Developing a Multispecialty Prostate Cancer Clinic

5 model programs demonstrate best practices including:

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- Bringing key stakeholders to the table
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20 Highlights from ACCC’s Guide to Best Practices in a Comprehensive Prostate Cancer Program

Successful prostate cancer programs provide quality care and empower patients to make educated decisions. Critical success factors include physician champions, a multidisciplinary team approach to care, and use of a patient navigator.

Palo Alto Medical Foundation’s Prostate Cancer Care Program, California
by Frank delaRama, Gordon Ray, and Daniel Yao

The foundation for this multispecialty group practice’s Integrated Prostate Cancer Care Program: patient feedback, a nurse navigator, and enhanced communication among specialties.

24 Maine Medical Center Cancer Institute’s Prostate Cancer Clinic, Maine
by Moritz Hansen

Two private practices and a hospital developed a clinic model that allows patients to be seen by multiple specialties. Plus, a prostate navigator pathway, an active surveillance tool, and a prospective Prostate Cancer Database.

The Center for Prostate Care, ProHealth Care Regional Cancer Center, Wisconsin
by Don Jewler

A dedicated care coordinator guides patients through diagnosis and treatment. Plus, a decision tool that lists pros and cons of treatment options and then asks patients to rate their concerns.

34 Clinical patient navigator, Jennifer Powers, MS, BSN, RN, CCRC, page 24

Presbyterian Prostate Center’s Prostate and Genitourinary Multidisciplinary Oncology Clinic, North Carolina
by Richard B. Reiling

At this hospital-based clinic model a multidisciplinary team discussion is followed by specialty visits with patients. Key to the clinic’s success: physicians work with referring physicians so that referral patterns are not “broken.”

40 The Allegheny Prostate Center, Pennsylvania
by Russell Fuhrer and Ralph Miller

Housed in the hospital, this clinic is staffed by private practice urologists and a hospital-employed radiation oncologist. Patient scheduling and follow-up are conducted by the urology practice.

48 Radiation oncologist Gordon Ray, MD, page 34
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How Does Your Management Measure Up

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The mission of the Association of Community Cancer Centers is to promote the continuum of quality cancer care. ACCC will fulfill its mission by pursuing the following six organizational strategies: Policy Development, Membership Support, Research in the Community, Oncology Program Management, Patient Advocacy, and Economic and Quality Issues.

On the World Wide Web: Check out selected articles from Oncology Issues at www.accc-cancer.org

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Take Advantage
by Christian Downs, JD, MHA

It’s fitting that this special edition of Oncology Issues arrives in September—Prostate Cancer Awareness Month. All the feature articles—developed as part of ACCC’s Prostate Cancer “Best Practices” Project—discuss delivery of prostate cancer care in the community setting. But don’t let the focus on “prostate cancer care” allow you to miss out on some broader themes.

First, as you know, ACCC is committed to multidisciplinary care. This type of care means involving not only physicians from different medical specialties, but also nurses, pharmacists, administrators, social workers, and all other team members committed to treating cancer. Prostate care delivery is a prime example of the benefits and challenges involved in multidisciplinary treatment.

Most of our prostate cancer patients have a choice of treatment options. They also have a choice of physicians to provide these services—surgeons, urologists, radiation oncologists, and medical oncologists. Studying how these different specialties work together (or in some cases do not work together) can provide insight into exactly how to deliver better quality multidisciplinary care in our communities.

Second, as you read this issue, you will notice that the “best practices” model programs are your colleagues. They see patients every day and struggle—just like you—with reimbursement constraints, workforce shortages, and increasingly restrictive regulations while still providing the best care possible to their patients. The recommendations made in ACCC’s Guide to Best Practices in a Comprehensive Prostate Cancer Program were not hatched in some business school or insurance company or planned out by a Washington, D.C., think tank. These “best practices” come from community cancer centers across the country.

Over the next year, ACCC’s educational initiatives will continue to use the experiences of its member programs to educate the entire membership. To do so, we have to continue sharing information on what works and does not work, where our programs have succeeded, and where we have struggled.

Finally, remember this educational tool is but one part of the resources you can take advantage of with your ACCC membership. Visit ACCC’s website www.accc-cancer.org for the latest information about reimbursement trends and policy issues. Read and pass on your copy of Oncology Issues to all of your team members. In fact, go one step further and email our managing editor (mmarino@accc-cancer.org) with an idea for an article.

Be sure to attend ACCC meetings—designed to optimize opportunities for member networking. Check out the Meetings section on ACCC’s website for information on the 5th Annual Hospital Summit (December 2009) and ACCC’s 36th Annual National Meeting (March 2010 in Baltimore). If traveling is a challenge, take advantage of ACCC’s webinars and conference calls.

ACCC’s multidisciplinary membership is unique and uniquely experienced in working across disciplines. As you read this special issue of ACCC’s journal, I hope you see—as I do—how the strength of the information provided comes from the participation of ACCC membership. Your ACCC membership is valuable, and you are a valuable part of ACCC’s membership. Take advantage!
In my first column, I introduced my thoughts about the increase in the number of cancer patients over the next 12 years—a whopping 55 percent. Estimates of growth in the number of practicing medical oncologists in that same time frame is only 14 percent and the estimated shortfall of nurses is 285,000 across America. These projections are enough to make you want to put your head in the sand and hope you can retire by then! But don’t despair. Ideas abound for solving or at least mitigating the problem. Last year, the Institute of Medicine (IOM) convened a summit focused on this issue. The workshop identified the following key solutions that ACCC members must consider:

- Rely upon mid-level practitioners.
- Rely upon expanded teams of professionals.
- Rely upon expanded use of primary care physicians, especially for survivors’ care.
- Improve oncology-specific EMRs to reduce administrative burden.
- Support demonstration projects to promote innovative cancer care.
- Try new physician practice arrangements, such as job sharing and part-time practices.
- Promote payment reform that ensures adequate reimbursement.
- Promote evidence-based practice.
- Encourage earlier referrals to palliative care and hospice programs.
- Add palliative care professionals to oncology practices.

Promising solutions—but not so simple to implement! A workshop summary, Ensuring Quality Cancer Care through the Oncology Workforce: Sustaining Care in the 21st Century, is available online at: http://www.iom.edu/CMS/26765/65873.aspx.

So what can ACCC as an organization do to help stem the tide of this shortage? Some personal suggestions:

- Educate our members on the issue; spotlight practice partnerships and models that work at our meetings.
- Explore the issues and models in our publications.
- Actively support legislation that improves payment to physician practices and hospital-based programs. One bill was recently introduced in the House that would pay for cancer-patient education by nurses.
- Support legislation and become a source of information to members regarding federal demonstration projects in care models.
- Actively support legislation that pays for higher education and scholarships for oncology professionals.
- Continue to explore evidence-based practice especially in the areas of survivorship and palliative and hospice care.

This is a long road; one that will extend over many years. And ACCC is a unique organization in a unique position to tackle this issue. Our membership is multidisciplinary. Our strategic plan is based on education and advocacy. Meeting this challenge will require each of us to think hard and change some of our ways—but our efforts are critical to our patients, our programs, and our membership.
AACC Gets Key Wins in Proposed HOPPS Rule

On Jul. 1, 2009, the Centers for Medicare & Medicaid Services (CMS) issued the proposed Hospital Outpatient Prospective Payment System (HOPPS) rule for calendar year 2010. The proposed rule was published in the July 20 Federal Register, and CMS accepted comments until Aug. 31, 2009. The final rule will be issued by Nov. 1, 2010. The Association of Community Cancer Centers (AACC) is pleased that several proposals in the 2010 HOPPS proposed rule appear to reflect the work of AACC and its partners:

Reimbursement for separately payable drugs and biologicals without pass-through status. In the proposed rule, CMS has finally recognized—after years of data from AACC and other stakeholders—that pharmacy overhead services are not being adequately reimbursed. The agency proposes to make payment for the acquisition and pharmacy overhead costs of separately payable drugs and biologicals without pass-through status at ASP+4 percent. The payment rate of ASP+4 percent is based on the cost of separately payable drugs and biologicals calculated from hospital claims and costs reports (ASP -2 percent) with an adjustment for pharmacy overhead cost achieved by reallocating $150 million from packaged drugs and biologicals to separately payable drugs and biologicals without pass-through status. CMS acknowledges that some flaws are inherent in its rate-setting system, admitting that “the current method of converting billed charges to costs has the potential to ‘compress’ the calculated costs to some degree.” On a less positive note, the agency did not adopt the methodology recommended by AACC and the APC Panel to establish more appropriate payments. AACC has been calling for payment of at least ASP+6 percent.

In comments to the proposed rule, AACC expressed appreciation for the fact that CMS has finally recognized the flaws in the ASP system and the lack of proper reimbursement.

ACCC continues to assert that the amount allocated for pharmacy overhead is still too low, and that CMS should be allocating more funds to cover those services, thereby further raising the ASP+ number. AACC continues to work with CMS in order to achieve the most accurate reimbursement rates possible.

Physician supervision. Another “win” for AACC and its partner, the Oncology Nursing Society (ONS), are the proposed physician supervision requirements outlined in the 2010 HOPPS proposed rule. For 2010 CMS proposes that non-physician practitioners, specifically physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives, may directly supervise all hospital outpatient therapeutic services that they may perform themselves in accordance with their State law and scope of practice and hospital-granted privileges, provided that they con-

CMS Proposes Coverage of PET Scans to Determine Cervical Cancer Treatment

In a coverage decision memo released Aug. 13, CMS proposes to cover positron emission tomography (PET) scans for beneficiaries diagnosed with cervical cancer in order to determine the best therapy.

According to the agency, the available evidence is adequate to determine that the results of FDG PET scans for beneficiaries diagnosed with cervical cancer “are used by the treating physician to make meaningful changes in therapeutic management and improve health outcomes, and thus are reasonable and necessary.”

As reported in the Aug. 17 BNA Health Care Daily Report, CMS proposes to cover only one FDG PET for beneficiaries who have “biopsy proven cervical cancer” when the beneficiary’s treating physician determines that the FDG PET study is needed to determine the location and/or extent of the tumor for specific therapeutic purposes. CMS proposed the scans could be used only “to determine whether or not the beneficiary is an appropriate candidate for an invasive diagnostic or therapeutic procedure; to determine the optimal anatomic location for an invasive procedure; or to determine the anatomic extent of tumor when the recommended anti-tumor treatment reasonably depends on the extent of the tumor.”

The agency is now accepting public comments on the proposed coverage decision. The proposed decision memo is available online at: https://www.cms.hhs.gov/mcd/viewdraftdecisionmemo.asp?id=232.
continue to meet all additional requirements, including any collaboration or supervision requirements as specified in the regulations.

CMS further proposes to define “direct supervision” for on-campus hospital outpatient services to mean that the physician or nonphysician practitioner must be present in the hospital or on-campus provider-based department of the hospital and immediately available to furnish assistance and direction through the performance of the procedure. This proposal is in contrast to the current definition that requires the physician to be present in the on-campus provider-based department.

In meetings with CMS earlier this year, ACCC and ONS advocated the use of the State scope of practice law rather than the direct supervision requirement instituted in the 2009 final HOPPS rule. ACCC is pleased that CMS has accepted this suggestion. In comments to the proposed rule, ACCC recommended that CMS institute this proposal.

Additional Highlights of the Proposed HOPPS Rule

In its proposed rule, CMS projects a market basket update of 2.1 percent for outpatient departments and estimates total payments of $31.5 billion under the HOPPS in 2010. Other highlights include:

**Drugs and biologicals with pass-through status.** CMS proposes to pay for pass-through drugs and biologicals at ASP+6 percent. Pass-through contrast agents, diagnostic radiopharmaceuticals, therapeutic radiopharmaceuticals, and implantable biologicals would also be reimbursed at ASP+6 percent. CMS proposes that the pass-through status of the following six drugs will expire on Dec. 31, 2009:

- C9354 Veritas collagen matrix, cm2
- C9355 Neuromatrix nerve cuff, cm
- J1300 Eculizumab injection
- J3488 Reclast injection
- J9261 Nelerabine injection
- J9330 Temsirolimus injection

CMS proposes to continue pass-through status for 31 drugs in 2010. For a complete list, see ACCC’s analysis of the proposed rule available at: www.accc-cancer.org.

**Non-pass-through drugs, biologicals, and radiopharmaceuticals with HCPCS codes but without HOPPS pass-through status.** CMS proposes to continue to use wholesale acquisition cost (WAC) or 95 percent of average wholesale price (AWP) to establish the initial payment rate for new non-pass-through drugs and biologicals and radiopharmaceuticals.

**340B program.** The agency did not follow the APC Panel’s recommendation to exclude data from hospitals participating in the 340B program from its rate-setting calculation for drugs. CMS proposes to continue to apply the same reimbursement rates to 340B hospitals as non-340B hospitals.

**Packaging threshold.** CMS proposes to increase the packaging threshold for 2010 from $60 to $65 for packaged drugs. The agency also proposes to end the exemption to the packaging threshold for 5-HT3 antiemetics. For 2010 CMS proposes to package payment for all 5-HT3 antiemetics, except palonosetron hydrochloride, consistent with its estimated per day costs from 2008 claims data.

CMS proposes to make packaging determinations on a drug-specific basis, rather than a HCPCS codespecific basis, for those HCPCS codes that describe the same drug or biological but different dosages. If the estimated cost per day for the drug is greater than $65, all HCPCS codes for the drug are separately paid. If the estimated cost per day is less than or equal to $65, all HCPCS codes would be packaged.

**Therapeutic radiopharmaceuticals.** CMS proposes to provide payment for separately payable therapeutic radiopharmaceuticals that have ASP information submitted through the existing ASP process at ASP+4 percent. If ASP information is not available, CMS proposes that payment be based upon mean unit cost from hospital claims data.

**Proposed coding and payment for drug administration services.** The agency proposes to continue to use the full set of CPT codes for drug administration services, but make minor reconfigurations of the APCs to account for changes in HCPCS code-specific median costs resulting from updated CY 2008 claims data and the most recent cost report data, and the CY 2010 drug payment proposal. (A comparison of 2009 and proposed 2010 drug administrative payment rates is available on the Members-only section of ACCC’s website at: www.accc-cancer.org.)

**Brachytherapy sources.** For 2010 CMS proposes to pay for brachytherapy sources based on median unit costs derived from the claims data for brachytherapy sources. The agency would assign future new HCPCS codes for new brachytherapy sources to their own APCs, with prospective payment rates set based on its consideration of external data and other relevant information regarding the expected costs of the sources to hospitals.

Of particular interest, CMS proposes to reassign CPT code 0182T, high dose rate electronic brachytherapy, per fraction from new technology APC 1519 (New Technology – Level IXX, $1700 to $1800) to APC 313 (Brachytherapy) with a proposed payment rate of $746.68.

**Payment reduction for failure to report quality measures.** Hospitals that fail to report quality data for outpatient services face a 2 percent reduction in their payment update factor. For the 2011 update, CMS proposes that hospitals that want to change their participation status must submit a form by March 2010. For the 2011 payment determination, CMS proposes to continue requiring hospitals to submit data on the existing 11 Hospital Outpatient Quality Data Reporting Program measures and does not propose to add any new measures.

Among the quality measures under consideration for 2012 and subsequent years are:

- Adjuvant chemotherapy is considered or administered within 4 months of surgery to patients under age 80 with American Joint continued on page 9
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Proposed PFS Brings Cuts to Medical Oncology and Radiation Oncology

The Medicare Physician Fee Schedule (PFS) 2010 proposed rule, released Jul. 1, 2009, will reduce payments to cancer care providers, with especially steep cuts projected for radiation oncology. Table 1 below shows the projected impact of 2010 PFS proposals on physicians involved in cancer care. The proposed 2010 PFS was published in the July 13, Federal Register. The agency’s comment period ended Aug. 31, 2009.

For 2010, CMS predicts the sustainable growth rate (SGR) formula will decrease the conversion factor by 21.5 percent. However, as in the past, Congress is likely act to prevent this cut from taking effect.

The agency proposes to remove physician-administered drugs from the SGR calculation beginning in 2010 and retrospectively to the 1996/1997 base year. CMS says this proposal would “eliminate the disproportionate impact that the large past increases in the costs attributable to physician-administered drugs would otherwise have upon future PFS updates.”

Highlights of the 2010 PFS proposed rule include:
- **PE RVU changes.** CMS proposes to complete the four-year transition from a top-down methodology to a bottom-up methodology for calculating PE RVUs in CY 2010. In 2010, PE RVUs would be calculated based entirely on the current methodology.
- The agency proposes to adopt a new data source for the PE RVUs. CMS proposes to use data from the American Medical Association (AMA) Physician Practice Information Survey (PPIS) in place of the AMA’s Socioeconomic Monitoring Survey (SMS) data and supplemental survey data to calculate PE RVUs for all Medicare-recognized specialties that participated in the PPIS for 2010. In general, this proposal would increase payments for primary care physicians and reduce payments for some specialties.
- According to Health Policy Alternatives, Inc., the impact of these proposed PE RVU changes would mean an overall reduction of about 5 percent for hematology/oncology; 17 percent for radiation oncology; and 10 percent for radiology.
- **Change in the utilization rate for equipment priced over $1 million.** CMS proposes to increase the equipment usage assumption rate for calculating PE RVUs from the current 50 percent usage rate to a 90 percent usage rate for equipment priced over $1 million. This proposal would reduce the costs of that equipment attributed to each procedure in which it is used.
- CMS calculates that the proposed change in utilization rate would have a “significant” effect on total Medicare payments to Independent Diagnostic Testing Facilities (IDTFs) and radiation oncologists. Payments to IDTFs would be reduced by 2 percent and payments to radiation oncologists would be reduced by 5 percent.
- **Consultation services.** CMS proposes to eliminate the use of all inpatient and office/outpatient consultation codes, except for telehealth consultation. Instead of a consultation code, physicians would bill an initial hospital care or initial nursing facility care code for their first visit to the hospital or nursing facility. The agency also proposes to create a modifier to distinguish the admitting physician of record who oversees the patient’s care from other physicians who may furnish specialty care.

**Physician resource use measurement and reporting program.** In 2009, as required by MIPPA, CMS implemented a Physician Feedback Program that uses Medicare claims and other data to provide confidential feedback reports to physicians. In phase I of the program, CMS disseminated approximately 230 reports to physicians in 12 different geographic locations. Although oncologists were not included in phase I of the program, prostate cancer is listed as one of the “high cost, high volume, or both” priority conditions that CMS states it intends to finalize in the CY 2010 PFS final rule. For phase II, CMS proposes to add reporting to groups of physicians and to add quality measurement information as a context for interpreting comparative resource use.

**E-prescribing incentive program.** CMS would continue implementation of the e-prescribing incentive program created by MIPPA and the ARRA. In 2010, successful e-prescribers are eligible for an incentive payment equal to 2 percent of the total estimated allowed charges for all covered professional services furnished during the 2010 reporting period.

**PQRI.** For 2010, the Medicare statute authorizes an incentive payment equal to 2 percent of the estimated total charges for all covered* continued on page 10

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**Table 1. Cumulative Effect on Total Medicare Payments***

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Allowed Charges (million)</th>
<th>Combined Impact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematology/Oncology</td>
<td>$1,888</td>
<td>-6 percent</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>$1,799</td>
<td>-19 percent</td>
</tr>
<tr>
<td>Radiology</td>
<td>$5,254</td>
<td>-11 percent</td>
</tr>
</tbody>
</table>

*These calculations are based on all of the 2010 PFS proposals (with the exception of the cut to the conversion factor) taking effect.

Source: Health Policy Alternatives
Medicare Rule Puts Some Damper on Lab Tests

A new ACCC survey reveals that Medicare’s “date of service” rule for laboratory testing may discourage some hospitals from sending out samples for advanced molecular diagnostic testing. Under current rules, if a hospital sends a specimen away to the lab for advanced molecular diagnostic testing within 14 days of blood draw or tissue biopsy, the lab must bill the hospital, which in turn must bill Medicare. However, if the hospital waits until day 15 or later to send off the specimen, the lab can bill Medicare directly.

To assess whether this arrangement discourages hospitals from ordering advanced molecular diagnostic tests, ACCC recently surveyed its membership. The main finding: One-third of respondents indicate that Medicare’s “date of service” rule does cause a reimbursement problem with their Medicare Administrative Contractor (MAC). Some hospitals delay sending out the sample for testing, and many report an increased administrative burden and increased patient waiting time for results. Nine percent have reduced the number of outside laboratory tests ordered due to reimbursement challenges.

A Senate bill (S. 1220) sponsored by Sens. Arlen Specter (D-Pa.) and Ron Wyden (D-Ore.) requires that “certain complex diagnostic laboratory tests performed by an independent laboratory after a hospital outpatient encounter or inpatient stay during which the specimen involved was collected shall be treated as services for which payment may be made directly to the laboratory.”

A similar bill (H.R. 1699) was introduced in the House in March by Reps. Jason Altmire (D-Pa.) and Tim Murphy (R-Pa.). ACCC supports both bills.

The vast majority of ACCC survey respondents (92 percent) are not aware of legislative efforts to eliminate the date of service rule. A majority of survey respondents (58 percent) express willingness to work with ACCC on its advocacy efforts concerning this issue and write their congressional representatives to support the legislative effort.

ISSUES

professional services furnished during the reporting period.

Quality measures. CMS proposes retiring seven 2009 PQRI quality measures. Two of these, Oncology: Medical and Radiation—Pain Intensity Quantified and Oncology: Medical and Radiation—Plan of Care for Pain, are proposed for retirement because they are too analytically challenging.

The agency proposes making nine measures currently reportable through claims-based reporting or registry-based reporting, reportable only through registry-based reporting, including:

- Melanoma: Follow-Up Aspects of Care
- Melanoma: Continuity of Care—Recall Systems
- Melanoma: Coordination of Care.

CMS also proposes adding 22 new measures—16 of which would be registry-only measures.

Currently, physicians report quality measures through claims-based reporting or registry-based reporting, CMS proposes to allow eligible professionals to choose to report data on PQRI quality measures through claims, to a qualified registry, or through a qualified electronic health record (EHR) product.

The agency has proposed a process for making incentive payments to group practices based on the determination that the group practice, as a whole, satisfactorily reports on PQRI quality measures for 2010.

Imaging accreditation. CMS proposes to implement a requirement under MIPPA that beginning Jan. 1, 2010, suppliers of the technical component of advanced imaging services need to be accredited. The agency outlines the criteria and process it will use to select accreditation organizations and standards to be applied to imaging suppliers. The CMS-designated accreditation organization would apply standards that set qualifications for non-physician medical personnel who provide the technical component of such advanced imaging (e.g., diagnostic MRI, CT, nuclear medicine, and PET).

Drug compendia. The proposed rule implements MIPPA’s requirement that “[o]n or after January 1, 2010, no compendia may be included on the list of compendia under this subparagraph unless the compendia had a publicly transparent process for evaluating therapies and for identifying potential conflicts of interest.” CMS proposes “that a compendium could meet this standard by publishing materials used in its evaluation process on its Web site.” All currently listed compendia will be required to comply with these requirements by Jan. 1, 2010, to remain on the list of recognized compendia.

Proposed coding and payment for drug administration services. Using the 2009 conversion factor and excluding any adjustments for geographic variations in cost, reimbursement for nearly all administration codes would be reduced between 7 and 25 percent. A comparison of 2009 and proposed 2010 drug administration payment rates is available on the Members-only section of ACCC’s website at: www.accc-cancer.org.

In its comment letter to CMS, ACCC voiced its concern and called for elimination of or reductions to the massive cuts to medical and radiation oncology under the proposed PFS. The Association called on CMS to work with Congress on a permanent fix to the SGR formula. ACCC will continue to work with its partners to ensure patient access to quality care.
Reimbursement Check-Up
by Cindy C. Parman, CPC, CPC-H, RCC

When the going gets tough, the tough review their reimbursement! During economically challenging times, reviewing services billed, payments received, and the revenue cycle process to ensure appropriate reimbursement is more important than ever.

That said—this is not the time for “creative coding” or “CPT surfing.” In other words, don’t sit down and leaf through your coding manual to find code descriptors for potential undiscovered reimbursement. However, the presence of an economic slowdown can be a catalyst for reviewing current patient care processes and determining if additional billable services are being provided.

The following is a list of services that may be overlooked when claims are filed. This is not a comprehensive list, but represents commonly performed services that may not be consistently billed by physicians, hospitals, and cancer programs.

**Tobacco Cessation Counseling**

Effective March 22, 2005, Medicare Part B initiated coverage for two levels of smoking cessation counseling. Medicare limits this coverage to patients who are competent and alert at the time services are provided, and:

- Use tobacco, and
- Have a disease or adverse health effect found by the U.S. Surgeon General to be linked to tobacco use, or
- Who are taking certain therapeutic agents whose metabolism or dosage is affected by tobacco use as based on FDA-approved information.

Medicare covers two attempts at quitting each year, and each attempt may include a maximum of four intermediate or intensive sessions. (The patient and physician determine the intensity of the session.) This means that Medicare covers a maximum of eight sessions in one year, but healthcare professionals should charge only one unit of a smoking cessation service per date of service.

The following codes report these services:

- **99406**: Smoking and tobacco-use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes
- **99407**: Intensive, greater than 10 minutes.

A minimal counseling service, defined as 3 minutes or less in duration, bundles into other services performed by the physician or facility and is not separately charged. The counseling service described by these codes includes a physician or qualified nonphysician healthcare professional counseling the patient face-to-face, separate from any other service performed on the same date. There must be a behavior change intervention, not just a review of the patient’s smoking status. CMS recommends that healthcare providers use its online resources as part of their counseling efforts ([http://www.smokefree.gov](http://www.smokefree.gov) and [http://www.cms.hhs.gov/SmokingCessation/](http://www.cms.hhs.gov/SmokingCessation/)).

In addition, smoking and tobacco-use cessation counseling claims are reported with the correct diagnosis code that reflects the condition the patient has that is adversely affected by the use of tobacco or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by the tobacco use. For example:

- **305.1**: Tobacco use disorder; tobacco dependence; tobacco abuse.

Tobacco use disorder is reported when the patient uses tobacco in a way that is damaging to his or her health or when there is tobacco dependence:

- **V15.82**: History of tobacco use
- **989.84**: Toxic effects of tobacco
- **E866.8**: Accidental poisoning, other specified substances.

Based on American Medical Association (AMA) guidance, either a physician or qualified nonphysician healthcare provider may perform these services. In the outpatient setting, the hospital may report these codes when documentation supports that qualified hospital personnel performed the counseling. If the healthcare provider performs a separately identified patient service on the same date, modifier 25 (significant, separately identifiable service) may be appended to the code. For more, see Table 1. Reimbursement for Tobacco-use Cessation Counseling, page 13.

**Prolonged Services**

Prolonged services codes report the provision of an extended professional service that requires face-to-face patient contact that is above and beyond the usual service. The prolonged service code is reported in addition to other physician services, including Evaluation and Management (E/M) services at any level. As a result, prolonged services codes will never be reported as “stand alone” services. Additional guidelines for
the use of these codes include:

- Report the total duration of face-to-face time spent by the physician on a given date providing prolonged service—even if the time spent is not continuous. Time spent by staff such as nurses or medical assistants or time the patient remains unaccompanied is not included in prolonged service time.
- Prolonged service of less than 30 minutes total duration on a given date is not separately reported because the work involved is included in the total work of the patient encounter or other service performed.
- Prolonged service of less than 15 minutes beyond the first hour or less than 15 minutes beyond the final 30 minutes is not reported separately.
- If time is considered the key or controlling factor in choosing the level of E/M service (more than 50 percent of the visit constitutes counseling and/or coordination of care), then the prolonged services codes should only be used in addition if the service has exceeded 30 minutes beyond the highest level of E/M in the appropriate category.

Here are the prolonged services codes:

+99354: Prolonged physician service in the office or other outpatient setting requiring direct (face-to-face) patient contact beyond the usual service (e.g., prolonged care and treatment of an acute asthmatic patient in an outpatient setting). First hour. (List separately in addition to code for office or other outpatient E/M service.)

+99355: Each additional 30 minutes. (List separately in addition to code for prolonged physician service.)

+99356: Prolonged physician service in the inpatient setting, requiring direct (face-to-face) patient contact beyond the usual service (e.g., maternal fetal monitoring for high risk delivery or other physiological monitoring, prolonged care of an acutely ill inpatient). First hour. (List separately in addition to code for inpatient E/M service)

+99357: Each additional 30 minutes. (List separately in addition to code for prolonged physician service.)

According to CMS in MLN Matters 5972: “Documentation, however, is required to be in the medical record about the duration and content of the medically necessary E/M service and prolonged services that you bill. Providers must appropriately and sufficiently document in the medical record that they personally furnished the direct face-to-face time with the patient specified in the CPT® code descriptors. Providers should make sure that they document the start and end times of the visit, along with the date of service.” Table 2, page 13, shows reimbursement for prolonged services codes.

Follow-up Visits

According to AMA in the 2009 edition of the CPT Manual: “Listings for Radiation Oncology provide for teletherapy and brachytherapy to include initial consultation, clinical treatment planning, simulation, medical radiation physics, dosimetry, treatment devices, special services, and clinical treatment management procedures. They include normal follow-up care during course of treatment and for three months following its completion.” As a result, the majority of payers do not allow separate reimbursement for physician follow-up visits unless the patient is post-therapy by at least 90 days or is being treated for a condition not related to the therapy.

The 90-day follow-up period covers all patient visit services for 90 days following completion of therapy. Therefore, for 90 days after completion of irradiation, payers consider patient visit codes related to treatment to be bundled into the treatment management (code 77427). This bundling includes follow-up care for the malignancy or area under treatment, as well as follow-up services for any other medical conditions treated by the radiation oncologist (such as nausea, vomiting, skin erythema, and mucositis). Payers do not consider this to be a “global period” because that concept only applies to surgery. Instead, payers consider the follow-up care for 90 days to be an extension of the treatment management (packaged service) and not separately billed.

This AMA authoritative coding guideline:

- Applies to all insurance payers (not only to Medicare)
- Means that physicians cannot charge the visits to any insurance. All visits that are billed may be paid in error, even if the visits occur within the 90-day period following treatment. To avoid the possibility of refunding incorrect payment (potentially with the addition of fines and penalties), physicians should ensure that they do not generate a claim for visits that occur within the 90-day period following therapy.

Keep in mind that this guideline applies only to professional reporting. Hospitals can capture and report all medically necessary facility visits, even during the 90 days following therapy. Because hospitals do not charge for treatment management, but instead report services on a daily episodic basis, they can charge each patient service individually.

In addition, as this requirement applies only to “follow-up” visits, some exceptions permit physicians to charge for patient visits during the 90-day period following therapy.

Follow-up Visits: Exception 1

Beginning with the 2007 CMS Final Rule for physician services, published in the Federal Register, December 1, 2006, Medicare states: “All of the codes in the family CPT® codes [77785 through 77787], are currently designated as 90-day global services. CPT® codes [77785 through 77787] are used to treat many clinical conditions, but primarily patients with prostate cancer, breast cancer, and sarcoma. Patients with any of these conditions usually receive several treatments (2 through 10) over a 2 to 10-day period of time. Due to the increasing variability in treatment regimens, it is difficult to assign RVUs for a ‘typical’ patient based on a global period of 90 days.”

“However, we propose, on an interim basis, to revise the work RVUs and PE inputs to reflect the removal of the postoperative visit,
should monitor services rendered and procedure codes charged on an ongoing basis, difficult economic times call for a more thorough analysis of billable procedures. Some of these services reimburse a small amount per encounter, but added up over a year they may constitute a significant increase in income.


Resources

CPT® code 99212 that is currently assigned to these services...Separate payment will be made for medically necessary post-therapy visits based on the documented level of E/M service for the post procedure encounter(s)...We [CMS] do not anticipate this change will have a significant impact on Medicare expenditures. The removal of the 90-day global period applies only to high-dose-rate (HDR) treatments and only then for Medicare patients. In addition, while the HDR treatment no longer has a global period, the placement of tandem and/or ovoids (or other surgical applicator insertion procedures) includes a 90-day surgical global period, and subsequent applications for planned treatments may require modifier 58 (staged procedure).

Follow-up Visits: Exception 2
Although payers consider routine physician follow-up visits after radiation therapy treatment to be included in the treatment management service, physicians can charge for patient encounters for new medical conditions. For example, if the radiation oncologist treated the patient for lung cancer, mucositis and nausea while under treatment, the reimbursement for code 77427 (physician weekly treatment management) would include payment for any follow-up visits for these medical conditions. If the patient presents during the 90-day follow-up period with a complaint of dizziness, the physician would charge the visit with the “new” diagnosis of dizziness as the primary diagnosis code for the encounter. This exception emphasizes the need for complete medical record documentation, especially the physician’s notation of “chief complaint” for each patient encounter. The reimbursement impact is shown in Table 3, above.

While all healthcare entities should monitor services rendered and procedure codes charged on an ongoing basis, difficult economic times call for a more thorough analysis of billable procedures. Some of these services reimburse a small amount per encounter, but added up over a year they may constitute a significant increase in income.


Table 1. Reimbursement for Tobacco-use Cessation Counseling

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Physician Payment*</th>
<th>Hospital Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99406</td>
<td>Tobacco-use cessation, 3-10 minutes</td>
<td>$12.98</td>
<td>$11.42</td>
</tr>
<tr>
<td>99407</td>
<td>Tobacco-use cessation, &gt; 10 minutes</td>
<td>$24.89</td>
<td>$11.42</td>
</tr>
</tbody>
</table>

*Average national Medicare reimbursement

Table 2. Reimbursement for Prolonged Services

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Average Payment*</th>
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</thead>
<tbody>
<tr>
<td>99354</td>
<td>Prolonged service, office, first hour</td>
<td>$91.97</td>
</tr>
<tr>
<td>99355</td>
<td>Prolonged service, office, each additional 30 min</td>
<td>$90.89</td>
</tr>
<tr>
<td>99356</td>
<td>Prolonged service, inpatient, first hour</td>
<td>$83.67</td>
</tr>
<tr>
<td>99357</td>
<td>Prolonged service, inpatient, each additional 30 min</td>
<td>$84.40</td>
</tr>
</tbody>
</table>

*Average national Medicare reimbursement

Table 3. Codes and Reimbursement for Follow-up Visits

<table>
<thead>
<tr>
<th>Code</th>
<th>Descriptor</th>
<th>Physician Payment*</th>
<th>Hospital Payment*</th>
</tr>
</thead>
<tbody>
<tr>
<td>99212</td>
<td>Established patient visit, level 2</td>
<td>$37.15</td>
<td>$68.96</td>
</tr>
<tr>
<td>99213</td>
<td>Established patient visit, level 3</td>
<td>$61.31</td>
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<tr>
<td>99214</td>
<td>Established patient visit, level 4</td>
<td>$92.33</td>
<td>$89.74</td>
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<tr>
<td>99215</td>
<td>Established patient visit, level 5</td>
<td>$124.79</td>
<td>$113.57</td>
</tr>
</tbody>
</table>

*Average national Medicare reimbursement
[Approved Drugs]

- Eli Lilly and Company (Indianapolis, Ind.) announced that the company received a fourth approval from the Food and Drug Administration (FDA) for Alimta® (pemetrexed for injection). The latest approval is for Alimta as a maintenance therapy for locally advanced or metastatic non-small cell lung cancer (NSCLC), specifically for patients with a nonsquamous histology whose disease has not progressed after four cycles of platinum-based first-line chemotherapy. Alimta is not indicated for treatment of patients with squamous cell non-small cell lung cancer.

- The FDA has approved Genentech Inc.’s (South San Francisco, Calif.) Avastin® (bevacizumab) plus interferon-alfa for people with metastatic renal cell carcinoma.

- BioDelivery Sciences International, Inc., (Raleigh, N.C.) and Meda AB (Solna, Sweden) announced FDA approval to market Onsolis™ (fentanyl buccal soluble film), formerly referred to as BEMA™ Fentanyl, for the management of breakthrough pain in patients with cancer, 18 years of age or older, who are already receiving and who are tolerant to opioid therapy for their underlying persistent cancer pain. Onsolis is available only through a restricted distribution program called the FOCUS Program and requires prescriber, pharmacy, and patient enrollment.

[Drugs in the News]

- The FDA has accepted for review the new drug application (NDA) for APF530 (A.P. Pharma, Inc., Redwood City, Calif.) for potential treatment of...
chemotherapy-induced nausea and vomiting. APF530 is a long-acting formulation of granisetron that utilizes the company’s proprietary Biochronomer™ drug delivery system. Based on the Prescription Drug User Fee Act, the FDA has issued an action date of March 18, 2010.

CyDex Pharmaceuticals, Inc., (Lenexa, Kansas) announced that the FDA has accepted the company’s investigational new drug application (IND) for a clinical study of Captisol-Enabled® melphalan HCL (CDX-353). In December 2008, CyDex received orphan-drug designation from the FDA for melphalan “as a high-dose conditioning treatment prior to hematopoietic progenitor (stem) cell transplantation.”

Sagent Pharmaceuticals, Inc., (Schaumburg, Illinois) announced that the company has launched ondansetron in 5% dextrose injection in premix bags, an antiemetic and selective 5-HT3 receptor antagonist used to prevent nausea and vomiting caused by chemotherapy. Sagent, a specialty pharmaceutical company, will offer ondansetron in 5% dextrose injection in 32 mg per 50 mL single dose premix bags.

Sagent Pharmaceuticals, Inc., has also launched fludarabine phosphate for injection, USP and epirubicin hydrochloride injection. Fludarabine for injection, USP will be offered in 50 mg single-use vials. Epirubicin hydrochloride injection will be offered in 50 mg per 25 mL and 200 mg per 100 mL single-dose vials.

Hospira, Inc., (Lake Forest, Illinois) announced FDA approval and launch of the company’s oxaliplatin injection. Hospira’s oxaliplatin injection is one of the first generic versions of this drug to come in solution form. Hospira will initially offer oxaliplatin in 50 mg and 100 mg single-use vials.

AstraZeneca (Wilmington, Delaware) announced submission of an NDA to the FDA for an investigational drug vandetanib 100 mg for use in combination with chemotherapy for the treatment of advanced non-small cell lung cancer in patients previously treated with one prior anti-cancer therapy. The submission is supported by data from Phase III clinical studies evaluating the safety and efficacy of vandetanib 100 mg in combination with chemotherapy. Pending approval, the treatment will be marketed as Zactima™.

Lilly Widens Income Eligibility for Patient Assistance Programs

On Aug. 1, 2009, Lilly USA adjusted the income eligibility for its most widely used patient assistance programs to allow enrollment of eligible patients with incomes at or less than 300 percent of the U.S. Federal Poverty Level. As an example, the new yearly eligible income limit for a family of two corresponds to approximately $44,000. Previously, the income eligibility limit was set at 200 percent of the Federal Poverty Level.

The company is broadening the income eligibility in response to concerns expressed by patients who have experienced strained financial circumstances—such as job loss and loss of insurance coverage—due to the recent economic downturn.

Patients who believe they qualify for any of Lilly’s patient assistance programs, or whose financial situation has changed from their last tax filing or application to Lilly’s programs, may contact the applicable patient assistance program or visit www.lilly.com/responsibility/programs for more information.

Label Change to Erbitux and Vectibix

New label information on the cancer treatment Erbitux® (cetuximab) will state there is no evidence that the drug works on a minority of colon cancer patients with a specific genetic mutation. Eli Lilly and Company and Bristol-Myers Squibb Company announced that the addition to the drug’s label will state that studies have not shown that Erbitux helps patients whose tumors have a mutated gene, or biomarker, called KRAS.

Amgen Inc. announced a similar label change for its cancer drug Vectibix® (panitumumab). Both Erbitux and Vectibix block the epidermal growth factor receptor, preventing cells from growing and expanding.

Devices in the News

The FDA granted clearance for Hologic, Inc.’s (Bedford, Mass.) R2™ DigitalNow™ HD software application. The R2™ DigitalNow™ HD software is the only FDA-cleared application intended to process digitized screen-film mammograms for comparison purposes. The software adapts each digitized film image to a selected contrast and tissue intensity that models a digital mammography system. It also embeds a series of look-up tables in the image that allow Integrated Healthcare Enterprise (IHE) mammography conformance workstations to draw out less evident regions of density within digitized films.

Elekta (Anaheim, Calif.) announced the company’s CMS Software has received FDA 510(k) clearance for the VMAT enhancement to Monaco, an advanced IMRT treatment planning solution. Monaco with VMAT can optimize single or multiple non-coplanar arcs simultaneously, providing the flexibility and control needed for complex treatment plans. Reducing planning time and increasing clinical throughput, arc plans can be delivered with a single button push at the linear accelerator console, gantry directions automatically sorted, and control points seamlessly integrated into a single deliverable arc sequence.
My job is to know where oncology practice is going so I can position my group for strength in a changing market. Through ACCC I have learned about innovations, where Washington is going to lead us, and what the main competitors and payers are trying to do.

Barbara L. McAneny, MD
New Mexico Oncology Consultants, Ltd.
Albuquerque, N.M.

“Our partnership with ACCC becomes increasingly important, especially as budget constraints continue, reimbursement becomes more challenging, and cancer care becomes more complex.”

Cheryl Hoechner, RPh, MS, BCOP
Tunnell Cancer Center
Beebe Medical Center
Lewes, Del.

“We benefit from reading about other community cancer center programs and experiences in Oncology Issues. An article about setting up a breast care center provided indispensable ideas and resources.”

Marlene Runyon, RN, BSN, OCN, CHTP
Franciscan Skemp Healthcare Cancer Center
La Crosse, Wisc.

“In terms of advocacy, ACCC does a better job giving voice to our cancer centers than the professional organizations that lobby mainly for the parochial interests of the individual profession.”

Dale E. Fuller, MD, FACR
Dallas, Tex.

“ACCC’s a marketing tool for our cancer program! Potential patients find us on our own page at ACCC’s website...and a local TV station aired a story about our participation in an ACCC educational program.”

Matt Sherer, MBA, MHA
The Medical Center, Inc.
John B. Amos Cancer Center
Columbus, Ga.

ACCC membership gives your oncology program a stronger voice and added value. Join today. For details, go to www.accc-cancer.org/membership.

The Association of Community Cancer Centers (ACCC) is the leading education and advocacy organization for the cancer team. ACCC provides tools to take your cancer program to the next level. Take advantage of information resources that incorporate a unique multidisciplinary perspective. Gain visibility by participating in high-profile education projects and highlight your program successes with ACCC resources in print and online.
Indiana University Melvin and Bren Simon Cancer Center
Indianapolis, Indiana
IU School of Medicine and Clarian Health partner to create a state-of-the-art facility

The Indiana University Melvin and Bren Simon Cancer Center is the only NCI-designated cancer center in Indiana that provides patient care. At the IU Simon Cancer Center, located on the 80-acre campus of the Indiana University School of Medicine in Indianapolis, more than 300 physicians and researchers work collaboratively to provide state-of-the-science cancer care and help bring new treatments from bench to bedside. Each year the program receives about 38,000 outpatient visits and 4,100 inpatient visits.

With the opening of a new cancer center in 2008, for the first time inpatient and outpatient adult cancer care is brought together under one roof. The new 405,000-square-foot $150 million facility—the culmination of years of planning, innovation, and creativity—is a partnership between the IU School of Medicine and Clarian Health. The relationship brings together the nationally recognized healthcare delivery system of Clarian Health with the scientific resources of the IU School of Medicine, the second largest medical school in the United States.

“The completion of the building strengthens our statewide strategy to raise the level of cancer care for all Indiana residents by applying evidence-based standards of care, increasing participation in clinical research protocols, and providing educational venues for physicians and other healthcare providers,” said Fuad Hammoudeh, cancer program administrator, Clarian Health.

Meeting Growing Needs
The impetus for the new patient care facility began about five years ago. “Both Clarian Health and IU School of Medicine assessed the cancer services available on the Indianapolis campus in consideration of the increase we expected in both the aging population and the demand for cancer services,” Hammoudeh explained. The objective was to improve patient access to services by offering seamless inpatient and outpatient care.

Vital Statistics
- Total hospital bedsize: 378
- Dedicated inpatient cancer unit beds: 80
- Number of new analytic cases per year: 4,144

Selected Patient Support Services
- CompleteLife Program (offered to patients free of charge)
- Financial counseling
- Oncology pharmacy consult
- Housing assistance for patients receiving care and families

The IU Simon Cancer Center offers both patients and visitors a soothing environment.
outpatient care provided in the downtown Clarian/IU facilities—Indiana University Hospital, Methodist Hospital, and Riley Hospital for Children—as well as affiliated facilities across the state of Indiana. Planners solicited input from an active patient advisory committee on what patients and families wanted to see in the new cancer center’s design.

From the moment visitors enter the IU Simon Cancer Center patient care facility, they experience a uniquely designed healthcare environment. In fact, the building’s interior design by Maregatti Interiors of Indianapolis has received several awards including best of show and first place in the healthcare and assisted living category at the 2008 International Interior Design Association’s IDEA Celebration. Overall, the building took the coveted Monumental Award, presented by Keep Indianapolis Beautiful, Inc., as the most significant project of the year in Marion County.

The new 5-story building houses 80 private patient rooms; 2 infusion “pods” with 34 chairs and room for expansion of another pod for a total of 60 chairs; 6 to 8 operating rooms with shell space for expansion to 14; radiology and imaging facilities; a retail pharmacy; a gift shop; and a café. Both valet parking and nearby dedicated patient parking are available.

Surgery is located on the facility’s lower level. Radiology and imaging services (CT, PET/CT, MRI) are on the first floor. The second floor houses the outpatient hematology clinic, the outpatient women’s clinic, and the infusion center along with a dedicated oncology pharmacy and an investigational drug pharmacy for patients on clinical trials. The third floor is an adult hematology/oncology inpatient unit. The fifth floor is the surgical intensive care unit. Currently, the fourth floor is shell space for future expansion.

Surrounded by Care
Exceptional design features reflect the level of care taken in planning the infusion services area. The current 2 infusion “pods” have a total of 34 chairs. Patients can choose to receive care in a private room equipped with a chair or bed, or in one of the cubicles that offer varying levels of privacy. Each cubicle is designed with sliding glass panels reminiscent of Japanese shoji screens. These panels can be extended to create more privacy or retracted for more social interaction. All cubicle chairs are situated to offer a view of the rooftop garden and to allow nurses to have direct eye contact with patients at all times. A uniquely homey touch is the inclusion of a fireplace within the infusion area. Four recliners offer a cozy seating option around the hearth.

The IU Simon Cancer Center offers interdisciplinary clinics for breast, thoracic, gastrointestinal, genitourinary, head and neck, melanoma, neuro-oncology, sarcoma, and testis cancer. These clinics are facilitated by nurse coordinators and allow patients to see physicians from multiple disciplines in one visit, combining treatment, research, and supportive-care expertise for each patient. Interdisciplinary treatment team members may include: medical oncologist; radiation oncologist; surgical oncologist; pathologist; hematologist; molecular geneticist; oncology nurse; physical therapist, occupational therapist, and/or speech therapist; oncology social worker; psychiatrist; and dietitian.

Personalizing cancer care to meet patients’ individual needs, the IU Simon Cancer Center works collaboratively with Clarian Senior Health to provide a clinic focused on the geriatric cancer patient. The clinic is available to IU Simon Cancer Center outpatients aged 65 or older who are being considered for treatment of cancer or a blood disorder or who are currently undergoing treatment of cancer or a blood disorder. The clinic is headed by a specialist in gerontology and offers patients access to interdisciplinary care.

Dedicated to improving the overall well-being of patients and their families, the CompleteLife Program offers a wide range of supportive-care services including: support groups, mindfulness-based stress reduction, nutritional counseling, psychological counseling, financial counseling, psychiatric care, social work services, and spiritual care. Services for enhancing self-care and well-being include: oncology pharmacy consultation, appearance consultation, mastectomy fitting, art therapy, music therapy, and massage therapy.

Access to Cutting-Edge Treatment
Attached to the new IU Simon Cancer Center building is the Indiana Cancer Pavilion, an 89,000-square-foot facility housing radiation oncology services and some additional outpatient care services. Here, state-of-the-art radiation oncology treatment modalities are available including Gamma Knife, SRS, IGRT, IMRT, 3D conformation radiation therapy, HDR, and prostate seed implant. The IU Simon Cancer Center also partners with the IU School of Medicine’s Department of Radiation Oncology and the Midwest Proton Radiotherapy Institute (MPRI) in Bloomington, Indiana, to offer proton beam therapy.

The IU Simon Cancer Center has received international recognition for treatment of breast, genitourinary, thoracic, hematologic, and gastrointestinal cancers. Currently, the IU Simon Cancer Center has $62.8 million in external research funding, including $14.8 million from the National Cancer Institute and $25.1 million from other National Institutes of Health organizations. The cancer center’s more than 200 researchers are working in a wide range of areas including experimental and developmental therapeutics, breast cancer, cancer control, and immunology. The IU Simon Cancer Center currently offers approximately 350 clinical trials for pediatric and adult cancers, and accrues 17 percent of new patients to clinical trials each year. The IU Simon Cancer Center partners with Hoosier Oncology Group (HOG) to collaborate with community oncologists to provide physician-initiated trials in the community.

The patient-centric design and exceptional amenities offered at the new IU Simon Cancer Center offer patients care in a uniquely soothing and restorative environment. But ultimately what brings the best of both high-tech and high-touch care to patients and their families is “our researchers, physicians, and our staff who provide the care. They are really what make the difference in our cancer program,” said Hammoudeh.
Clinical Research Manager
Boise, Idaho

St. Luke’s Mountain States Tumor Institute is a part of the St. Luke’s Health System in Idaho and one of the Northwest’s most respected cancer care centers. We have an immediate opening for a full-time Clinical Research Manager. This position is responsible for the oversight of pediatric and adult clinical trials at five MSTI sites, ensuring compliance with federal regulations pertaining to human subject research.

This position requires a bachelor’s degree, clinical research or related experience such as oncology nursing or institutional review board (IRB), and leadership experience.

For more information, please contact Jan Greene, recruiter, by phone: 866.554.1400 or email: greenej@slrmc.org. Qualified candidates can also apply online at: www.stlukesonline.org.

Director, Cancer Center
Southeast Kansas

A not-for-profit medical center with 188-beds is seeking a Director for its Cancer Center. This individual will report to the Chief Operating Officer and will be responsible for the executive direction of all oncology services in a growing and dynamic program. Ideal candidates will be registered nurses who are clinically competent with an oncology background; and who possess strong communication, relationship building, leadership abilities, and physician relation skills; and have in-depth compliance knowledge that will foster a customer service environment. Master’s degree and OCN preferred. An excellent salary, commensurate with background and experience, is available.

The hospital earned national recognition from both the American Hospital Association and the Catholic Health Association. It maintains a tradition of innovation and community service and recently underwent a $16.5 million expansion project that impacted and expanded the radiology department, emergency room, and outpatient services. The community has a population of approximately 19,000 and is one of southeast Kansas’ major shopping destinations. Area residents enjoy year-round, outdoor recreational activities, including hiking, swimming, golfing, biking, camping, hunting, and fishing. Housing is readily available and the cost-of-living is below the national average.

Interested candidates should contact: George Laurin, BA, Vice President, Executive Search, B. E. Smith, Inc., by phone: 800.397.2078 or email: glaurin@besmith.com.

Mammography Supervisor
Bellevue, Washington

The Mammography Supervisor for Overlake Hospital’s high volume, digital Breast Health Center leads and supervises approximately 10 Mammography Technologists and a dedicated Breast Ultrasound Technologist. The position hires, schedules, trains, and evaluates staff, and participates in overall planning initiatives for the Center. Our technologists perform stereotactic and core biopsies, needle localizations, and both screening and diagnostic mammograms. We are a comprehensive breast health center, working in conjunction with Overlake Hospital’s Cancer Care Program. In addition, we are proud to be an American College of Radiology (ACR) Center of Excellence.

Upon hire, this position requires current licensure as a Radiology Technologist in Washington State. Bachelor’s degree and 5+ years lead or management experience preferred.

Overlake Hospital offer competitive pay and excellent benefits, including a management incentive program, medical/dental/vision, generous sick/vacation accrual, a bank of Extended Illness Hours, flexible spending accounts, retirement plan with matching employer contribution, long-term disability insurance, free parking, employee discounts, relocation assistance, and more.

To learn more about Overlake and to complete an online application, go to: www.overlakehospital.org. Qualified applicants may also contact Jennifer Garrepy at: jennifer.garrepy@overlakehospital.org. EOE

Practice Manager
Baltimore, Maryland

Sinai Hospital of Baltimore, member of LifeBridge Health, seeks an experienced Practice Manager for the Alvin & Lois Lapidus Cancer Institute at Sinai Hospital.

Reporting to the Director of Cancer Institute, the Practice Manager is responsible for all revenue cycle functions performed in the faculty practice through collaboration and communication with physicians, staff, and billing services to ensure efficient and effective operations. This individual will manage the staff and operations of the faculty practice, evaluating operational needs and providing recommendations to continually improve performance against budget and standards.

Three to five years of practice management experience required (preferably in oncology).

Sinai Hospital offers a comprehensive salary and benefits package, including tuition assistance, free parking, and a discounted membership to LifeBridge Health & Fitness. To apply online go to: www.lifejobs.org.
The need for education and support for prostate cancer care is clearly unmet in many communities across the country. ACCC’s new Prostate Cancer Project is designed to assist community cancer centers by outlining the process and structures that successful community-based prostate-specific cancer programs throughout the U.S. have used to initiate and grow their prostate cancer programs.

—ACCC Executive Director Christian Downs, JD, MHA

To address the need for education and support in prostate cancer care, the Association of Community Cancer Centers (ACCC) launched its Prostate Cancer “Best Practices” Project in June 2008. Phase 1 of the project involved identifying five prostate-specific cancer programs that: 1) empower patients with information and knowledge about choices, 2) coordinate multidisciplinary services starting with diagnosis, and 3) collect standardized treatment outcomes data.

Through its Center for Provider Education, ACCC created a multidisciplinary Advisory Panel of medical oncologists, urologists, radiation oncologists, surgeons, nurses, pharmacists, and program administrators with experience in prostate cancer care. Using an application process, the Advisory Panel, in conjunction with The Pritchard Group, an oncology consulting company, identified five prostate-specific cancer programs from across the country to serve as “models” from which ACCC could develop measures of effectiveness and quality assurance, and disseminate to other professionals interested in advancing the treatment of prostate cancer patients. From the applications received, ACCC’s Advisory Panel selected five prostate cancer programs:

- Allegheny General Hospital, Pittsburgh, Pennsylvania
- Maine Medical Center, Scarborough, Maine
- Presbyterian Hospital, Charlotte, North Carolina
- Palo Alto Medical Foundation, Palo Alto, California
- Regional Cancer Center, ProHealth Care, Waukesha, Wisconsin.

The Pritchard Group conducted three extensive conference call interviews with team members from each program, including medical and radiation oncologists, urologists, nurses, nurse navigators, social workers, pharmacists, administrators, and others. These interviews provided the foundation for a report on best practices in the development of a prostate-specific cancer program, Guide to Best Practices in a Comprehensive Cancer Program. The full report is available online at www.accc-cancer.org/education/pdf/Prostate-Cancer-Program-Guide.pdf. The following highlights summarize 10 key points from the report.

Program Philosophy and Critical Success Factors

Successful prostate cancer programs share a common philosophical approach. Their primary objectives are two-fold: 1) to provide quality care and 2) to empower patients to make educated decisions. Quality programs emphasize the patients’ access to a team of providers who effectively collaborate and inform. Armed with information about all available options, patients can personally manage their healthcare and make their own educated treatment decisions. Patients want choice and believe that the best programs and physicians are those that provide all the information they need to make informed decisions. Comprehensive education is at the core of “model” programs.

Successful prostate cancer programs range from sophisticated programs—featuring one-stop care with all services and all available treatment options in one location—to smaller programs that focus on providing education and patient advocacy without providing diagnostic or treatment services. There is no one ideal model; various approaches work effectively depending on the community and the providers. Any size hospital or practice can establish a community-based prostate cancer program. The keys to success are to define the scope of the program and to align the program with the needs of the patients in the community. That said, all successful prostate cancer programs share common elements. They all:

- Match the prostate cancer program to identified needs in the community
- Quantify and justify need and set financial objectives based on market reality
- Secure an unbiased physician champion(s)
- Engage appropriate clinical players
- Establish a multidisciplinary team approach
- Empower patients with information and knowledge
- Invest in a patient advocate and/or nurse navigator position
- Evaluate clinical and financial outcomes through ongoing data collection and analysis
obtain their recommendations for improvements

4. Understanding how the program ranks in the community.

Justify the Need for the Program and Set Realistic Financial Objectives

Once the community needs assessment is completed, the next step is to develop financial information that quantifies and justifies the need for the program. Prepare a strategic or business plan that includes a \textit{pro forma} using metrics likely to be expected by hospital or practice administration, such as patient volumes, program expenses and revenue, and return on investment. This information is a key step in the process of setting realistic program financial objectives based on market reality—a critical factor for program success.

Use volume data targets to create a \textit{pro forma} for the prostate program. To build the \textit{pro forma} use comprehensive cost information that includes insurance, supervisory time, CME, rent, utilities, etc. A three-year \textit{pro forma} is recommended rather than a five-year plan, particularly in light of the current economic environment and the changing health service market.

To launch the program, the initial \textit{pro forma} may only show expected increases in existing service lines. For example, surgeries and radiation service growth would be included in the prostate cancer program \textit{pro forma} while existing services would be in other department budgets. (For more information, see the full report and “Developing a Prostate Program Budget” in the report appendix. The report is available on ACCC’s website at: www.accc-cancer.org.)

Present the needs assessment, volume data, and \textit{pro forma} for consideration to the leadership. These tools will determine acceptability of the project. Influence program decision-makers and providers by including actual customer feedback from local prostate cancer patients gleaned from focus groups.

Secure a Physician Champion and Engage Clinical Players

To be successful, a prostate cancer program needs both an administrative leader and an unbiased physician champion to serve as the medical leader. Dynamic clinical leadership is a critical factor in creating a shared vision and mutual appreciation for a multidisciplinary approach to prostate cancer care. The clinical leader must be able to:

- Build trust and mutual respect among professional colleagues

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Critical Volume Measures to Track and Monitor

- Prostate cancer cases
- Prostate cancer cases by provider (in addition to total cases)
- Incidence in primary and secondary service areas
- Unduplicated patient count
- Surgical procedures by type
- Radiation treatments by type
- Active surveillance
- Medical oncology
- Initial exams
- Nurse navigator visits
- Follow-up visits
- Biopsies
- Inpatient admissions
- Referral sources
- Survivorship visits
- Group participation
- Education visits
- Clinical trial accruals
- Screenings by service area zip code
- Non-chargeable visits
- In- and out-migration to and from other service areas

- Collect and publish standardized treatment outcomes data
- Promote effective marketing and outreach in the community.

These factors can serve as a point of reference both for programs just starting out and for those working to enhance an existing prostate-specific program. Keep in mind that a prostate cancer program does not have to provide all treatments and services in one location or at one institution. Through collaborative partnerships, virtual programs can successfully meet patients’ needs for uniform access to quality prostate cancer care.

Match the Program to Identified Community Needs

Successful prostate cancer programs conduct community assessments to identify the specific market needs in their communities. The program should be developed with an understanding of the current population and the growing needs for prostate cancer diagnosis and treatment. Steps in community assessment include:

1. Identifying local market needs for prostate cancer services with particular emphasis on specific high-risk populations in the community
2. Developing volume measures
3. Conducting focus groups with prostate cancer patients, including a group of newly diagnosed patients and another group of patients several years post-treatment, to confirm their experiences and

Oncology Issues September/October 2009
Endorse an inclusionary attitude among professional peers
Encourage a non-competitive spirit and open lines of communication
Establish new relationships and nurture existing ones to encourage cross referrals
Effectively communicate the benefits of a multidisciplinary program approach
Promote the value of patient-focused cancer care that emphasizes quality of life and informed patient decision making
Illustrate efficiency and process improvements resulting from the team approach
Encourage participation in the prostate program by meeting with individual providers and group practices in the community.

With the leadership on board, next bring key administrative and clinical players together and engage them in the prostate cancer program process. Establish a prostate steering committee from clinical representatives from the core group of providers.

Model prostate cancer programs reported using the following protocols, guidelines, and standards in implementing their programs:
- National Comprehensive Cancer Network (NCCN) Prostate Guidelines
- American College of Surgeons Commission on Cancer
- American Urological Association Practice Guidelines.

Additionally, model programs develop program-based clinical pathways for specific protocols.

**Develop a Team Approach to Coordinated Care**

The multidisciplinary prostate cancer team is a group of specialists with a common interest in helping patients reach informed decisions based on their personal needs. In model prostate cancer programs, this team most often includes the following core members: 1) urologists, 2) radiation oncologists, and 3) a patient advocate and/or nurse navigator. Internists and medical oncologists often have important perspectives to offer. The radiologist, pathologist, and tumor registrar may also be included as team members.

With a team approach to care, various providers come together with the goal of increasing patients’ understanding of their disease and providing positive experiences so that patients can make educated decisions and achieve satisfaction from their personal treatment choices and outcomes.

One enormous hurdle that prostate-cancer-specific programs face is that no single treatment alternative is optimal for prostate disease. There are mutually exclusive treatments directed by different specialists—urologists and radiation oncologists. Urology practices are often community based and are typically affiliated with more than one hospital. Radiation oncologists are often affiliated with only one hospital and based at that location. Rarely are these providers in practice together. (While a recent trend has urologists owning radiation treatment centers and employing radiation oncologists, this practice is not widespread.)

Therefore, many programs interested in developing a prostate-specific program are stuck at the starting gate, asking questions such as:
- How do we get multiple groups of urologists together?
- How do we get urologists and radiation oncologists to offer advice to patients when there are a variety of treatment choices available?
- How do we make sure that the patient has a choice and understands the possible outcomes of each option?

Regular, ongoing open communication is important to ensure that information flows effectively among the team. The program’s clinical leader and patient advocate and/or nurse navigator are critical to facilitating open, productive communication. The patient advocate and/or nurse navigator serves as a conduit between the patient and the medical providers. This individual often collects all necessary patient information and facilitates the case discussions during team meetings.

Prostate cancer programs that have a multidisciplinary team approach to care establish regularly scheduled team meetings such as tumor boards, prostate workgroups, and/or patient conferences that include all core team members. Prostate cancer team members discuss patient cases and review program measures. Team meetings can be as frequent as several times a week to once every week. Physician conferences or patient-physician conferences often serve as the meeting forum to discuss prostate cancer patient care options. These meetings should be scheduled to accommodate the newly diagnosed patient’s need for immediate support and information.

**Empower Patients with Information and Knowledge**

For optimal communication with patients, successful programs suggest the following:
- From the outset, let patients know that they are in control of their healthcare decisions, with providers ensuring access to information about various treatment options.
- Early in the process, discuss which specific team member will follow up with the patient to talk about his final decision.
- Keep the patient’s needs foremost; minimize the time from initial diagnosis to consultation with provider(s) about treatment options.
- Provide the patient with comprehensive, understandable, straight-forward information that will allow him to be at peace with his personal decision.
- Include caregivers and family members in education and decision-making sessions if the patient approves. There is a wealth of information for patients to digest and having family support can be helpful to individuals as they try to understand a wide array of options.

The way in which prostate cancer programs communicate essential information to patients varies. Some examples include:
- The patient meets with a patient advocate and/or nurse navigator for basic education about options followed
up by individual meetings with the providers.

- The patient meets with a radiation oncologist and an urologist simultaneously for a concurrent discussion of treatment options.
- The patient meets with individual providers (e.g., radiation oncologist; urologist) sequentially followed by a summary meeting with the patient advocate and/or nurse navigator.
- The patient has a team meeting with all members of the multidisciplinary team.
- The prostate cancer team meets independently and reviews every prostate cancer case. One member of the team is assigned to then meet with the patient to discuss the various options.

Invest in a Patient Advocate and/or Nurse Navigator

A critical success factor gleaned from model prostate cancer programs is that they employ a neutral patient advocate. In many programs the advocate is a registered nurse who is designated as the patient navigator or care coordinator, although some prostate cancer programs use medical oncologists as the unbiased objective conduit between the patient and urology and radiation oncology providers. The patient advocate and/or nurse navigator is a cornerstone to program success and the critical link to providers.

The neutral patient advocate and/or nurse navigator are knowledgeable, unbiased third parties, who serve as a single point of contact for the patient from the initial diagnosis and throughout the treatment plan. Having a readily available contact helps reduce patient anxiety and provides support for patients as they explore information and reach informed decisions. The patient advocate and/or nurse navigator encourages the patient to take an active role throughout the treatment process and continuum of care. The advocate takes the lead in providing the patient, family, and the community at large with prostate-specific education about diagnosis and treatment options. And, finally, the patient advocate and/or nurse navigator promotes and channels open patient-physician communication.

Evaluate Clinical and Financial Outcomes

Successful programs establish qualitative and quantitative criteria to measure program success before launching the prostate cancer program. The multidisciplinary care team should discuss and agree on definitions and criteria for quality measures prior to the initiation of the program. For example, specific complications such as urinary incontinence, sexual function, etc., can be monitored and tracked using existing validated tools.

A critical success factor for prostate cancer programs is standardizing data collection across the system. Data can then be effectively quantified by stratifying information so that the program and the team can evaluate clinical and financial outcomes by such factors as stage of diagnosis, patient age, treatment modality, and quality-of-life factors.

Successful prostate cancer programs:
- Standardize data collection across the system
- Ensure ongoing monitoring and tracking of critical data in an organized manner
- Establish regular reporting vehicles to communicate results to team and stakeholders
- Schedule regular multidisciplinary team meetings that include discussion of outcome reporting and identify strengths and problems areas that require immediate action and improvement.

While volume data are a critical data requirement, they are only one significant indicator used to monitor program success. Volume data alone do not provide an adequate picture of the program’s financial or clinical quality. They must be accompanied by accurate cost and revenue calculations for a full appreciation of the financial success or shortcomings of the program and must include detailed patient outcome data to validate clinical quality. Data management should include collecting statistics for uncompensated care provided by the multidisciplinary team. This data collection enables the program to quantify fundraising needs for prostate cancer patients.

Collect and Publish Standardized Treatment Outcomes Data

One distinct advantage of having a prostate cancer program is to give the patients access to outcomes data regarding treatment. Collecting critical measures allows community cancer centers to compare outcomes to competitors or established academic programs rather than offer anecdotal information to patients. Prostate-specific programs have the opportunity to measure quality-of-life issues and impact on patient satisfaction. Physicians who participate in successful prostate cancer programs also experience increased satisfaction, improved quality of life, and practice efficiencies. In addition, outcomes data can be shared beyond the prostate cancer team with referring physicians as a means of communicating positive program results to the community.

Promote Effective Marketing and Community Outreach

For the prostate program to be successful, it is important to increase awareness of the program and its benefits not only to the general public but also to professionals in the community. Marketing and promotion should highlight quality-of-life measures and patient satisfaction scores (such as Press Ganey) as concrete evidence that the program meets or exceeds national benchmarks. Providers (including system-wide physicians, hospital department heads, referring physicians, and general group practices) need to be part of the marketing approach. Include local civic groups, media, and businesses in the outreach and marketing plan.

Going Forth

Remember, successful prostate cancer programs vary in size and shape from “virtual” programs focused on education and advocacy to “all-services-in-one-location” programs that provide state-of-the-art surgical and radiation oncology services in one location. What these successful programs all have in common is a shared vision: Empowering patients to manage their healthcare and make educated treatment decisions.

ACCC’s Center for Provider Education’s Prostate Cancer “Best Practices” Project was made possible through a sponsorship funded by sanofi-aventis US.
At Maine Medical Center Cancer Institute in Portland, Maine, prostate cancer represents one of our largest volumes of cancer patients. In 2007 we set out to develop a virtual prostate cancer clinic. At the outset, we solicited provider and patient feedback and set a goal to develop a care approach that would be patient and family focused (see Figure 1, page 27). The foundation of our multidisciplinary prostate cancer clinic was based on a commitment to improving the care and services offered to our prostate cancer patients and their families. Our goal was to ensure that all prostate cancer patients had uniform access to the consultations they would need. We also wanted to distinguish our program by incorporating a decision-making process that would improve the quality of our care. The implementation plan was threefold: 1) develop a uniform process for bringing prostate cancer patients into our healthcare system, 2) record clinical outcomes, and 3) use this data as a benchmark to compare our prostate cancer clinic to other nationally prominent programs.

The first step to developing a virtual prostate cancer clinic was to bring all the players to the table. Fortunately, in our community we have a limited number of key players involved in prostate cancer care. Maine Medical Partners-Urology (a multispecialty group practice affiliated with Maine Medical Center) and Spectrum Medical Group (a private radiation oncology practice) partner with Maine Medical Center’s Cancer Institute to treat prostate cancer patients. Other practices involved in providing patient care at our Cancer Institute, such as the Maine Center for Cancer Medicine, a private medical oncology practice, were included in the planning process. While medical oncologists often do not see prostate cancer patients unless other treatment modalities have failed, the medical oncologists were eager to engage with patients earlier in the disease process. For other community cancer centers, perhaps with more players involved, developing a model prostate cancer clinic may be more challenging.

Our Prostate Cancer Workgroup
In 2007 Maine Medical Center Cancer Institute established a Prostate Cancer Workgroup. The group’s task was to create a clinic model that would allow patients to be seen by all specialties involved in the management of prostate cancer. In prostate cancer, however, there is not always uniformity surrounding treatment decisions. To resolve this issue, the group had to reach consensus on how key providers could collaborate in a way that would benefit prostate cancer patients.

An active surveillance protocol was the first area in which our urologists, radiation oncologists, and medical oncologists were able to come to a consensus. The Prostate Cancer Workgroup developed a protocol that outlined how these patients would be followed and what mechanisms would trigger treatment (see page 30). Starting with this patient subset, the workgroup was then able to adopt a best practice treatment guideline, using published guidelines for reference. Mechanisms were put in place to ensure that these patients are seen at regular intervals. This consensus was an important milestone for our virtual prostate cancer clinic and one that required a high degree of cooperation among all participants.

Consensus was soon reached in another key area—the educational information that would be distributed to all prostate cancer patients. The Prostate Cancer Workgroup developed a packet of information describing all of the surgical and radiation treatment options and follow-up care. No matter where patients enter the healthcare system—at the urology practice, at the radiation oncology practice, or at the hospital—they receive the same packet of information.

Our Multidisciplinary Prostate Tumor Board
Prior to the development of the Prostate Cancer Workgroup, interaction between the urology and radiation oncology practices was limited. Establishing communication forums, such as a multidisciplinary prostate tumor board attended by representatives from all practices, and hiring a dedicated clinical patient navigator employed by the hospital were key to greatly improving our interpractice communication.

Today, Maine Medical Center Cancer Institute’s Genitourinary Cancer Program uses a multidisciplinary forum to discuss genitourinary cancer patient clinical information, as well quality improvement measures designed to improve care for all prostate cancer patients.

Our genitourinary tumor conference meets on the first
and third Thursday of each month. Cases are submitted in advance to the Genitourinary Clinical Patient Navigator. (For more on this key position, see the following page.) All genitourinary cancer cases are welcome and are accepted on a first-come, first-served basis. The multidisciplinary team, which includes medical oncology, pathology, radiation oncology, urology, and the clinical patient navigator, reviews each case.

Additionally, our virtual prostate cancer clinic has interdepartmental support from radiology, pathology, and the tumor registry. While physician attendance is voluntary, our expectation is that this multidisciplinary approach to care will ultimately help us remain focused on a care approach that supports informed decision making and is patient and family centered.

Prostate cancer patients may have multiple—often equally effective—management options. Often, prostate cancer does not require an urgent treatment as with other cancers. And in some cases, the best management approach is active surveillance or a watchful waiting approach. For these and other reasons, attending physicians are not always in complete agreement about treatment decisions. To help in these situations, our tumor board uses treatment algorithms that have been jointly developed by our multidisciplinary team.

**Our Clinical Patient Navigator**

Another key component of our virtual prostate cancer clinic was the creation of a full-time position to help patients navigate the decision-making process and to organize the genitourinary tumor board meetings. In our model, a hospital-employed cancer clinical patient navigator is responsible for bringing physicians from all relevant private practices together to meet on a regular basis. This neutral, third-party healthcare professional educates patients about all management options for prostate cancer and ensures that every patient is seen by the appropriate surgical, radiation, or medical oncology specialist.

In place since April 2008, our clinical patient navigator
focuses on the overall picture of the prostate cancer patient and understands how the patient and his family are affected by treatment. The navigator assists patients and families as challenges arise and helps anticipate issues going forward. Depending on the acuity of patients, our clinical patient navigator supports between 200-250 patients each year. Job responsibilities include:

- Empowering prostate cancer patients and their families
- Advocating for prostate cancer patients and their families
- Supporting physicians
- Ensuring that prostate cancer patients have the necessary information to make a fully informed treatment decision and access to all available resources
- Encouraging prostate cancer patients to meet with all specialties—urology, radiation oncology, and medical oncology
- Referring patients and families to social services and nutritional and genetic counseling.

One specific area that our clinical patient navigator has focused on is cancer treatment regret—making a decision without knowing all of the treatment options. Fortunately, our virtual prostate cancer clinic has been able to mitigate this experience for patients.

Our clinical patient navigator also serves as the front-line mechanism for screening patients for appropriate clinical trials offered at the medical oncology practice, the radiation oncology practice, or the urology practice. Medical oncologists are able to counsel high-risk patients regarding ongoing clinical chemotherapeutic trials. Prostate patients who wish to have definitive treatment, but who are undecided between radiation and surgery, can also consult with a medical oncologist.

In addition to the clinical patient navigator, other members of the cancer support service team meet with prostate cancer patients and family members, including a dedicated outpatient oncology social worker, a certified oncology nutritionist, and an American Cancer Society (ACS) patient navigator. The ACS patient navigator is available to all of our cancer patients and families that need assistance with issues related to finances, insurance, transportation, and more. The ACS navigator supports between 500-750 patients per year.

**Our Core Services**

Our virtual prostate cancer clinic offers a full range of management options, to include:

- Active surveillance
- Robotic-assisted prostatectomy
- Open radical prostatectomy
- High-dose rate brachytherapy
- Low-dose rate brachytherapy (prostate seed implants)
- External beam radiation therapy (IMRT)
- Cryosurgery
- Hormonal therapy
- Chemotherapy
- Clinical trials.

While having cutting-edge technology, such as a robotic surgical program, can increase referrals to a prostate cancer clinic, not all community cancer centers need to offer a full range of services. Instead, consider establishing relationships with larger cancer centers that do offer certain treatments. The key to this cooperative relationship is to ensure that patients are returned to their community for follow-up care after treatment.

**Quality Care Indicators**

Maine Medical Center Cancer Institute has been prospectively collecting outcomes data on prostate cancer since 1998. Our Prostate Cancer Database is a dynamic measurement tool that uses a numerical graduation to collect quality of life indicators beyond the standard cancer registry data set, including information on pre- and post-treatment quality-of-life parameters, such as urinary, bowel, and sexual dysfunction (see Figure 2, page 32). The database includes nearly 2,000 patients and consists of demographics, treatment-specific complication rates, and quality-of-life outcomes. Patients managed with surgery, radiation therapy, and active surveillance are followed in the same manner.

Nurses and physicians collect these data from the urology and radiation oncology practices at each patient visit. (Radiation oncology services are provided at the hospital and affiliated off-site locations; the urology practice has its own offsite location.) The complexity of data interpretation, informed decision making, and individualized treatment requires the coordination of the clinical patient navigator. Clinical outcome data are stratified by age, management option, and follow-up interval. The data are then integrated into the workflow of the hospital’s tumor registry. At the Prostate Workgroup’s quarterly meeting, outcome data is reviewed and then reported annually to Maine Medical Center Cancer Institute’s Steering Committee.

Initially, we were challenged to get physicians motivated to participate and believe in the benefits of collecting and maintaining clinical outcomes in a standardized manner. Some physicians were worried about sharing outcomes data—particularly if their outcomes data were not as positive as other physicians. We were able to work through this issue by assuring physicians of anonymity. Our data are an aggregate of all physicians; no one physician can be singled out. The only individual who has access to surgery data stratified by physician is the medical director of the Genitourinary Cancer Program, who reviews this information annually for quality improvement initiatives.

Outcomes data for the prostate cancer clinic are housed at the Maine Medical Center Cancer Institute and disseminated in multiple ways, including:

- Maine Medical Center Cancer Institute Physician Symposia
- Maine Medical Center’s Annual Community Forum
- Various local groups, such as prostate cancer support groups
- Prostate cancer patients and family members.
Community prostate cancer referral centers have an obligation not only to record the care that is provided to patients, but also to communicate this information back to referring physicians. We used our outcomes data in our 2009 *Prostate Cancer Quality Report on Clinical Outcomes*, a comprehensive guide that is mailed to all referring physicians in Maine. The purpose of the guide is to provide detailed information to our referring community about the depth and breadth of services available at Maine Medical Center and to help facilitate collaboration between specialties—ultimately improving patient care.

**Patient Volume and Market Share**

Maine Medical Center Cancer Institute monitors market-share data from the top five cancer sites, including prostate cancer. Our Oncology Information Services tracks patient volume, incidence, and market share. Volume is tracked through:

- The hospital’s tumor registry (including prostate cancer patients on active surveillance)
- The hospital’s radiation oncology services
- Services offered at Maine Medical Partners (a multi-specialty group subsidiary affiliated with Maine Medical Center, which provides patient-centered care).

The use and distribution of volume and market-share data has evolved over the years. For example, our physicians now have access to three-year or five-year averages when making programmatic decisions. We also keep track of the number of prostate cancer patients who choose surgery and those who choose radiation treatment. We are careful not to over simplify how we interpret the data and take into account other information such as the age of the patient and co-morbid medical conditions.

**Making a Business Plan**

At Maine Medical Center, the prostate cancer clinic is one part of the overall budget for the Cancer Institute. The clinical patient navigator, nutritionist, and social worker are budgeted hospital positions. The ACS navigator is a partnership with the hospital and the American Cancer Society.

Our hospital does not use a return on investment model to make its funding decisions. Instead decisions about new equipment and additional staff are based on needs and...
merit—what is best for our patients. Maine is also a Certificate of Need state, so we are regulated in what we can do in our budget process.

We have encountered a fair amount of resistance from payers regarding the more costly treatment options, such as robotic surgery. Our Prostate Cancer Database shows that while some procedures are more expensive, they are also associated with decreased hospital readmissions and treatment complications. Having access to quality outcomes data that can be shared with payers has helped in contract negotiations.

When purchasing and/or instituting new technologies, we have also used our Prostate Cancer Database to compare clinical outcomes to existing treatments.

**Marketing Our Virtual Prostate Cancer Clinic**

Maine Medical Center Cancer Institute recently undertook a communications and marketing planning process that included prostate cancer as a priority area in its community awareness efforts. While target audiences will shift and vary dependent upon the exact service or product being promoted, we will target the following internal and external stakeholders to receive key messages and marketing information about our virtual prostate cancer clinic.

**Internal Stakeholders**
- Board of Trustees
- Executive leadership
- Physicians (specifically, medical staff leaders)
- Management
- Employees
- Volunteers

**External Stakeholders**
- Consumers (potential patients)
- Physicians—both primary care physicians (referral sources) and specialists
- Media
- Employers
- Civic organizations
- Business and opinion leaders

As noted previously, Maine Medical Center Cancer Institute is the first hospital in the region to publish an outcomes data and referral guide. The guide provides an overview of Maine Medical Center Cancer Institute, an in-depth look at our clinical outcomes, and a review of program-related services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible. The guide was recently mailed to all primary care physicians and select people and services that make it all possible.

Annually, Maine Medical Center Cancer Institute offers a free prostate cancer screening to men without routine access to medical care.

**Outreach Efforts**

Annually, Maine Medical Center Cancer Institute offers a free prostate cancer screening to men without routine access to medical care. This effort is supported by the hospital and staffed by hospital-employed and private practice physicians. We screen between 100-185 men. Everyone is seen by a physician and has a PSA test and rectal examination. Patients are then absorbed into the healthcare system. So far, the cost of this outreach effort has not been a major issue for the hospital. Maine Medical Center Cancer Institute has a very generous uncompensated care plan. Everyone with cancer is treated—regardless of their ability to pay.

We work collaboratively with Maine prostate cancer survivor and advocacy groups. A brochure listing contact information for these groups is available at most sites providing cancer care throughout the state.

We also conduct focused physician education efforts. In 2007 community dialogue focused on prostate screening and treatment. Physician education strategies included developing Web content, providing physicians from our virtual prostate cancer clinic for grand rounds and other symposia presentations around the state, and participating in the development of state-wide prostate cancer screening guidelines.

**Reference**

Genitourinary Navigator Referrals

Portland Urology Associates, Radiation Oncology, or Medical Oncology (currently). Referrals come via fax, email, and or verbal communication.

- **Portland Urology Associates:**
  - H&P (history and physical) via email; patient demographics via fax

- **Radiation Oncology:**
  - Referral via email with patient name, date of birth, date of service, and provider

- **Medical Oncology:**
  - Referral via phone, fax, or email

- Assess patient barriers
- Assess patient education (re: provider and treatment options)
- Determine consultation needs based on NCCN (National Comprehensive Cancer Network) Guidelines
- Make appropriate referrals

- Patient education
- Offer patient educational materials
- Offer community support

- Refer patient to:
  - Social worker
  - Nutritionist
  - ACS Navigator

- Radiation oncology
- Urology
- Medical oncology
- Clinical trials
- Second opinion
- Diagnostic testing

**Appropriate GU Navigator Referrals include:**
- All newly diagnosed prostate cancer patients
- Recurrent prostate cancer patients
- Newly diagnosed or recurrent renal cancer patients
- Newly diagnosed or recurrent bladder cancer patients
- Newly diagnosed or recurrent testicular cancer patients
- Newly diagnosed or recurrent penile cancer patients
- GU tumor conference patients

Questions? Please call (insert appropriate name, credentials, position title, and contact information here).

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Active Surveillance Tool

What is it?
Active surveillance is closely monitoring a prostate cancer patient’s condition without giving any treatment until cancer progression is demonstrated. This would include a PSA doubling time that occurs in < 3 years or a tumor grade progression to Gleason score ≥ 7. This approach is commonly used in men with early stage disease.

Who is Appropriate for it?
- Prostate-specific antigen (PSA) ≤ 10
- Gleason score ≤ 6 (tumor grade)
- T1c to T2a (tumor stage)
- For men with > 15 year life expectancy, < 3 core biopsies involved, < 50% of any core biopsy

Follow-up Schedule
- PSA, digital rectal exam (DRE) every 3 months for 2 years, then every 6 months thereafter (as long as PSA is stable)
- 10-12 core biopsies at 1 year, and then every 3 years until 80 years
- Optional transrectal ultrasound (TRUS) on alternate visits

Intervention
- For PSA doubling time < 3 years
- For tumor grade progression to Gleason score ≥ 7

PSA-based prostate cancer screening results in the diagnosis of prostate cancer in many men who will not have disease progression during their lifetime. Good-risk prostate cancer is defined as the following: a Gleason Tumor Grade of 6 or less, PSA < 10, and tumor staging T1c to T2a. In most of these cases, the disease is slow growing. It is estimated that the majority of newly-diagnosed men are not going to die as a result of their prostate cancer. Active surveillance may represent an appropriate strategy for some of these men.

A selective approach to treatment of favorable-risk prostate cancer is critical. It will provide a solution to the serious problem of over diagnosis, which can threaten the value of early detection of prostate cancer using PSA screening.

In order for this approach to be successful, the patient needs to understand and comply with the follow-up schedule. Without this cooperation, active surveillance will not achieve its intended goals. That is, almost all men undergoing active surveillance will die as a result of causes unrelated to prostate cancer.

I understand that my Active Surveillance follow-up care will be with Dr. _________________________________.

I have read, or have had read to me, the above information before signing this consent form. I agree to participate in Active Surveillance for my prostate cancer. I also authorize my permission to use or disclose my personal health information for the purpose of this follow-up. I have been offered ample opportunity to ask questions and have received answers that fully satisfy those questions.

Signature of Patient or Authorized Representative __________________________ Date ______________________ 24-hour Time ______________________

Printed Name of Patient or Authorized Representative __________________________ Date ______________________

Signature of the Person Obtaining Consent __________________________ Date ______________________

Signature of Witness __________________________ Date ______________________ 24-hour Time ______________________

A signed copy of this consent form must be given to each patient entering active surveillance for prostate cancer.

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Prostate and GU Clinical Patient Navigation Program
Patient Satisfaction Survey

Please take a moment to share your experience with us. Your comments will be used to evaluate and improve our Prostate and Genitourinary Patient Navigator Program. Please mark only one answer for each question and return it in the postage-paid envelope provided.

Please circle the appropriate choice, with 1 being “poor” and 5 being “excellent.”

<table>
<thead>
<tr>
<th>(Poor)</th>
<th>(Excellent)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>The patient navigator was courteous.</td>
<td>The patient navigator was friendly.</td>
</tr>
</tbody>
</table>

Comments:________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

I utilized the services of the Patient Navigator (✓) Yes ☐ No ☐

If NO, why?________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

Do you have suggestions for improving this service? _________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________
___________________________________________________________________________________________________

If you would like to discuss this survey or your experience further, please include your name and contact information.
Name: __________________________________________ Best time to contact you: _____________________
Telephone (or other contact information): ______________________________________________________________
### Figure 2. Prostate Cancer Clinic Quality Indicators

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rationale</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Volume</td>
<td>Measure impact of CSSP (Clinical Service Strategic Plan) initiatives on</td>
<td>Maine Medical Center Prostate Clinic</td>
</tr>
<tr>
<td></td>
<td>patient and procedure volumes</td>
<td>Patient navigator utilization</td>
</tr>
<tr>
<td>Screening/Enrollment in Clinical Trials</td>
<td>Measuring access to advanced treatment options</td>
<td>Percentage of patients enrolled in clinical trials</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage of patients screened for clinical trials</td>
</tr>
<tr>
<td>Access to Support Services</td>
<td>Ensuring completeness of care</td>
<td>Percentage of patients accessing nutritional and psychosocial support</td>
</tr>
<tr>
<td>Timeliness of Treatment</td>
<td>Ensuring timeliness of care</td>
<td>Time from presentation to treatment</td>
</tr>
<tr>
<td>Multidisciplinary Conference Attendance</td>
<td>CoC (Commission on Cancer) requires the Oncology Steering Committee to</td>
<td>Urology Conference requires surgery, pathology, radiology, radiation</td>
</tr>
<tr>
<td></td>
<td>set, monitor, and track physician attendance</td>
<td>oncology, and medical oncology participation</td>
</tr>
<tr>
<td>Informed Decision Making</td>
<td>Ensuring patient is fully informed of treatment options</td>
<td>Percentage of patients offered a consult with a urologist and a radiation</td>
</tr>
<tr>
<td></td>
<td></td>
<td>oncologist</td>
</tr>
<tr>
<td>Surgical Margin Positivity Rate</td>
<td>Leading indicator for surgical outcomes</td>
<td>Percentage of prostatectomy patients with positive margins</td>
</tr>
<tr>
<td>Radiation Therapy: Brachytherapy</td>
<td>Relapse free survival is greater for patients receiving D90&gt;130Gy vs.</td>
<td>Post-implant dosimetry</td>
</tr>
<tr>
<td></td>
<td>patients receiving D90 &lt;130Gy V 100</td>
<td></td>
</tr>
<tr>
<td>Radiation Therapy: 3D Radiotherapy</td>
<td>3D conformal radiation therapy (CRT) reduces both acute and normal tissue</td>
<td>Percentage of patients receiving external beam radiation therapy (EBRT) to</td>
</tr>
<tr>
<td></td>
<td>toxicity in patient with prostate cancer and allows higher cumulative</td>
<td>the prostate only (no metastases) who receive 3D radiation therapy or IMRT</td>
</tr>
<tr>
<td></td>
<td>doses to be delivered</td>
<td></td>
</tr>
<tr>
<td>Bladder Neck Contracture</td>
<td>Monitoring acute complications to treatment</td>
<td>After surgery or radiation therapy, treatment for bladder neck or urethral</td>
</tr>
<tr>
<td>Patient Assessment of Quality of Life (QOL) Indicators</td>
<td>Leading indicator for treatment outcomes</td>
<td>Percentage of patients assessed for urinary, sexual, and bowel function</td>
</tr>
<tr>
<td></td>
<td></td>
<td>post-treatment</td>
</tr>
</tbody>
</table>
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Palo Alto Medical Foundation’s Prostate Cancer Care Program

Patient-centered care in a California multispecialty group practice

by Frank delaRama, RN, MSN, AOCNS; Gordon Ray, MD; and Daniel Yao, MD

Our Program At-a-Glance

Palo Alto Medical Foundation (PAMF) for Health Care, Research and Education is a large multispecialty group practice located in California’s Silicon Valley. An affiliate of Sutter Health, PAMF employs more than 1,000 primary and specialty physicians in four locations: Palo Alto, Mountain View, Fremont, and Santa Cruz. All PAMF physicians—including primary care and specialty physicians—are members of a partnership. Each year, PAMF sees approximately 250 new analytic prostate cancer cases. These patients receive multispecialty care through PAMF’s Integrated Prostate Cancer Care Program at the Palo Alto campus. The Prostate Program offers surgery, radiation therapy, medical oncology, chemotherapy and hormonal treatment, clinical trials, and palliative care and pain management. Radiation treatment modalities include brachytherapy, IMRT, IGRT, and EBRT. Supportive care services include:

- Nurse navigator services
- Patient and family education programs
- Psychological and sexual counseling
- Social services
- Financial counseling
- Nutrition counseling
- Physical therapy services
- Survivorship program and Buddy Program
- Complementary services, such as healing imagery for cancer patients.

PAMF’s nurse navigator consults with a patient. Above, radiation oncologist Gordon Ray, MD, with a patient.

Prior to the creation of PAMF’s Integrated Prostate Cancer Care Program in 2006, a urology and radiation oncology cancer conference met regularly for well over a decade. Pathologists brought slides to the conference and any PAMF provider could attend. In the early days, mainly retrospective cases were presented to address issues in quality improvement or to discuss rare and unusual clinical cases. This multispecialty format fostered dialogue among providers. Today, these conferences include urology, radiation oncology, and medical oncology, as well as other pertinent specialists. A patient’s primary care provider can also choose to attend the conference. Most cases are now discussed prospectively to best determine the individualized treatment plan of care for each patient. The Urology-Oncology tumor board meets formally at least once a month, and ad hoc meetings are arranged as needed.

The driving force behind the creation of an Integrated Prostate Cancer Care Program was PAMF’s Patient-Focused Cancer Care (PFCC) Committee. This committee includes nurse managers and administrators from the various.
departments that serve cancer patients (Medical Oncology, Radiation Oncology, Urology, Radiology, General Surgery and Plastic Surgery, Health Education, and the Cancer Care Clinic), nurse navigators, and several cancer survivors who were treated at PAMF. The PFCC Committee has met regularly for more than eight years. PFCC Committee recommendations are also routinely reviewed by our physician-based Oncology Committee, and the two committees have become critical in optimizing cancer care at PAMF.

Originally, the PFCC Committee was formed to address issues in patient satisfaction, particularly around standardizing the path from diagnosis to starting treatment for breast and prostate cancer. Today, the committee has expanded to address issues in cancer survivorship, community and provider education, and continues to examine patient satisfaction and improvement for our cancer patients in general.

PAMF’s Urology-Oncology Work Group also provided direction to the Integrated Prostate Cancer Care Program. This group is a multidisciplinary team of physicians, including urologists, radiation oncologists, medical oncologists, pathologists, radiologists, administrators, and nurses, including a nurse navigator. The Urology-Oncology Work Group, which has been meeting for more than a decade, runs the monthly urology-oncology conferences.

In addition to these two groups, several environmental factors helped foster the creation of our Integrated Prostate Cancer Care Program, such as a practice provider group of forward-thinking urologists and radiation oncologists, and the practice’s non-competitive culture. Shared decision-making regarding prostate cancer treatment decisions is the primary model employed at PAMF (see Figure 1, page 36). The aim is for newly diagnosed patients to come to a final decision themselves, based on numerous objective opinions given by healthcare providers. The nurse navigator guides the patient and family through a comprehensive, prospective assessment of quality-of-life issues that may occur, taking into account their own personal needs and concerns.

### Getting Started

Before establishing our Integrated Prostate Cancer Care Program, a team from PAMF that included physicians, nurses, and administrators, visited the Mayo Clinic in Scottsdale, Ariz., and the Forsythe Cancer Center in Durham, N.C., to observe existing multispecialty cancer programs in operation. We used our cancer registry data to identify the number of patients diagnosed with prostate cancer and our outmigration patterns. In addition, the PFCC Committee conducted an environmental assessment looking at all educational and support resources available in the community for prostate cancer. As a result of this assessment, we identified a need for additional resources in the community and worked to develop these resources. Two examples of these new resources include our Buddy Program, which connects newly diagnosed patients with prostate cancer survivors, and the Prostate Cancer Survivorship Care Plan, where with the help of a nurse navigator, a detailed plan is outlined for post-treatment care that addresses physical, emotional, and practical issues for the prostate cancer survivor.

Three additional factors were vital to the success of PAMF’s Integrated Prostate Cancer Care Program:

1. **Patient feedback**
2. **A nurse navigator**
3. **Communication.**

### The Patients’ Perspective

In 2004 and with the help of its diagnosing physicians, PAMF recruited patients and convened several focus groups in an attempt to answer two basic questions: after initial diagnosis—1) why did some patients stay and 2) why did other patients choose to go elsewhere for treatment? Outmigration numbers were small (fewer than 10 patients), but the practice still wanted to identify areas for potential improvement.

These initial focus groups were limited to breast and prostate cancer patients diagnosed within the previous year. We hosted onsite focus groups for patients treated at PAMF; in-depth telephone interviews were conducted with patients who opted for treatment elsewhere to help understand why they had decided to leave PAMF for their cancer care. All focus group participants received a small honorarium for their time.

While the focus groups provided a wealth of information, one fact stood out—patients wanted a coordinated effort from their treating physicians, especially when facing a new cancer diagnosis. We learned that patients were open to the option of having an extended meeting involving all of the cancer specialists soon after diagnosis so that they could thoroughly learn about all available treatment options and the pros and cons of each option. This finding seemed to negate an initial concern that such a multispecialty clinic might be overwhelming for patients and their families.

In the end, the decision to develop our Integrated Prostate Cancer Care Program grew out of these patient focus groups. In other words, it was not a “top-down” decision. Since the development of this program, PAMF has conducted additional focus groups as one method to measure the program’s impact on patient perception of quality of care.

### Nurse Navigator— the “Glue”

At PAMF, Frank delaRama, RN, MSN, AOCNS, clinical nurse specialist and prostate cancer navigator, is described as the “glue” that brings everything together at the Inte-
grated Prostate Cancer Care Program. Mr. delaRama came to the practice in 2000 as a radiation oncology nurse. Radiation Oncologist Gordon Ray, MD, identified the need for a nurse navigator for prostate cancer patients, and by 2004, Mr. delaRama’s primary role had become prostate cancer nurse navigator, with additional nurses hired to fill his original radiation oncology nursing duties.

He has been a driving force in the multispecialty prostate program since its inception. As the patient navigator of the Integrated Prostate Cancer Care Program, his focus is on shared decision making with the goal of empowering prostate cancer patients to share in the treatment decision-making process. To that effect, PAMF developed and implemented a nurse-delivered, treatment decision-making support intervention. Using a Patient Notebook that includes information and various decision aids, the nurse navigator works with the patient and his physicians to facilitate treatment decision making (see pages 38-39).

The nurse navigator has completed the City of Hope Survivorship Training Program and also serves as PAMF’s survivorship coach. Through the Buddy Program mentioned above, the nurse navigator can put newly diagnosed prostate patients in touch with men who’ve completed a range of prostate cancer treatments.

In 2006, PAMF hired a “cancer care concierge” assistant to the patient navigator. The concierge is a non-clinical staff member who helps with appointment scheduling—providing an important service to our prostate patients.

Prostate Cancer Multispecialty Clinics are held in PAMF’s Cancer Care Program, a space set aside for multispecialty clinic visits for breast and prostate patients. Here, newly diagnosed patients meet with several specialists, as well as the nurse navigator and other team members (social worker, dietician, financial counselor) all in one morning.

Welcome to the Clinic
An important focus of PAMF’s Integrated Prostate Cancer Care Program is providing smooth, effortless transitions for patients and families—especially for newly diagnosed cancer patients—among the practice’s different departments. Every patient has access to multispecialty patient-team conferences, patient-family-team conferences, individual meetings with radiation oncologists and urologists, and an opportunity to discuss treatment options and the availability of clinical trials. The goal of our program is for patients to make well-informed treatment and disease management decisions. The patient treatment team may include the following:

- Medical oncologist
- Radiation oncologist
- Urologist
- Oncology nurse
- Nurse navigator
- Social worker and/or counselor
- Financial counselor
- Pharmacist
- Physical therapist
- Dietitian.

EMR Enhances Communication
Communication was vital in the development of the robust, patient-centered Integrated Prostate Cancer Care Program. Since 1999, PAMF has employed an integrated electronic medical records (EMR) system that enhances communications among providers and between providers and patients. An integrated EMR allows providers to communicate easily and also allows secure email communication with patients. The EMR has also made ordering tests and medications very easy with minimal chance for any error. When under time constraints, the EMR makes virtual case discussions an option, and allows for review of imaging studies on demand. For the prostate clinic, the EMR is a great communication tool, enabling all involved providers to be aware of specific information provided to patients during physician visits, particularly in terms of treatment decisions. The EMR also helps to keep the patient’s primary care provider in the loop through all phases of the prostate cancer care continuum, from diagnosis through treatment and into follow-up care and survivorship. And yet, because providers participating in the Integrated Prostate Cancer Care Program are in one site of service, communication in person or by phone also occurs easily.

![Figure 1. Prostate Cancer Decision-making and Care Flowchart](image-url)
Here is how a typical patient might move through our program. The primary care physician oversees the patient’s prostate cancer screening (PSA checks, yearly DRE), and if there is anything of concern at these visits, the patient is referred to Urology for consideration for prostate biopsy.

If the prostate biopsy comes back positive, the urologist is the first to know. At this point in the process, urologists will routinely refer patients to the nurse navigator. The urologist will either call or email the prostate nurse navigator who will arrange either a multispecialty clinic meeting or a traditional meeting consisting of a set of several separate appointments. The type of meeting scheduled is based on patient preference (some patients may be too overwhelmed with a multispecialty meeting) or physician scheduling.

PAMF follows NCCN Prostate Guidelines for the multispecialty prostate clinic to provide a firm foundation for all the medical specialty opinions given to newly diagnosed prostate cancer patients. The clinic is usually held on Friday mornings. If needed, patients can be accommodated on other days as well, schedules permitting. In one morning the patient can meet with a surgeon (urologist), a radiation oncologist, and the nurse navigator. Patients are introduced to supportive care resources and provided with information on these services, which are available free to patients. Patients can also meet with a social worker and nutritionist; however, meetings with supportive care staff are usually scheduled for another date because the multispecialty clinic can run as long as three hours.

The prostate nurse navigator tries to connect with every newly diagnosed prostate cancer patient as soon as possible either by phone or email. Each patient is offered an office visit/education session, an opportunity to discuss his case individually. Patient navigation services are provided to patients free of charge.

If a patient is unable to attend a multispecialty clinic, the navigator ensures that the patient gets the information he needs. If the patient arrives with a packet of information and asks for help, the nurse navigator explains the educational materials in more depth. If the patient wants a second opinion—either internal or external—the nurse navigator helps facilitate the appointment. The nurse navigator also arranges follow-up appointments for imaging, radiation therapy, and more. PAMF recognizes that the nurse navigator, who helps patients from diagnosis through decision making and treatment, has often developed a great relationship with the patients and their families, so once treatment is done, the navigator becomes the patient’s cancer survivorship coach and compiles a detailed survivorship plan for the patient. For those patients who do not want a formal survivorship plan, the patient navigator remains a resource.

Marketing the Program

Once the Integrated Prostate Cancer Care Program was up and running, the next obvious step was to educate referring physicians, patients, and the community about the program. To date, our marketing efforts have focused on:

- Revamping the website of the Integrated Prostate Cancer Care Program (www.pamf.org/prostate)
- Arranging for the prostate nurse navigator and physicians to speak at community events on such topics as “Prostate Cancer: An African-American Crisis Revisited,” “Prostate Cancer: Concerns for Latin-American Men,” and “The Genetics of Prostate Cancer.”
- Hosting several prostate survivors’ panel discussions that included physician participation.
- Offering a DVD describing the patient experience at PAMF. This DVD was created as a personal project by a former patient with a background in broadcasting.

Outcome Measures

An integrated prostate cancer care program can serve as a springboard for quality improvement projects.

PAMF uses a Press Ganey survey to measure patient satisfaction—quarterly for all patients in the practice—and an outbound phone survey to measure patient satisfaction on physician-related issues. Currently, these measures are not specific to the Integrated Prostate Cancer Care Program; however, in 2010 PAMF will implement an oncology-specific Press Ganey survey for patient satisfaction.

The Integrated Prostate Cancer Care Program has used repeat focus groups as one way to measure improvement in patient satisfaction. The program surveys patients on quality of life issues at 3 months and 1 year post-treatment.

PAMF is also developing a disease-site-specific program to measure satisfaction in its prostate cancer patients. This program will incorporate validated measures (e.g., EPIC-26, City of Hope Cancer Survivor QOL Questionnaire) to develop a tool that will be administered by phone or through the Internet.

This research project is designed as a two-year intervention pilot test with a historical control. The study will look at patient quality of life outcomes for those who received PAMF’s nurse-delivered treatment decision-making support intervention (prostate nurse navigator services utilizing PAMF’s Patient Notebook with information and various decision-making aids) versus outcomes for men diagnosed during a period when the intervention was not available. Outcome measures include decisional conflict, the interval between diagnosis and treatment decision, treatment chosen, prostate-cancer-specific quality of life, prostate-cancer-specific anxiety, general health-related quality of life, and health resource utilization.

Future Directions

Given the success of the Integrated Prostate Cancer Care Program, PAMF plans to expand the clinic model to other practice locations; however, radiation oncology services will continue to be provided at only one site of service. If the program expands, the administrative burden of running the multispecialty care program (i.e., consent forms, educational materials developed for the current multidisciplinary clinic, etc.) will be shared among all practice sites. In this way, PAMF will achieve economies of scale while providing individualized patient care.

Additional future plans include increasing awareness of PAMF’s prostate survivorship program and post-treatment directed-care plan. PAMF’s survivorship plan includes such post-treatment planning as psychosocial support, shared decision-making, nutrition support, a pain management plan, and charitable care.

Frank delaRama, RN, MSN, AOCNS, is clinical nurse specialist and prostate cancer navigator; Gordon R. Ray, MD, is chairman of the Department of Radiation Oncology; and Daniel Yao, MD, is a urologist at the Palo Alto Medical Foundation, Palo Alto, Calif.
Shared Decision-Making Process
With contributions from Nancy L. Brown, PhD, Palo Alto Medical Foundation Research Institute; Gordon Ray, MD, Palo Alto Medical Foundation; and D. Jeffrey Demanes, MD, California Endocurietherapy Cancer Center.

Step 1: Where do I start?
My risk group is: ___________________________________________________________________________________________________

Doctor-recommended treatment options
Rank your options (“1” being the best option, or describe)
   Low Risk of Recurrence
       _____ Watchful waiting
       _____ Surgery
       _____ Radiation (external beam and/or brachytherapy)

   Intermediate Risk of Recurrence
       _____ Watchful waiting
       _____ Radiation (external beam and/or brachytherapy)
       _____ Surgery

   High Risk of Recurrence
       _____ Hormonal therapy plus radiation
       _____ Surgery and radiation

Describe, if different:
______________________________________________________________________________________________________________________

Step 2: Identifying my Goals (Rank your goals, “1” being the most important.)
My Prostate Cancer Goals are:

   _______ Avoiding Side Effects

   Vignette 1: Age 73 (T2a, Gleason = 6) “The thought of being incontinent or needing a diaper depressed me…the options were surgery or radiation, and I thought proton therapy might reduce the possible side effects…and I have been extremely satisfied.”

   _______ Maintaining Quality of Life

   Vignette 1: Age 55 (T1c, Gleason = 7) “I am a young, sexually active gay man…I am unwilling to consider living the rest of my life without erections…I chose to watch and wait.”

   Vignette 2: Age 83 (T3b, Gleason = 9) “I wanted to stay active. I golf, ski, and work part time. I did hormones, then brachytherapy, then external beam radiation.”

   _______ Getting the Cancer Out/Gone

   Vignette 1: Age 78 (T1c, Gleason = 8) “I wanted to get rid of the cancer and live longer. Radiation was the best option. I did hormones while I was deciding what treatment to pursue.”

   Vignette 2: Age 58 (T2a, Gleason = 7) “I wanted to get rid of the cancer and know more about the disease. Surgery was the best option.”

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Making Treatment as Convenient as Possible

**Vignette 1: Age 63 (T1c, Gleason = 6)** “I wanted a short treatment phase, fewer complications, and a short recovery time. HDR brachytherapy was best for me.”

**Vignette 2: Age 63 (T1c, Gleason = 5)** “I am the primary caretaker for...and I have a job that requires my presence. I had to be able to miss zero days of work. I chose permanent seed brachytherapy.”

---

### Step 3: Setting Priorities (Rank your priorities, “1” being the most important)

**My priorities for treatment are:**

- **Avoiding immediate side effects of treatment**
  - Incontinence
  - Urine
  - Bowel
  - Impotency/erectile dysfunction
  - Bowel problems
  - Other (Please specify: ____________________________)

- **Avoiding long-term side effects of treatment**
  - Incontinence
  - Urine
  - Bowel
  - Impotency/erectile dysfunction
  - Bowel problems
  - Other (Please specify: ____________________________)

---

### Step 4: Making a Decision

**My realistic options are:**

<table>
<thead>
<tr>
<th>Priorities</th>
<th>Option 1</th>
<th>Option 2</th>
<th>Option 3</th>
<th>Option 4</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**The next steps I need to take are:**

- **Find more information**
- **Date I expect to accomplish this goal:**
- **Support I need:**
  1. 
  2. 

- **Talk to family members**
  1. 
  2. 

- **Make appointments**
  1. 
  2. 

**Patient signature:** ____________________________  **Date:** __________

**Navigator signature:** ____________________________  **Date:** __________
The Center for Prostate Care, ProHealth Care Regional Cancer Center, Wisconsin

A prostate care coordinator supports, educates, and guides patients through diagnosis, treatment, and follow-up

By Don Jewler

The Center for Prostate Care in Waukesha, Wisconsin, is dedicated to treating men with prostate and other urological and genital cancers. Two programmatic elements set the center apart from its competitors. First, every patient’s care is coordinated and administered in one facility by a multidisciplinary team of specialists. Second, a care coordinator makes the journey easier by guiding patients through all aspects of diagnosis and treatment.

Located at ProHealth Care Regional Cancer Center, Waukesha Memorial Hospital, the Center for Prostate Care serves prostate cancer patients from Waukesha County and all of southern Wisconsin. It offers urologic surgery, medical oncology services, and radiation oncology services, including brachytherapy, intensity-modulated radiation therapy (IMRT), and CyberKnife®. The Center for Prostate Care was one of the first sites in Wisconsin to offer the da Vinci® Surgical System for robotic prostatectomy.

Patients have access to clinical research specific to prostate cancer. In fact, the Regional Cancer Center was recognized by the Commission on Cancer in 2007 as one of the most successful community-based oncology clinical research programs in the country for enrolling a record number of patients in cancer clinical and prevention trials.

Free screenings are offered all year round through the Center for Prostate Care. In addition, screenings are held at all three of the Regional Cancer Center locations, which are geographically distributed in Waukesha County. Following American Cancer Society guidelines, screenings are available to men age 50 and older (or age 45 and older if African American or with a family history of prostate cancer).

A Dedicated Care Coordinator Trained in Mental Health Counseling

A core philosophy of the Center for Prostate Care is that patients should be empowered with information and knowledge. Most patients will meet with the care coordinator who provides support and education, and acts as a guide through diagnosis and treatment.

“Not all men understand their diagnosis and all of their treatment options,” said prostate care coordinator Craig Gordon, RN. “Yet knowing your options is key to making the best treatment choice. That’s why we’re committed to educating men upfront about prostate cancer and the treatment options available. As a result, they and their families feel more comfortable and ready to make informed decisions.”

Gordon is there for patients throughout the navigation process from initial diagnosis to treatment and follow-up contacts—two-week follow-up, six-month follow-up, and at one year. All along the way he provides education and emotional support.

A background in mental health and counseling helps Craig identify his patients’ existing stressors and coping skills and assess the potential for developing new skills. At his first meeting, he administers a Distress Tool to

Prostate care coordinator
Craig Gordon, RN (left), Waukesha Memorial Hospital (right)
The prostate care coordinator, meets weekly to discuss ProHealth Care's multidisciplinary team, which includes speaker and fields all community calls. He also acts as a community mentor with the patient, urologist, and radiation oncologist, during Second Opinion service, where he coordinates the appoint-
volume study visit, and a day of surgery procedure visit. Gordon helps prostate seed implant patients with imaging test scheduling, receive assistance with imaging test scheduling and at least one week post op. External beam radiation therapy patients receive assistance with imaging test scheduling and at least two visits at the time of their treatments. Gordon helps prostate seed implant patients with imaging test scheduling, a volume study visit, and a day of surgery procedure visit. Gordon also leads the monthly prostate cancer support group. As support group facilitator, he has met with 80 per-
cent of the men before they start the group, and developed a rapport that helps lessen their discomfort or anxiety.

The prostate care coordinator is responsible for more than education and providing emotional support. As patient navigator, he is available at multiple points in the treatment process to assist with appointments and procedures. For example, a prostatectomy patient also receives assistance with scheduling imaging tests (bone scans and CTs), the one-day inpatient visit, and the cystogram appointment one week post op. External beam radiation therapy patients receive assistance with imaging test scheduling and at least two visits at the time of their treatments. Gordon helps prostate seed implant patients with imaging test scheduling, a volume study visit, and a day of surgery procedure visit.

Gordon is active in ProHealth Care’s Prostate Cancer Second Opinion service, where he coordinates the appoint-
ment with the patient, urologist, and radiation oncologist, as well as himself, on one visit. He also acts as a community speaker and fields all community calls.

A Multidisciplinary Team Approach
ProHealth Care’s multidisciplinary team, which includes the prostate care coordinator, meets weekly to discuss individual cases and carefully consider the best treat-
ment options for each patient. These weekly multidis-
ciplinary conferences foster communication among the team and provide a second, third, and even fourth opin-
ion that represent a variety of critical specialties. Results of the conference are shared with all participating physi-
cians as well as the primary care physician.

Most patients receive an individual meeting with the radiation oncologist along with their urologist. All the community medical oncologists are invited to participate in the weekly multidisciplinary conferences. Before each conference, the prostate care coordinator enters Gleason score, medical history, PSA, and past surgeries on the conference template and distributes these to each participant.

Engaging the community urologists to refer patients and to take part in the conferences was “challenging,” according to Gordon. His counseling background helped. Craig’s challenge was to instill a sense of trust that his role was to provide education, not steer patients one way or another. “It took a couple of years until they had a comfort level high enough to refer patients.” The community urologists (primarily two group practices) now frequently refer their prostate cancer patients to the Center for Prostate Care to meet with the care coordinator, and the urologists more frequently take part in the team conference, depending on their schedule and availability.

A multidisciplinary Prostate Steering Committee meets quarterly to discuss continuous improvement of program services. Committee members include the:
- Radiation oncology medical director
- Prostate Center associate medical director (a urolo-
gist)
- Regional Cancer Center medical directors (a pathol-
gist and a medical oncologist)
- Prostate care coordinator
- Regional Cancer Center executive director
- Outreach and education coordinator
- Marketing coordinator.

The committee’s key recommendations are brought to the Regional Cancer Center Medical Director Meeting to be discussed and then reviewed at the Cancer Committee.

The case studies presented on pages 42 show how two patients have benefited from the Center for Prostate Care.

Don Jewler is senior editor at the Association of Community Cancer Centers in Rockville, Md.
The Center for Prostate Care: Two Real-world Case Studies

Case 1

This 66-year-old patient was vacationing in Florida where his wife suggested they attend a free health screening. The patient agreed and chose a prostate cancer screening, which consisted of a DRE and a PSA blood test. The patient’s rectal exam was normal, but his PSA test came back elevated at 4.33. When they came back to Wisconsin, he followed up with his primary care physician and was referred to a urologist, who recommended a prostate ultrasound with biopsy procedure. The patient’s biopsy results came back positive for prostate cancer, which was found bilaterally with a Gleason score of 4+3=7.

The patient had heard positive comments about the Center for Prostate Care at Waukesha Memorial Hospital, so he called for a second opinion. The prostate care coordinator scheduled an appointment at the center with a urologist and a radiation oncologist. The prostate care coordinator would also meet with the patient. All records were obtained prior to the appointment so the medical team could review them. This multidisciplinary approach is very effective for the patient and the medical team, because it allows the patient to be seen at one visit with multiple doctors and with the care coordinator, who can provide education and emotional support.

A distress tool was administered to establish the patient’s current stress level and determine the need for education about coping skill development. The prostate care coordinator determined that the patient was coping well and had positive support mechanisms already established. Later that same week the patient’s case was discussed at the multidisciplinary GU cancer conference, providing the opportunity for multiple physicians to review the case and provide treatment recommendations.

The patient decided on CyberKnife® treatment for his prostate cancer and the prostate care coordinator scheduled him for fiducial placement. The procedure was performed in the center for Prostate Care with the urologist, radiation oncologist, and prostate care coordinator in attendance. A week later the patient had a CT scan and MRI scan, which would provide the imaging needed to develop a treatment plan for his CyberKnife treatment. A week later the patient began his treatment, which included five total treatments lasting approximately one hour each.

The patient tolerated the treatment well and has become a mentor to other men who are interested in choosing CyberKnife treatment for their prostate cancer. Through the entire process the patient was contacted by the prostate care coordinator at multiple intervals to answer any questions and to provide ongoing emotional support. The prostate care coordinator continued to provide ongoing follow-up with phone calls at six-months and one-year post-treatment.

Case 2

This 61-year-old patient was referred to the Center for Prostate Care by his urologist who scheduled a prostate ultrasound and biopsy procedure due to an elevated PSA level of 4.19. The patient’s biopsy result came back positive for prostate cancer, which was found, bilaterally with a Gleason score of 3+4=7.

The patient was then referred by his urologist to the Center for Prostate Care for consultation. The urologist and prostate care coordinator attended this consultation. At the start of the consult, the patient was administered the Distress Tool, which demonstrated a high level of anxiety and stress, level 8 on a scale of 0-10. The patient said that most of his stress was due to fear of the unknown and that he would have difficulty making a decision about a treatment option.

The prostate care coordinator then provided extensive education about prostate cancer and the different treatment options as well as emotional support to help reduce his anxiety level. The patient was also given educational materials, including pamphlets, stress management techniques, a healthy prostate cancer diet, details about the mentor program, and prostate cancer support group information.

The prostate care coordinator helped the patient complete the Decision-making Tool (pages 44-47) designed to help the patient choose a treatment option. It allowed the patient to place a weight value on the different pros and cons of each treatment by selecting a number between 0-10 for each. The tool demonstrated that the patient had a strong interest in robotic-assisted prostatectomy surgery. When the patient was again evaluated post-consultation, his stress level had been reduced to a level 2.

The patient was very interested in attending the prostate cancer support group, which was being held that same evening at Waukesha Memorial Hospital. He heard from others who had been through different types of treatment and how they coped, and also what had benefited them with their stress when they were diagnosed. The patient found the education and emotional support provided that day was beneficial and aided in making his treatment decision.

The prostate care coordinator scheduled the patient to see a radiation oncologist to further enhance his understanding of all his treatment options. After meeting with the urologist, radiation oncologist, and prostate care coordinator, the patient selected robotic-assisted prostatectomy surgery. The prostate care coordinator continued to follow up with the patient on an ongoing basis in the hospital and with follow-up phone calls. The patient continues to be an active member of the prostate cancer mentor program and support group.
Has Any of the Following Been a Recent Cause of Distress?

Please check all that apply:

**Practical**
- Housing
- Insurance
- Work and/or school
- Transportation
- Childcare
- Finances
- Care for another adult

**Emotional Concerns**
- Worry
- Fears
- Sadness
- Nervousness
- Adjusting to my illness
- Guilt
- Loss of interest in things

**Spiritual and Religious Concerns**
- Relating to God
- Loss of faith
- Death and dying
- Meaning of life
- Prayer life

**Physical Problems**
- Pain
- Nausea
- Fatigue
- Sleep
- Getting around
- Skin itch and/or rash
- Breathing
- Mouth sores
- Eating
- Constipation
- Diarrhea
- Changes in urination
- Fevers and/or chills
- Tingling in hands and/or feet
- Feeling swollen
- Sexual concerns
- Trouble remembering things

Information Needed

- About my diagnosis
- About my treatment
- About complementary therapies
- About diet
- About communication with my:
  - Partner
  - Children

How can we help you?

__________________________________________________________

__________________________________________________________

Name: ________________________________

Date: ________________________________

Please return this questionnaire to the nurse you see today. Completion is voluntary and confidential.

Circle the Number that Describes Your Level of Distress*

Extreme distress

No distress

*Distress Level—your level of anxiety, stress, sorrow, or suffering
The Center for Prostate Care Decision-making Tool

This survey is to help you sort through the prostate cancer treatments and to rate the pros and cons of each option. The treatment options that are surveyed consist of: 1) surgery; 2) external beam radiation; 3) internal radiation (brachytherapy/seed implants); 4) CyberKnife®; and 5) active surveillance.

Directions:
1. Please rate the four treatment concerns (curability, side effects, pain, and length of treatment) based on a scale of 1-10, with 1 meaning very low concern or importance and 10 meaning the highest concern or importance.
2. Rate each numbered statement again on a rating scale of 1-10, with 1 meaning very low concern or importance and 10 meaning the highest concern or importance. Write your number on the line provided.

Four Treatment Concerns
(Please rank on a scale from 1-10, with one meaning very low concern or importance and 10 meaning the highest concern or importance.)

1. Curability
2. Length of Treatment and Recovery
3. Side Effects
4. Pain

Surgery (Prostatectomy)

1. Surgery will allow the cancer to be accurately staged through pathological exam.
2. Urologist will have easy access to lymph nodes to evaluate them.
3. Robotic approach will allow for faster recovery (2-3 weeks) and stay (24-48 hours).
4. Long-term studies show slightly lower recurrence rates than X-beam at 15 years.
5. The PSA test can be used as an accurate predictor of whether the cancer has been completely removed or if it has returned.
6. Nerve-sparing technique can reduce impotence rates.
7. Surgery can cure prostate cancer, if cancer is localized.

PRO’s TOTAL

1. It is a major operation; the recovery period is 2-3 weeks (robotic) and 4-8 weeks (open).
2. Small risk of significant blood loss, so you may need blood transfusions during surgery.

In some cases, your rated number should be based upon percentages that are provided in the statement. For example, under the “Con” section of the “Surgery” treatment option, the statement related to cardio-pulmonary complications should take into account the low risk of blood clot formation (2.5%).

3. The treatment option that has the largest difference between the total “Pro” number and the total “Con” number is the option you may be leaning towards. If the difference is small, the validity of that choice may not be as positive as a larger differences. The table below demonstrates the validity of this test.

4. Validity of Decision Choice
   0-1 points Low
   6-10 points Moderate
   11 or greater High

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3. You may experience erectile dysfunction (impotence). Risk factor: 50-75 %.
4. You may experience loss of urinary control (incontinence). Risk factor 8-10% mild; 2-4% severe.
5. Small risk of cardio-pulmonary complications, such as blood clot formation. Risk factor: 2.5%
6. Can experience pain after surgery, but usually controlled with medication.
7. Urinary catheter will be in place post-surgery for 7 days.

CON’s TOTAL

PRO’s CON’s

RATIO _______/_______ = _______

Radiation Therapy (External Beam)

1. It is performed on an outpatient basis. After your clinic visit, you can go home.
2. No surgical risks (hospitalization, bleeding, pain).
3. Lower risk of impotence compared to surgery. Risk factor: 30-50%
4. Lower risk of incontinence compared to surgery. Risk factor: less than 5%
5. Low amount of restrictions on working and being active during course of treatment.
7. External beam radiation can cure prostate cancer, if cancer is localized.

PRO’s TOTAL

1. Long, rigid treatment schedule (6 weeks Monday-Friday).
2. Significant fatigue may occur, usually towards the end of treatment.
3. May experience frequent bowel movements, diarrhea.
4. Risk of impotence (30-50%).
5. Small risk of bladder damage: cystitis (inflammation of bladder; painful urination or blood in the urine), usually subsides after several months.
6. Common side effect is radiation proctitis: pain, bowel frequency, bowel urgency, and bleeding or rectal leakage. Usually disappears 3-6 months post-treatment. Occasionally, however, symptoms can become chronic in approximately 5% of men.
7. Fear that cancer is left in the body.

CON’s TOTAL

PRO’s CON’s

RATIO _______/_______ = _______

Radiation Therapy (Brachytherapy/Seed Implants)

1. The procedure takes less time than X-beam radiation and is done on an outpatient basis.
2. Incontinence rate is 2-5%.
3. Studies indicate that it is as effective as X-beam or surgery in the short term (12-15 years).
4. The procedure is relatively non-invasive.  
5. There is minimal effect on sexual dysfunction (20-30%).  
6. During recovery you will have minimal discomfort that may last a week or so.  
7. Lower chance of bowel irritation compared to X-beam radiation (20-30%).

**PRO's TOTAL**

<table>
<thead>
<tr>
<th>PRO's</th>
<th>CON's</th>
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1. Long-term studies past 12-15 years are not available (recurrence rates).  
2. It may cause urinary problems: urgency, frequency, burning, irritation, blood in urine, as high as 60%.  
3. It may cause rectal problems: pain, burning, frequency, urgency (20-30%).  
4. It may cause impotence. Risk factor: 20-30%.  
5. May need to provide safe distance between young children and pregnant women for first 2 months.  
6. After treatment, you are no longer a good candidate for surgery if you have a recurrence.  
7. Lymph nodes are not evaluated or treated.

**CON's TOTAL**

CyberKnife®

1. One of the most advanced forms of radiosurgery. A painless, non-invasive treatment that delivers high doses of precisely targeted radiation to destroy cancerous cells.  
2. Uses a robotic arm that has extreme flexibility to deliver highly focused beams at multiple angles to treat the cancer.  
3. Continually checks and compensates for any movements you make during treatment, ensuring accuracy.  
4. Eliminates surgery risks, including potential for infection, complication from anesthesia, and post-operative bleeding.  
5. Requires no recovery period. Treatments are done on an outpatient basis. Patients undergo their treatments and immediately resume normal activities.  
6. Patient receives 5 treatments for 1 week, compared to 30 treatments (6 weeks) with external beam radiation therapy.  
7. Initially has been shown to demonstrate low rates of incontinence (less than 5%).

**PRO's TOTAL**

<table>
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<tr>
<th>PRO's</th>
<th>CON's</th>
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1. There are no long-term studies and/or outcome data for prostate cancer treatment.  
2. The treatment will take 1 hour, compared to 20 minutes for external beam radiation.  
3. You will need to have a separate procedure performed (fiducial placement) prior to receiving CyberKnife treatment.  
4. You will need to use enemas and stool softeners prior to each CyberKnife treatment and will need to carefully watch your diet during treatment.  
5. You are usually no longer a candidate for surgery if cancer is not eliminated or returns.
6. Potential for urinary irritability symptoms such as urgency, frequency, or burning on urination (30-40%).

7. It may cause bowel irritation such as diarrhea, bowel urgency, and frequency (30-40%).

CON's TOTAL _______

PRO's CON's

RATIO _______/_____ = _______

---

Active Surveillance

1. Some science experts conclude that for some men with early localized cancer (tumor that has not spread outside of the prostate gland) studies show that no available treatment appears to extend life by a significant amount.

2. There are no immediate adverse effects. Cure-attempting treatment for prostate cancer can lead to incontinence and impotence.

3. For some men, the choice of watchful waiting means that prostate cancer will produce only minimal impact on their lives and their lifestyles.

4. Active surveillance is the least expensive treatment alternative in the short-term.

5. For those who select cure-delaying watchful waiting, it helps to know that treatment choices may be the same later—radical prostatectomy or radiation—as they would have been had they undergone therapy at the onset.

6. Active surveillance allows you to make a calm and rational treatment decision with your family and your doctor. Prostate cancer can be a very slow growing cancer.

7. In a few cases, a man chooses active surveillance in hopes that the near future will bring some new discovery that increases the chances of cure.

PRO's TOTAL _______

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1. The main trouble with active surveillance is that it gives the cancer a chance to grow and spread beyond the prostate.

2. With active surveillance, you’re essentially betting that you have some time before the cancer poses a threat.

3. PSA is not a predictor. Active surveillance involves watching for a rise in your PSA level. As your PSA level rises, so do the odds that the cancer has begun spreading outside the walls of the prostate. PSA levels only give an indirect idea of what is happening with the prostate cancer.

4. There are fewer options should the cancer spread beyond the prostate during the active surveillance period. Total cure is no longer an option.

5. If you’re the type of man who will feel terribly anxious about harboring a malignant, unpredictable, and potentially lethal disease in your body, active surveillance may lead to a high level of stress for both yourself and your loved ones.

6. Treatment that begins only after the cancer has spread can be more complicated and unlikely to result in cure. The cost—both financially and emotionally—can be high.

7. If you live longer than you expected, or if your cancer advances faster than you predicted, you might need to undergo more aggressive treatments or procedures.

CON's TOTAL _______

---

PRO's CON's

RATIO _______/_____ = _______
The Allegheny Prostate Center

Comprehensive evaluation and unbiased counseling on treatment options

by Russell Fuhrer, MD, and Ralph Miller, MD

In Brief

Allegheny General Hospital is a tertiary care teaching hospital in Pittsburgh, Pa., and the flagship of the nine-hospital West Penn Allegheny Health System. The Allegheny Prostate Center was the first and is the busiest organized multidisciplinary clinic in the health system and in the region. The Allegheny Prostate Center sees about 250 new analytic patients a year. At this unique multidisciplinary clinic, patients undergo a three to four hour evaluation and education process where they are evaluated by both a urologist and a radiation oncologist. A pathologist is also in attendance to review the patient slides. At the end of the examination, patients participate in a group discussion of all major treatment options. Here’s how this innovative program was started and how it is structured today.

Historically Allegheny General Hospital has been a leader in innovative approaches to the delivery of healthcare. In the early 1990s, researchers began investigating cryosurgery for the treatment of tumors. Jeffrey Cohen, MD, and Ralph Miller, Jr, MD, urologists at Allegheny General Hospital, saw the potential for adapting this technology to treat their prostate cancer patients. These physician leaders then developed and pioneered a program for the treatment of prostate cancer with cryosurgery. As the technology developed and was described in medical and popular literature, the number of patients seeking cryosurgery at Allegheny General Hospital soon increased rapidly. For a variety of reasons, however, many men who presented with the intent of undergoing cryosurgery were not candidates for this procedure and instead were sent to see a radiation oncologist.

It became obvious to both specialties that patients were presenting intent on cryosurgery but were not well informed about the myriad of other treatment options for prostate cancer. The urologists and radiation oncologists soon came to agree that the best way for patients to be fully informed about all the options for prostate cancer treatment was to talk with both specialties—ideally in a multidisciplinary clinic setting.

A Unique and Successful Partnership

The concept for the Allegheny Prostate Center was born in 1996. The idea was to have a multidisciplinary clinic, which was not modality or “sales” oriented, but rather provided patients with options for management of their disease. Educating patients about their disease, describing to patients the various treatment modalities, and allowing the urologist and radiation oncologist to discuss patient cases as part of a multidisciplinary team would create an environment that would foster effective and competent decision making.

In addition to the unique partnership that was developing between the urologists and the radiation oncologists, the multidisciplinary clinic allowed patients to be more involved and vocal in the decision-making processes. In an unexpected outcome, the Allegheny Prostate Center soon fostered an environment of “group therapy” for men with prostate cancer and their families. Patients were not only able to speak with providers about the objective aspects of their disease, but they also were able to talk with other men who were going through the same experience.

Our Model

The Allegheny Prostate Center is housed in Allegheny General Hospital’s Cancer Center and is staffed by two alternating urologists who are members of the same private group practice, Triangle Urology Group, and one hospital-employed radiation oncologist. Other hospital-employed staff includes a radiation oncology nurse, billers, and a secretary. A hospital-employed pathologist is always available to review pathology slides on the day of the consultation. Though rarely required, when appropriate, a medical oncologist and a staff psychologist are also available to consult with patients.

Patients who are seen at the Allegheny Prostate Center are referred by multiple sources. Many referrals are made through the private urology practice that helps staff the prostate center. Other patients are referred by the hospital’s radiation oncology department. Urologists and radiation oncologists outside of our healthcare system also refer patients to the Allegheny Prostate Center, generally for a specific treatment modality or for a second opinion. Still other patients are self-referred—either because they have heard about the program from other patients or because they found the program on the Internet.

The Allegheny Prostate Center sets aside two and one-half days per week for the multidisciplinary clinic. All patient visits are scheduled through the urology practice. Up to seven patients may be scheduled for 30 minute appointments within a four-hour period. Patients are encouraged to bring family members and are told to expect to spend the entire afternoon at the clinic.
The Clinic Visit

When an appointment is made, the urology practice sends a packet of information to the patient, including:

- A DVD and booklet about the Allegheny Prostate Center and the multidisciplinary clinic process.
- A list of what the patient needs to bring to the multidisciplinary clinic.
- A description of what to expect at the clinic visit. Emphasis is placed on the 3-4 hours of time the patient will spend at the Allegheny Prostate Center.

Basic information about prostate cancer and treatment modalities. Patients are also encouraged to go to the Allegheny Prostate Center’s website at: www.prostatecancercare.com.

A medical history and urologic history worksheet that must be completed by the patient and brought to the clinic visit.

Once patients are registered, the patient’s outside records are requested and copied, and the patient’s pathology slides are sent for internal review.

When they arrive at the Allegheny Prostate Center, patients are seen separately by the urologist and the radiation oncologist for full history and physical examinations. After all patients are seen and the pathology review is completed, patients go to a conference room. Here the urologist and the radiation oncologist provide an overview of the prostate cancer disease process and specific treatment modalities. Patients are then asked for permission to discuss their case with the group. If permission is given, the urologist and radiation oncologist will review individual cases and discuss treatment options with all patients and family members attending the clinic.

On the day of the visit, no decisions are made by the patient. And—because of the nature of this disease—only rarely is a patient encouraged to make a “quick” decision. Instead, patients are told to go home and think about the various treatment options and about where they would like to receive treatment—from their referring physicians or by physicians associated with the Allegheny Prostate Center.

At the end of the multidisciplinary conference, patients receive contact information for both the urologist and the radiation oncologist. Within one week of the clinic visit, a nurse at the urology practice follows up with patients by phone to discuss how they wish to proceed and to help with arrangements.

Our Treatment Options

The Allegheny Prostate Center offers a full range of treatment modalities. At the multidisciplinary meeting, the urologist and radiation oncologist discuss these treatment options:

- Surgery (both a standard prostatectomy and a da Vinci prostatectomy)
- Radioactive seed implants (brachytherapy)
- External beam radiotherapy (IMRT and IGRT)
- Cryosurgery
- Androgen deprivation to inhibit testosterone production (hormonal ablation therapy)
- Expectant management (a “watch and see” approach)
- A combination of these treatments.
Our treatment results with each of these modalities are shared with the patients and generally reflect our conservative approach to treatment.

While the Allegheny Prostate Center does not have written treatment guidelines, our urologists and radiation oncologists have developed general “agreements” about appropriate options related to patient age, performance status, PSA level and history, Gleason score, AUA score, SHIM potency index, prostate size, and other factors. Over the past nine years of working together, rarely do the urologist and radiation oncologist drastically disagree on treatment recommendations. When disagreements arise, we tell the patient the rationale for our disagreement and work with them to resolve the issue. Generally the two specialties are able to agree on and provide a few reasonable treatment options for patients to consider.

**Figure 1. Program Strengths and Weaknesses**

**Areas of Strength**
- Our ability to present options to patients without “pushing” or “favoring” any specific modality.
- Urologists and a radiation oncologist who philosophically agree on prostate cancer and its treatment.
- Our willingness to send patients back to their referring doctors for treatment.
- A low-stress patient environment.
- The quality and range of procedures that we can provide for patients.
- A consistent pathology review by one or two experienced pathologists.
- An environment that promotes patient interaction and participation.
- A budget that is entirely funded through community fundraising efforts of hospital staff and patients. Our fundraising efforts and our non-profit organization support our website (www.prostatecancercare.com), development of our educational materials, the purchase of equipment for use in the treatment of prostate cancer patients, and the sponsorship of patient education events for the community.

**Areas for Improvement**
- We would like to begin prospective and long-term outcomes data collection.
- We would like to implement a marketing plan for patients and referring physicians.
- We would like to collect qualitative and quantitative patient satisfaction data.
Changes in Treatment Patterns

The Allegheny Prostate Center has undergone significant changes in referral patterns over the years (see Figure 2). As stated previously, most patients were initially seen for cryosurgery, although many ultimately received other forms of treatment. When prostate brachytherapy was not widely utilized, the Allegheny Prostate Center began to see many patients interested in seed implants. As more community cancer centers began opening seed implant programs, those referrals decreased. Recently, the Allegheny Prostate Center initiated a robotic prostatectomy program and many patients are now drawn to the prostate center to specifically discuss this option. In other words, the Allegheny Prostate Center has observed that an increase in popularity of a certain procedure in the lay literature generally results in more patients coming to the prostate center intent on that procedure. After an in-depth discussion of the various treatment options, however, patients may or may not ultimately undergo the procedure that they initially thought they wanted. And even those patients who do stay with their initial preference are much better informed of the details and alternatives to whatever procedure they choose.

While the Allegheny Prostate Center was originally conceived to help manage patients who were being evaluated for a specific treatment modality, cryosurgery, the center has evolved into a clinic where patients come for an unbiased review and discussion of their disease and its potential impact on them, recommendations for treatment, and a general overview of prostate cancer. Our patients learn about all the different modalities that are available and specifically, which ones are appropriate to their care. Patients understand that there is rarely a singular treatment that would be “best” for them and that they have choices about their care. Our multidisciplinary team helps patients and families work through the complex decision-making process inherent in comprehensive prostate cancer treatment.

As a physician who has seen well over 1,000 prostate cancer patients in nine years at the Allegheny Prostate Center, I can attest to the fact that a horizontally integrated, multidisciplinary approach to a complex disease and decision-making process ensures that patients make informed and appropriate decisions. There is no better way of providing informed consent for patients. I believe that all patients would benefit from such a process, and I encourage physicians and community cancer centers to develop programs that would be appropriate to the needs of their patients.

Russell Fuhrer, MD, is system director of Clinical Services at Allegheny Hospital, Department of Radiation Oncology, and director of Radiation Oncology at the Allegheny Prostate Center, and Ralph Miller, MD, is director of the Allegheny Prostate Center, West Penn Allegheny Health System, Pittsburgh, Pa.
A Prostate and Genitourinary Multidisciplinary Oncology Clinic in a Multi-Hospital System

by Richard B. Reiling, MD, FACS

In Brief
At Presbyterian Cancer Center in Charlotte, N.C., we are seeing a higher incidence of prostate cancer as the population ages. The good news is that we are also seeing an increased public awareness—especially related to the need for screening and evaluation for men in the African-American community who are at greater risk for this disease.

Effective, mutually exclusive, and/or complementary treatment options currently exist for prostate cancer. So in one sense, our Prostate and Genitourinary Multidisciplinary Oncology Clinic functions similarly to a second-opinion clinic model in that newly diagnosed prostate cancer patients are given the opportunity to fully understand their disease and the treatment options so that they can make informed healthcare decisions. Our Prostate and Genitourinary Multidisciplinary Oncology Clinic also serves as a resource for men with complicated prostate cancers and for men who have completed initial treatment to discuss additional treatment options, including the benefits of clinical trials. Finally, the clinic can benefit patients in their palliative care course of progressive prostate cancer, providing them the same opportunity to discuss treatment options that affect quality of life.

Our physicians understand that the Prostate and Genitourinary Multidisciplinary Oncology Clinic is not just a service for men who are unsure about which therapy option to accept. The program serves a much-needed educational purpose for patients in their initial encounters with GU tumors, as well for patients who are experiencing recurrences. For example, our experience has been that many men come to the Prostate and Genitourinary Multidisciplinary Oncology Clinic without really understanding what their Gleason scores mean, what their surveillance PSAs are, and what they could be doing to improve their overall prognosis.

Presbyterian Cancer Center’s multidisciplinary oncology clinics—as currently structured—began in the mid-1990s. The multidisciplinary breast clinic was the first to be implemented. Observing the success of the breast clinic model, urologic and radiation oncologists recognized that such a multidisciplinary clinic approach could be beneficial for patients with prostate and other cancers. In 2001 Presbyterian Cancer Center initiated the Genitourinary (GU) Multidisciplinary Oncology Clinic.

We soon found that the majority of the patients we were seeing in the GU multidisciplinary clinic were prostate cancer patients. To reflect this, the clinic is now referred to as the Prostate and Genitourinary Multidisciplinary Oncology Clinic. Today this clinic is a practical option for our patients and their families and provides referring physicians an in-network option for a second opinion. Often patients migrate to the source of the second opinion for eventual treatment, providing additional opportunity to keep the patient in the healthcare system. This clinic sees about 80 new cases per year of which about 95 percent are prostate cancer patients, representing about 20 percent of the Cancer Center’s new prostate cancer patients.

Urologist Daniel L. Watson, MD, has been a driving force in the creation of Presbyterian Cancer Center’s Prostate and Genitourinary Multidisciplinary Oncology Clinic. In championing the program, Dr. Watson wanted to mirror a multidisciplinary prostate program that he had participated in at Dana-Farber Cancer Institute, which included medical oncologists, radiation oncologists, and urologists—an approach easily accomplished in an academic setting. Implementing the model in a community-based setting in which physicians are independent providers is challenging. However, Presbyterian Cancer Center had the model of its successful Multidisciplinary Breast Clinic to show that it could be done.

In the Prostate and Genitourinary Multidisciplinary Oncology Clinic, patients are seen by a team that includes a urologist, radiation oncologist, medical oncologist, dietitian, nurse navigator, social worker, and research staff (see Figure 1). A diagnostic radiologist and pathologist participate in the clinic’s discussion phase and are available if the patient or his family feels that speaking with these providers will help make a decision or alleviate anxiety about an image or diagnosis.

Patient referrals to the Prostate and Genitourinary Multidisciplinary Oncology Clinic come from the hospital’s network physicians, from urologists and medical oncologists outside of the network, and self-referrals. When Internet users find our unique program and are
eager to participate, we have received referrals from across the country and even from other countries.

Today, the Prostate and Genitourinary Multidisciplinary Oncology Clinic is overseen by the Prostate Advisory Board, which consists of providers and hospital administrators. The Board meets periodically to discuss all aspects of the program and reports to the medical staff-appointed Cancer Committee.

**How the Clinic Works**

Within one week of when a patient registers for the Prostate and Genitourinary Multidisciplinary Oncology Clinic, his appointment is generally scheduled. Clinic staff, an RN manager and an associate, receive the information in a designated hospital clinic area. All of the Cancer Center’s multidisciplinary oncologist clinics are coordinated and staffed at this location with occasional assistance from other personnel, especially our nurse navigators.

Clinic staff gathers and prepares all the information needed for the clinic visit, obtaining imaging and pathologic studies to provide to physicians in advance so that they may prepare for the conference. This information gathering and coordinating probably represents the most time consuming and sometimes frustrating aspect of the multidisciplinary oncology clinics. The nurse navigators specific to each clinic are of great assistance in this process, especially in talking with outside diagnostic imaging centers and with the prospective patient. On the day of the scheduled appointment, the patient arrives at the Prostate and Genitourinary Multidisciplinary Oncology Clinic one hour before the actual physician interviews and examinations. The clinic manager (along with the RN and the assistant) serves as the principal contact. During this time period, the patient undergoes an in-take by the nursing staff and is visited by other staff members (such as dietitian, research coordinator, physical therapist, social worker) as needed or requested. (See sample clinic visit schedule, page 56.)

Generally, three to four patients participate in the Prostate and Genitourinary Multidisciplinary Oncology Clinic in a half-day block. As a team, physicians discuss each case and then a physician from each specialty—urology, radiation oncology, and medical oncology—visits personally with the patient and his family. After every physician has seen the patient, the team reconvenes to determine the best course of treatment. Finally, one of the physicians returns to the patient to review the recommended plan and answer any questions (see Figure 2, page 55). At the conclusion of the Prostate and Genitourinary Multidisciplinary Oncology Clinic, a physician dictates a detailed report for the referring physician.

Effective communication between our Prostate and Genitourinary Multidisciplinary Oncology Clinic and referring physicians is critical to the success of the program. We are sensitive to the needs and perceptions of our referring physicians—particularly those outside of our network. For example, some patients participating in the Prostate and Genitourinary Multidisciplinary Oncology Clinic have asked our physicians to assume the role of care provider. Our physicians are careful to maintain a “separation” and continue to work with referring physicians so that referral patterns are not “broken” and there is no perception that our physicians are taking over patient care. In other words, even though the Prostate and Genitourinary Multidisciplinary Oncology Clinic is seen as a tremendous tool in the diagnosis and treatment of prostate cancer, it is only one part of the larger, compre-
We closely track and monitor physician performance in the Prostate and Genitourinary Multidisciplinary Oncology Clinic. The Cancer Center, although not a separate credentialing body of the hospital, monitors the following:

- Physician participation in cancer conferences
- Accuracy of staging
- Concurrence with national, evidence-based guidelines
- Accrual in clinical trials.

Our medical director oversees all aspects of care management, which includes, for the most part, the six competencies of the Accreditation Council of Graduate Medical Education, comprising knowledge as well as self-evaluation, system-based practice, and professionalism. Adherence to these competencies ensures our commitment to fulfilling our vision of providing remarkable patient care.

**Physician Buy-In**

One of the key elements to the success of a Prostate and Genitourinary Multidisciplinary Oncology Clinic at a community hospital is physician commitment. A physician champion(s) is a must. Providers participating in the multidisciplinary clinic must share and accept a common goal—better care of cancer patients without necessarily a financial incentive.

Often, the first step to establishing a Prostate and Genitourinary Multidisciplinary Oncology Clinic is to gather several specialists together to discuss the concept of such a clinic and its benefits to patients and staff. If this group of specialists is able to come to consensus and agree that a Prostate and Genitourinary Multidisciplinary Oncology Clinic is workable, the next step is to get buy-in from all the specialists involved. Altruism and professionalism from all participants is necessary to an effective and successful Prostate and Genitourinary Multidisciplinary Oncology Clinic.

One challenge can be physician reimbursement. Consider reimbursing the physicians participating in your Prostate and Genitourinary Multidisciplinary Oncology Clinic a set fee for every clinic they attend. This practice allows physicians to receive some compensation for their time away from their productive office practices. Keep in mind, however, that physicians participating in the multidisciplinary clinic cannot individually bill the patient for E&M (evaluation/management) services.

Another important component of buy-in is to secure every participating physician's commitment to make the Prostate and Genitourinary Multidisciplinary Oncology Clinic work. For physicians, this means committing to attend the multidisciplinary clinic on time and to never cancel without advanced notice. Surgeons, especially, must consider operating room time scheduling and the potential for delays on scheduled clinic days.

In establishing our Prostate and Genitourinary Multidisciplinary Oncology Clinic, Presbyterian Cancer Center was fortunate to be able to partner with one main urology group. Only a few surgeons at the practice specialized in oncology, so the rest of the group referred their prostate cancer patients to these specialists. A scenario in which every urologist, including those with low volumes of cancer patients, insisted on being a part of a Prostate and Genitourinary Multidisciplinary Oncology Clinic would be challenging. It is not as critical for participating radiation and medical oncologists to have the same type of specialty with regards to prostate cancer. However, radiation oncologists should be experienced in brachytherapy treatment—both catheter and seed placement.

**Institutional Support**

In addition to physician buy-in, commitment, and support, the Prostate and Genitourinary Multidisciplinary Oncology Clinic must have institutional support. This support includes a commitment to acquire highly trained staff and advanced technology. Usually a high-performing and successful multidisciplinary clinic will have access to:

- Dedicated nurse navigator(s)
- New technology, such as the da Vinci Surgical System, intensity-modulated radiation therapy (IMRT), and brachytherapy
- Clinical trials
- A molecular laboratory
- Genetic counseling
- Supportive resources, such as social workers and financial counselors.

Presbyterian Cancer Center provides all of these services as its Prostate and Genitourinary Multidisciplinary Oncology Clinic, as well as others services that complement our comprehensive cancer program, including palliative care and pain management, hospice, outreach facilities, and the Buddy Kemp Caring House—a dedicated psychosocial support program located off-campus in a pleasant residential setting (see Buddy Kemp Caring House Client Information Sheet, page 57).
Quality Indicators
Because multiple physicians from multiple specialties see every patient in our Prostate and Genitourinary Multidisciplinary Oncology Clinic, we have identified several quality indicators. For example, we review pathology (whether it is from an internal or external pathology department), especially in regard to the Gleason staging. Imaging studies are likewise reviewed.

Presbyterian Cancer Center has adopted NCCN guidelines, and our Prostate and Genitourinary Multidisciplinary Oncology Clinic uses these guidelines to monitor the care plans of our prostate patients. Deviations from NCCN guidelines are documented, along with the reason for the deviation. We monitor and evaluate other quality parameters, including:

- Pathologic margins at time of resection
- Long-term incidence of incontinency
- Evidence of long-term proctitis
- The number of patients who have the option to initially see both surgical and radiation oncologists.

It makes little sense to monitor a parameter that cannot be measured or one that is not in need of modification, or to not evaluate variations in the monitoring process. Accordingly, our medical director oversees and is able to substitute or add QA options to the Prostate and Genitourinary Multidisciplinary Oncology Clinic. In general, we have found that consistent performance is an excellent way to improve overall patient care.

Budget Considerations
At Presbyterian Cancer Center, one budget covers all of the multidisciplinary cancer clinics. We accept these clinics as “loss leaders,” although this corporate strategy may not be ideal or even possible for other community cancer centers. The issue of quality of services delivered is paramount; however, cancer programs cannot operate at a constant loss. In the long term, we have found that the down-stream revenue generated from our multidisciplinary clinics more than pays for their upfront costs. For example, every new patient into our healthcare system generates $15,000-20,000 of revenue (excluding any reimbursement to private physicians). If the patient chooses to receive radiation therapy, we also see a very satisfactory return on investment. Finally, do not overlook revenue related to diagnostic imaging and laboratory studies.

A common challenge faced by community cancer centers is that most data captured is inpatient data, while most oncology care is provided as an outpatient service. At Presbyterian Cancer Center, we use multiple resources to collect the following patient data: demographic, financial, cancer registry, and QA. Having these data on our multidisciplinary clinics readily available means that inventory, costs, outputs, and reimbursement is transparent to participating physicians.

As part of Novant Health, Presbyterian Cancer Center has a specific business planning process conducted in conjunction with the Finance Department and the Business Planning Department. In general terms, when any new program is being considered, our business planning process evaluates the following components:

- **Market share.** Is this an area for possible expansion?
- **Physician champion(s).**
- **The health system-wide view.** As part of a multi-hospital system, how will this program impact other programs? In other words, we attempt to ensure that there is a true addition to market share—not just shifting from one program to another
- **Vision.** Does the program complement the health system's vision?

Community Impact and Outreach
Presbyterian Cancer Center has annual community outreach goals, including educating the community about early detection and prevention of prostate cancer. Along with the American Cancer Society and other community groups, we partner to reach underserved and high-risk populations.

**Parish nursing.** We work with parish nurses at local churches to conduct health fairs, screenings, and educational programs. We offer a special training program to teach parish nurses about health education programs that are available through the hospital. When appropriate, we also work directly with pastors who have played an important role in helping spread the message of the importance of...
prostate education and screening and the services available in the community.

Community relations. We network with local businesses and organizations to provide information on cancer prevention and early detection through health screenings and health fairs in the local community.

Survivorship programs. We offer extensive support services for patients and their families regardless of where the patient received treatment for his or her cancer. Programs include support groups, such as a long-standing prostate cancer support group, individual and family counseling, case management, and rehabilitation and wellness.

Physician education. When developing our Prostate and Genitourinary Multidisciplinary Oncology Clinic, an important element was to ensure that all physicians in the Novant Health network are aware of the advantages of this integrated program. We educate network physicians about the Prostate and Genitourinary Multidisciplinary Oncology Clinic through presentations at departmental meetings, lunch-time office visits, brochures, emails, and by “word of mouth.” We also reach out to regional and referring physician practices with information about our Prostate and Genitourinary Multidisciplinary Oncology Clinic in a variety of ways including via brochures, personal letters, and occasional phone calls.

Lessons Learned and Future Directions
Creating a Prostate and Genitourinary Multidisciplinary Oncology Clinic in a community cancer center is an ongoing project and will not be perfected until the disease itself is under complete control. Presbyterian Cancer Center continues to strive for excellence both in quality and patient satisfaction. The program has learned from its own operations and adjusted accordingly to issues such as scheduling, location, support personnel resources, and costs. There is still much to be gained in the future with regard to reimbursement, especially for the multidisciplinary clinics, which are not readily recognized by Medicare and other payers.

Our future goal is to have the resources to provide multidisciplinary clinics or a similar multidisciplinary approach for all cancer patients. Currently time and resources do not permit us to fully realize this goal. It should be noted, however, that any patient who is sent to one of our multidisciplinary clinics is not refused—regardless of the individual’s ability to pay!

Richard B. Reiling, MD, FACS, is medical director of Presbyterian Cancer Center in Charlotte, N.C., and former president of the Association of Community Cancer Centers.

What Should I Expect During My Urology Clinic Appointment?

Before Your Appointment
Try to eat lunch before you come. You will be here approximately 3–4 hours and we want you to be comfortable while you are here. We also provide light refreshments for your convenience.

During Your Appointment
12:30 - 1:00 PM
A staff member will escort you from the waiting room to the clinic. We check your weight and bring you to your exam room. You will be in this room for the remainder of the appointment. We check your vital signs.

1:00 - 2:00 PM
Individual cancer care team members will see you, including:
- A nutritionist—to help with nutritional concerns related to cancer and cancer treatment
- A social worker—to offer information on support groups, and other counseling and practical concerns
- A urology nurse navigator—to help answer questions after you leave the clinic
- A clinic nurse—to prepare you for the clinic and organize your information for the team.

1:00 - 2:00 PM
During this time, your case is presented and discussed in our pre-conference with the multidisciplinary oncology clinic team. Your pathology and radiology tests are reviewed by our radiologist and pathologist, and a preliminary plan is discussed. You are also considered for eligibility in clinical trials and, if indicated, a member of our research staff may see you later during the appointment.

2:00 - 3:00 PM
The physicians will see you, including:
- A urologist—to talk about surgery and anti-hormonal drug treatments
- A medical oncologist—to talk about drug treatments, including chemotherapy
- A radiation oncologist—to talk about radiation therapy treatments.

3:30 - 4:00 PM
The multidisciplinary team meets for its post-conference to discuss your case and come up with its final recommendations. One of the three physicians will come back to your exam room to discuss the final recommendations and offer you another chance to ask questions. This physician will call your referring physician with our recommendations. A written report is also forwarded to your referring physician. If you are self-referred, please let this physician know to which physician you would like us to communicate our recommendations.

Please keep in mind, all times are approximate and may vary depending on the needs of the patients attending the clinic.
Buddy Kemp Caring House Information Sheet

Name: __________________________________________________________________________   DOB: ___________________________________________________________________________

Address: ______________________________________________________________________________________________________________

Email Address: ______________________________________________

Home Phone: ___________________________  Cell Phone: ___________________________   Work Phone: _____________________

May we leave a message for you if you are not at home?  □ YES  □ NO

Type of Cancer: _______________________________________________  Date of Diagnosis: ________________________________

Primary Care Physician: __________________________________________   Surgeon:  _________________________________________

Radiation Oncologist: _____________________________________________   Medical Oncologist:  _____________________________

Hospital that provides your care: ______________________________________________________________________________________

Marital Status:  __________________________________________   Name of Spouse or Significant Other:  _____________________

Names and ages of children: _________________________________________________________________________________________

Would you like to be able to have (more) children?  □ YES  □ NO

Employer:  _____________________________________________________   Occupation:  _________________________________________

How would you describe your personal support system?  ____________________________________________________________

________________________________________________________________________________________________________________________

________________________________________________________________________________________________________________________

The following are problems commonly experienced by patients and families dealing with a cancer diagnosis. Please check areas of concern for your or your family:

☐ Managing Emotions  ☐ Pain Management  ☐ Communicating with the Healthcare Team

☐ Loss of Faith  ☐ Sexuality or Fertility  ☐ Communicating with Family or Friends

☐ Problem Solving  ☐ Body Images  ☐ Communicating with Children

☐ Fatigue/Endurance  ☐ Work or School  ☐ Caregiving

☐ Insurance  ☐ Finances  ☐ Transportation

☐ Hospice/End of Life

Are you already discussing these issues with a social worker from Buddy Kemp Caring House?  □ YES  □ NO

May our social worker call you to discuss these issues?  □ YES  □ NO

On a scale of 1 to 10, with 10 being the highest, how depressed do you feel?   1 2 3 4 5 6 7 8 9 10
Does fatigue, depression, or pain interfere with your ability to perform your normal routine?  □ YES  □ NO

If yes, please describe: _________________________________________________________________________________________________

Are you having trouble sleeping?  □ YES  □ NO  Are you having suicidal thoughts?  □ YES  □ NO

Are you frequently tearful?  □ YES  □ NO  Are you presently in counseling?  □ YES  □ NO

Have you sought counseling or psychiatric services in the past?  □ YES  □ NO

List any antidepressants, anti-anxiety, or sleep aids you are currently using: ___________________________________________________________

________________________________________________________________________________________________________________________

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ACCC and Medscape Oncology Bring Community Perspective to Scientific Meeting Data

The Association of Community Cancer Centers and Medscape Oncology are launching a new online educational initiative that offers a community provider perspective about emerging data and treatment strategies presented at scientific meetings, such as those of the American Society of Clinical Oncology (ASCO) and the American Society of Hematology (ASH).

While much of the data coming out of large national meetings is important and relevant to cancer patients and providers, sometimes it is not clear how this information translates into practice in the community setting. With this in mind, ACCC and Medscape have teamed up to provide community-based oncologists, nurses, pharmacists, and others with perspectives from their colleagues in the field.

The first program is on multiple myeloma and looks at data presented at ASCO and the European Hematology Association meetings. In this online program, Ammar Hasan, PharmD, scientific director, MedscapeCME Oncology, spoke with two community oncologists, Leon Dragon, MD, medical director, Kellogg Cancer Care Center in Highland Park, Ill., and Amy Skorupa, MD, a hematologist/oncologist at Cancer Specialists of Tidewater, Virginia Beach, Va., about the impact that these data may have on the management of multiple myeloma in the community setting.

Details are available on ACCC’s website, www.accc-cancer.org, in the education section.

ACCC Welcomes its Newest Members

- Florida Hospital, Waterman Cancer Institute
  Tavares, Fla.
  Delegate Representative: David DeProspero
  Website: www.fbwat.org

- Martha Jefferson Hospital, Martha Jefferson Cancer Care Center
  Charlottesville, Va.
  Delegate Representative: Faye Satterly
  Website: www.marthajefferson.org

- Medical City Dallas Hospital
  Dallas, Tex.
  Delegate Representative: Mary Wylie
  Website: www.medicalcity.com

- Metropolitan Hospital, The Cancer Center at Metro Health Village
  Delegate Representative: Tara Visser
  Website: www.metrohealth.net

- OncoLogics, Inc.
  Lafayette, La.
  Delegate Representative: Nichole Forstall
  Website: www.oncologics.net

- Paoli Hospital/Main Line Health
  Paoli, Pa.
  Delegate Representative: Susan Zuk
  Website: www.mainlinehealth.org

- Southeastern Regional Medical Center, Gibson Cancer Center
  Delegate Representative: Pamela Ann Clark
  Website: www.srmc.org

- Spectrum Health, Spectrum Health Cancer Program
  Grand Rapids, Mich.
  Delegate Representative: Richard Funnell
  Website: www.spectrum-health.org

- Virginia Cancer Institute
  Richmond, Va.
  Delegate Representative: Thomas Gallo
  Website: www.vacancer.com

Oncology State Society Membership Conferences

- SEPTEMBER
  Michigan Society of Hematology and Oncology
  Sept. 25-26, 2009
  The Homestead Resort
  Glen Arbor, Mich.

- OCTOBER
  Tennessee Oncology Practice Society
  Oct. 9, 2009
  Nashville Marriott
  Nashville, Tenn.
Virginia Association of Hematologists and Oncologists
Oct. 9-10, 2009
Boar’s Head Inn
Charlottesville, Va.

Nevada Oncology Society
October 15, 2009
Peppermill
Reno, Nev.

Indiana Oncology Society
Oct. 16, 2009
The Westin Indianapolis
Indianapolis, Ind.

Minnesota Society of Clinical Oncology
Oct. 22, 2009
Minneapolis Marriott City Center
Minneapolis, Minn.

Iowa Oncology Society
Oct. 23, 2009
Sheraton West Des Moines
West Des Moines, Iowa

Pennsylvania Society of Oncology and Hematology
Oct. 30-31, 2009
The Hotel Hershey
Hershey, Pa.

Arizona Clinical Oncology Society
Oct. 31, 2009
Westin La Paloma
Tucson, Ariz.

• NOVEMBER
Missouri Cancer Coalition
Nov. 6, 2009
Hilton Garden Inn
Columbia, Mo.

Florida Society of Clinical Oncology
Nov. 6-7, 2009
Tampa Airport Marriott Hotel
Tampa, Fla.

Illinois Medical Oncology Society
Nov. 13, 2009
Hyatt Regency Woodfield
Schaumburg, Ill.

Hawaii Society of Clinical Oncology
Nov. 21, 2009
Waialae Country Club
Honolulu, Hawaii

Arizona Clinical Oncology Society
Oct. 31, 2009
Westin La Paloma
Tucson, Ariz.

Give Your Patients The Look & Feel of Home...

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How Does Your Management Measure Up?

by Ellen R. Kolender, RHIA, CTR

I n my more than 28 years in the record management field, I have seen a variety of management styles accompanied by varying degrees of success. As a manager, I continue to learn from my successes and my mistakes. I hope that sharing some of my experiences will help others facing similar situations.

Talking the Talk

Departmental communication can make or break work relationships. Communicating on a “need to know” basis can cause fragmentation within a department. It can be difficult to decide whom to share information with and how much to share. In my opinion, it is better to be honest and err on the side of sharing more rather than less. Including all employees affected by change in discussions before the change occurs leads to successful outcomes. When you allow employees to be a part of the change, they are more likely to respond positively when the implementation takes place. Excluding people can lead to resentment fueled by a lack of understanding.

One way to stay in touch with your employees is by meeting monthly with each direct report. Talking at a scheduled time each month enhances communication and makes employees feel their needs, work, and efforts are valued.

At Ease

Typically, manager and employee communication—whether professional or casual—occurs over the barrier of a desk. Communication with a boss seated behind a desk tends to send an authoritarian message. On the other hand, I have found having an employee sit to the side of my desk—a more casual seating arrangement—to be more effective. Being able to make direct eye contact and talk without a desk dividing our conversation is valuable and effective.

Take Time to Explain

Answers that sound “automatic” can be unnerving to me. A simple “no” without discussion may be appropriate when parenting a child, but in the office setting, employees appreciate an explanation for the “no.” While employees know the boss has the final say, understanding the reasons behind the decision can be helpful.

Communicate Honestly and Often

I believe that clarifying issues and talking honestly with employees allows effective working relationships to develop. Once I had to let an employee go and—unbelievably—the employee actually thanked me! The conversation did not come as a surprise, because we had been addressing the employee’s progress—or lack of progress—each month. We had established time frames for meeting standards, and we had discussed how not performing at the set standard was holding the department back. When we discussed the termination, I explained that while the present job was not working out, there were many other positions at which the employee could excel.

Stand By Your Staff

Embarrassing your employee in public (for example, at a committee meeting or a conference) is a good way to tear down a working relationship. Not only can this ruin your rapport with your direct report, it may also influence how others perceive the employee. In public situations, I believe managers should stand by their subordinates. If you do not agree with what your employee is saying, make it clear that you will meet with the employee to discuss the matter further and report to the group later.

Give Credit

Recognizing employees for work well done is essential for a manager and his or her department to succeed. Acknowledging employees’ work offers tangible benefits. First, it lets them know that their manager has recognized their work. It is also important for employee satisfaction. Acknowledgment can range from a simple verbal, “Thank you for your excellent work” to a written note of appreciation or an invitation to lunch.

Walking the Walk

Effective communication, a positive attitude, and frequent employee recognition are characteristics of successful managers. Remember, your attitude—whether positive or negative—is contagious and will travel through your department. Modeling behavior has always been the number one behavior preached to managers—and “walking the walk” does matter! If you are often late to work, dress unprofessionally, or project a negative attitude, you can expect the same behavior or worse from your staff. It may not be possible to be a “perfect” manager, but you can still strive for excellence and usually your staff will follow your lead.
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