ASSOCIATION of CANCER EXECUTIVES

ACE update

Vol. 10 / No. 2
April–May 2009

Infusion Nursing Resources:
One Approach to Doing More with Less

By David Delaney, MD
Chief Medical Officer, MedAptus, Inc.

As any infusion nurse will attest to, coding and billing for infusion services is highly challenging. Not only are multiple and concurrent therapies delivered in a single clinic visit – chemotherapy, non-chemotherapy and hydration – but the regulations that govern reimbursement for these services also tend to change frequently, creating another level of complexity.

It wasn't that long ago that only a small number of codes were used in the infusion billing process. This made it practical for the coding process to happen at the point-of-care, relying on nurses for entry given their direct knowledge of what services were provided. However, over time, new codes were created, others were renumbered and a coding hierarchy was introduced, resulting in the need for nurses to spend more and more time on this task as well as related training.

While some clinics, in response to increased infusion complexity, elected to move the process to the back-office using specialized coders who rely on clinical notes to extract charge data, most groups still rely on nurses given their first-person encounter knowledge. These nurses in turn typically rely on paper to document charges – paper that creates a host of potential issues.

Paper superbills might seem to make sense in other outpatient areas where coding is more straightforward, as in the selection of a single procedure code, but they simply do not represent the infusion coding hierarchy in a way that is intuitive. The result can be confusion around "primary" relationships between chemo services, therapeutic or other services, and hydration, not to mention several distinct procedure codes for initial, sequential, additional and concurrent services. Encounters that are mis-coded can lead to compliance issues, which are of growing concern given today's environment of recovery audit contractors (RAC) who have an awareness that infusion coding is complex and thus likely to yield mis-payment situations.

And since nursing resources in busy clinics are typically quite tight, the utilization of encounter forms requires initial training, re-training as codes change, and also lead to missing charges, depending on how shift changes are handled. For clinics that allow shift changes during a patient's appointment, services can be omitted if one nurse believes the other has already completed documentation. The worst case scenario is one where forms become misplaced

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President's Message

Leading in Difficult Times

Patrick A. Grusenmeyer, ScD, *Senior Vice President, Cancer and Imaging Services, Christiana Care Health System*

The ACE Annual Meeting last February in Sarasota, Florida was a great success. Thanks to the Education Committee, the speakers and all those who attended. As always, it was great to reconnect with old friends, meet new colleagues and learn ways to improve my cancer program.

In these economic times, many of us find that we are facing new challenges in providing excellent care and service to our patients. According to the American Hospital Association report issued in March, fewer patients are being treated at hospitals with discharges down 0.5%, hospital operating margins are down from 3.0% to 1.8%, and total margins are down from 4.6% to negative 7.8% in the fourth quarter of 2008 compared to 4th quarter 2007. Charity care and bad debt are increasing. Many hospitals are responding by laying off staff and cutting back capital equipment purchases. In an example of the impact on hospitals, formerly believed to be "recession proof", an April 12 *Wall Street Journal* article was titled, Recession Now Hits Jobs in Healthcare.

Cancer programs are not immune. Capital equipment purchases for linear accelerators and CT scans are being cut back. Cancer Center expansions or new construction projects are being scaled back, put on hold or canceled. Moreover, perhaps most difficult, some cancer programs are losing staff to cut backs. The challenge for cancer program administrators is in how to maintain or continue to improve the level of services and the quality of care provided to patients in the face of cutbacks. It is usually unrealistic to expect to maintain the *status quo* during cutbacks. We are faced with difficult decisions about what activities can be eliminated without affecting the patient experience and quality of care. Are there activities or programs that generate little value to the patient

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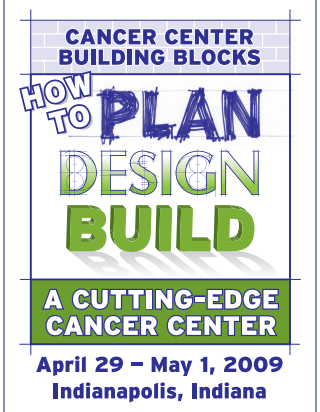
ACE Calendar



INFUSION NURSING RESOURCES

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altogether, leading to a loss of vital revenue.

Beyond compliance and financial concerns stemming from paper processes, there is the reality of nurses whose training is in delivering care and compassion having to manage these administrative responsibilities while trying to balance clinical duties surrounding patient care. These challenges, while frustrating, are not new to healthcare. These are essentially what led to the development of automated charge capture software applications for physicians, leveraging the introduction of handheld computers in the 1990s.

Charge capture technology has evolved significantly over the past several years – tools have grown from simple coding mechanisms to intelligent advisors that provide immediate and real-time feedback to users, driving appropriate coding and reducing downstream denials. Adoption in academic settings in particular has grown tremendously given the solution's positive impact on revenue cycles (now more important than ever).

"Recently, charge capture automation for the outpatient infusion setting has been introduced."

Recently, charge capture automation for the outpatient infusion setting has been introduced. Using the tool, nurses simply click on the line items that represent services rendered; calculations as per the coding hierarchy are performed and the appropriate charge data master codes generated. If a potential coding violation is identified during this process, such as an IV infusion of less than 16 minutes not reported as an IV push, or the erroneous selection of hydration as the primary service, the user is alerted, proactively, to correct the oversight.

The utilization of charge capture technology also shortens the entire infusion billing process. Beyond the elimination of paper handoffs between staff, both clinical and administrative, the usage of a computerized system allows immediate transmission of clean charges from the point-of-care to the billing system. In fact, at two large cancer centers using infusion charge capture software, 99 percent of charges are sent for billing on the same day of service. Nurse users at these sites additionally report high satisfaction with the application and characterize it as both easy to learn and easy to use.

The demand for oncology services is showing no signs of slowing, even as early detection and survival rates improve. Clinics that want to be proactive in their approach to managing increasing demand in the face of an existing nursing shortage must explore all options for expanding the capacity of nurses. Infusion coding and billing is a complex area that many nurses are directly responsible for, yet, these vital resources are appropriately much more interested in spending that time providing patient care. Charge capture automation is an option that has shown success in alleviating nurse administrative burden while simultaneously driving both compliance and financial benefit. The net result? A win for nurses, a win for the organization and a win for patients. ■

Dr. Delaney is responsible for driving MedAptus product development and strategy. Before joining MedAptus, Dr. Delaney was the Director of Web Development and Applied Informatics at Beth Israel Deaconess Medical Center in Boston, where he still practices as a staff intensivist. Dr. Delaney frequently lectures on medical and technology topics. He can be reached via email at ddelaney@medaptus.com.

National Accreditation Program for Breast Centers (NAPBC) Begins Accreditation Process for Breast Centers

By Rosanne Iacono, RN.C., MSN, CRNP
Administrator, Jefferson Breast Care Center, Thomas Jefferson University Hospital, Philadelphia, PA

The National Accreditation Program for Breast Centers has officially launched their accreditation process, with the inaugural group of four centers receiving accreditation in March 2009. An additional 19 centers will be recognized with NAPBC accreditation in April (a complete listing of NAPBC accredited centers is at http://accreditedbreastcenters.org/resources/find.html).

The National Accreditation Program for Breast Centers represents a consortium of national, professional organizations, including the **Association of Cancer Executives,** dedicated to the improvement of the quality of care and monitoring of outcomes of patients with diseases of the breast. This mission is pursued through standard-setting, scientific validation, and patient and professional education. The NAPBC Board has worked diligently to assure multidisciplinary leadership representation and has recently sanctioned its program structure and standards, which include nationally recognized breast cancer quality performance measures that will serve as an initial platform for measuring quality improvement.

"This mission is pursued through standard-setting, scientific validation, and patient and professional education."

The objectives include:

- Consensus development of standards for breast centers and a survey process to monitor compliance
- Strengthen the scientific basis for improving quality care
- Establish a National Breast Disease Database to report patterns of care and effect quality improvement
- Reduce the morbidity and mortality of breast cancer by improving screening mammography and advocating for increased access to and participation in clinical trials

This interdisciplinary quality improvement program continues to draw the attention of centers across the United States. Applications are currently being accepted for NAPBC Accreditation. An on-site survey is part of the accreditation process and must be scheduled within six months from the date the application is accepted by the NAPBC. To date, over 900 breast centers have expressed interest in becoming accredited by the NAPBC.

If you would like to learn more about the National Accreditation Program for Breast Centers and the accreditation process, please visit **http://accreditedbreastcenters.org** or contact the NAPBC Administrative office by e-mail at napbc@facs.org. ■

HONI's "Industry Insiders" – *Q&A with ACE Board*

Ed. Note: ***Hematology & Oncology New & Issues*** *(HONI) is featuring the ACE Board of Directors in a monthly "Industry Insiders" column, which we are pleased to reprint here.*

Shirley Johnson
ACE Immediate Past-President

Submitted by **Shirley Johnson,** RN, MS, MBA, *ACE Immediate Past-President*
Chief Nursing & Patient Services Officer, City of Hope National Medical Center

Q: *When practices consider the quality of their patient service, how would you advice them to measure their performance and assess it?*

A: CUSTOMER SERVICE IS A KEY FACTOR in our delivery of cancer care across the vast continuum of our cancer patient needs. Nothing is quite as powerful as understanding from the "voice" of the customer our ability to meet, and more importantly, exceed, the expectations they have of us. Many settings engage in some type of patient satisfaction survey process. While monitoring the ratings over time is good, large numbers of responses are often needed to achieve statistically meaningful information, and it may take as long as a year to garner this amount of data from which to draw conclusions. Of particular importance, though, is the ability of patients and their families to write comments on these surveys. Themes of issues can be more readily defined and corrective plans put into place much sooner than more general information may be available. Ask your staff to complete the survey that is currently being used to measure patient satisfaction as if they were their patients completing it. Such an exercise might help identify opportunities for improvement.

However, I have found that nothing substitutes for the process of directly asking our patients about their experiences with us. If I know a particular area of our care delivery model is a challenge for us to meet expectations, focused questions about the patient's experience with this process and understanding the issues from their point of view is key. Acknowledging that we understand that we have a broken process, and seeking their input on how we might improve that process, creates a partnership for improvement.

"…nothing substitutes for the process of directly asking our patients about their experiences…"

Wait times that a cancer patient experiences for just about any component of their care is an area which requires ongoing performance measurement. If it is an area of focus for your practice, engage patients who might be interested in helping you monitor your own performance. Identify the areas of "waiting" during their visit and provide them with a form with these areas identified on a clipboard with a small digital clock attached, and ask them to document their times of "waiting" for a particular process to be completed. Use this as feedback for problem solving and engage them again to monitor the process after corrective actions have been taken related to the delays.

Another tool is to develop a "script" that can be used by staff that are making routine calls to patients and just adding a question such as, "Was there anything that occurred during your last visit with us that would cause you not to have considered that an excellent experience?"

Have staff log these answers and again look for themes of issues for improvement. I have found this to be useful in both the inpatient and outpatient settings. Again, nothing substitutes for hearing the "voice" of our patients. ■

PRESIDENT'S MESSAGE

> *Continued from page 1*

or care giver? How can we do things differently? For administrators, an important question may be – what reports are not reviewed. Try eliminating a report and see if anybody notices. However, often, significant changes must be made.

As Greg Shea indicates in his new book, *Your Job Survival Guide: A Manual for Thriving in Change,* we are in a new era, what he terms ***permanent*** whitewater. As managers and leaders, we are accustomed to periods of turbulence and change. In Shea's analogy, in the recent past, there were periods where we experienced rough water and rapids of change as we navigated the river, but then things returned to normal and we had periods of relative calm, smooth water. However, in the 21st century, those periods of calm no longer exist. We are faced with permanent white waters of change. Either we learn to lead in this era of rapid change or we will not survive. There are no simple solutions. Then, as we like to say around my cancer center, if it was easy, anybody could do it. Rahm Emanuel, President Obama's Chief of staff is quoted as saying (probably quoted from Stanford economist Paul Romer) – "A crisis is a terible thing to waste". This current economic crisis presents opportunities to explore how we might do things differently, and may serve as a trial run for the potential significant changes that may be brought about by national healthcare reform.

I would love to hear your comments, suggestions or descriptions of how you are managing in these difficult times, either personally or professionally. Feel free to send me an email at pgrusenmeyer@christianacare.org. If I receive many comments, we can add this to the ACE listserve or start a separate members-only blog on the ACE webpage.

Cancer Center Building Blocks Conference

For those institutions that are currently planning for an expansion of their cancer program, the ACE Cancer Center Building Blocks Conference is being held April 29 – May 1 in Indianapolis, Indiana. The conference is a fabulous primer on the processes required to design and build a new cancer center. A session will also highlight the decision making process in determining whether to renovate or build. Additional information is available at www.cancerexecutives.org.

2010 Annual Meeting

Planning is under way for the **2010 Annual Meeting,** to be held **February 13–16** at the Westin Gaslamp Quarter in San Diego, California. Joy Soleiman, ACE President-Elect and the ACE Education committee, leads the planning effort. If you would like to be part of the planning, please contact Joy at joy.soleiman@mail.jci.tju.edu. ■

Treating Prostate Cancer with RapidArc Radiation Therapy

By Lawrence B. Tena, MD

The Saint Vincent's Comprehensive Cancer Center in New York, NY (links to www.svccc.com), where I am an associate attending radiation oncologist, was among the earliest adopters of RapidArc™ radiation therapy technology from Varian Medical Systems. As of this writing, we are still the only cancer center in Manhattan offering RapidArc treatment, a new image-guided approach to intensity-modulated radiation therapy (IMRT) that is delivered in just a fraction of the time compared to conventional IMRT.

"The entire process, including imaging, positioning, and treatment, takes about five minutes from start to finish."

Introduction

A 72-year-old prostate cancer patient became one of our first RapidArc patients last October 2008. A self-referred patient, he had been diagnosed with prostate cancer in April 2008, and chose "watchful waiting" to deal with his condition–until he saw a television news story about RapidArc being discussed by me at the St. Vincent's Comprehensive Cancer Center. He came in for a consultation to see if he would be a candidate and to learn more about it.

During his consultation, we discussed all of his treatment options, including: watchful waiting, surgery, conventional IMRT, seed implants, and RapidArc. He chose RapidArc for his treatment because he perceived that it would be less invasive compared to surgery or seed implants, and quicker than conventional IMRT without any compromise in accuracy or cure rate.

In addition, during the early days of our RapidArc deployment, we routinely compared our RapidArc treatment plans for prostate cancer with plans for conventional seven-field IMRT treatments, which had been our standard of care for the past 8.5 years. We were pleased to find that the dose volume histograms for the prostate, rectum, bladder and femoral heads were similar for either treatment modality, and the plans were completely comparable on other dimensions, as well. In simpler terms, the radiation dose sparing of normal tissues and the accuracy of treatment of the prostate was similar between conventional IMRT and RapidArc. However, the seven-field IMRT treatment times were taking about 20–25 minutes total each day, so a reduction to less than five minutes was significant for us and for our patients. We were able to show our patients that RapidArc™ was, indeed, at least as accurate as conventional IMRT, and in some cases, more accurate.

Advanced Treatment

The patient was treated between 11/4/08 and 1/13/09. He received a total dose of 77.4 Gy to the prostate over 43 fractions of 1.8 Gy each. The first 26 fractions delivered 46.8 Gy to his prostate and seminal vesicles, and the remaining 30.6 Gy were part of a "boost" confined to the prostate alone.

We start each RapidArc treatment by generating a cone-beam CT image of the area to be treated, using the On-Board Imager™ device–an integral part of the RapidArc system. Varian's technology allows us a choice of an automated or a manual process for comparing the images with reference images from the treatment plan, and repositioning the patient to correct for any displacements. We use the automated matching tool. This step takes about 3-4 minutes.

Then, we deliver a complete volumetric modulated arc therapy (VMAT) treatment in roughly seventy seconds. RapidArc technology varies the multileaf collimator aperture (which shapes the radiation beam), the speed of gantry rotation, and the dose rate to produce an IMRT-quality dose distribution with just one revolution around the patient. The entire process, including imaging, positioning, and treatment, takes about five minutes from start to finish.

Improved Outcome

The patient, like others we have since treated for prostate cancer, experienced only minor side effects during his treatment, and required no medication for relief of side effects. There were no significant skin changes or gastrointestinal side effects. He did not develop any fatigue and continued his routine daily activities without interruption. He did not require any treatment breaks. He experienced a mild increase in urgency and frequency of urination, which I expect will resolve within a short time post-treatment.

New York City happens to be a big media market, and so, there was an unanticipated benefit to our early adoption of RapidArc technology. Because the St. Vincent's Comprehensive Cancer Center was the first in Manhattan to treat a cancer patient with RapidArc technology, we were featured in a number of television news broadcasts newspaper stories covering advances in cancer care. Some of these stories are available online:

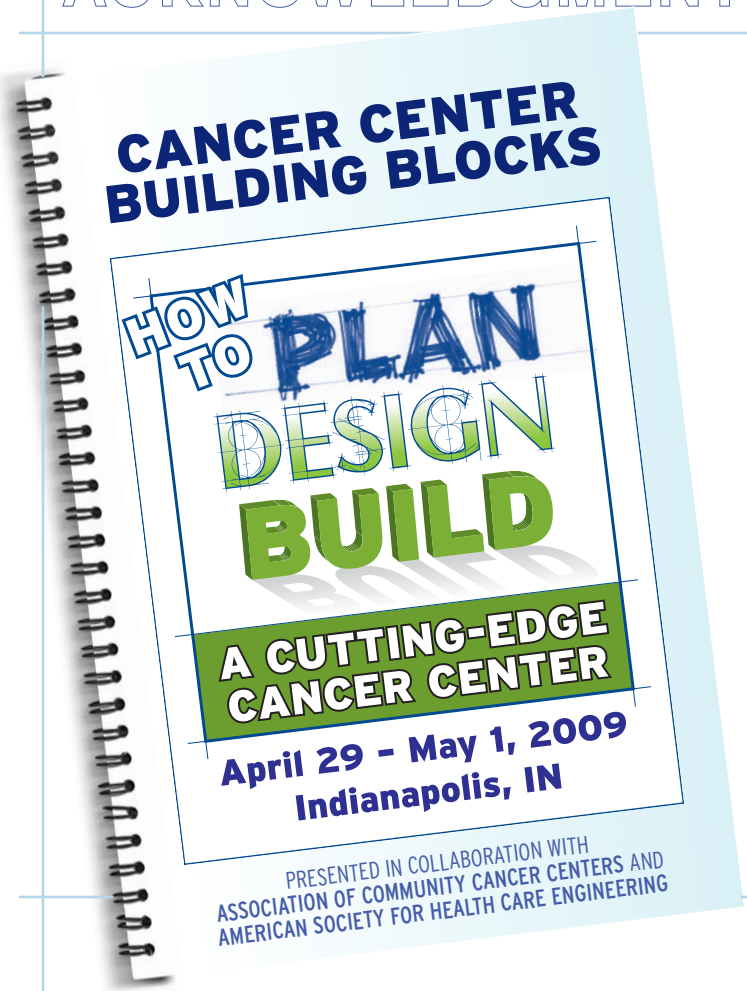
"Rapid Radiation Treatment" (FOX News)
"Health Watch: Rapid Arc Cancer Treatment" (WCBS)
"Health Watch: Prostate Cancer and Radiation Therapy" (WCBSTV.COM)
"Fighting Cancer in Less Than Two Minutes" (WPIX)
"Latest Cancer Treatment for NYers on the Go" (New York Post) ■

Lawrence B. Tena, MD, is an associate attending radiation oncologist at the St. Vincent's Comprehensive Cancer Center (325 West 15th Street, New York, NY, 10011) and is an Assistant Professor in the Department of Radiation Oncology at New York Medical College. He can be reached at (212) 604-6084 or at ltena@aptiumoncology.com.

The links for the news stories above are:

http://www.foxnews.com/video/index.html?playerId=videolandingpage&streamingFormat=FLASH&referralObject=3460103&referralPlaylistId=playlist)
http://wcbstv.com/video/?id=121473@wcbs.dayport.com
http://wcbstv.com/seenon/health.watch.cancer.2.889708.html
http://varian.mediaroom.com/file.php/355/WPIX+RapidArc+NY.wmv
http://www.nypost.com/seven/12012008/news/regionalnews/latest_cancer_treatment_for_nyers_on_the_141651.htm

ACKNOWLEDGMENT



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James Bachman
Saint Clare's Health System
23 Pocono Rd,
Denville, NJ 079834
T: 973-625-6792
E: jbachman@saintclares.org

Robert Baird
Dayton Physicians, LLC
3500 Park Center Drive, Suite 150
Dayton, OH 45414
T: 937-280-8400
F: 937-280-8378
E: rbaird@daytonphysicians.com

Martha Beck
INSIGHTEC
11909 Marblehead Drive
Tampa, FL 33626
T: 813-818-4897
E: marthab@insightec.com

Sally Eggleston
Revenue Cycle Inc.
1817 W. Braker Lane
Bldg. 2, Suite 200
Austin, TX 78758
T: 405-823-0433
E: seggleston@revenuecycleinc.com

Lori Fonte
Slidell Memorial Hospital
1001 Gause Blvd
Slidell, LA 70458
T: 985-649-8688
E: fontel@smhplus.org

Brenda Gordon
Moffitt Cancer Center
12902 Magnolia Drive
Tampa, FL 33613
T: 813-745-4200
E: brenda.gordon@moffitt.org

Christina Harrison
Tallahassee Memorial HealthCare Cancer Center
1300 Miccosukee Road
Tallahassee, FL 32308
T: 850 431-5038
F: 850 431 6402
E: christy.harrison@tmh.org

Sandra Hewlett
Bothwell Regional Cancer Center
Bothwell Regional Health Center
601 E. 14th Street
Sedalia, MO 65301
T: 660-829-8835
F: 660-826-7698
E: shewlett@brhc.org

Ann Jones
HOPEgroup
535 Forest Drive
Council Bluffs, IA 51503
T: 402-658-8765
E: annkuglinjones@gmail.com

Mary Mencarelli
Spectrum Health
100 Michigan NE
Grand Rapids, MI 49501
T: 616-486-5897
E: mary.mencarelli@spectrum-health.org

Lise Mendham
Dana Farber Cancer Insitute
40 Buttrick Road, Suite B
Londonderry, NH 03053
T: 603-552-9140
E: lise_mendham@dfci.harvard.edu

Janet Porter
Dana-Farber Cancer Institute
44 Binney Street
Brookline, MA 02115
T: 6176324602
F: 6176325246
E: janet_porter@dfci.harvard.edu

Matt Schneider
Texas Health Presbyterian Dallas
8200 Walnut Hill Ln, Jackson Building
Dallas, TX 75231
T: 214-345-8545
E: mattschneider@texashealth.org

Linda Sershon
United Hospital
333 Smith Ave N
St Paul, MN 55102
T: 651-241-84454
F: 651-241-7878
E: linda.sershon@allina.com

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ASSOCIATION of CANCER EXECUTIVES

YOUR INPUT IS IMPORTANT TO US!
ACE appreciates member feedback
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Share Your News

Announce your organization's achievements, program changes, staff transitions and events to the entire ACE membership! Send an email with your news and press releases to:
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ACE Update is published by **Association of Cancer Executives**
2300 N Street NW, Suite 710 • Washington DC 20037
202.521.1886 • Fax: 202.833.3636 • info@cancerexecutives.org

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