your custom page presentation to align with your overall brand messaging.

On Facebook, each page is separately indexed by search engines. Similar to your cancer center or oncology practice

Figure 1. Medical Information Sought by Internet Users³

<table>
<thead>
<tr>
<th>Facility</th>
<th>Provider</th>
<th>Treatment</th>
<th>Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>40%</td>
<td>60%</td>
<td>20%</td>
<td>0%</td>
</tr>
</tbody>
</table>

³| March–April 2012 | www.accc-cancer.org
website, you will need to apply keyword optimization to content. Keep the tone informal for this social media venue. You might also consider installing an RSS feed, a content delivery application that syndicates relevant news or other types of web content specified by you. This allows you to continually maintain fresh content to support search relevancy and elevated rankings on search-engine results pages.

Designate a staff member to sign up at www.twitter.com. Keep your “user name” brand relevant, i.e., the name of your cancer center or oncology practice.

After logging in, scan Trending Topics for relevance to your area of specialization. These topics-of-the-moment are being tweeted by thousands of users, all using the same term or hashtag (#). Look for cancer care hashtags to locate opportunities to make new connections and share information.

Create your cancer center or oncology practice Twitter bio, incorporating important keywords as appropriate to draw searchers. Upload your professional email contacts and follow those with whom you want to keep in touch, for example your referring physicians. After you “follow” your key professional contacts, click the “Following” link in your profile on your Twitter homepage. Some applications let you find people based on your indicated interests or specialties or keyword searches. Click the “Who-to-Follow” link at the top of the page to search for similar-interest users, clicking the “Follow” button next to additional people you want to track.

Run some searches via www.twitter.com or www.tweetdeck.com (a robust Twitter application) to check for mentions of your cancer center or oncology practice or other relevant keywords. “Follow” industry thought leaders or blogs—theyir messages will then automatically appear on your Twitter homepage incoming timeline, as will your messages to your “followers.” Limit the number of your “Follow” accounts to a manageable number. For most of us, 80 is a good ceiling number.

Designate a staff member to sign up at www.youtube.com with his or her email address. Review videos submitted by cancer programs and other healthcare providers, as well as organizations and vendors within your area of specialization. You can start by going to www.accc-cancer.org and selecting “Find a Cancer Center.” ACCC-member programs are listed by state and have individual pages that link directly to their program websites. Look for social media icons on the program’s homepage.

Spend several weeks becoming acquainted with these three platforms, their users, and the type of information most sought after on each platform. Then begin indexing your content by topic and/or keywords. Include web pages, white papers, case studies, videos (if they are current), webinars, and so on—as much relevant content as your cancer center or oncology practice can gather.

Phase 2: Develop a Social Media Strategy

Unless you have defined, specific social media goals that align with your overall practice goals and have developed a clear plan for achieving these goals, you should not engage in online activity. Begin by answering these questions.

**What are our social media goals?** State what your cancer center or oncology practice is trying to achieve. Options might include:

- Raising community awareness to encourage cancer screenings
- Educating patients and their families on treatment options
- Facilitating patient referrals by clinicians
- Improving brand awareness
- Increasing patient traffic to your website
- Generating fundraising contributions
- Fostering clinical trial interest

**Who do we want to connect with?** Profile your target population(s), age range, gender if applicable, and preferred blogs or social platforms. Based on your Phase 1 research, identify the information they seek and the type of content that draws them into discussions.

**How can we best engage our audience and communicate the information they need?**

**Are we able to continue conversations over the long term?**

If you cannot commit to regular monitoring, timely responses, and ongoing dialogue, your cancer center or oncology practice will not realize success in its social media efforts.

Map out your social media strategy for the year, choose your media platform(s), and assign realistic time frames. For example, if one goal is to achieve “X” number of “Likes” on your cancer program’s Facebook page, you will need to expand your contacts through your profile by posting a link to your Facebook page in staff emails, on your program’s website, blog, and Twitter site—everywhere you can. If you want to build relationships within your local community, you may include lighter, more general health and wellness content within a local context, as well as more in-depth, disease-specific posts and news. If you are targeting referring physicians, your staff can offer tremendous insights based on their daily practice interactions and frequently asked questions. More interaction requires more sharing. You may need to consider posting insightful comments or thought-provoking questions more than once a week.

**Who will be charged with tactical implementation tasks?**

Schedule updates into staff calendars so your cancer center or oncology practice stays on course with its social media strategy. Assume the role of publisher (versus advertiser), gather as much meaningful content as you can, and plan posts out several months in advance—always assuming the
HOW MANY PEOPLE ARE USING SOCIAL MEDIA?

Facebook
30 billion pieces of content—links, stories, blog posts, notes, and more—are shared on Facebook every month. By the end of 2011, there were more than 800 million active users, each of whom averages 130 Facebook Friends. The interactive nature of your Facebook business page enables relationship building through discourse with an expanding network, simultaneously educating an interested community, facilitating referrals, and potentially supporting increased search engine visibility.

Twitter
As of October 2011, about 25 million tweets are sent every day. Real-time dialogue via succinct messages enables providers to stay informed on industry developments while growing a reputation as a thought leader. Networks of followers can increase visitors to your website or blog, while allowing you to monitor and respond immediately to what’s being said about your providers, your cancer center or practice, your programs and services, or industry areas of specialization.

YouTube
About 2 billion videos are watched daily on YouTube. As the largest video sharing community in the world, YouTube enables you to engage and inspire an audience already highly interested in your area of specialization. Draw new patients to your cancer center or practice and build brand recognition and your reputation as a market leader—all while supporting search engine optimization through fresh content and inbound, optimized website links.

perspective of your target audience to keep the information you are sharing relevant to them.

Phase 3: Participate & Create in Social Media
Reciprocity fuels social media. Your cancer center or oncology practice will benefit by becoming a network contributor who brings value to your community members. Ask and answer questions. Help others. Continually share meaningful content to draw visitors to your website and build your brand. Here are more tips specific to the three social media sites discussed above.

Recommend any Facebook groups you like by clicking on the “Like” icon (a hand with thumb facing up). You may want to start with professional organizations such as:

- The Association of Community Cancer Centers (ACCC): www.facebook.com/acccncancer
- The American Society of Clinical Oncology (ASCO): www.facebook.com/ASCOCancer
- The Oncology Nursing Society (ONS): www.facebook.com/OncologyNursing

And patient and advocacy organizations such as:

- The American Cancer Society (ACS): www.facebook.com/AmericanCancerSociety
- The Susan G. Komen Foundation: www.facebook.com/susangkomenforthecure
- The Lance Armstrong Foundation: www.facebook.com/pages/Lance-Armstrong-Foundation/108519699170201

Include the “Like” option on your program’s Facebook page, as well as your cancer center or oncology practice website, so visitors can recommend your program to their Facebook Friends. Add a Tweet button to encourage sharing.

Ask and answer questions, offering meaningful commentary and encouragement to raise awareness of cancer, cancer treatment, and cancer prevention. Use a warm, informal tone, as most users will not identify and engage with an overtly clinical or technical presence. Present ideas, accompanied by a call-to-action in the form of a keyword-rich link to one of your relevant YouTube videos, blog posts, a website landing page, white paper, case study, webinar, “Top 10” list, or other resources. Click on “Publish” to take it live. See page 43, for a look at what ACCC member programs are doing with social media.
Since conversations drive Twitter, your best chance at success is to post meaningful content. Tweet about cancer care topics. Initiate dialogue through public messages sent to an individual. (For novices, this means posting your Tweet as “@username + your message”). The message will go to the individual, as well as all of his/her followers. Any of them may choose to retweet the message, which re-circulates the information to all of their followers as RT@username + original message. Retweets are the power of Twitter, spreading postings quickly to an extended audience. A user-relevant message of 100–120 characters leaves room for the message to be retweeted in its entirety.

When your cancer center or oncology program elects to follow individuals or groups, their tweets and retweets appear on your Twitter homepage incoming timeline. As you develop followers, they will likewise see your messages. The more followers you develop, the more extensive your communications reach. You can also send private, direct messages (DMs) as “d username + your message” to followers.

Twitter posts are limited to a maximum of 140 characters—characters that exceed this threshold will be dropped from the message. An intriguing headline in combination with rich media (links to content-rich landing pages, videos on your YouTube channel, or a request form) can be a highly effective call to action that moves respondents further along the process. Provide value to build credibility.

Search YouTube by keyword to find channels within your area of specialization. Subscribe to those channels your cancer center or oncology practice finds most relevant. Rate some videos. If your cancer center or oncology practice has video tools that are current, post them. For example, go to http://www.youtube.com/watch?v=gY7F9Bsr unQ&feature=channel_video_title to see how ACCC used a video to promote membership benefits.

When you choose a “favorite,” it will display on your channel. Share your channel video by becoming a Video Friend of a channel or an individual user.

Start to develop ideas for videos about your cancer center or oncology practice, such as:
- Topic-relevant testimonials or patient stories (obtain patient’s written permission)
- Brief introductions to unique programs or services
- Informal physician profiles, approaches, or perspectives
- Specific treatment information
- Survivorship support
- Community outreach efforts.

In general, videos longer than three minutes run the risk of losing their audience. Consider segmenting longer videos into shorter clips. Shorter, emotionally compelling videos are far more likely to be shared and discussed. If your current videos are outdated, remove and update with more current presentations that are relevant to the target audience needs revealed by your research. You may wish to check out Freemake Video Converter (www.freemake.com), video conversion and editing software that allows direct uploads to YouTube and Facebook.

### Phase 4: Launch & Expand Your Social Media

Make it easy for patients and their families to spread the word about your cancer center or oncology practice. Once you establish social media channels, promote them everywhere you can, and encourage patient participation.

Once you hit “Publish” your Facebook website is live. “Like” your site and ask your staff to do the same. This will display on your Profile wall (aggregated content display) and will enhance your Page visibility. As Fans engage with your content, their activity is communicated to all of their Facebook Friends through their news feed, which increases your reach.

Invite all of your patient base, as well as professional contacts to participate and become Facebook Fans. Provide them with a link to make it easy for them. There are no limits imposed, so encourage your network connections to “Like” and share your Page. Provide links to your Page whenever possible, including email signatures, website, blog postings, and other practice communications. Add fresh content at least once per week, always including a call to action such as those mentioned previously.

Connect with other professional and professional organizations, such as:
- ACCC: www.facebook.com/accccancer
- ASCO: www.facebook.com/ASCOcancer
- ONS: www.facebook.com/OncologyNursing
- Association of Oncology Social Workers (AOSW): www.facebook.com/AssociationofOncologySW

Post relevant content to your organization’s Twitter page at least a few times weekly to foster deeper engagement and to advance your communications and publicity goals. Contribute meaningful ideas, ask questions, suggest additional resources, and encourage sharing via links and retweets. Over time, you should notice an increase in the questions directed to your program, as you build your reputation as a thought leader.

www.accc-cancer.org | March–April 2012 | OI 41
Launch videos on your cancer center or oncology practice YouTube channel. As you post videos, promote and cross-promote across all of your market outreach, particularly social avenues, such as your Twitter stream. Link to it from your website, and incorporate it into your Facebook account. Subscriptions trigger automatic notifications whenever you upload new material, so encouraging viewers to subscribe encourages sharing and additional visits.

**Phase 5: Monitor & Expand Your Social Media**

Continue to monitor across platforms to keep your finger on the pulse of your audience and assess your effectiveness, and always keep building your network connections. The rule of thumb: listen 90 percent of the time and spend the remaining 10 percent of your networking time contributing and building connections. Publish everything your cancer center or oncology practice has, anywhere you can. Monitor. Ask. Answer. Invite. Share. When forming responses, keep in mind that defensiveness or overt self-promotion can quickly damage your online reputation. If you encounter positive feedback, thank the individual responsible. If you share someone else’s material, credit the originator.

Free monitoring tools are available online at:

- [www.google.com/alerts](http://www.google.com/alerts)
- [www.socialmention.com/alerts](http://www.socialmention.com/alerts)
- [www.tweetdeck.com](http://www.tweetdeck.com)
- [www.facebook.com](http://www.facebook.com)
- [www.youtube.com](http://www.youtube.com).

**Phase 6: Measure & Adjust Your Social Media Efforts**

Listen to questions and comments to hone continually your understanding of what users are looking for. Measure, analyze, assess, and adapt as needed, but do not abandon your social media plan. Successful social media take time, so your cancer center or oncology practice must be willing to invest the time. At a minimum, track your social media on a monthly basis. Key metrics include:

- Website visitors
- Facebook Fans (People who “Like” your cancer center or oncology practice) and activity (the number of “Likes” and comments per post)
- Twitter activity
- YouTube video views
- Inbound links
- Subscribers
- Patients generated from social media outlets.

Facebook provides a built-in analytics program called Insights, which can be used to track your Fan-base growth and engagement, page views, wall posts, discussion threads, fan demographics, feedback, and more. If, for example, your cancer center or oncology practice observes spikes or drops in engagement around a particular post, these changes are an indicator for making adjustments in your content strategy and editorial calendar to increase or decrease the number of posts around a given topic. To use this program, click on “View Insights” in your Page’s left-side navigation. Watch for spikes in Fan growth and try to identify growth initiators. Monthly growth of 10 to 13 percent is likely the highest your cancer center or oncology practice can achieve organically, or naturally.

You may also be interested in using Grader ([www.grader.com](http://www.grader.com)), a robust suite of tools that measure and analyze online marketing efforts, such as Facebook, Twitter, press releases, blog posts, and your website.

**Virtual Discourse & Risk Mitigation**

Given the daunting topic of cancer and the increasing expansion of social network participation, digital media offer cancer centers and oncology practices a means by which to develop and maintain relationships with patients and referring providers to an extent previously unattainable. Enabling virtual conversations, social media channels facilitate give-and-take communications that embody trust and honesty from a patient-centered perspective.

Yet, the use of social media is not without challenges. While the permanence of virtual communications may legitimately underscore exposure concerns, such as potential negative publicity, and regulatory and privacy risks, cancer centers and oncology practices can mitigate risks through creative planning. Protect your program by:

- Developing written social media use guidelines for all individuals connected with your organization. Consider coupling these guidelines with discussion and training. Examples you may wish to review include guidelines by Vanderbilt Medical Center ([www.mc.vanderbilt.edu/root/vumc.php?site=socialmediatoolkit](http://www.mc.vanderbilt.edu/root/vumc.php?site=socialmediatoolkit)) and the Mayo Clinic ([http://sharing.mayoclinic.org/guidelines/for-mayo-clinic-employees/](http://sharing.mayoclinic.org/guidelines/for-mayo-clinic-employees/)).
- Creating a pre-determined plan and a professional contact who can help your cancer center or oncology practice navigate a negative situation in the event one should arise.
- Mapping out potential discussion topics in advance, and only posting content that has been preapproved by an internal review board. One easy solution may be to draw from your Frequently Asked Questions, website content, or blog posts.
- Ensuring that your cancer center or oncology practice does not use social media to “practice medicine.” Bottom line: avoid giving individual medical advice online.
- Protecting the identity of your program and your staff. For...
example, do not include employee ID numbers, which are often the individual’s Social Security number.

- Avoiding blatant self-promotion. Keep posts conversational, bypassing aggressive marketing or constant self-focused commentary. Remember, with social media, it’s about the audience.
- Maintaining realistic expectations. Start slowly and give it time.

Open Your Virtual Doors

Digital media offer unprecedented access to patients and clinicians who are actively participating in conversations about their specialization. With careful planning, cancer centers and oncology practices can embrace new opportunities to expand the breadth and depth of their market penetration. Those organizations that fail to adopt virtual strategies may find themselves trying to catch up to their competitors. Those organizations who join in the discussion to share knowledge and expert opinions online can help large groups of individuals obtain the accurate information necessary to informed decisions—even as they build their center brand, facilitate customer service, and drive positive public relations. 

— Kat Gerlich is customer marketing manager, Elekta Region North America, where she develops tools and programs to support cancer practices in achieving their growth goals. She may be contacted at: kat.gerlich@elekta.com.

References

SURVIVORSHIP MIDWEST STYLE
BY SANDRA CARBONE

Cancer survivorship as a distinct phase of the continuum of care has drawn much public attention since the Institute of Medicine’s 2005 landmark report, From Cancer Patient to Cancer Survivor: Lost in Transition, which motivated cancer centers of all types to establish survivorship programs.

Multidisciplinary, integrative care has always been at the center of services at Indiana University Health Goshen Center for Cancer Care. Formed in 1999 to serve the residents of Northern Indiana, Goshen Center for Cancer Care offers medical, surgical, radiation, and naturopathic oncology, onsite diagnostics, and supportive care services, including dietitians and complementary therapy all in one building. Approximately 1,200 new patient consultations are provided annually. Treatment planning for cancer patients is patient centered and begins at weekly prospective planning conferences where all members of the team participate.

Program Development
With the cancer center’s history of dedication to innovative, patient-centered care, development of a cancer survivorship program was a natural next step. In spring 2008 at the annual cancer survivor celebration, Joseph Gagliardi, senior vice president, announced that the cancer center would be developing a survivorship program and invited former and current patients to contribute ideas for what the new program would offer. By August 2008, a survivorship coordinator was hired to begin the process of developing the survivorship program. Funding for the survivorship program was included in the cancer center’s Integrative Care budget.

Focus groups followed, composed of 55 cancer patients and family members. The groups produced a wealth of ideas that provided the basis for the new program. Some focus group members offered to serve as volunteer members of the Coordinating Committee to help guide program development. By January 2009, the first survivorship newsletter, “The Link for Hope,” was published. The name for the newsletter, developed by Coordinating Committee members, was seen as a statement on survivorship—that linking survivors together gave them hope for the future.

“The Link for Hope” includes cancer-related information from the cancer center’s medical oncologists, naturopathic physicians, dietitians, and mind-body counselors. Each issue also includes a story of hope, written by a survivor who shares how he or she has adjusted to the “new normal.” The newsletter also connects patients to survivor resources such as CANCERcare® Connect workshops, Relay for Life events, Look Good—Feel Better classes, and other health-related opportunities. “The Link for Hope” is now mailed bi-monthly to more than 3,000 homes, and is distributed electronically to network members and 1,400 IU Health Goshen colleagues.

Outreach Efforts
In January 2009, the cancer center hosted a Join the Network Night, an opportunity for survivors and family members to share a meal and learn more about healthy living. Response to the first event was encouraging, with over 120 attendees.

Social gatherings are an important part of the Survivor Network, offering opportunities for new patients and long-term survivors to meet and share experiences. Join the Network Night was held again in 2010 and effectively helped build membership and increase visibility for the new survivorship program. Both events offered attendees an opportunity to hear the latest in cancer advances from a cancer center oncologist. A December holiday celebration was established in 2009 and continues. This annual event features a survivor speaker, catered lunch, musical entertainment, and a survivor ornament to celebrate survivorship. All events are

The Survivor Network often hosts displays with cancer education materials at Goshen Center for Cancer Care-related events. Pictured at the annual Run for Research event is Cancer Survivorship Coordinator Sandra Carbone (left) with Emmy Conley, member of the Survivor Network Coordinating Committee.
provided free of charge to an audience of 150 survivors and family members.

Providing education and information was a top priority for the new survivor program. In 2009 a local attorney presented at a Lunch & Learn to educate survivors about the Americans with Disabilities Act and the employment rights of cancer survivors. Attendees received copies of the booklet, “Working It Out,” by Barbara Hoffman, JD, available from the National Coalition for Cancer Survivorship. The survivorship program distributes no cost educational materials from the American Cancer Society, the Leukemia & Lymphoma Society, the National Coalition for Cancer Survivorship (Cancer Survival Toolbox), and the National Cancer Institute.

In 2010 the Network continued to connect survivors to education and resources through the addition of a survivor-specific website: www.goshensurvivors.org. This site allows the Network to provide up-to-date news, education, and information that can be accessed at the survivor’s convenience—anywhere, anytime. The site had nearly 1,200 site visits in the first six months it was operational.

Beyond Support Groups
In the focus groups, patients had requested a mechanism to provide encouragement and support for one another in a format outside of the support groups offered by the cancer center’s counselors. Two strategies were developed to meet this request:

- Creation of a structure and guidelines for off-site, informal self-help friendship groups
- Development of a Survivor Buddy program, for one-to-one support.

At Goshen Center for Cancer Care, patients are considered survivors from the moment of diagnosis, and the survivorship coordinator is available to all patients beginning with their first visit to the center. New patients typically receive a personal welcome from the survivorship coordinator and are introduced to the integrative care model, as well as offered information about support services and the opportunity to have a Survivor Buddy. Interested patients can join the Goshen Cancer Survivor Network, which has enrolled more than 1,700 patients to date. HIPAA issues were addressed by including a Join the Survivor Network enrollment form in all new patient paperwork packets.
A collaborative effort with the Leukemia & Lymphoma Society has recently been established to provide an educational seminar and dinner in 2012 at no cost for hematology patients in Northern Indiana. Grace Suh, MD, medical oncologist at Goshen Center for Cancer Care will present the educational program designed to promote understanding of hematologic cancers.

One-on-one support is available through the Survivor Buddy program. Cancer Survivorship Coordinator Sandra Carbone (left) with volunteer “Buddy” Nancy Leichty.

The first friendship group was Mujeres De Esperanza, for Spanish-speaking female cancer survivors. The Survivor Buddy program began in April 2009, and was offered to new cancer patients at the cancer center. The Survivor Buddy program expanded on a previous program, which provided support to patients through contact with another patient with similar treatment experiences.

There are now two additional friendship groups: PINK—Positive Influence N Knowledge for women breast cancer survivors, and CanSurvivors, a group of retirees with winter homes in Estero, Fla. All three friendship groups were started by IU Health Goshen Center for Cancer Care patients who wanted to encourage other cancer survivors. The Survivor Buddy program has been successful with 30 trained survivors providing encouragement and support to 82 new patients.

**Beyond Treatment**

Another important initiative of the new Network was the development of treatment summaries and survivor care plans for patients completing treatment. A team from Goshen Center for Cancer Care attended the 2009 final conference of the NCI-funded national project, Survivorship Education for Quality Cancer Care, conducted by City of Hope National Medical Center in Duarte, Calif. The team consisted of the new survivorship coordinator and a RN, OCN. The team returned with formal goals to advance the cancer center’s new survivorship program, including:

- Establishing a treatment summary and survivor care plan
- Recruiting a physician champion to endorse the survivorship program
- Educating cancer center colleagues about survivorship issues.

A team of colleagues and cancer center physicians formed a process improvement group to determine how to move forward with the provision of treatment summaries and survivorship care plans. After nine months of planning, two pilots were launched, one for medical oncology patients and one for radiation oncology patients. Survivors were scheduled with a nurse practitioner for a follow-up visit. Copies of the treatment summary and care plan were given to the patient and also sent to the patient’s primary care physician. Patients were also given the NCI booklet, “Facing Forward: Life After Cancer Treatment.” The pilots were completed in 2011 and are now being transitioned to a new electronic medical record (EMR) system, which will dramatically reduce the time required to create the documents.

Two continuing education classes focused on cancer survivorship issues were provided to nurses and other health system colleagues, and an online class is available for all health system colleagues.

A program to provide supplements recommended by the cancer center’s naturopathic oncologists at no cost to new patients with limited income, was established in October 2010, with the creation of the Patient Supplement Fund. Original funds to start the program came from family and friends of loved ones who did not survive their cancer battles. Since then, the fund has received donations from the Goshen Hospital Auxiliary, local civic organizations, businesses, Network members, and others. Currently, the fund has more than $15,000 available to benefit patients, and an active fundraising effort is being conducted by the Network Coordinating Committee.

To learn more about the IU Health Goshen Cancer Survivor Network, visit: www.goshensurvivors.org or call 866.775.4673. [21]

—Sandra Carbone is cancer survivorship coordinator with Indiana University Health Goshen Center for Cancer Care, Goshen, Ind. She was a team participant at the 2009 final conference of the NCI-funded national project Survivorship Education for Quality Cancer Care, which was conducted by City of Hope National Medical Center, Duarte, Calif.
COMING THIS YEAR!
The Financial Information and Learning Network for Community-Based Cancer Programs

A new education program from ACCC’s Center for Provider Education

In response to the growing need to offer cancer patients comprehensive financial assistance, ACCC is developing a 10-part, online interactive course on financial assistance services. Delivered as a series of live and archived webinars, the course will cover the basics of financial assistance (such as how to find co-pay programs) as well as include more technical and comprehensive pre- and post-treatment financial planning and support.

Sample topics include the following:
- Evaluating and Improving Your Revenue Cycle
- Improving the Patient Experience
- Financial Specialists as Part of a Multidisciplinary Cancer Care Team
- Patient Counseling 101
- Reporting Back to the CEO
- Justifying a Financial Specialist Position

If you are responsible for helping patients deal with the complex issues surrounding their cancer treatment and diagnosis, plan to participate in this course.

Do you have any financial assistance tools or resources that you or your program would be willing to share?

www.accc-cancer.org/filn

This project is sponsored by Teva Oncology, Genentech, Lilly Oncology, and Novartis Oncology
The Association of Community Cancer Centers 2012 Innovator Awards, sponsored by GE Healthcare, will recognize and honor pioneering strategies for the effective delivery of cancer care in the community setting. ACCC is looking for programs that empower cancer care teams to create change. If you have an innovative approach or outstanding program, tell us! Innovations should advance the goals of improving access, quality, and/or cost effectiveness of cancer care. Your achievement could bring your program national recognition.

2012 Innovator Award winners will share innovations at the ACCC 29TH NATIONAL ONCOLOGY CONFERENCE October 3–6, 2012
Grand Hyatt San Antonio  •  San Antonio, Texas
All entries will be peer reviewed. Applicants must be affiliated with ACCC as a Cancer Program Member.

For details and an application form, go to: www.accc-cancer.org/innovator
Best Practices in Advanced Non-Small Cell Lung Cancer: Update on Pathologic Considerations and Treatment Selection and Duration | This program describes new recommendations regarding multidisciplinary approaches to non-small cell lung cancer (NSCLC) classification, as well as evidence-based strategies to optimize first-line therapy for the individual patient with NSCLC based on the results of pathologic analyses, the performance status of the patient, and the efficacy and safety of available cytotoxic and biologic agents. These factors, as well as the disease response to first-line therapy, form the basis for decision making regarding maintenance therapy. Earn CME credit through this program.

Multiple Myeloma: Challenges for the Community and Academic Oncology Team | This learning activity reviews the evidence base for multiple myeloma treatment regimens; the factors influencing the selection and timing of induction therapy, maintenance therapy, and transplantation; and strategies for managing patients with treatment-related toxicities. Earn CME credit through this program.

For more information, go to the ACCC Blackboard at: www.accc-cancer.org/education/education-blackboard.asp.
Does Your Cancer Program Offer Financial Assistance Services?

ACCC is launching a multi-year educational program entitled, *The Financial Information and Learning Network for Community-based Cancer Programs*. This educational program has many components, including a 10-part online course, interactive workshops held concurrently with ACCC’s regional meetings, and a provider-specific web-based portal for cancer program staff delivering financial assistance services. Another program component is the development of a practical toolkit. If your program offers financial assistance services to your cancer patients, we would love to hear from you. Please share your processes and flowcharts for providing these important services. Specifically, we are looking for ACCC members to share replicable strategies, tools, forms, SOPs, guidelines, resources, job descriptions for your financial assistance staff, and any other materials or resources your program uses to deliver financial assistance to your patients in need. Interested in participating in this innovative educational program? Email: mmarino@accc-cancer.org today!
NURSE NAVIGATOR ONCOLOGY SERVICES
Burlington, Massachusetts

The Nurse Navigator is a patient educator and advocate who will serve as a liaison throughout the clinic and is committed to improving the cancer experience of each patient.

Responsibilities
- Provides nursing care and guidance to the cancer patient from early diagnosis to survivorship.
- Assesses, plans, implements, and evaluates care according to Oncology Nursing Society (ONS) standards of practice.
- Provides education and information to the patient and family, helping to make care seamless, continuous and comprehensive.
- Facilitates appointments for consults and support services.
- Serves as essential link between patients and all care providers.
- Works with Cancer Registry staff to collect data, track outcomes, and support strategic planning.

Qualifications
- Bachelor’s in Nursing, required, with (5 years of experience in Oncology)
- RN License; Oncology Nurse Certified or obtain within 18 months of hire.

To apply, email your resume to: rldattilo@health-partners.org or apply online at: www.mercy.jobs

NURSE CLINICIAN
Southwest Ohio

Mercy Health is an integrated healthcare organization that includes six acute-care hospitals. Conveniently located in Cincinnati’s northeast suburbs, The Jewish Hospital–Mercy Health is a full-service, 200+ bed acute-care facility providing leading-edge treatments in a variety of areas, and is home to the region’s only adult blood and marrow transplant center. The BMTC is officially recognized for overall excellence by the Foundation for the Accreditation of Cellular Therapy (FACT).

Reporting to the Director of the Blood and Marrow Transplant Center, the Nurse Clinician will be the lead point person for promoting quality nursing care to patients. You will work closely within the multidisciplinary team to care manage patients, as well as act as a patient advocate in the continuum of care. Additionally, we will count on your advanced clinical skills to detect physiologic and psychological problems to help facilitate early intervention.

The ideal candidate must have a current Ohio RN licensure and 3 to 5 years of nursing experience (blood and marrow or oncology experience preferred). Bachelor’s degree preferred and Oncology Certified Nurse (OCN) preferred.

For more information, contact: Susan Carlow, VP, Steve Harvey & Associates, at: smc@sharveyassoc.com.

DIRECTOR CANCER CENTER AND ONCOLOGY SERVICES
Middletown, Connecticut

Middlesex Hospital is seeking a Director, Cancer Center and Oncology Services. In 2002 the cancer program moved to a new cancer center that combines radiation oncology, medical oncology, and supportive services at a single site in close proximity to diagnostic radiology including PET, CT, and MRI. The cancer program is an ACoS-approved Comprehensive Community Cancer Center most recently accredited in 2009. Clinical trial participation includes patient entry on NSABP, CALGB, and industry-sponsored protocols.

The Director, Cancer Center will be responsible for the overall management, growth, and development of outpatient cancer care and treatment. The Director will work collaboratively with the cancer center Medical Director, a practicing member of the medical staff under contract to provide physician leadership. The position reports to the VP, Operations.

A bachelor’s degree in Health Sciences or business-related field, as well as a master’s degree is required. A minimum of three years experience in managing cancer or oncology facilities or programs is also required. The ideal candidate will ensure that high-quality patient care is delivered in a cost-effective manner.

For more information, contact:
Susan Carlow, VP, Steve Harvey & Associates, at: smc@sharveyassoc.com.

ONCOLOGY SERVICES NURSE NAVIGATOR
Silver Spring, Maryland

You will be responsible for assessing, planning, implementing, evaluating, and, if necessary, delegating patient care provided to a specified group of patients. You will collaborate with physicians, medical professionals, and other staff to ensure the quality of care given and provide care for the neonate, pediatric, adolescent, adult, or geriatric patient.

To qualify, you must have a bachelor’s degree (MBA, MHS, or other health-related master’s degree preferred); current RN licensure by the Maryland State Board of Nursing (OCN preferred); four years experience in a professional navigator role, with a minimum of two years experience working with oncology patients; and current BLS certification.

For complete details on this extraordinary career opportunity and to apply online, visit us at: www.holycrosshealth.org. With an excellent benefits package (including PTO, 403[b] and pension plans, tuition assistance, and student loan repayment program) and competitive salary, you’ll find Holy Cross Hospital will give you more room for your career. EOE, M/F/D/V. Pre-employment drug/alcohol screening required. Smoke-free workplace.

Apply online at www.holycrosshealth.org.
FIRST PERSON

Leigh and Joshua in Wonderland

When my 11-year-old son, Joshua, was diagnosed with Acute Lymphoblastic Leukemia in January 2011, I felt like I was unwillingly cast in my own version of Alice in Wonderland. I had fallen down the rabbit hole into a world where nothing made sense. As a media relations consultant for ACCC, my job has been to make sense of cancer care policy and communicate it to reporters and editors. I can talk about Average Sales Price, Medicare reimbursement issues, patient navigators, and oral chemotherapy trends. But I had never heard the words “neutrophils” or “neutropenic” before in my life. The language of oncology practice is so different from the language of oncology policy. Everything I knew about the business of cancer care faded to the back of my mind.

They speak a different language in Wonderland. A “white rabbit” appeared to guide me around and introduced me to a whole new cast of characters, the likes of which I’ve never seen or imagined before. Everything started happening fast and furious, yet inside the walls of the Pediatric Oncology floor, time ceased to have any real meaning. Night becomes day and day becomes night. Editorial deadlines and news release embargoes become nonsense. I struggled to remain standing as new words and new information crashed down on me like a judgment from the Queen of Hearts. I knew about the business of cancer care faded to the back of my mind.

Just like an investigative journalist, my questions uncovered some undesirable information about our son’s medical care in the form of mistakes and omissions. After I discovered that Joshua’s first dose of chemo was calculated incorrectly, the doctor-patient relationship started to break down. When we were unable to get Joshua into remission on Day 29 in the wake of significant omissions and misstatements from the medical staff, we went to another hospital’s cancer center for a fresh perspective. The contrast was striking. I liked the way the new doctors and nurses spoke to Joshua, instead of over him, and put him at ease. We are the parents, yes, but he is the patient. They never forgot that. It felt comforting to hear doctors explaining things in words he could understand. At the first hospital, I always got the feeling that there was something the doctors weren’t telling us because they didn’t think we could handle it. The doctors, nurses, and administrators at the second hospital always answered us honestly and clearly. Their words cultivated a trust that grew and never wavered.

Our journey through Wonderland ultimately led us, not to a tea party or a game of croquet with the Red Queen, but to a half-match bone marrow transplant as part of a clinical trial at the new hospital. On Joshua’s discharge day after the transplant, I ran into our main doctor, the head of the pediatric leukemia program. I will tell you what I told him: please don’t ever forget the impact your words have on the parents of your patients. I thanked him for his honesty, optimism, and confidence. I urged him to always choose his words carefully as they resonate long after they’re spoken. As the parents of a child with cancer, my husband and I hung on his every word. His words rang in my head like a calming mantra and helped me get through the toughest days. Here are some his most important and potent words to us:

• “We are thrilled that his counts recovered so quickly.”
• “I remain optimistic for a cure for Joshua and if that ever changes, I will tell you.”
• “I have no hesitations about doing this half-match transplant and if I did, I wouldn’t do it.”

We listened to his words and they led us out of Wonderland, hopefully never to return again.

—Leigh A. Bluestein is a media relations consultant for the Association of Community Cancer Centers, Rockville, Md.
Advanced therapies made easier

Radiotherapy techniques are becoming increasingly sophisticated, requiring more time and skill to ensure safe delivery. By simplifying the variables in planning, patient setup, treatment verification, and delivery, Elekta gives you greater confidence to define and raise the standard of human care. Visit us at elekta.com/experience.
HELPING BLOOD CANCER PATIENTS
LIVE BETTER, LONGER LIVES.

On March 14th, The Leukemia & Lymphoma Society will conduct a free telephone/web education program – Update on Peripheral T-Cell Lymphoma featuring Steven M. Horwitz, MD. Listen and ask Dr. Horwitz a question during the Q & A session. Visit www.LLS.org/programs to register today. If you miss the live event, all programs are archived at www.LLS.org/pastprograms.

Lynn, lymphoma survivor